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Title: Public Opinion and Mental Health in Virginia

Abstract:

According to a recent report from the CDC entitled, "Mental Health, Substance Use, and Suicidal Ideation during the COVID-19 Pandemic—United States, June 23-30, 2020A," more Americans than before grapple with substance abuse, anxiety, depression, alongside Americans who already struggle with mental health problems and disorders. The coronavirus pandemic has harmed us both physically, and mentally. In my project, I answer the question: What are the public's perceptions of mental health? And, are these perceptions related to mental health policies or insurance coverage? Even before the coronavirus pandemic, disparities in mental health insurance coverage for poorer and minority Americans have caused mental health issues for both groups to be harder to address, with some not even seeking help because they lack insurance coverage. However, now in the thralls of the pandemic, my research takes on new importance. In order to answer these questions, I use my own data collected through the Institute for Policy and Opinion Research (IPOR) at Roanoke College. In this survey, questions were asked in order to discern Virginians' thoughts on mental health insurance and mental health stigma. In the data analysis, I focus mental health stigma, mental health insurance, and state mental health policy in Virginia. From the data analysis, it was found that race and ideology play a determining role in thoughts on government intervention in relation to public mental health insurance; however, other questions remain surrounding some of the other questions in this project and the role age, party, education, and income play in shaping public opinion surrounding public mental health insurance.

Introduction:

The broader research questions mentioned in the abstract of this project provide the underlying goal and broader questions to think about for this project. Specifically after the literature review, though, questions surrounding the role of race and age in relation to support for public mental health insurance become apparent. Broadly speaking, though, other demographics like education, ideology, party, and income may also play a role in regard to the overall question about public opinion surrounding public mental health insurance.

The importance of this project and these questions is two pronged: one in relation to the broad issue of the cost of mental health care and varying public insurance coverage for that issue, but also in regard to the COVID-19 pandemic and the stress and other mental health issues like substance abuse that developed from it. In tackling the first concern, I can speak to this issue both personally and objectively. Within my own state of Tennessee, my family and I had to navigate the insurance arena in regard to a severe case of Obsessive Compulsive Disorder (OCD) my little brother was diagnosed with at age 5. Through growing up with my brother and discussing the topic of prescriptions and therapy coverage, I saw through his growth how necessary it is for the presence of both medicinal care and therapeutic care for someone grappling with a mental health disorder. Additionally, research found in the literature review illustrates the need for both prescription coverage and therapeutic coverage when attempting to gain control of mental health disorder. Because of this necessity, it is important to look at if both of types of treatment are being covered and provided for families, because it also becomes much harder to get better at controlling a disorder the older one gets—the learning process becomes more challenging.

Additionally, as seen from the CDC report mentioned in the abstract, at the time of beginning the detailed analysis for this project the pandemic had already been in full-effect. From the pandemic too, it has been noted not only by the CDC, but broader news outlets that a mental health crisis is on the horizon both during and following the pandemic. Further information about the current relevancy of this project is noted in the first section of the literature review; however, because of this trend and warning, the issue of public mental health insurance has never been more important.

For this project, as mentioned, survey questions were sent out through Roanoke College's Institute for Policy and Opinion Research (IPOR). The survey itself was sent out of May this past summer (2020). This survey not only asked the questions that pertain to this project, but they also asked demographics questions, other political opinion questions, and questions related to the COVID-19 pandemic. This survey included 8 questions that gauged Virginians' awareness of mental health as well as mental health insurance. The questions are designed to discern how Virginians think about mental health issues as well as how mental health relates to public insurance coverage. Though the questions do not ask specifically about mental health and stigma, questions related to health insurance like if people would pay more, or desire for mental healthcare to be covered by health insurance implicitly provide some information on how Virginians perceive mental health. Specifically, is it enough of a problem or do Virginians consider it a priority when thinking about public policy? Question 4 and Question 5 of these survey questions specifically targets this facet of questioning. Further, the demographic information provided by the rest of the IPOR survey will be helpful for this project as well.

As discussed later in the literature review of this paper, minorities, low-income families, and transitional age youth (TAY) tend to not seek treatment for mental illness unless covered by

insurance; so, socio-economic status, age, and race/ethnicity may affect the responses to these questions. If these responses reflect what has been studied in the literature review, then Virginians within those groups might desire coverage more, but may be less inclined to pay more. Similarly, those who believe that mental healthcare should be covered and possess a higher socio-economic status might be willing to pay more given a larger disposable income. Further, political ideology might also affect this analysis, and that factor will also be studied. Also, as mentioned in the abstract, the coronavirus pandemic might also affect the responses given to these survey questions. Further, with the pandemic contributing to these problems, it will be interesting if the results of this survey reflect a broader desire for mental health coverage.

Twelve tests were run in SPSS in order to discern answers to some of these questions, particularly those related to support for government intervention. Though not all of the variables and survey questions analyzed or considered in the preliminary analysis yielded significant results, significant findings did arise. These findings include a significant relationship between support for government intervention based on ideological lines and racial/ethnic lines, which also supports the lens of race theory when approaching the question of public opinion in regard to public mental health insurance.

