Behavioral Health During the First Year of the COVID-19 Pandemic: An Update on Need and Access in Massachusetts 2020/2021

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INTRODUCTION

Although Massachusetts has long been a national leader in health care reform and the push toward universal health insurance coverage,[1, 2] gaps in access to health care have persisted in the Commonwealth. That is particularly true for behavioral health care (inclusive of mental health and substance use disorder services), where the delivery system is fragmented and difficult to navigate.[3] Over the past several years, the Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) has focused on identifying opportunities to reform the behavioral health care system in the Commonwealth. To inform this work, the Foundation has commissioned research to understand the need for behavioral health care services and the experiences in accessing those services, including through its 2018 Massachusetts Health Reform Survey (MHRS).[4, 5] The MHRS found that in early 2018, nearly one-quarter (23%) of Massachusetts adults ages 19 to 64 reported seeking behavioral health care for themselves or a family member over the past 12 months. Among those who sought care, more than half reported difficulty obtaining needed behavioral health care.[4]

This brief provides an updated snapshot of the need for behavioral health care and experiences accessing it in the Commonwealth as of 2020/2021, based on a new survey commissioned by the Foundation—the Massachusetts Health Survey (MHS). The MHS, which was fielded by NORC at the University of Chicago between December 2020 and March 2021, gathered information on the need for and access to mental health and/or substance use care (referred to in this report as behavioral health care) among Massachusetts adults ages 19 and older and their close relatives.[a] The survey gathered information on the experiences of Massachusetts adults during the past 12 months, which covers the period January 2020 through March 2021. Given the timing of the survey and its 12-month look-back period, the MHS collected information over roughly the first year of the COVID-19 pandemic. Linked to that timing, the MHS also included a series of questions focused explicitly on the link between the COVID-19 pandemic and the need for behavioral health care.

Rather than provide definitive estimates, the findings from the MHS raise issues and questions about the experiences with behavioral health care for Massachusetts adults and their close relatives; this is because the MHS estimates are subject to greater uncertainty than those in the MHRS. This uncertainty, which is addressed in the technical overview section, is a result of both design elements that made the survey feasible from a cost perspective *and* the unique and significant challenges of fielding a survey in the midst of the COVID-19 pandemic. The latter likely led to lower response rates and, thus, smaller sample sizes for the MHS than were originally anticipated. Had the survey response rates been in line with those initially anticipated, the MHS would have yielded a stronger assessment of behavioral health care needs and access to care within the Commonwealth.

The smaller than expected sample sizes also limit our ability to provide estimates for some of the subgroups that were of particular interest when the study was commissioned, including populations that are racially, ethnically, and socioeconomically marginalized. For this reason, throughout the report, we report findings based on race and ethnicity as "non-Hispanic White" and "race/ethnicity other than non-Hispanic White" and family income as "above 300% Federal Poverty Level (FPL)" and "at or below 300% FPL." For reference, in 2020, 300% FPL equates to income of $38,280 a year for an individual and $78,600 a year for a family of four.

These results provide important insights to consider with respect to the need for and experiences accessing behavioral health care services for individuals and their families and the impact of the COVID-19 pandemic on the need for behavioral health care. Massachusetts policymakers have worked for much of the last decade to improve the Commonwealth's behavioral health care system, and yet more work is needed to create a system that enables individuals to easily access the behavioral health care services they need. To that end, in spring 2019, the Executive Office of Health and Human Services (EOHHS) launched a series of listening sessions across the state to inform its understanding of the challenges and opportunities associated with accessing behavioral health care services and navigating the behavioral health care system. Based on the information gleaned through this process, and as part of its ongoing commitment to improve the behavioral health care system, in February

[a] The survey defined close relatives as including a spouse/domestic partner, girlfriend/boyfriend, child(ren)/stepchild(ren), and parents/in-laws.

2021, EOHHS announced a *Roadmap for Behavioral Health Reform*. The Roadmap is a multiyear initiative with the goal of expanding access to behavioral health treatment, making treatment more effective, and improving health equity in access to behavioral health care.

The findings from this study serve as a baseline for identifying issues, needs, and experiences to monitor and address as the state embarks on this effort to reform the behavioral health care system. It will be important to continue to track the need for behavioral health care in the state and the experiences of Massachusetts adults in accessing behavioral health care services over time as key policy and delivery system changes are implemented. While final sample sizes in this survey precluded researchers from analyzing differences in need and experiences seeking services across racial and ethnic subgroups, this must be a priority moving forward, particularly in light of prior research highlighting that culturally responsive behavioral health care for racially, ethnically, and linguistically marginalized communities can be difficult to find.[3]

KEY FINDINGS

- More than one in three (35%) Massachusetts adults ages 19 and over reported needing behavioral health care for themselves or a close relative over the past 12 months, which corresponds to roughly the first year of the COVID-19 pandemic given that the survey was fielded from December 2020 through March 2021.

- More than a quarter (27%) of Massachusetts adults reported a behavioral health care need for themselves over the past 12 months, with the level of need disproportionately high among younger adults ages 19-39 (50% reporting a need versus 17% for adults ages 40-64), among adults who identify as a race or ethnicity other than non-Hispanic White (39% reporting a need versus 22% for non-Hispanic White adults), and among adults with lower family incomes (39% reporting a need versus 20% for adults with higher income).

- Among the Massachusetts adults who reported needing behavioral health care over the past 12 months, 26% did not receive *any* behavioral health care, while 74% received at least some behavioral health care services.
  - Fewer than half (43%) of the Massachusetts adults who needed behavioral health care reported receiving behavioral health care services *and* always being able to obtain a behavioral health care appointment when care was needed.
  - More than half (57%) of the Massachusetts adults who needed behavioral health care either had difficulties getting appointments for care when needed *or* did not obtain any behavioral health care. Issues of affordability, accessibility, and stigma/confidentiality were all cited as barriers to obtaining needed behavioral health care services.
  - For Massachusetts adults who needed and obtained behavioral health care, the most common mode of behavioral health care was in-person visits (78% of adults), followed by audio-only telehealth visits (68%), and audio and video telehealth visits (68%). The availability of telehealth visits likely increased access for those concerned about seeking in-person care during the COVID-19 pandemic.

- The COVID-19 pandemic has compromised the health, economic, and/or social well-being of many Massachusetts adults. Most notably:
  - 49% of Massachusetts adults reported a reduction in work hours or loss of employment since the beginning of the COVID-19 pandemic in March 2020;
  - 10% of Massachusetts adults reported needing to move to a new place or having others move in with them because of the COVID-19 pandemic; and
  - 28% of Massachusetts adults reported consuming alcohol and/or cannabis more often since the COVID-19 pandemic began and 17% reported that their consumption of alcohol and/or cannabis had caused serious problems with their personal responsibilities at home, work, or school over the past 12 months.

- The trauma and stress caused by the COVID-19 pandemic has had a significant impact on behavioral health care needs in Massachusetts as 64% of the adults who reported a need for behavioral health care over the first year of the COVID-19 pandemic reported that their need was due to or exacerbated by the pandemic.

- Looking ahead, more than one in four (27%) Massachusetts adults expected to need behavioral health care over the next six months, roughly the same level of need as was reported over the past 12 months. However, almost one-fifth of the adults who expected to need behavioral health care in the future did not report needing behavioral health care over the past 12 months, suggesting a relatively large influx of people looking for services.

TECHNICAL OVERVIEW OF THE MASSACHUSETTS HEALTH SURVEY

Key methodological elements of the Massachusetts Health Survey (MHS) are reviewed here. More detailed information is provided in the companion Methodology Report.

The MHS collected information on community-based Massachusetts adults ages 19 and over. Adults residing in institutional settings such as inpatient mental health settings or residential substance use disorder treatment facilities are excluded from the sample as gathering information on that population requires a different type of survey. The MHS used a blended sample that combined two probability samples and a nonprobability sample (i.e., a convenience sample). The latter was used as a relatively low-cost approach to expand the overall sample size for the study and to increase the sample sizes for hard-to-reach populations, including racially, ethnically, and socioeconomically marginalized adults. The probability samples for the MHS were drawn from the Massachusetts component of NORC's AmeriSpeak panel, a national probability-based panel that is designed to be representative of the U.S. household population, and a supplemental address-based sample (ABS) of Massachusetts households. The AmeriSpeak panel was used as the foundation for the MHS probability sample because the survey costs associated with sampling from the panel were substantially lower than the costs for a new ABS sample. The supplemental ABS sample was included to increase the size of the probability sample underlying the MHS beyond the sample size for Massachusetts available from AmeriSpeak.

The response rates were 6.5% for the AmeriSpeak sample[b] and 1% for the supplemental ABS sample. The lower-than-expected response rate on the latter may have stemmed from the challenges of conducting the survey during the COVID-19 pandemic and amidst mail-delivery issues confronting the U.S. Postal Service. Since the probability of a member being selected for the nonprobability sample cannot be calculated, there is no response rate defined for that sample. Surveys with low response rates and surveys that utilize nonprobability samples carry more risks and potential errors than surveys with higher response rates and surveys that only rely on probability samples. Potential sources of bias, including nonresponse bias, are only partly mitigated through the survey weighting.

The final sample size for the MHS was 1,719 adults, with 307 from AmeriSpeak, 126 from the supplemental ABS, and 1,286 from the nonprobability sample. The overall MHS sample was weighted to reflect the probability of selection into the survey and includes post-stratification adjustments to reflect the characteristics of community-based Massachusetts adults ages 19 and older. All estimates reported here are weighted. Because of the uncertainty associated with the MHS estimates, we do not report out detailed estimates for subgroups that had a weighted sample size of less than 200. This limits our ability to provide estimates for some subgroups of particular interest, including, as noted above, some populations that are racially, ethnically, and socioeconomically marginalized.

[b] The response rate for the AmeriSpeak sample incorporates the survey completion rate for the MHS sample as well as the response rates for panel recruitment and panel participation in the AmeriSpeak panel.

In making comparisons across subgroups, tests of differences with p-values less than .05 are judged to be statistically significant. However, because of the extra uncertainty introduced by using a nonprobability sample in the MHS, we use a more conservative z-score of 2.11 rather than the standard of 1.96 in assessing significance (see the Methodology Report for details on the blending of the probability and non-probability samples and the assessment of statistical significance).

Reporting Behavioral Health Needs in Surveys

The MHS, like all surveys, relies on self-reported responses, including self-reported responses about overall health and mental health status and the need for and experiences obtaining behavioral health care. Because of the sensitivity and continued stigma associated with mental health and, particularly, substance use, it is likely that the MHS underestimates the true scope of behavioral health care needs in the Commonwealth. Moreover, because the sample is limited to adults living in the community, it does not include those adults with behavioral health care needs who were in institutional settings, such as inpatient mental health settings or residential substance use disorder treatment facilities, at the time of the survey. Therefore, the findings should not be interpreted as capturing the behavioral health care needs and care-seeking experiences of all Massachusetts adults.

The information collected on close relatives of the respondent are subject to these same limitations and their behavioral health care needs are likely to be further underestimated since this data collection relies on the respondent's knowledge of the need for behavioral health care among their close relatives. There may also be additional stigma associated with reporting behavioral health care needs for children that further limit the accuracy of reported need for children. On the whole, we have more confidence in the reported levels of need for the adults themselves, who are reporting on their own need, than for the reported need among their close relatives.