Literature Review and Hypotheses:

A. Current Relevancy:

As already alluded too, mental health and mental health insurance coverage is a prominent problem today during the coronavirus pandemic; however, mental health insurance and particularly insurance and aid for children and those in a lower economic status has been discussed as an issue even before the pandemic. Liz Kowalczyk wrote an article in 2019 titled, “Federal judge: State fails to provide prompt mental health care to poor children,” alluding to the

issue of poorer children receiving mental health care coverage in Massachusetts. This article points to a lack of funding and prompt responses for children struggling with mental health issues, particularly in relation to ensuring coverage for children. Though in a different state, this article among others points to the issue of mental health treatment and coverage for poorer children not being provided by the state.

Further, in relation to the pandemic, the CDC has published numerous reports on the adverse mental health effects that have grown out of the pandemic, on top of existing mental health problems. Additionally, articles in the *Washington Post*, *New York Times*, and others have reflected this growing trend. Emma Goldberg, a journalist for the *New York Times*, wrote in an article titled, "Teens in Covid Isolation: 'I felt like I was Suffocating'" points to the effects of lockdowns, online learning, and the uncertainty of the pandemic increasing anxiety and depression amongst adolescents. This article points to the social isolation of the pandemic leading to increased problems of anxiety and depression, even referencing a study that found that out of 3,300 high school students, a third of them stated that they had felt more depressed in the past few months (Goldberg). These implications according to the National Alliance on Mental Illness, are also leading to more harmful effects of mental illness, such as weight loss and substance abuse. Further, more emergency room visits for children and adolescents are related to mental illness, with the amount of mental health related visits drastically increasing during the pandemic (Goldberg). This article was published in early November, illustrating how the prolonging of the pandemic is still affecting mental health of Americans even when measures like social distancing and isolation have been ongoing for almost a year.

Similarly, in May of 2020, William Wan wrote an article titled "The Coronavirus Pandemic is Pushing America into a Mental Health Crisis," hinting at the outcome that Goldberg

and the CDC have referred to. In this article, Wan writes that there will be and currently is a "historic wave of mental-health related problems" including substance abuse, depression, PTSD, and even suicide. These claims reflect in the studies conducted today as well, even though this article was written earlier in the pandemic. Wan cites a Kasier Family Foundation poll too, noting that at the time nearly half of Americans confessed that the pandemic was harming their mental well-being. Further, the article cites that even the congressional relief bill passed in early may allocated only a small amount towards mental health (Wan). Since many Americans are feeling more overwhelmed in regard to their mental health, this lack of funding illustrates a potential gap between how Americans feel about their mental health needs and what policy is actually provided for those needs. This latter point depicts the relevancy of this research, as well as research potentially showing a disconnect between the prevalence of mental health problems and the lack of funding and coverage for these problems. Additionally, with the Goldberg's article, the increase in mental health problems of adolescents points to the issue of mental heatlh insurance in relation to transitional age youth. Both of these points not only demonstrate the importance of this research, but it also shows that these problems in mental health care and mental health insurance are present in the modern-day life of Americans.

B. Transitional Age Youth, Minorities, Low-Income, and Healthcare Access

Beyond the popular literature alluding to a growing concern of a mental health crisis nationally, scholars also point to similar issues of mental health treatment and coverage for those in transitional age youth and other groups. Scholar Peter Szilagyi examines the specific health insurance problem of children with disabilities. It discusses the correlation between health insurance and access to health care, echoing popular journalism. Szilagyi discerns that children with physical disabilities have better access and receive better treatment within health insurance

than those struggling with mental disabilities (127). Additionally, across the board, Szilagyi's study concludes that children with disabilities whose families have health insurance are far more likely to seek and receive treatment for said disabilities (122). Szilagyi points to Medicaid as the most comprehensive form of public funding for children with disabilities, particularly in relation to chronic conditions of mental health issues (128). However, the article also finds that since states vary on what constitutes "chronic conditions" or "medically necessary" when providing this coverage, "many eligible families do not use its services" due to how complicated the process is (129). This last point illustrates not only the trend of families not seeking help due to lack of coverage, but also due to ease of coverage.

Scholar Sara Heron echoes Szilagyi's analysis. In the study's sample size, it examines how many participants were receiving care and how they received care. This study offers a case example about mental health coverage, and it also acts as an example as to why mental health problems should be covered. This last point is shown because one of the findings from this study is that if TAY (18-27) do not know how to understand their benefits or access coverage, they will not seek help in the future. This point directly pertains to the gap between those who need coverage and those who receive it. If a person in this age group does not receive insurance coverage for a mental health problem, the chances professional help is sought for this issue decreases. Heron reiterates this claim when she states that "TAY are less like to continue mental health treatment if they cannot use insurance, and although some are willing to pay out of pocket, most are not willing to pay providers' average rates" (Heron). This age group pertains to the at-risk group of those with mental health disorders once graduating from parental insurance coverage.

Christina Studts reiterates these points from Heron and Szyilagyi in a broader way, by directly analyzing access to healthcare based on socio-economic status. Studts focuses on food stamps and welfare as well as other socio-economic indicators in relation to access to health care more broadly. Though Studts does not focus on mental health care specifically, her findings reflect the points explored by Szilagyi and Heron among other scholars; in that, the amount of coverage or lack thereof for an individual or family is correlated to socio-economic status (534). Further, Studts discerned from her findings that those who already lack insurance, have a lower monthly income, and/or experience food insecurity are less likely to have access to healthcare (536-537). Though Studts focuses her study on Kentuckians and their access to healthcare, it illustrates a similar trend found in national studies as well, such as Heron's analyses. Further, though not related to mental health insurance specifically, access to health care in general as explored in Studts article relates to the access of mental health insurance as well.

Scholars Philip S. Wang and Catherine McLaughlin in two different articles analyze the effect of treatment delays for mental disorders in relation to health insurance coverage. Additioanlly, McLaughlin writes that "mental health care services are not covered by health insurance packages and health plans to the same degree as physical health care services." This quotation illustrates the connection between broader health care and mental health care, justifying Studts's article as telling in that if normal health care coverage is not provided, there would be an even smaller likelihood of substantial mental health coverage offered. McLaughlin points to ages 25-34 years, with part of this range within the TAY age, as a prevalent age for mental illness to develop and is simultaneously the population that is the most uninsured. This lack of insurance leads to a delay in treatment; further, mental illness and income have a negative correlation, which increases the inability to seek treatment amongst this population. These other

factors such as income, coverage, and educational attainment lead to a "complex circle of correlation that suggests various paths of causation" for the lack of insurance coverage or mental health. McLaughlin asserts that lack of coverage leads to lack of routine care or check-ups, as well as the opportunity for early identification of mental health disorders and issues. This lack of early identification can worsen the success of someone with a mental disorder, and lead to the other issues that cause a lack of insurance as McLaughlin identifies. Wang's study reiterates McLaughlin's points about delays and the issues of coverage in relation to mental health. She states "the vast majority (80.1 percent) of people with a lifetime […] disorder eventually make treatment contact, although delays average more than a decade." These delays relate back to the points about socio-economic status and coverage that other scholars have identified. Further, Wang's findings show that delay of treatment form an important component in regard to the unmet need for mental health care. With these delays correlating to socio-economic status and educational attainment in regard to mental health coverage, Wang argues for the need of insured primary medical care in order to shorten these delays and provide the help needed for these individuals.

In a study conducted by Shervin Assari, Sharon Cobb, Mohammed Saqib, and Hohsen Basargan, the authors focus on mental health issues and coverage in relation to race. The study focuses on older black adults, and finds that economic strain can worsen the physical and mental health problems of older black adults (49). The scholars compared the effects of economic strain in relation to both health outcomes and educational attainment of members in the older black community. The study also finds that economic strain can act as "a more salient social determinant of the health of black older adults" (57). This claim reiterates some of the points made by other scholars in relation to economic status in regard to its effects on mental health

insurance and coverage. However, rather than focusing on widening public health insurance coverage, the authors argue for these economic factors to be alleviated through public policy (55). Though the solutions proposed to the problem differ, these authors note the confluence of mental health care and health care access in general with socio-economic status.

More broadly, scholars Donna D. McAlpine and David Mechanic also note the role of demographics in relation to treatment of mental health care and mental health insurance. The study focused on severely mentally ill patients and found that many of these patients were "disproportionately African American, unmarried, male, less educated, and have lower family incomes than those with other disorders and those with no measured mental disorders" (277). This quotation shows a connection between minority groups and family income in regard to those who receive treatment for their mental disorders. Further, McAlpine and Mechanic also connect this statement with the likelihood of coverage and treatment, stating that one in five of the persons studied with severe mental illness were uninsured and that Medicaid or Medicare insures 37 percent of this group (277). Further, though, the authors also state that those covered by public insurance are "almost six times more likely to have access to specialty care" and treatment (286). This latter statement points to the same relationship established by other scholars, where insurance corresponds to access to treatment as well as the actual seeking of treatment. This point not only makes Medicare and Medicaid some of the most important routes for receiving treatment for low-income individuals or minority groups, but it also shows the importance of comprehensive coverage and treatment for these individuals, particularly when 37% of people with severe mental illness are insured by public health insurance.

C. Policy

Policy implications and the influence of current policy should also be included when studying this topic. In focusing on public health insurance, coverage and range of coverage in regard to mental health varies from state to state; however, trends in the importance of coverage can be discerned. An article published in 2018 by Kristi Nelson in the *Knoxville News Sentinel* highlights the importance of mental health coverage by public health insurance. The article discusses the importance of the ACA in relation to preexisting conditions in Tennessee. The news article discusses how one third of Tennesseans have pre-existing conditions, many of those mental health related, and risk losing coverage under the Trump administration's changes to the ACA (Nelson). These changes reinforce the importance of mental health insurance and the relevance of exploring this topic because it is still being challenged and changed today. The narrative found in the article is specific to Tennessee, but it also follows the common thread of many ACA related articles in 2018/19 in that it is about the loss of coverage if the ACA were to disappear.