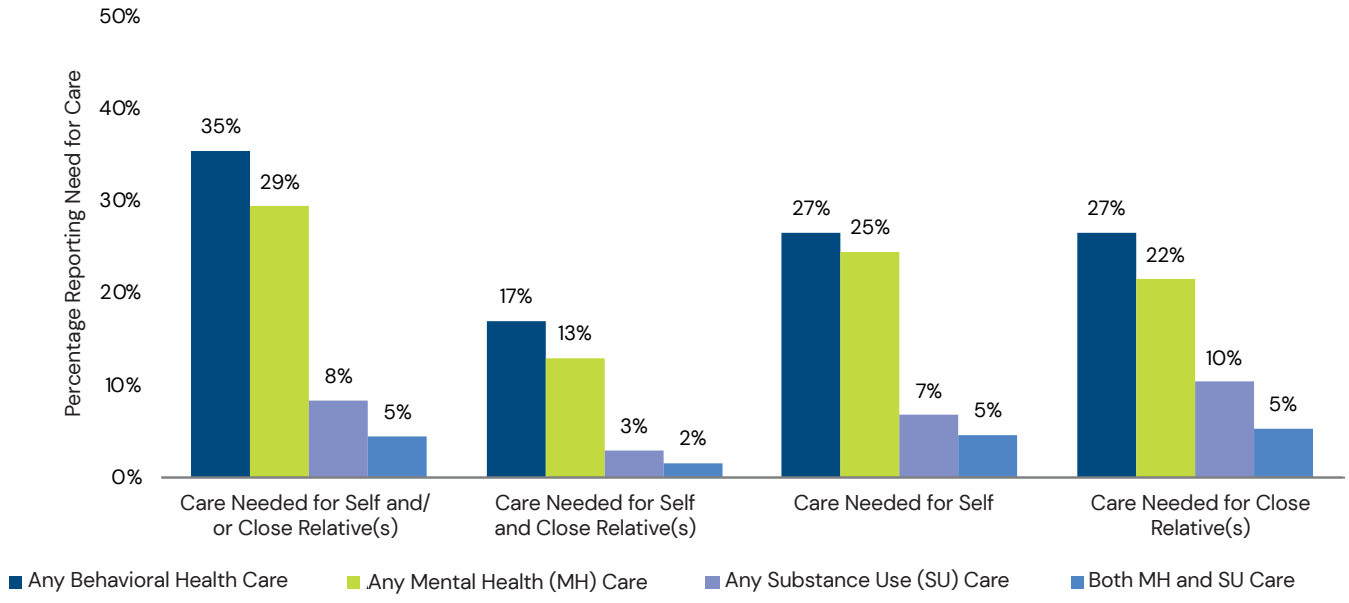
FINDINGS

What Is the Need for Behavioral Health Care Among Massachusetts Adults and Their Close Relatives?

More than one in three Massachusetts adults (35%) reported needing behavioral health care for themselves or a close relative over the past 12 months (Exhibit 1), which corresponds to roughly the first year of the COVID-19 pandemic given that the survey was fielded from December 2020 through March 2021. That includes 27% who reported a behavioral health need for themselves and 27% who reported a behavioral health need for a close relative. Altogether, 17% of the adults reported a need for behavioral health care for themselves *and* a close relative. Thus, much of the reported need for behavioral health care appears to be concentrated among one-sixth of Massachusetts adults and their close relatives.

Among both Massachusetts adults and their close relatives, the reported need for mental health care was much greater than the reported need for substance use disorder care—over three times as high for the adults themselves (25% versus 7%) and over twice as high for their close relatives (22% versus 10%). However, as noted above, it is likely that the need for behavioral health care overall and, in particular, the need for substance use care, is underreported.

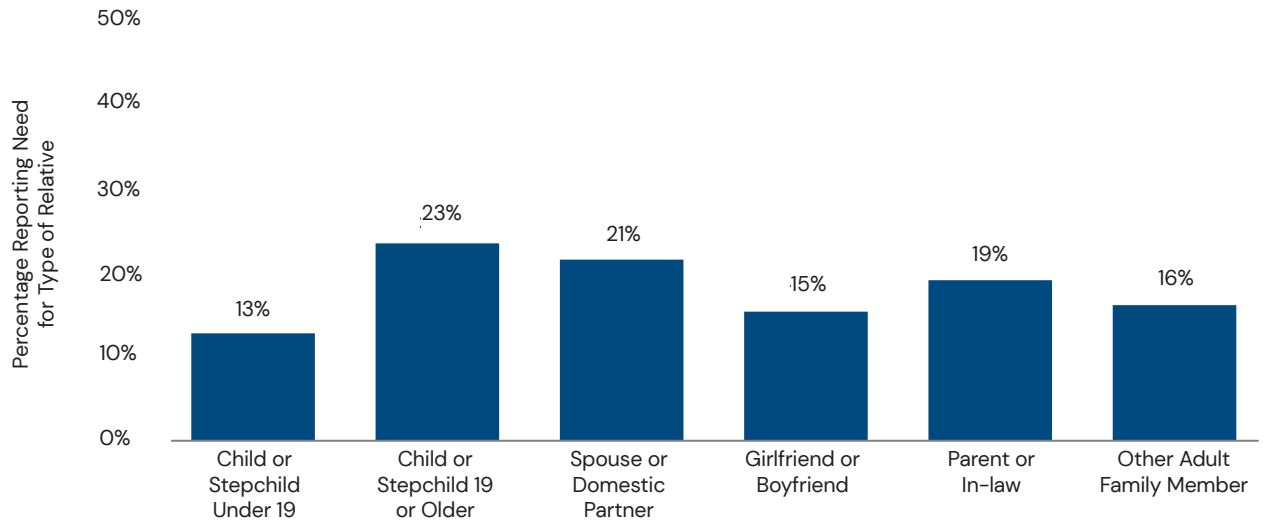
Exhibit 1. Massachusetts Adults Who Reported a Need for Behavioral Health Care for Themselves and/or Close Relatives Over the Past 12 Months



Notes: Sample is all Massachusetts adults (n=1,719).

The close family members with a reported need for behavioral health care over the past 12 months included adults and children across all age groups (Exhibit 2). Among the Massachusetts adults who reported having one or more close relatives who needed behavioral health care in the past 12 months, it was most common for those relatives to include adults, including adult children or stepchildren (reported by 23% of adults), spouses or domestic partners (reported by 21%), and parents or in-laws (reported by 19%). However, more than 1 in 10 of the adults reported that a close relative who needed care included a child or stepchild under age 19. The children/stepchildren who needed care were of all ages, including infants,[c] toddlers, preschoolers, grade-schoolers, and teenagers (data not shown).

Exhibit 2. Types of Close Relatives Who Needed Behavioral Health Care Among Massachusetts Adults Who Reported a Need for Behavioral Health Care for a Close Relative Over the Past 12 Months



Notes: Sample is Massachusetts adults who reported that at least one close relative needed behavioral health care over the past 12 months (n=456). Nine respondents did not report the relationship for the close relative(s) who needed behavioral health care and so are excluded from this exhibit.

[c] While behavioral health needs can arise at any age, behavioral health needs at birth will be affected by the mother's physical and mental health during pregnancy, including any substance misuse (e.g., binge drinking, illicit substance use, or misuse of prescription drugs).

[d] As noted in the technical overview section, due to the smaller sample size and the demographic composition of the Commonwealth's population, we could report out only on higher-level racial/ethnic subgroups used in the MHRS as well (i.e., "non-Hispanic White" and "other than non-Hispanic White").

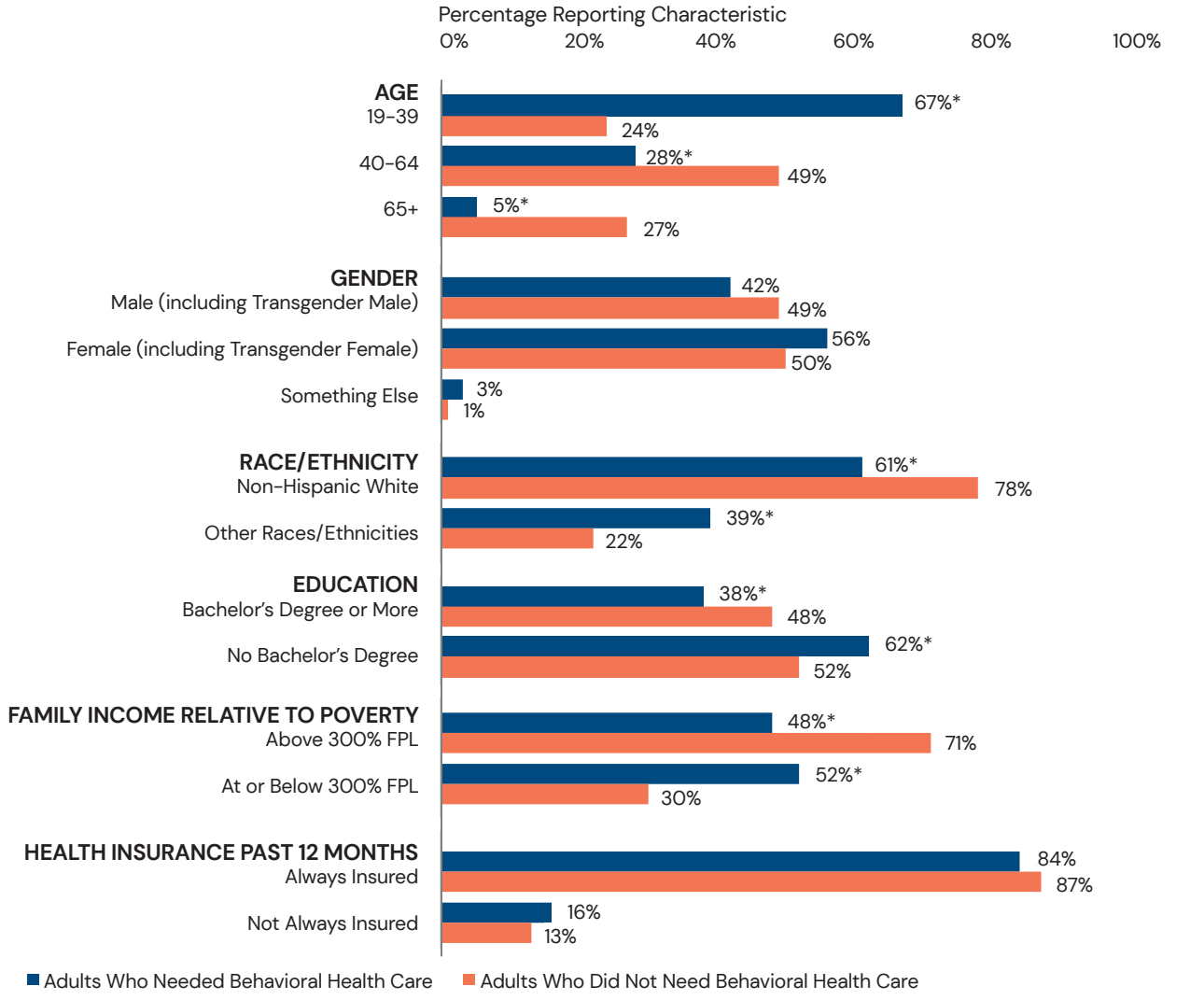
[e] As MHS respondents were asked to rate their overall health and their overall mental health as excellent, very good, good, fair, or poor, these data are subjective assessments (as with any standard self-reported measure of health status).

Who Are the Massachusetts Adults Who Need Behavioral Health Care?

Massachusetts adults who reported a need for behavioral health care for themselves during the first year of the COVID-19 pandemic crossed all demographic, socioeconomic, and health subgroups (Exhibits 3 and 4). However, relative to Massachusetts adults who did not report a need for behavioral health care over the past 12 months, the adults who reported a need for behavioral health care were significantly more likely to be younger (ages 19-39) and to identify as a race or ethnicity other than non-Hispanic White[d] (Exhibit 3). They were also significantly more likely to have less than a college education and lower family incomes.