Cynthia Cox, a scholar for the Kaiser Family Foundation, in an article from October of this year titled "Mental Illnesses May soon Be the Most Common Pre-Existing Conditions," illustrates the relevancy and importance of protection for pre-existing conditions. Cox refers to the coronavirus pandemic as a cause for this increase in mental illness as a preexisting condition, showing that between Jan-Jun 2019 in comparison to July 2020, there's been an almost 30% increase in adults who report symptoms of anxiety or depression. Similarly to the article from Nelson, Cox argues against the elimination of the ACA and its coverage of preexisting conditions. As long as the ACA and this coverage remains law, people will hopefully be able to find access to mental healthcare through the ACA. However, state compliance to ACA guidelines is presented as crucial for securing mental health care. In that, if states follow the

ACA accurately, it helps ensure coverage for those that struggle with mental illness and also aids in providing treatment. However, if short-term plans as argued by President Trump are established in place of the ACA, Cox in analyzing these plans “found that more than half of the short-term plans didn’t offer coverage for mental illness at all, meaning that if a person with mental illness was offered coverage, their plan wouldn’t pay for mental health treatment.” This point ties into the issue of socio-economic status: if these treatments and care are not covered financially, people with mental illness might not actually receive help if they cannot afford to pay for it. This article not only points to the growing concern of mental illness in regard to health insurance coverage and treatment, but also shows the importance of pre-existing condition coverage and the ACA when insuring treatment and coverage of mentally ill individuals.

Carol Potera provides a similar analysis of and places importance on the ACA in regard to mental health treatment as well. She not only alludes to most mental illnesses being know by age 24, again within the TAY age range, but she also shows that the ability for people to remain on their parent’s insurance until age 26 as established by the ACA helps ensure that people receive mental health coverage for their health care. Potera also points to the Mental Health Parity and Addiction Equity Act as key for providing mental health coverage and treatment. This act helped reduce the rate of claim rejection for mental health insurance claims, leading to better insurance and treatment of those with mental health issues. Potera asserts that before this policy, private insurers would reject mental health coverage or copayments at a rate of 50% or higher (14). Though this claim pertains to private insurance, it shows the importance of health insurance coverage when receiving treatment, and it asserts the importance of states following the ACA when administering public health insurance. Further, Potera quotes Kathleen Sebelius, former Secretary of Health and Human Services, in regard to insurance coverage. Potera quotes

Sebelius's statement that "nine in 10 Americans with substance abuse disorders do not receive the care they need, and 60% of Americans living with a mental condition do not receive the care they need" (14). Though the ACA and the Mental Health Parity and Addiction Equity Act help alleviate these problems, these large percentages illustrate the importance of these policies but also the need for better coverage for these individuals in order to actually receive the treatment needed.

Scholar Barry Colleen provides background information on how insurance rates adjust for those with mental health problems and how this process works after changes made under the Affordable Care Act. Mental illness itself is held as a backdrop to this article, and it mainly relates to those with chronic mental disorders rather than ones that just have the added expense in relation to care. It provides a background piece of information for how mental health insurance has operated under the Affordable Care Act, though this piece of legislation has changed under the Trump Administration. Colleen found that the risk adjustment as created by the Affordable Care Act does protect against insurance price costs rising drastically for those suffering with mental health disorders (Colleen). This observation means that mental health insurance policy nationally does attempt to protect those with mental health disorders; however, Colleen acknowledse in the study that what is protected in this legislation is price changes, not the care provided (which varies state to state) or the high prices themselves.

Though brief, an editorial by Rachel Garfield and Benjamin Druss examines the Affordable Care Act (ACA) with a focus on mental health care. It discusses the use of generous plans for those with mental health disorders, but also how those generous plans really only cover the bare-minimum level of care that is necessary for people with mental health disorders (Garfield and Druss). Because what should be covered initially is only included in generous

plans, which still vary state to state, people who want mental health public insurance coverage have to pay significantly more (Garfield and Druss). This problem creates a disadvantaged group, because there is a pay-wall for care that people need. This observation directly helps with understanding the importance of this project because it highlights the importance of class and the fact that there is a barrier to accessing mental health insurance for those in the lower classes based on the high price.

D. Mental Health Stigma in relation to Policy

A lot of literature found also pertains to mental health stigma and the mental health community. Though stigma is not directly targeted in this project, it still affects policy implications through its relationship to public opinion about mental health. In regard to mental illness stigma, Patrick Corrigan tackles the issue whether or not mental illness stigma should be looked at as a public health problem or a social justice problem. The public health side of this article pertains to the actual harm of mental illness and how social stigma magnifies this issue; whereas, when perceived as a social justice problem it relates to how mental illness stigma and mental illness relate to an individual's ability to progress economically and socially in society (Corrigan). Corrigan elaborates on this point by stating that the social justice aspect of sigma "explains stigma as a power issue and incorporates the various social and economic processes that are frequently the foundation of these issues" (Corrigan p. 366). Corrigan recommends a combination of these two perspectives in order to advocate against mental health stigma; further, this article sets the stage for how this problem is perceived as well as how mental health stigma and issues related to it pertain directly to the economic class of these individuals, affecting mental health insurance coverage.

Bernice Pescosolido also examines mental health stigma and how it forms through stigma theory, but she also blends these aspects with mental health insurance, or lack thereof. Pescosolido focuses primarily on the general public's beliefs and actions related to mental health stigma. Pescosolido also offers the definition of stigma as provided by stigma specialist, Erving Goffman. The definition provided defines stigma as "a 'mark' that signals to others that an individual possesses an attribute reducing him or her from 'whole and usual' to 'tainted and discounted'" (Pescosolido, p. 3). The mental health stigma that Pescosolido analyzes is really based on all mental health problems rather than specifically disorders; however, she does find a connection to mental health insurance. In that, the fact that some individuals do not receive coverage only intensifies the stigma received by the public (Pescosolido). This observation combined with the analysis of stigma as a whole offers good information on how mental health stigma forms, with lack of health insurance being one such cause.

David Mechanic also provides a good analysis of mental health stigma in relation to mental health insurance, primarily focusing on what are the actual priorities of mental health. Mechanic comments that the lack of consensus on how to tackle mental health problems within policy, in relation to state by state care, and outside of policy makes planning for individual needs incredibly difficult for those struggling with mental health issues (Mechanic, p. 501). Further, Mechanic elaborates on this point by stating that entitlements and insurance funding makes the insurance planning process difficult for those with mental health problems (Mechanic, p. 511). This article helps add another nuance to the issue of mental health public insurance in that not only does the availability of care matter for those affected by mental health issues, but the way in which care and coverage is provided also affects those struggling with mental health issues.

John Salermo, a writer for the National Library of Medicine and National Institutes of Health, reviews the effectiveness of school-based mental health awareness programs among youth in the US. This article not only pertains to mental health stigma, but also mental health insurance in regard to awareness aiding in seeking treatment. Salermo found that all awareness programs did help increase knowledge of mental health; however, only 7 of the 15 studies analyzed showed an increase in "help-seeking" tendencies, and only 4 of these studies focused on suicide awareness. However, overall, school based awareness programs did help better mental health knowledge and attitudes towards mental health, showing a potential shift in popular opinion in regard to mental health within the younger generation of the population (Salermo). This point might be important in particular to the need for TAY individuals to seek mental health care: if popular opinion of these groups shows a better awareness of mental health issues, better attitude in regard to stigma, and receives coverage, these school programs may be helpful in leading more students to seek treatment. Salermo, in approaching the issue of mental health and health insurance through public education, argues for an educational policy solution rather than mental health insurance policy solution. He advocates for teachers to be trained in administering school-based mental health interventions and also teach longer mental health focused curriculum in the classroom in order to address mental health stigma and improve treatment-seeking. He argues that if students are more aware of mental health problems and have a reduced stigma towards mental health, treatment might be sought out more frequently, which would lead to more treatment for mental health issues.

E. Hypotheses:

These hypotheses base themselves in the information found in the literature review as well as other information derived from other course-work and studies. I hypothesize that when

age/age-group is tested, younger age groups will support more coverage, whereas older age-groups might not. This hypothesis grounds itself in not only the differing political trends of the generations, but also in regard to TAY individuals and their need for coverage before seeking help. Further, I also hypothesize, though, that these younger individuals might not be willing to pay more given that they might not be as high on the income ladder.

I also hypothesize that democrats will be more likely to support public mental health insurance coverage than republicans; and, I also predict the same along ideological lines. I am slightly unsure about this hypothesis, because I could see republicans in support of public mental health insurance coverage. However, I do not think that republicans or ideological conservatives would be in favor of it if it meant paying higher premiums. I also hypothesize that minority groups will support public mental health insurance, and this hypothesis grounds itself in the trend seen in the literature review of minority families seeking care primarily when covered by public health insurance.

In specifically targeting socio-economic status in relation to income, I predict that higher income individuals will not support public mental health insurance coverage, or not have a strong opinion, because this group would most likely be covered by private insurance. However, those that do support it out of that group I believe will be more willing to a pay higher premiums for that coverage. Additionally, I believe that lower-income individuals will likely support public mental health insurance coverage, but may be less likely to pay more since these individuals are in a lower income bracket. In regard to education as an independent variable, I think that higher educated individuals will most likely support public mental health insurance and be willing to pay more, and that less-educated individuals will also support public mental health insurance.

However, I think the latter group might not be willing to pay as much given the relationship between education levels and income.

From the literature review, we know that minority groups and transitional age youth disproportionately seek out and receive public mental health care. Further, from this literature review, there is a relationship between the presence of public health insurance coverage provided by the government and the likelihood an individual or family will seek out care for mental health illnesses and others. From these relationships, this project attempts to look at these discrepancies from a different angle. Rather than looking at the results of the presence of public mental health insurance and the likelihood someone will seek treatment, particularly for minorities and TAY, this project attempts to garner the public opinion from these groups about public mental health insurance. From this reverse approach, instead of adding to the plethora of research done about the relationship between coverage and these groups, the gap in research about what these groups also want will be filled. From this information, the issue of public mental health insurance can be addressed and analyzed in the future not only through existing research about public mental health insurance and the relationship between coverage and these groups, but it can also be analyzed with knowledge of public opinion about the issue as well. This added information will help make it easier to approach the topic of public mental health insurance in a more holistic way; and, because of that, race theory and the theory around TAY will be the primary theories involved when thinking about these hypotheses, beyond just the political trends and other components that informed my decision making about other hypotheses.

Variables and Hypotheses:

A. Variables

The variables for this project primarily relate to the demographic variables in comparison to the survey answers collected from the IPOR survey. The variables this project aims to test relate to the demographics: age/age-group, education, race/ethnicity, political party, political ideology, and income/Socio-economic class status. The primary reason for these independent variables being chosen is in order to compare survey responses across class groups, partisan lines, ideological lines, educational level, ethnic/racial groups, and socio-economic status. Furthermore, age-group has been chosen as independent variables in relation to the Transitional Age Youth concept found in the literature review. Similarly, ethnicity/race and socio-economic status are also tested as independent variables in order to test connections seen in the literature review. These tests were conducted in order to analyze the relationship between seeking and desiring public mental health insurance coverage in relation to race/ethnicity and socio-economic status.