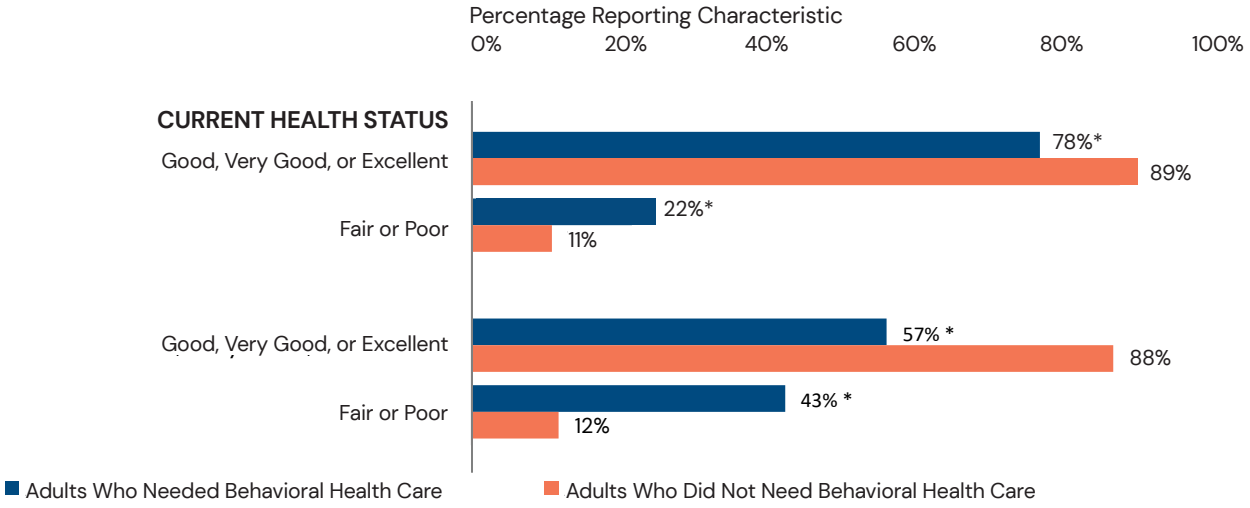
The Massachusetts adults who reported needing behavioral health care were also significantly more likely to report their overall health and mental health status as fair or poor (Exhibit 4).[e] It is important to note that these health measures reflect the adult's self-reported health and mental health status at the time of the survey, which may differ from their perceived health status at the time of their behavioral health need. Further, although likely correlated with clinical health status, self-reported health status and mental health status should not be interpreted as measuring actual clinical health; obtaining information on health conditions and mental health conditions requires a more complicated set of questions than was feasible for this survey.

*Exhibit 3. **Demographic and Socioeconomic Characteristics of Massachusetts Adults by Whether They Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months***



Notes: Samples are Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458) and those who did not report needing behavioral health care over the past 12 months (n=1,261). Categories may not sum to 100% due to rounding. * Indicates estimate for adults who reported needing behavioral health care is significantly different from estimate for adults who did not report needing behavioral health care at the .05 level, two-tailed test.

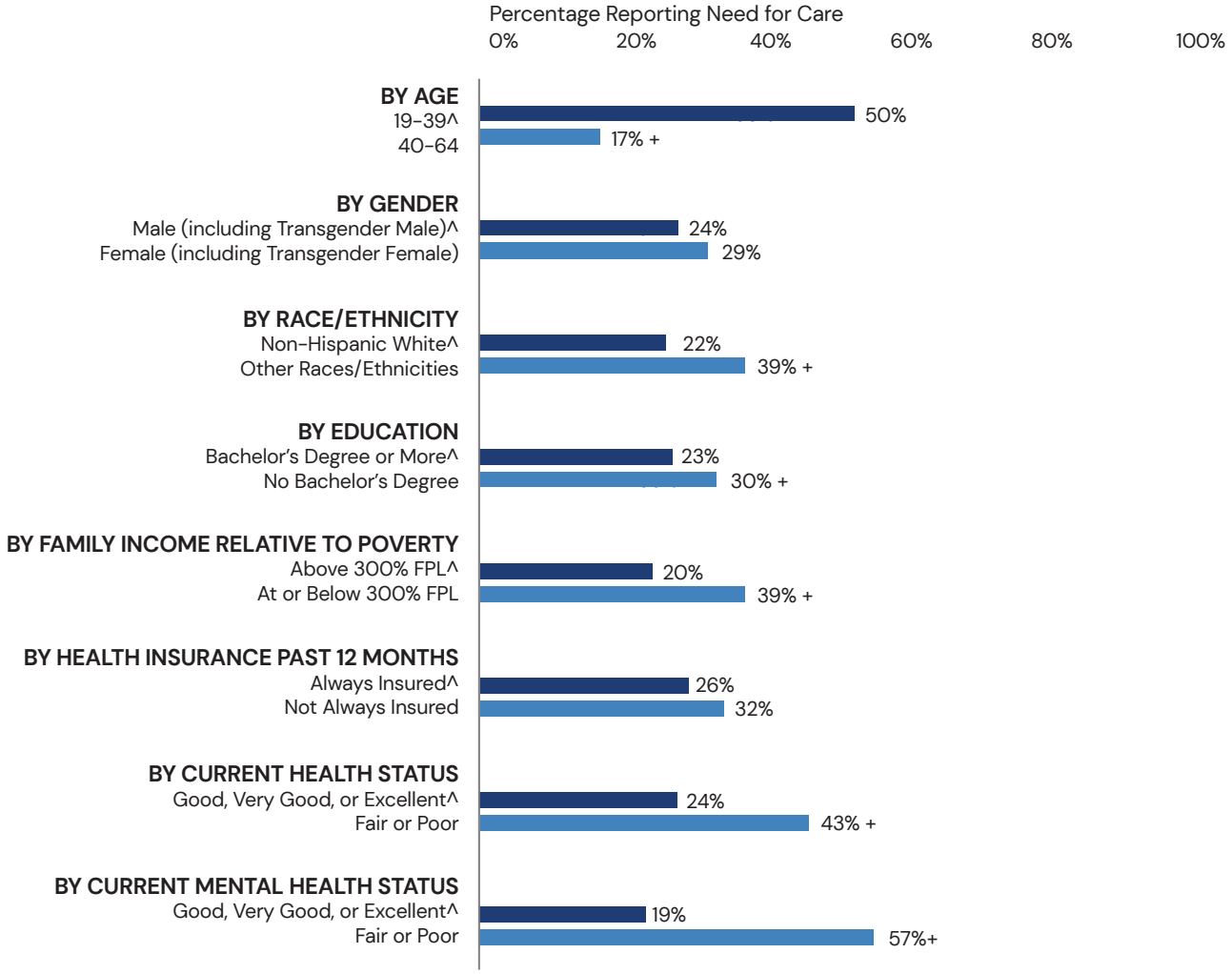
Exhibit 4. Health Characteristics of Massachusetts Adults by Whether They Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months



Notes: Samples are Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458) and those who did not report needing behavioral health care over the past 12 months (n=1,261). Categories may not sum to 100% due to rounding. * Indicates estimate for adults who reported needing behavioral health care is significantly different from estimate for adults who did not report needing behavioral health care at the .05 level, two-tailed test.

The level of reported need for behavioral health care was disproportionately high among certain subgroups of Massachusetts adults, including those who are racially, ethnically, or socioeconomically marginalized (Exhibit 5). For example, reported need for behavioral health care was significantly higher among younger adults ages 19-39 (50% reporting a need versus 17% for adults ages 40-64), among adults who identify as a race or ethnicity other than non-Hispanic White (39% reporting a need versus 22% for non-Hispanic White adults), and adults with lower family incomes (39% reporting a need versus 20% for adults with higher income). Moreover, Massachusetts adults who reported being in fair or poor overall health at the time of the survey or fair or poor mental health at the time of the survey were significantly more likely to report a need for behavioral health care than their counterparts in good, very good, or excellent health (43% versus 24% for overall health status and 57% versus 19% for mental health status, respectively). Notwithstanding the greater need among some subgroups, it is noteworthy that reported need was also relatively high— between 17% and 24%—across the remaining subgroups, including older adults (ages 40-64), non-Hispanic White adults, adults with a college education, higher-income adults, and adults who reported being in good, very good, or excellent overall health or mental health.

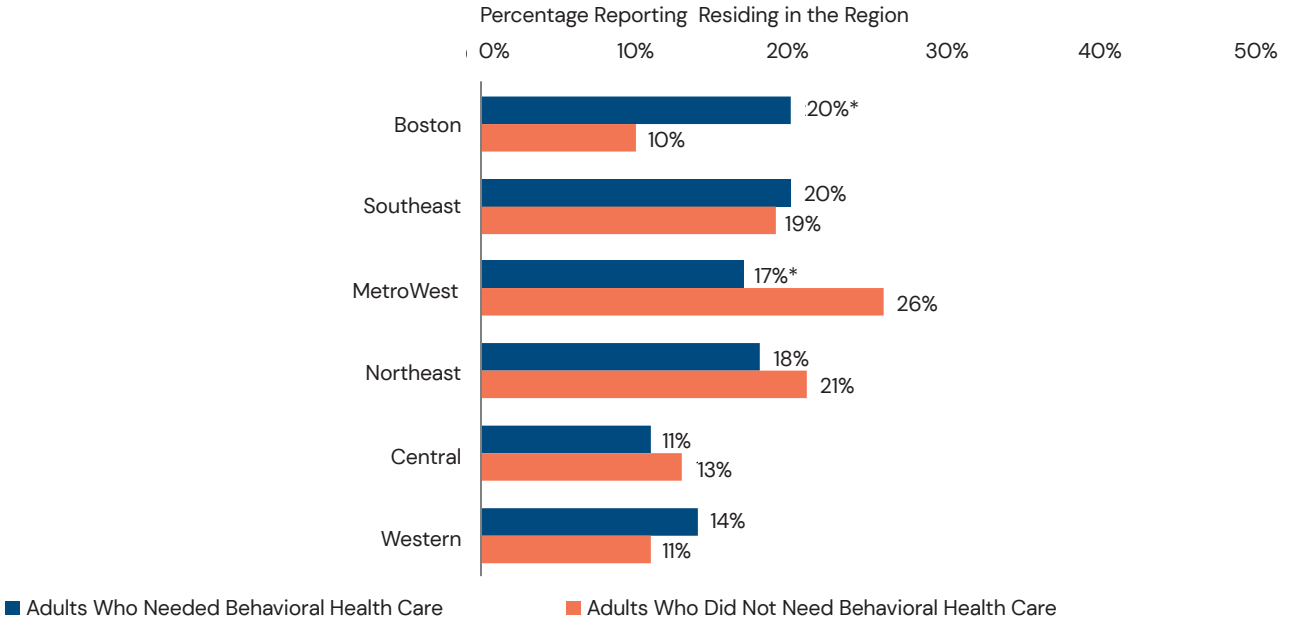
Exhibit 5. Massachusetts Adults Who Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months Within Each Demographic, Socioeconomic, and Health Subgroup



Notes: Samples are Massachusetts adults who reported needing behavioral health care in the past 12 months within each subgroup (e.g., adults ages 19-39, adults ages 40-64, etc.). The smallest sample sizes were for adults who were not always insured all year (n=233), adults with fair or poor overall health status (n=236) and adults with fair or poor mental health status (n=236); the average sample size was 828. Data for adults who reported their gender as "something else" and those who are 65 or older are not reported here because of small sample sizes. + Indicates a significant difference in the percentage of adults reporting a need for behavioral health care relative to the base category (indicated by ^) at the .05 level, two-tailed test.