The dependent variables for this project as already mentioned will be the answers to the specific survey questions related to mental health public insurance coverage. These questions that will be tested include: general desire for public mental health insurance coverage, level of prescription drug coverage and therapy coverage, knowledge of a person's own mental health coverage, mental health disorder familiarity, and financially how much would someone be willing to pay for additional coverage if insurance premiums were to rise. These dependent variables will be tested by the various demographic information discussed in the previous paragraph.

Data Analyses

A. Introduction

When beginning the data analysis, I found that the one question that garnered significant results was Question 5 of my Survey Questions (See Appendix for Q#5). That does not mean that the other relationships I sought to evaluate do not exist; rather, further research would need to be conducted in order to fully analyze them. By focusing primarily on Question 5 though, thoughts on government intervention in regard to healthcare can be found, and significant and interesting findings still related to my hypotheses arose.

The data I used to approach these research questions and hypotheses as mentioned came from survey responses to a survey sent out in May of 2020 by Roanoke College's Institute for Policy and Opinion Research (IPOR). After receiving the data, I recoded it in order to scale the survey responses correctly for data analysis. This recoding information can also be found in the appendix under Table 1. Additionally, though, when I recoded the data I conflated the ethnicity and race demographics questions and instead made it a yes/no response to a "nonwhite" question. Making these changes in the data's coding helped ensure that the tests performed did not lead to inaccurate results through background coding in my data. Additionally, non-responses to the demographics questions for Question 5 of the survey itself were excluded from the analysis. Table 1 provides the average responses not only to the survey question itself, but also the individual demographic variables that were tested in tandem with Question 5: age, education, party, ideology, income, and nonwhite. The number of responses slightly varied with each demographic question, with income providing the fewest responses at 459, and age providing the most responses at 511. Education had 510 responses, Party had 493 responses, Ideology had 482 responses, and nonwhite had 505 responses.

However, in addition to these original independent variables, after beginning data analysis I decided to introduce two new independent variables based off of two of the other

survey response questions: knowledge of someone with a mental health disorder, and general mental health awareness. The "Know" variable was created by recoding Question 8 in the survey to a 1= respondent said yes to knowing someone with a mental health disorder, and 0=no, the respondent does not know someone with a mental health disorder. This variable was created in order to measure whether or not knowing someone with a mental health disorder shifts one's opinion about government intervention related to mental health. Similarly, the mental health awareness variable was created by the use of Question 7 in my survey. In that, a respondent was coded on a scale of 0-6 for how many of the various disorders listed in the survey they knew. This variable had a similar purpose as the "know" variable: addressing the question of does having more knowledge about various mental health disorders shift one's opinion in regard to government intervention related to public mental health insurance. There were 505 total responses to the "Know" variable and 513 responses for the general mental health awareness variable. The recoding information in regard to how these respondents' answers surrounding these independent variables and the dependent variable of Question 5 were measured can be found in the recoding section under Table 1 in the Appendix.

Findings:

When analyzing this data, I ran twelve tests in SPSS: descriptive statistics, a regression model, mean comparisons, and two cross-tabulations (see Appendix). After running these tests, my regression analysis results yielded two significant results so that the null hypotheses were rejected: nonwhite and ideology (see Table 2).

B. Nonwhite

The regression test for nonwhite responses in relation to Question 5 led to a p-value of .008, demonstrating that the relationship is in fact significant and that the null-hypothesis can be

rejected (Table 2). Further, the test found that the coefficient for this relationship was .643, meaning that for every one-unit increase the responses to Question 5 moved up on average .643 (Table 2). Because of the recoding for nonwhite responses, this result means that when a person answered that they were nonwhite (1) their responses on average increased by .643. The mean comparison for this demographic question in relation to Question 5 responses illustrates this trend as well. White respondent's average answer was 4.3333 on a seven-point scale, and nonwhite responses were 5.1800 (Table 8). Further, the cross-tabulations for this analysis also illustrated the difference between white and nonwhite responses (Table 10). 69% of respondents who were nonwhite (100 responses total) answered Question 5 with a response of 5 or greater. In contrast, 48.6% of white respondents (405 total) answered Question 5 with a response of 5 or greater. This roughly 20% jump in tandem with the significant p-value illustrate the significance of this relationship between race and public opinion about government intervention in regard to public mental health insurance.

C. Findings: Ideology

While my original hypotheses also somewhat conflated party and ideology in regard to responses, the data at least for this question only possessed a significant relationship between ideology and Question 5. As seen in Table 1, the mean response to ideology was 2.2693, showing that there were mostly conservative respondents. Table 2 further provided a significance value of .000, which means that the relationship between this question and ideology is highly significant. Therefore, the null hypothesis in this relationship can be rejected. Further, the coefficient of this relationship was -.707, meaning that for each one unit increase in responses, i.e. becoming more conservative, there was a -.707 change in respondents' answers to Question 5 (Table 2). Further, the mean comparison for each of these demographic groups depicts these

changes. Liberal respondents answered on average with a response of 5.5195, moderate respondents answered with an average response of 4.6587, and conservative respondents answered with an average response of 3.8639 (See Table 6). This trend continues in the cross-tabulation analysis as well, with 78% of liberal respondents, 55.8% of moderate respondents, and 39.1% of conservative respondents answering Question 5 with a response of greater than or equal to 5 (See Table 9).

D. Rest of the Data:

The rest of the demographic tests in regard to Question 5 did not yield significant relationships, and further tests will be done in order to adjudicate these demographic effects on attitudes related to public government health insurance. However, the mean comparisons still provide interesting information to a degree in regard to respondents. Additionally, there are hints of trends that may appear in the later analyses of the rest of the data. For example, the mean comparison of income responses showed that the lowest income bracket had the highest support for government intervention (see Table 7). The mean comparison for education showed that less than a high-school level of education is highest in support for intervention; however, there were not many respondents that fit into this category (see Table 4). The mean comparison for age also reflected the literature; in that, younger individuals were in favor of more government intervention (Table 3). However, as is the case for all of these results, these relationships were shown to not be significant in regard to this specific question. For example, the younger respondents being in favor of government intervention could relate to the issues of Transitional Age Youth found in the literature review, or the fact that younger individuals also tend to identify as liberal. Further data analysis and research will need to be done in order to assess the relationships between these demographic questions and public opinion on mental health

insurance as a whole, and in regard to Question 5 of this survey. The average responses for Question 5 across all respondents without controlling for any variables though yielded a result of 4.5010, which means that on average public opinion slightly leans towards government intervention in relation to public mental health insurance.

Conclusion and Future Research

The findings from the analyses in regard to the nonwhite demographic independent variable confirm one of the project's hypotheses and theories. These responses serve as evidence of an issue found in the literature review of public health insurance needing to be provided before minority families seek treatment for mental health issues. The literature related to this question pertains to age and income as well as other factors. As several of the scholars in the literature review noted, there is a relationship between severely mental ill patients and lower income and minority families. Further, the presence, or lack thereof, of coverage has been shown to be a factor in whether or not a family seeks mental health treatment. As seen in the results, minority families showed a higher support for government intervention in regard to providing public mental health insurance coverage, and this result demonstrates the relationships found in the literature review. This finding supports my hypothesis in regard to minority support for more public mental health insurance. Further, it also provides affirmation to the theory of looking at problems of public mental health insurance from the theoretical perspective of race theory. In looking specifically at nonwhite respondents, there was a significant change in the outcome of answers, which support the application of this theory when looking at this topic. As a country, mental health issues are spiking, and in order to even have some families seek help for these issues before they become severe, coverage for treatment appears to be an important pre-

requisite for seeking coverage. The higher average answer in regard to desire for government intervention illustrates this point.

Further, the results from the tests completed for the ideology independent variable also affirm the hypothesis formed before running these analyses: that ideologically more conservative respondents would not be as in favor of more government intervention in regard to public mental health insurance as more ideologically liberal respondents would be. These results tie back to the literature review in regard to how ideology plays a role in thoughts on public mental health insurance. This result also supports national trends in regard to how different ideologies tend to think about government intervention broadly. Further the significance of this relationship depicts just how strong these ideologies are when thinking about support for public mental health insurance. Further, though, the fairly even spread amongst conservative respondents, even though on average answers were lower, shows that public mental health insurance could be a potential policy avenue for nonpartisan collaboration.

The findings from the rest of the data analyses, though not significant does raise questions for further research. Though along ideological lines and racial/ethnic lines questions regarding support for government intervention some hypotheses and research questions were addressed, some of the survey questions included in my project still need to be tackled. For example, even though we know the level of support for government intervention in regard to these wo independent variables, questions remain in regard to several categories. What does that additional scope of intervention entail? I.e. More therapy coverage, prescription coverage, both? Would people be willing to pay more for that added scope of intervention, or would their answers change when cost is involved? These questions require additional research and maybe even a larger pool of respondents in order to gleam a sufficient answer to these questions.

Additionally, I was not able to find conclusive support for the theory and hypotheses related to Transitional Age Youth either. Though there were signs that this theory could be applicable, such as the higher support for government intervention amongst younger respondents, conflating factors could have affected that decision more than just being young (such as the trend for more young people to identify as a liberal ideologically speaking). Because of these other variables and the lack of a significant relationship, this theory and my hypotheses cannot be conclusively adjudicated. Ergo, the null hypotheses cannot be rejected. From this survey, only 23 respondents fell within the category that would be considered TAY. In order to know whether this theory would be supported in regard to public opinion on public mental health insurance research, more research would need to be done. This research could entail something like a targeted survey at just that age group, which would help guarantee a larger pool of respondents so that this theory and hypothesis can be better analyzed. Further, this additional research could help answer the question about the role TAY plays when thinking about public mental health insurance research and public opinion within this group.