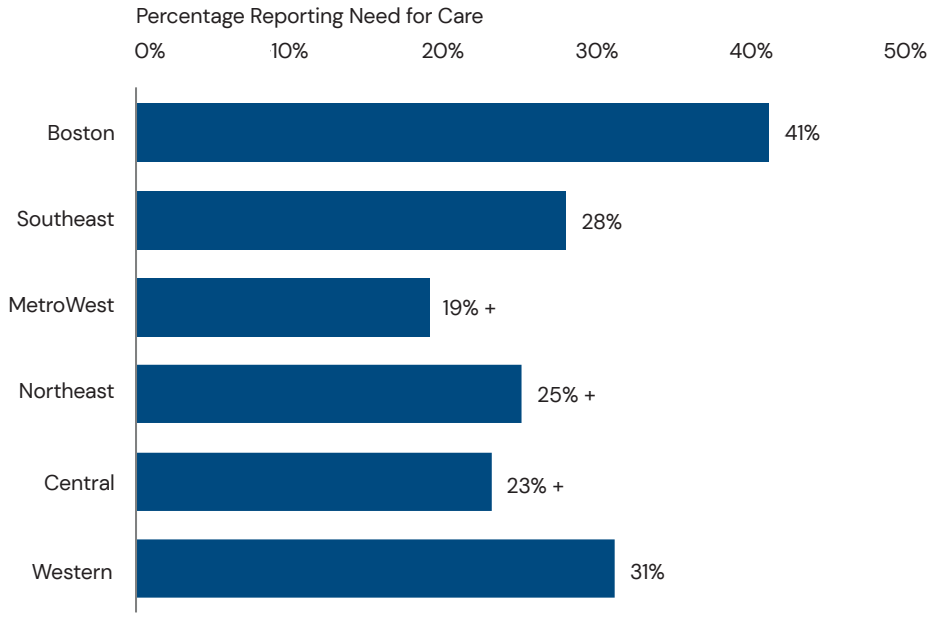
Massachusetts adults across all regions of the Commonwealth reported needing behavioral health care over the past 12 months (Exhibits 6 and 7). However, the Massachusetts adults who reported a need for behavioral health care were significantly more likely to reside in the Boston region (20% versus 10% for adults who did not need behavioral health care) and significantly less likely to reside in the MetroWest region (17% versus 26% for adults who did not need behavioral health care) (Exhibit 6). This disproportionate need for behavioral health care among adults in some areas of the Commonwealth is illustrated further in Exhibit 7. As shown, the share of adults reporting a need for behavioral health care was 41% in the Boston region, which was the region with the highest reported need in Massachusetts, as compared to 19% in the MetroWest region, which was the region with the lowest reported need in Massachusetts. Relative to the Boston region, the level of reported need was significantly lower in the MetroWest, Northeast, and Central regions.

Exhibit 6. Region of Residence of Massachusetts Adults by Whether They Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months



Notes: Samples are Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458) and those who did not report needing behavioral health care over the past 12 months (n=1,261). One respondent did not provide information on their county of residence and so is excluded from this exhibit. * Indicates estimate for adults who reported needing behavioral health care is significantly different from estimate for adults who did not report needing behavioral health care at the .05 level, two-tailed test.

Exhibit 7. *Massachusetts Adults Who Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months Within Each Region of Residence*

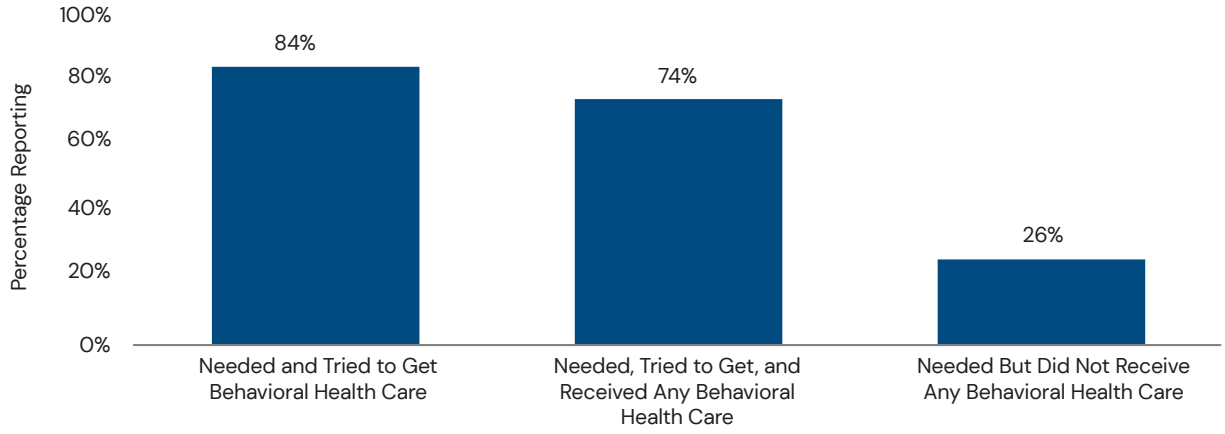


Notes: Samples are Massachusetts adults who reported needing behavioral health care over the last 12 months in each region. Sample sizes ranged from 208 (Western) to 401 (MetroWest). One respondent did not provide information on their county of residence and so is excluded from this exhibit. + Indicates a significant difference in the percentage of adults reporting a need for behavioral health care relative to the Boston region at the .05 level, two-tailed test.

Are the Massachusetts Adults Who Need Behavioral Health Care Getting Care?

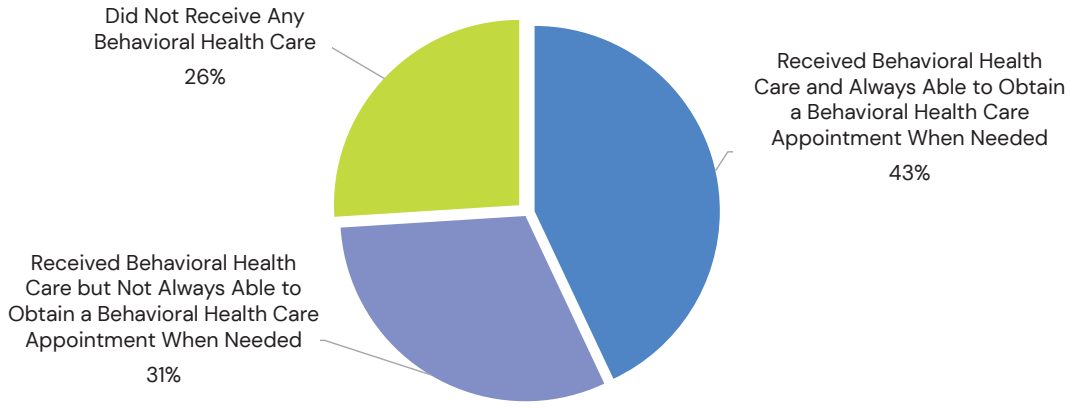
Not all Massachusetts adults who needed behavioral health care tried to get care and, among those who tried to get care, not all were able to get care during the first year of the COVID-19 pandemic (Exhibits 8 and 9). Among the Massachusetts adults who reported needing behavioral health care for themselves over the past 12 months, 84% reported that they tried to get care, and 74% reported receiving at least some behavioral health care services (Exhibit 8). Thus, 26% of adults who reported needing behavioral health care did not receive *any* behavioral health care services over the past 12 months. As shown in Exhibit 9, more than half of Massachusetts adults who needed behavioral health care either did not receive any services *or* had difficulties getting appointments for care when needed. Fewer than half (43%) of the adults who needed behavioral health care reported receiving behavioral health care services and always being able to obtain a behavioral health care appointment when care was needed.

Exhibit 8. Massachusetts Adults Who Reported Trying to Get and Receiving Any Behavioral Health Care Services Among the Adults Who Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months



Notes: Sample is Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458).

Exhibit 9. Massachusetts Adults Who Reported Receiving Any Behavioral Health Care Services Among the Adults Who Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months

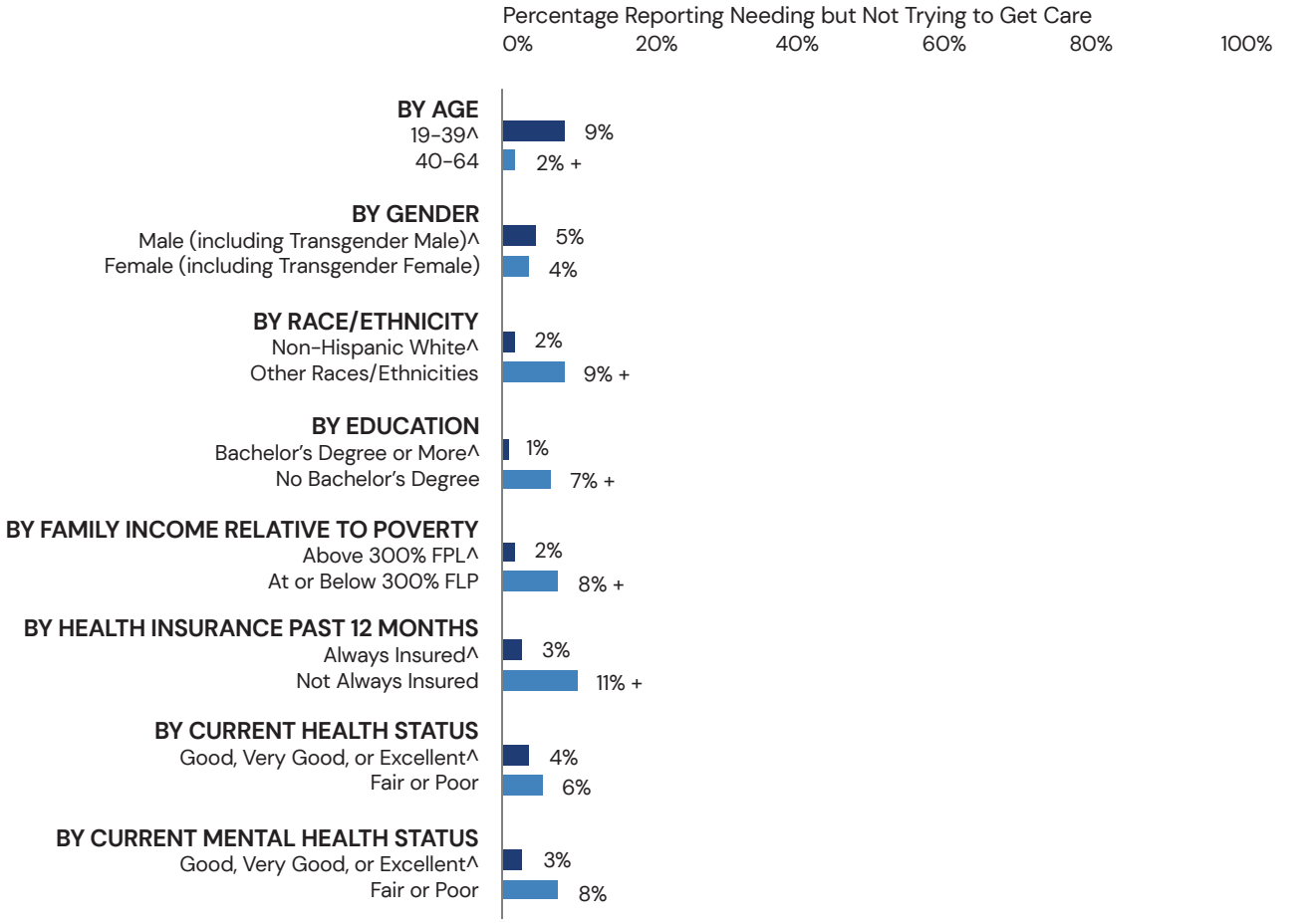


Notes: Sample is Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458).

While at least some behavioral health care services were available to most of the Massachusetts adults who tried to get behavioral health care over the past 12 months, 16% of those who needed care did not try to get care (data not shown). The majority of the Massachusetts adults who did not try to get behavioral health care cited affordability/cost issues, confidentiality/stigma issues, and/or accessibility issues as their reasons for not trying to get care (data not shown given small sample size, n=73), suggesting a broad array of barriers to behavioral health care for some.[f] Among the adults who tried to get behavioral health care but were not able to get behavioral health care services, the majority cited affordability/cost issues and accessibility issues (data not shown given small sample size, n=45).

There are significant differences in the share of Massachusetts adults who reported needing but not trying to get behavioral health care over the past 12 months across demographic, socioeconomic, and health subgroups (Exhibit 10). The Massachusetts adults who were most likely to report needing but not trying to get behavioral health care tended to be younger (ages 19-39) and racially, ethnically, or socioeconomically marginalized. In particular, 11% of the adults who were not insured all year reported needing but not trying to get behavioral health care, compared to 3% of the adults who were insured all year. While that difference is not necessarily due to the lack of health insurance coverage, it does reinforce the importance of ensuring outreach and support for those without stable health insurance coverage who need behavioral health care.

Exhibit 10. Massachusetts Adults Who Reported Needing But Not Trying to Get Behavioral Health Care Services for Themselves Over the Past 12 Months Within Each Demographic, Socioeconomic, and Health Subgroup



Notes: Samples are Massachusetts adults who reported needing but not trying to get behavioral health care over the past 12 months within each subgroup. The smallest sample sizes were for adults who were not always insured all year (n=233), adults with fair or poor health status (n=236), and adults with fair or poor mental health status (n=236); the average sample size was 828. Data for adults who reported their gender as "something else" and those who are 65 or older are not reported here because of small sample sizes. + Indicates a significant difference in the percentage of adults reporting needing but not trying to get behavioral health care relative to the base category (indicated by ^) at the .05 level, two-tailed test.

[f] Accessibility issues include not knowing how to find a provider, not having sufficient phone/internet access, and not having time to obtain care (e.g., due to a job, childcare needs). Affordability/cost issues include care not covered by insurance, insurance not paying enough of the costs, not having insurance, and could not afford. Confidentiality/stigma issues include not having enough privacy for telehealth visits, not wanting others to find out, and concerns about confidentiality of care.

Most of the Massachusetts adults who reported trying to get behavioral health care over the past 12 months relied on existing relationships with providers when searching for a behavioral health care provider, suggesting strong ties to the health care system as a starting point for seeking care (Exhibit 11). Nearly half (47%) of the Massachusetts adults who tried to get care contacted a mental health provider with whom they had an existing relationship when searching for a provider[g] and 27% sought a referral from another provider (e.g., their primary care provider). Consistent with that pattern, nearly all the adults who tried to get behavioral health care relied on a doctor's office or community health center as their usual place of care (84%; data not shown). Less common strategies for searching for a behavioral health provider included seeking a referral from other sources (e.g., an employee assistance program), seeking a recommendation from friends and family, reviewing a list of providers in their health insurance plan's network, and searching for a provider online.

The survey does not allow us to look separately at the experiences of those who had prior behavioral health care needs and those who were new to needing behavioral health care. For those who were new to needing or seeking behavioral health care, they would not, by definition, have had the option of contacting a mental health provider with whom they had an existing relationship.

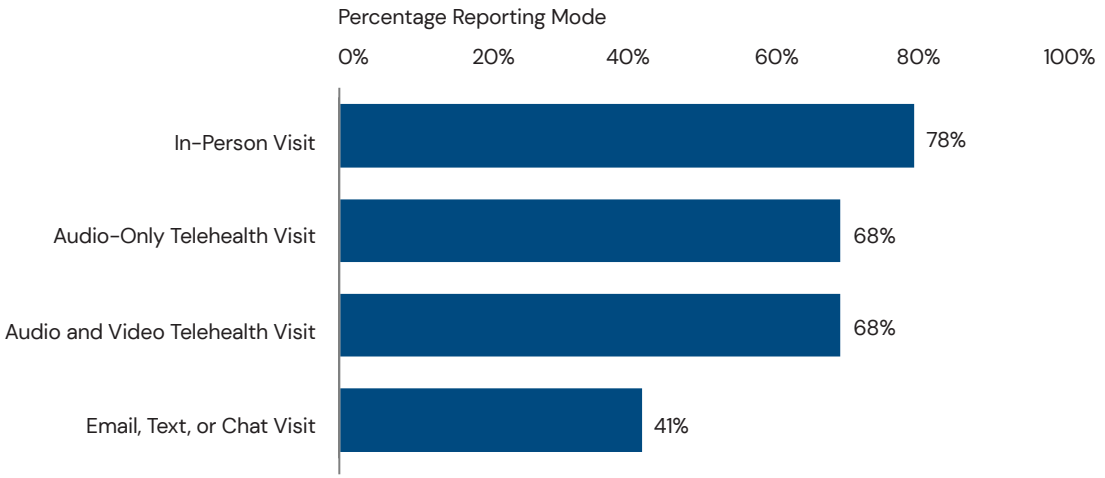
Exhibit 11. Strategies Used in Trying to Find a Provider by Massachusetts Adults Who Reported Needing and Trying to Get Behavioral Health Care for Themselves Over the Past 12 Months

Notes: Sample is Massachusetts adults who reported needing and trying to get behavioral health care over the past 12 months (n=365).

[g] Note that this is the share who contacted a provider with whom they had an existing relationship; it does not mean they were able to obtain care from that provider.

Massachusetts adults who reported needing and receiving behavioral health care services relied on multiple modes for behavioral health service over the past 12 months (Exhibit 12). The most common modes of behavioral health care were in-person visits (78%), audio-only telehealth visits (68%), and audio and video telehealth visits (68%). Email/text/chat visits were less common, at 41%. The relatively high levels of telehealth and other emerging modes of care are likely a direct result of the COVID-19 pandemic, which shifted all care, including behavioral health care, away from in-person visits.[6] While the availability of telehealth, email, text, and chat visits likely provided continued health care access during the pandemic for many Massachusetts residents, there is evidence that telehealth may not be a viable alternative for residents who lack secure internet access and/or private places at home for remote visits.[7]

Exhibit 12. Modes of Care Used by Massachusetts Adults Who Reported Needing and Receiving Any Behavioral Health Care Services for Themselves Over the Past 12 Months



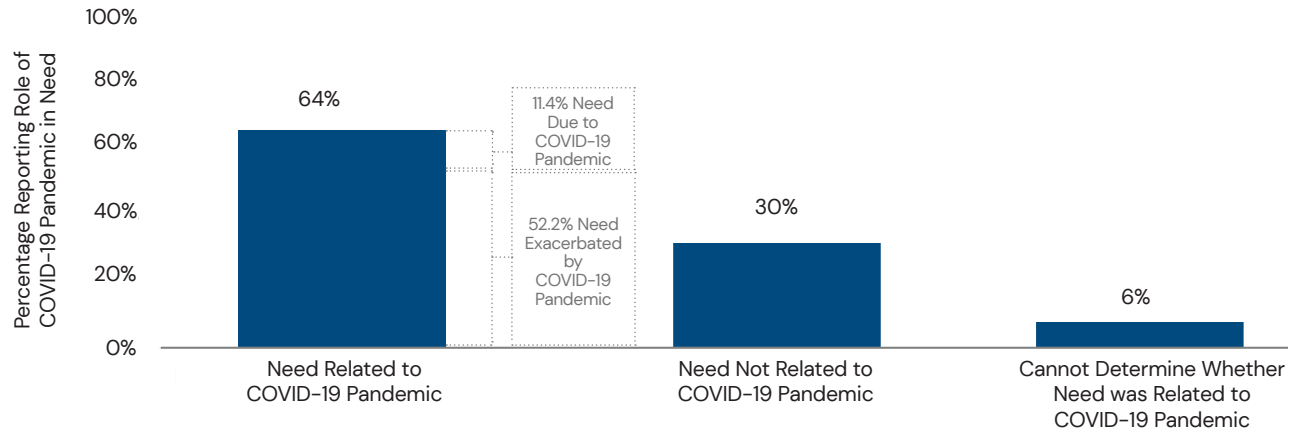
Notes: Sample is Massachusetts adults who reported needing, trying to get, and receiving behavioral health care over the past 12 months (n=340).

Did the COVID-19 Pandemic Increase the Need for Behavioral Health Care in Massachusetts?

In the year following the onset of the COVID-19 pandemic, Massachusetts residents faced a serious health threat from COVID-19, along with upheaval in daily routines, employment interruptions and losses, and social isolation due to policies designed to mitigate the spread of COVID-19. Over half of (56%) Massachusetts adults reported a direct impact of COVID-19 through being tested for COVID-19 (46%), having symptoms for and/or testing positive for the coronavirus (10%), or being quarantined due to exposure or possible exposure to the coronavirus (11%) (data not shown). A smaller share of the adults (10%) reported an indirect impact of the COVID-19 through a disruption in their living situation, including moving to a new place or having people move in with them because of COVID-19. Beyond those affects, nearly half (49%) of adults reported a reduction in work hours or a loss of employment during the COVID-19 pandemic. All those factors would be expected to take a toll on the behavioral health of Massachusetts residents.

Almost two-thirds (64%) of Massachusetts adults who reported a need for behavioral health care during the first year of the COVID-19 pandemic reported that the need was due to or exacerbated by the pandemic (Exhibit 13). For more than half (52%) of the Massachusetts adults who reported a need for behavioral health care over the past 12 months, the need for care began before the COVID-19 pandemic but was reported to have gotten worse because of the COVID-19 pandemic. Another 11% of those who reported a need for behavioral health care, reported that the need began during the COVID-19 pandemic and was due to the COVID-19 pandemic. Not surprisingly, many (43%) of the adults who reported that their need for behavioral health care was due to or exacerbated by the COVID-19 pandemic reported that their mental health at the time of the survey was worse or much worse compared to the prior year (data not shown).

Exhibit 13. ***Reported Impacts of COVID-19 Pandemic on the Need for Behavioral Health Care Among Massachusetts Adults Who Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months***

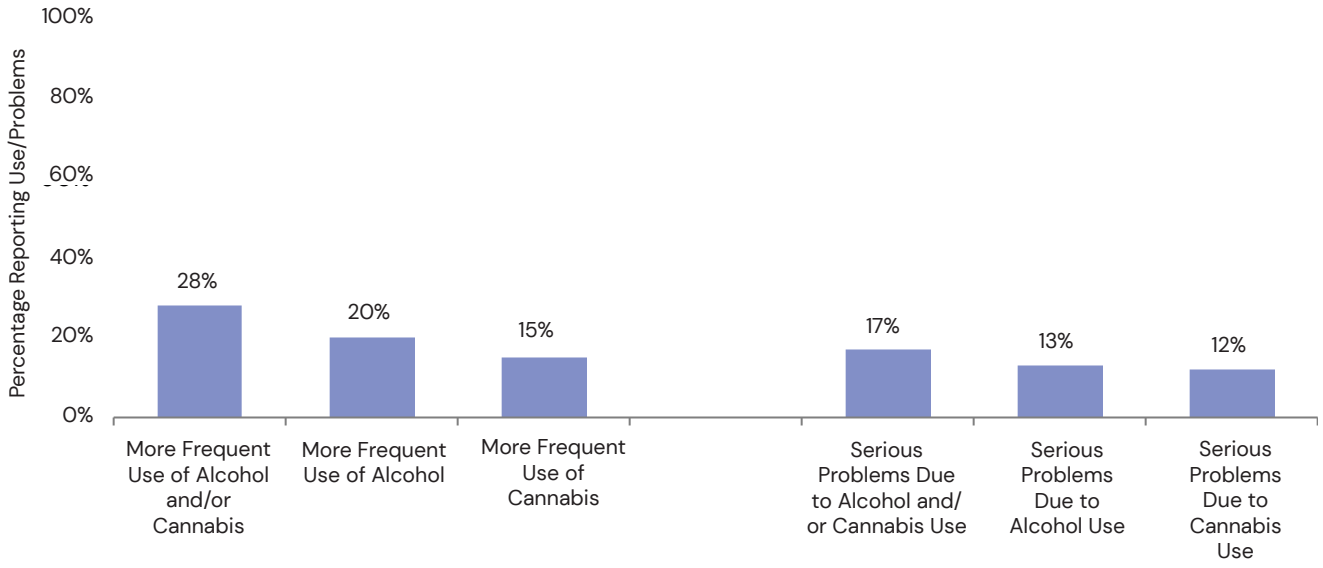


Notes: Sample is Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458).

How Has Alcohol and Cannabis Consumption Changed Under the COVID-19 Pandemic in Massachusetts?

Likely contributing to the impacts of COVID-19 on behavioral health care need, more than a quarter (28%) of all Massachusetts adults reported consuming alcohol and/or cannabis more often since the COVID-19 pandemic began in March 2020 (Exhibit 14). More frequent alcohol consumption was reported by 20% of Massachusetts adults, while more frequent cannabis consumption was reported by 15%. For 17% of Massachusetts adults, their consumption of alcohol and/or cannabis over the past 12 months was reported to have caused serious problems with their personal responsibilities at home, work, or school, such as doing a poor job at work or school, missing work or school, losing a job or dropping out of school, or neglecting children. Alcohol and cannabis use were equally likely to have caused serious problems, at between 12 and 13% of the adults.

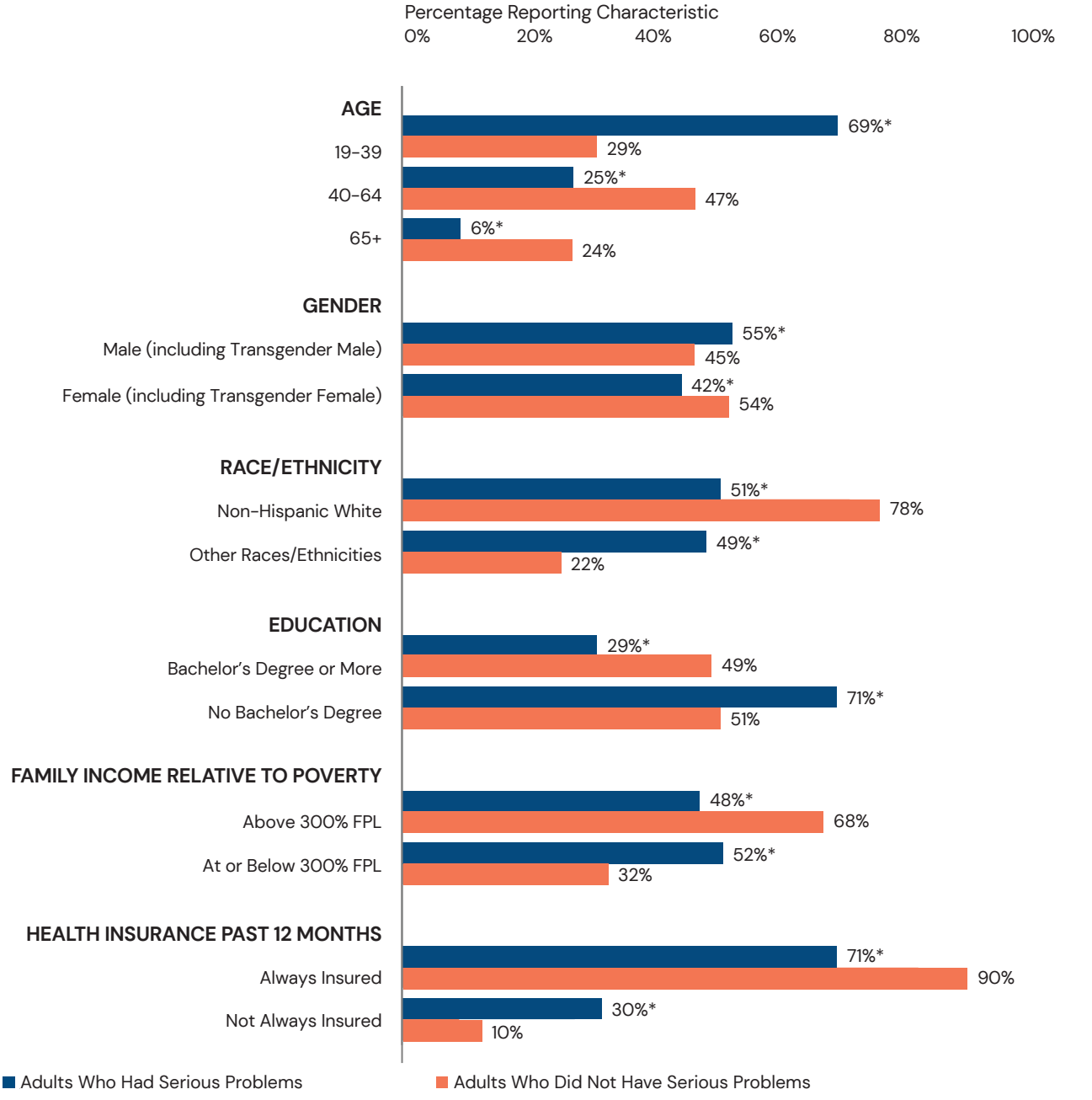
Exhibit 14. ***Massachusetts Adults Who Reported More Frequent Alcohol and/or Cannabis Use Under the COVID-19 Pandemic or Serious Impacts of Alcohol and/or Cannabis Use Over the Past 12 Months***



Note: Sample is all Massachusetts adults (n=1,719).

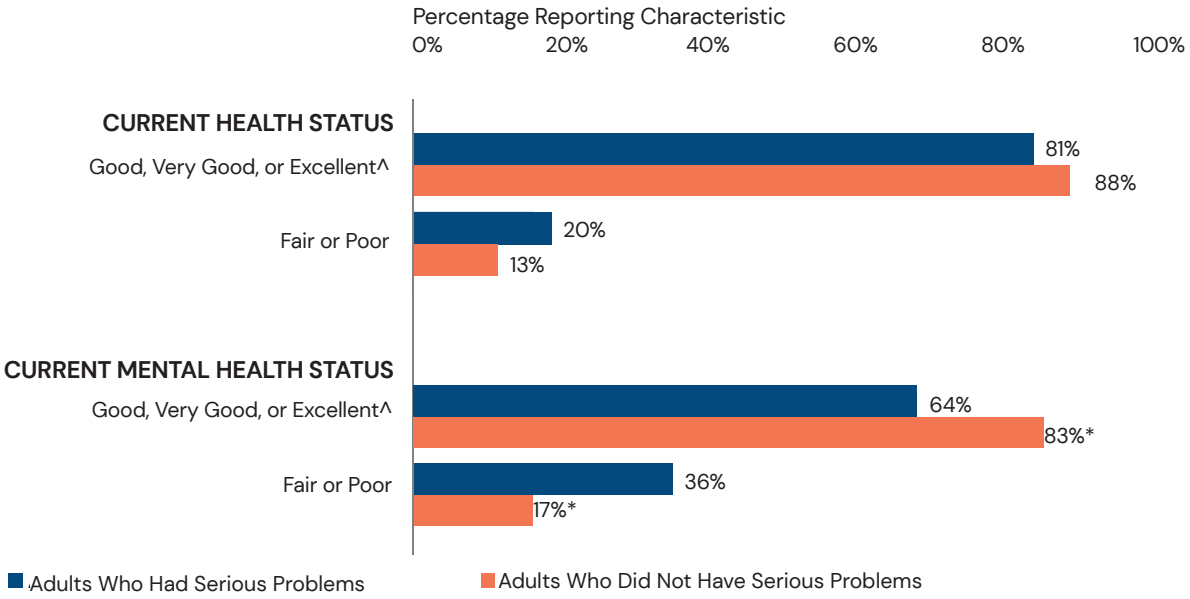
Massachusetts adults who reported serious problems with personal responsibilities due to the consumption of alcohol and/or cannabis over the first year of the COVID-19 pandemic crossed all demographic, socioeconomic, and health subgroups (Exhibits 15 and 16). However, relative to adults who did not report serious problems with alcohol and/or cannabis, the Massachusetts adults who reported serious problems with alcohol and/or cannabis tended to be younger (ages 19-39) and racially, ethnically, or socioeconomically marginalized (Exhibit 15). They were also more likely to report that their current mental health status was fair or poor (Exhibit 16).

Exhibit 15. Demographic and Socioeconomic Characteristics of Massachusetts Adults by Whether They Reported Serious Problems Due to Alcohol or Cannabis Use Over the Past 12 Months



Notes: Samples are Massachusetts adults who reported serious problems due to alcohol and/or cannabis over the past 12 months (n=295) and those who did not report serious problems over the past 12 months (n=1,424). Categories may not sum to 100% due to rounding. * Indicates estimate for adults who reported serious problems is significantly different from estimate for adults who did not report serious problems at the .05 level, two-tailed test.

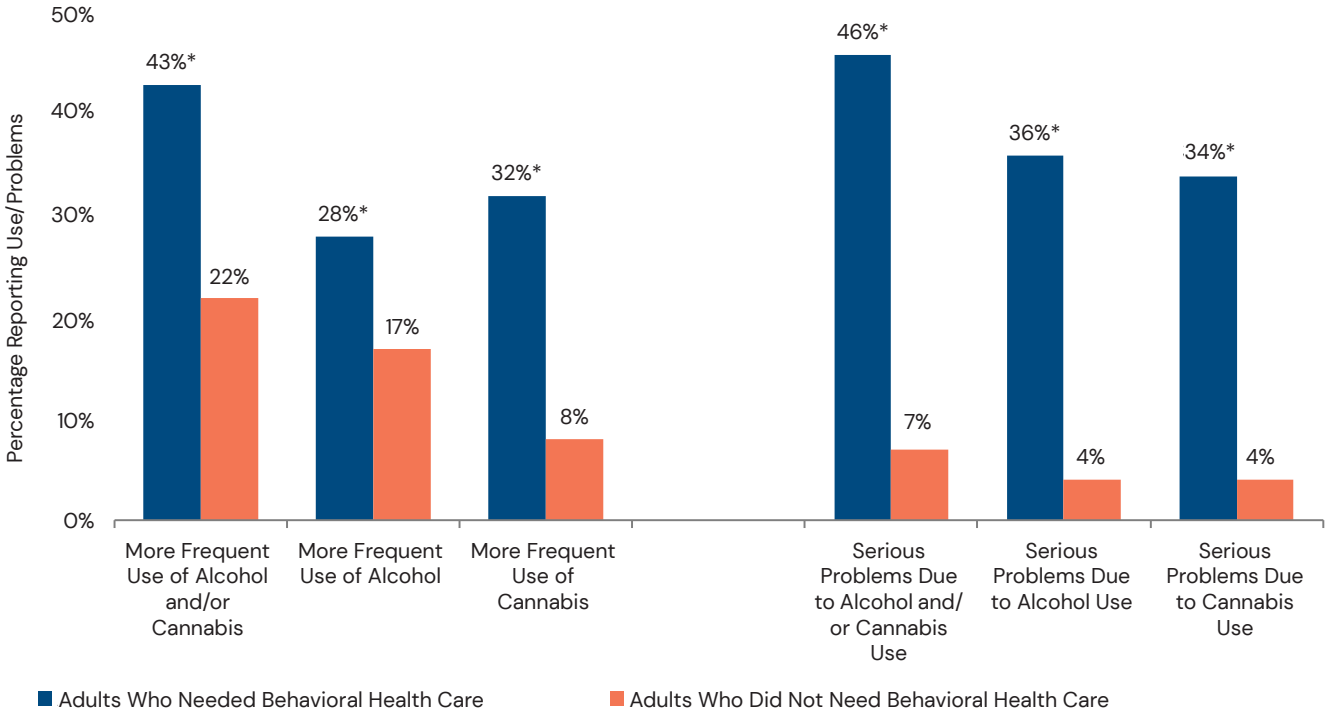
Exhibit 16. Health Characteristics of Massachusetts Adults by Whether They Reported Serious Problems Due to Alcohol or Cannabis Use Over the Past 12 Months



Notes: Samples are Massachusetts adults who reported serious problems due to alcohol and/or cannabis over the past 12 months (n=295) and those who did not report serious problems over the past 12 months (n=1,424). Categories may not sum to 100% due to rounding. * Indicates estimate for adults who reported serious problems is significantly different from estimate for adults who did not report serious problems at the .05 level, two-tailed test.

More frequent consumption and serious problems with alcohol and cannabis consumption were more common among the Massachusetts adults who reported needing behavioral health care over the past 12 months relative to those who did not report needing behavioral health care over the past 12 months (Exhibit 17). Nearly half (43%) of Massachusetts adults who reported needing behavioral health care over the past 12 months reported more frequent use of alcohol and/or cannabis because of the COVID-19 pandemic and nearly half (46%) reported that the consumption of alcohol and/or cannabis had caused serious problems with their personal responsibilities in the past 12 months. The comparable figures for those who did not need behavioral health care over the past 12 months were 22% for more frequent use of alcohol and/or cannabis and 7% for the consumption of alcohol and/or cannabis causing serious problems with their personal responsibilities, respectively.

Exhibit 17. ***Massachusetts Adults Who Reported More Frequent Alcohol and/or Cannabis Use Under the COVID-19 Pandemic or Serious Impacts of Alcohol and/or Cannabis Use Over the Past 12 Months by Whether They Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months***

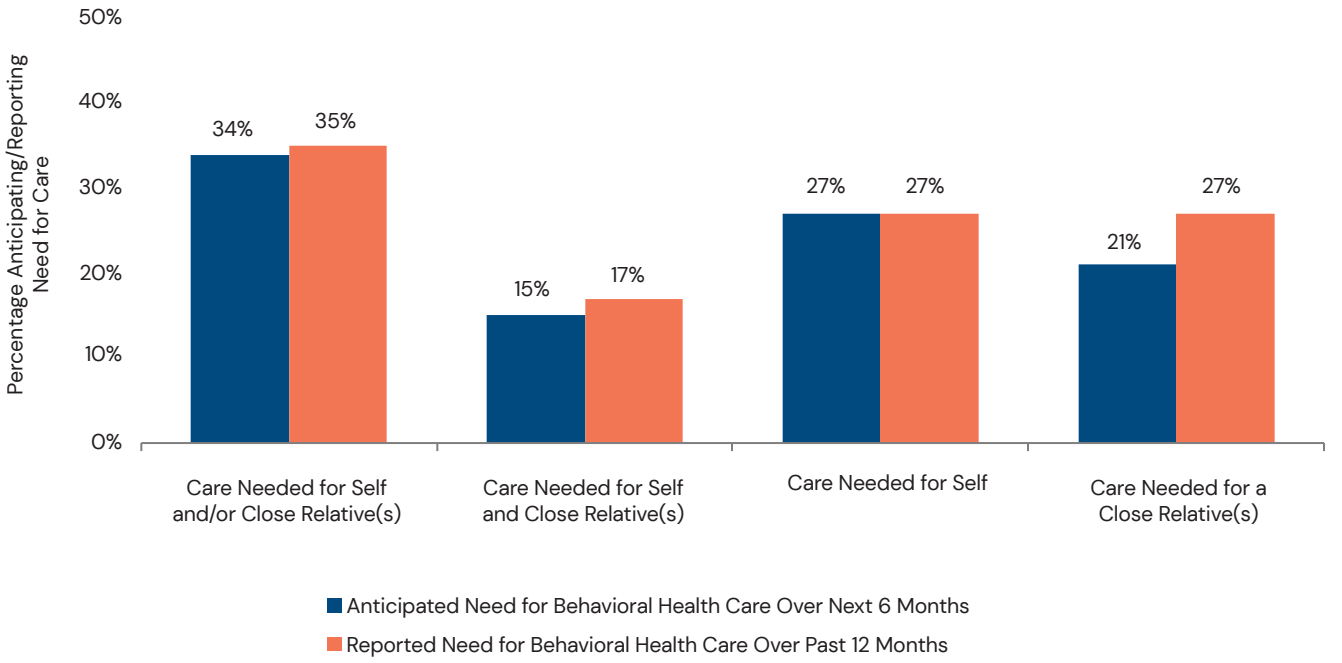


Note: Samples are Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458) and those who did not report needing behavioral health care over the past 12 months (n=1,261). * Indicates a significant difference between adults who reported needing behavioral health care and those who did not report needing behavioral health care at the .05 level, two-tailed test.

What Is the Anticipated Need for Behavioral Health Care in Massachusetts Going Forward?

When asked about their anticipated need for behavioral health care over the next six months, more than a third (34%) of Massachusetts adults anticipated a need for behavioral health care for themselves and/or a close relative in the future (Exhibits 18). Thus, the overall level of anticipated need for the future was very similar to the level of reported need over the past 12 months (34% versus 35% over the past 12 months). Overall, Massachusetts adults anticipated similar levels of behavioral health need for themselves going forward as was reported over the past 12 months (27%) but anticipated lower levels of future need for their close relatives than was reported over the past 12 months (21% versus 27%). While it is not clear why Massachusetts adults expect lower behavioral health care need in the future among their relatives, it may reflect the difference in reporting on past need (e.g., observed need over the past 12 months) versus anticipated need where the respondent may know less about the current circumstances of their relatives to make an assessment for the future.

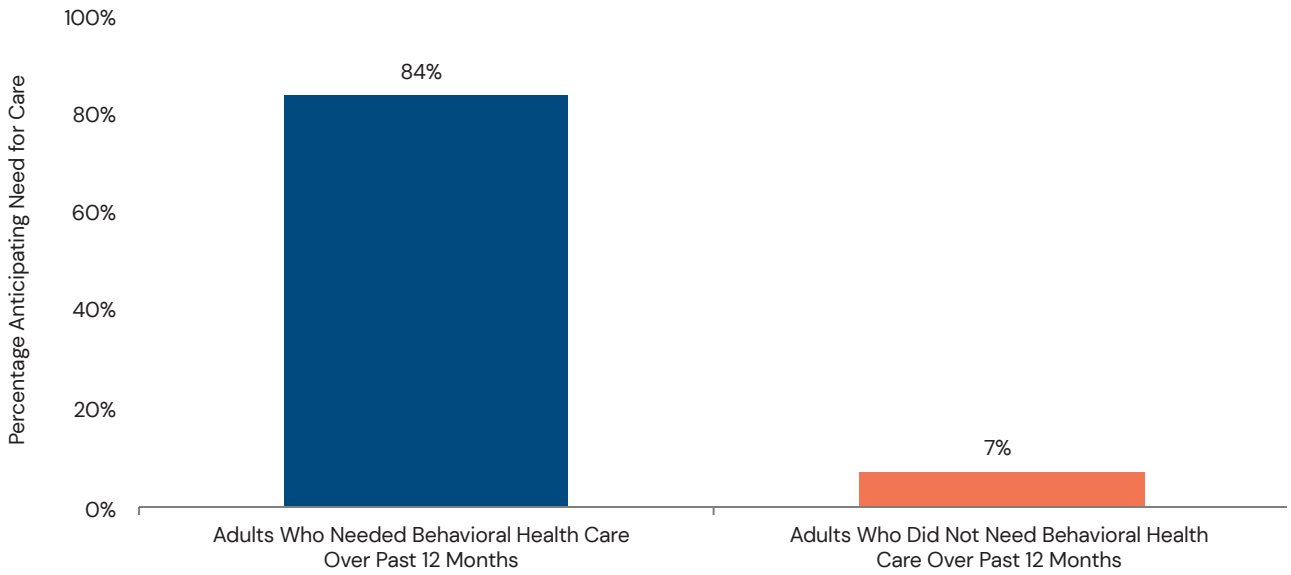
Exhibit 18. ***Anticipated Need for Behavioral Health Care Over Next Six Months and Reported Need for Behavioral Health Care Over Past 12 Months for Massachusetts Adults and Their Close Relatives***



Notes: Samples are Massachusetts adults who anticipated needing behavioral health care over the next 6 months (n=471) and Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458).

Most (84%) of the Massachusetts adults who reported needing behavioral health care for themselves over the past 12 months anticipated continuing to need behavioral health care over the next six months (Exhibit 19). Similarly, nearly all (93%; data not shown) of the Massachusetts adults who did not report needing behavioral health care over the past 12 months did not foresee a need for behavioral health care in the future. However, 7% of the adults who did not report needing behavioral health care in the past 12 months anticipated needing behavioral health care in the future.

Exhibit 19. Massachusetts Adults Who Anticipated a Need for Behavioral Health Care for Themselves Over the Next Six Months by Whether They Reported a Need for Behavioral Health Care for Themselves Over the Past 12 Months



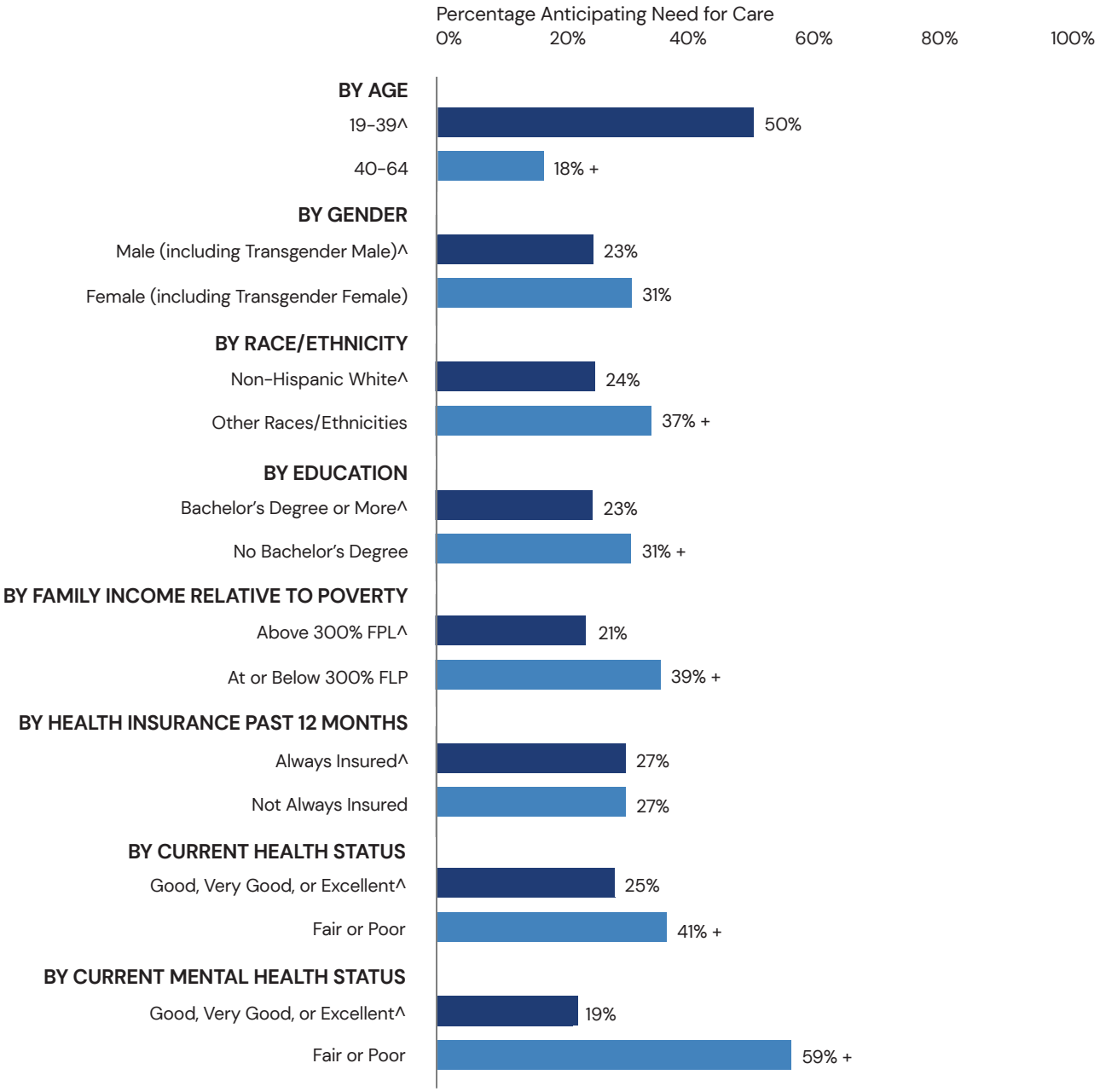
Notes: Samples are Massachusetts adults who reported needing behavioral health care over the past 12 months (n=458) and those who did not report needing behavioral health care over the past 12 months (n=1,261).

Since the share of Massachusetts adults who did not report needing behavioral health care is so much larger than the share who did report needing care over the past 12 months (73% versus 27% of adults), the net result is roughly the same overall level of need going forward as was needed over the past 12 months—more than one in four Massachusetts adults (28%) expected to need behavioral health care over the next 6 months (data not shown).[h] Also, worth noting, 18% of those who anticipated needing behavioral health care over the next six months did not report needing behavioral health care over the past 12 months, suggesting a high level of turnover among the behavioral health care caseload (data not shown).

[h] This is calculated as 84% of the 27% of adults who reported needing behavioral health care over the past 12 months plus 7% of the 73% of adults who did not report needing behavioral health care over the past 12 months: (84%*27%) + (7%*73%)=28% of all adults.

As was true of the Massachusetts adults who reported needing behavioral health care for themselves over the past 12 months (see Exhibit 5), the adults who anticipated needing behavioral health care for themselves over the next six months crossed all demographic, socioeconomic, and health subgroups (Exhibit 20). The anticipated need for behavioral health care was particularly high among younger adults ages 19 to 39 (50%), adults who identify as a race or ethnicity other than non-Hispanic White (39%), adults with lower family incomes (39%), and adults who reported fair or poor health (43%) or fair or poor mental health (57%) at the time of the survey. However, it is noteworthy that reported need was also relatively high—between 18% and 27%—across the remaining subgroups, including older adults (40-64), non-Hispanic White adults, adults with a college education, higher-income adults, and adults who reported being in good, very good, or excellent overall health or mental health.

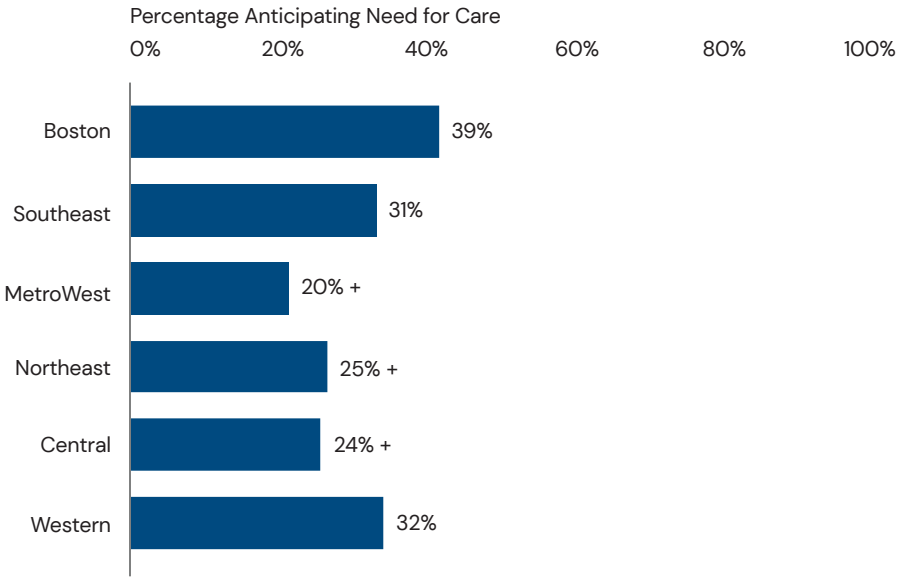
Exhibit 20. Massachusetts Adults Who Anticipated Needing Behavioral Health Care for Themselves Over the Next Six Months Within Each Demographic, Socioeconomic, and Health Subgroups



Notes: Samples are Massachusetts adults anticipating a need for behavioral health care for themselves over the next six months within each subgroup. The smallest sample sizes were for adults with fair or poor overall health status (n=236) and adults with fair or poor mental health status (n=236); the average sample size was 828. Data for adults who reported their gender as "something else" and those who are 65 or older are not reported here because of small sample sizes. + Indicates a significant difference in the percentage of adults anticipating a need for behavioral health care relative to the base category (indicated by ^) at the .05 level, two-tailed test.

As was true for the Massachusetts adults who reported needing behavioral health care for themselves over the past 12 months (see Exhibit 7), Massachusetts adults from across all regions of the Commonwealth anticipated needing behavioral health care over the next 12 months (Exhibit 21). Also as was true of reported need over the past 12 months, the share of adults anticipating a need for behavioral health care in the future was highest in the Boston region (39%) and lowest in the MetroWest region (20%). Relative to the Boston region, the level of anticipated need was significantly lower in the MetroWest, Northeast, and Central regions.

Exhibit 21. Massachusetts Adults Who Anticipated Needing Behavioral Health Care for Themselves Over the Next Six Months Within Each Region of Residence



Notes: Samples are Massachusetts adults anticipating a need for behavioral health care for themselves over the next six months within each region. Sample sizes ranged from 208 (Western) to 401 (MetroWest). One respondent did not provide information on their county of residence and so is excluded from this exhibit. + Indicates that the percentage of adults anticipating a need for behavioral health care in the region is significantly different from the proportion of adults anticipating a need for behavioral health care in the Boston region at the .05 level, two-tailed test.

DISCUSSION

Studies in Massachusetts have shown a gap between the reported need for behavioral health care and access to that care in the Commonwealth.[4, 5, 8] This study expands on these prior studies with contemporary data (from December 2020-March 2021) based on a new survey of community-based Massachusetts adults ages 19 and over. Moreover, the timing of this study is such that it also serves as a useful indicator of need for behavioral health care services during the first year of the COVID-19 pandemic, providing insights into the impacts of COVID-19 on behavioral health care needs over the past year and anticipated behavioral health care needs moving forward.

This study finds that over a third of Massachusetts adults reported needing behavioral health care for themselves or a close relative during the first year of the COVID-19 pandemic, with more than a quarter reporting a need for themselves. While the reported need for behavioral health care among Massachusetts adults crossed all demographic and socioeconomic subgroups, the need was significantly higher among younger adults, adults who identify as a race or ethnicity other than non-Hispanic White, and adults with lower family incomes (at or below 300% FPL).

While reported need was high for behavioral health care among Massachusetts adults, not all adults who need behavioral health care were able to access behavioral health care. Among the adults who reported needing behavioral health care for themselves, 26% did not obtain any behavioral health care services. Even among those who were able to access behavioral health care, not all were always able to get an appointment for care when needed. In fact, the majority of Massachusetts adults who needed behavioral health care (57%) either did not obtain any behavioral health care services or had difficulties getting appointments for behavioral health care when needed. Issues of affordability, accessibility, and stigma/confidentiality were all cited as barriers to obtaining needed behavioral health care.

Further, when we look at the 16% of Massachusetts adults who reported needing but not trying to get behavioral health care services, we find significant differences across adults with different demographic, socioeconomic, and health characteristics. The Massachusetts adults who reported needing but not trying to get behavioral health care tended to be younger (ages 19-39) and racially, ethnically, or socioeconomically marginalized. In addition, 11% of the adults who were not insured all year reported needing but not trying to get behavioral health care, compared to 3% of the adults who were insured all year.[i] While we do not have data that allows us to address the role of specific barriers in trying to access behavioral health care, these findings reinforce the importance of ensuring outreach and support for those without stable health insurance coverage and those without strong connections to the health care system who need behavioral health care. Trusted community-based organizations who know the needs of their communities, and who have strong and well-established relationships with individuals in their communities, may serve as one locus point for helping to provide those with a need for behavioral health care supports necessary to initiate the process of seeking services.

The large gap between the need for behavioral health care and access to behavioral health care reported here reinforces the need to improve the experience of accessing behavioral health care services. Other studies in the Commonwealth have found a large percentage of behavioral health providers do not accept insurance or accept only a subset of insurance plans, which may be associated with longer wait times and other barriers to access.[5, 8] In addition, prior research suggests that the lack of a behavioral health care workforce that reflects the demographics of those who need care may also adversely impact access to care, particularly for individuals who are racially, ethnically, and linguistically marginalized.[5] Finally, geographic barriers (e.g., lack of provider supply, limited public transportation) may further exacerbate access problems for those living in marginalized communities.

These findings also highlight the importance of outreach and programs that focus on Massachusetts adults and their families with incomes at or below 300% FPL ($38,280 for an individual and $78,600 for a family of four in 2020), individuals who are racially or ethnically marginalized, and younger adults. MassHealth, the Commonwealth's Medicaid and Children's Health Insurance Program, provides health insurance coverage to individuals, families, and people with disabilities who meet income and other eligibility requirements. MassHealth continues to be the primary public insurance program serving individuals

[i] Small sample sizes prevent an in-depth look at the role of health insurance coverage in access to behavioral health care.

and families with lower family income, who were more likely to report a need for behavioral health care for themselves or a close relative. In September 2021, MassHealth implemented a new policy providing coverage for preventive behavioral health services (e.g., short-term interventions in supportive groups, individual, or family settings aimed at cultivating coping skills and strategies for symptoms of depression, anxiety, and other social/emotional concerns) for members under age 21 who have a positive behavioral health screening, but do not meet criteria for a behavioral health diagnosis and therefore do not meet medically necessary criteria for behavioral health treatment services.[9] This policy represents an important step in facilitating coverage and access to behavioral health services, especially in light of evidence that behavioral health needs often begin during childhood or adolescence.[10] Experience with this policy should also be used to inform consideration of an analogous policy for adults 21 and older, particularly given that this study shows younger adults are most likely to report a behavioral health care need.

The widespread use of telehealth for behavioral health care during the pandemic likely increased access for some individuals who previously did not seek care in person or who were concerned about seeking in-person care during the COVID-19 pandemic. These high levels of telehealth use were supported by telehealth coverage policy changes implemented as a result of the pandemic.[11] More research is needed to understand whether the increased availability of telehealth services may have exacerbated health care disparities during the COVID-19 pandemic by leaving behind those without access to either the technology or private spaces needed for such visits.[12, 13]

Finally, the COVID-19 pandemic placed unprecedented stress on the health care system. These findings are consistent with early evidence that the pandemic has exacerbated access issues and the need for behavioral health care along the care continuum.[6] The state's "Roadmap for Behavioral Health Reform" aims to address several issues that have characterized access challenges with the behavioral health care system, including making it easier to connect to services by establishing a centralized "front door" and expanding access to service along the continuum of care through a variety of delivery system reform initiatives.[14] Several of the key features of the Roadmap for Behavioral Health Reform are intended to address other longstanding challenges of the behavioral health care system (e.g., cultural and linguistic competency of the workforce, timely access to care). It will be important to monitor implementation of this reform initiative, particularly to ensure the experience is improving and meeting the needs of population subgroups with high need and barriers to access (e.g., affordability, accessibility of services, challenges finding clinicians who accept their type of health insurance or will see patients without health insurance). These enhancements are critical, especially in light of these findings suggesting that nearly all of the adults reporting behavioral health care needs over the past 12 months anticipate behavioral health care needs moving forward. Moreover, preliminary research on the effects of social isolation as a result of the pandemic suggests that social isolation does have detrimental effects on psychological well-being.[15, 16] Addressing the gap between behavioral health need and behavioral health access for individuals and families will require focused attention and ongoing monitoring, particularly with respect to growing health care disparities in the context and aftermath of the COVID-19 pandemic.

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