The results yielded from the relationship between race, ideology, and Question 5 not only affirm my hypotheses, but also relate to issues and discrepancies found in the literature review. If other studies have shown that minority families experience mental illness issues at a higher rate than white families and that the presence of coverage dictates whether these families seek help, then the higher support for government intervention affirms these trends found in previous studies. Further, though, it shows public opinion support for government intervention in public mental health insurance. Ergo, if studies themselves have shown that there is inequity in terms of access and the seeking out of mental health treatment by minority families, and that public opinion itself demonstrates this trend, then policy questions should be asked as to why this

problem has not been rectified. It would be interesting for future research in the field to address this policy angle. Further, the ideological results depict not only known ideological trends, but the spread of conservative responses and the in general average responses to Question 5 leaning towards government intervention illustrate that public mental health insurance could potentially be a policy field that could acquire broader political support. These results in tandem with the rising public mental health issues due to the COVID-19 pandemic create interesting further research opportunities. In that, now after a full year of the pandemic, it would be interesting for further public opinion surveys to be conducted on support for government intervention related to public mental health insurance. After a year of national mental health issues rising, would public support have grown for government intervention since the survey was conducted? Further, similarly to the further research in regard to the relationship in the data with race, this research brings up policy questions as well that would be interesting to research further.

Though when this project began the scope was much larger, the data available to analyze all of these questions and relationships just was not there. That does not mean that these relationships derived from the literature review do not exist, but it does mean that more research is needed in order to adjudicate if they do exist. However, the findings in regard to ideology and nonwhite demographics in relation to support for government intervention does provide significant and interesting results. Further, these results, even some of the data more broadly, and the literature review combined raise interesting policy questions in regard to public mental health insurance. Though it is smaller in scope, this project still contributes to the field of public opinion research surrounding public mental health insurance through the affirmation of the use of race theory and ideology when thinking about the needs and desires of the public in regard to public mental health insurance.

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Appendix

Survey Questions:

These are the survey questions specifically related to this project, in addition to the additional questions that IPOR asked.

1. Regardless of the type of health insurance plan a person may have, do you think that plan should cover mental illness the same way it covers physical illness?
1) Yes 2) No

2. And should prescriptions related to mental health be covered the same as other prescriptions?
1) Yes 2) No

3. Assuming a patient may need to see a therapist or counselor more often than they see a medical doctor, should there be a limit on the number of visits covered by insurance in a year?
1) Yes 2) No

4. Would you be willing to pay higher insurance premiums for equal coverage of mental health?
1) Yes 2) No

4 B. If yes, how much more money would you be willing to pay?
1) 5% 2) 10% 3) 15% 4) 20%

5. Some people think that the federal government should prioritize containing cost of health care. Let us say this is point 1 on a 1-7 scale. Others think that the federal government should provide insurance coverage for prescription drugs/therapy to treat mental health. Let us say this is point 7 on a 1-7 scale. Of course, some other people have opinions somewhere in between 1 and 7. Where would you place yourself on this scale?

1) Prioritize containing cost of health care
2) –
3) –
4) –
5) –
6) –
7) Providing insurance coverage for mental health treatment

6. Does your current insurance plan cover mental health?
1) Yes 2) No 3) I don't know

7. Are you very familiar, somewhat familiar, not very familiar or not at all familiar with the following disorders:

- Tourette Syndrome
- Obsessive Compulsive Disorder (OCD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Asperger Syndrome
- Anxiety

- Depression

1) Very Familiar 2) Somewhat Familiar 3) Slightly Familiar 4) Not Familiar

8. Do you know a person with a mental health disorder?
   1) Yes 2) No

Table 1: Descriptive statistics for measures of Attitudes on Government Intervention in Public Mental Health Insurance

	Mean	Dispersion or Skewness?	Min value	Max value
Dependent variable				
Attitudes on Government Intervention in Public Mental Health Insurance	4.5010	1.9507	1	7
Independent variables				
Age	3.3662	.80700	1	4
Education	4.1636	1.56250	1	6
Party (Rep, Ind, Dem)	2.0280	.78086	1	3
Ideology (Lib, Mod, Cons)	2.2692	.71758	1	3
Income	4.3137	1.60786	1	6
Nonwhite (yes or no)	.1956	.3968	0	1
Know Someone W/ Mental Health Disorder	.7727	.41942	0	1
Mental Health Awareness	4.6202	1.73590	0	6

Code Key for Descriptive Statistics

Age: 1-4 (higher values = older)
Education: 1-6 (higher values = higher education groups)
Party: 1-3 (Higher values = more Republican)
Ideology: 1-3 (higher values = more conservative)
Income: 1-6 (higher values = higher income groups)
Race: 0-1 (nonwhite = 1, white = 0)
Know: 0-1 (1=yes, knows someone with a mental health disorder, 0 = no, does not know someone with a mental health disorder)
Mental Health Awareness: 0-6 (range variable that measures the number of disorders listed in the survey that a respondent is very or somewhat familiar with)

Question 5: values on scale range from 1-7, respondents response on that scale is what they were coded for.

Table 2: Regression results for Survey Question 6: Attitudes on Government Intervention in Public Mental Health Insurance			
Variable	*Coefficient*	*St. error*	*Sig. (p-value)*
Constant (y-intercept)	7.009	.689	.000
Age	-.191	.117	.105
Education	.039	.072	.590
Nonwhite (yes or no)	.643	.241	.008*
Income	-.101	.067	.132
Party 3 Cat (Rep, Ind, Dem)	-.123	.152	.418
Ideology 3 Cat (Lib, Mod, Cons)	-.707	.167	.000*
Know Variable	-.067	.247	.785
MH Awareness Variable	.027	.070	.700
R^2	.136		
Root MSE (St. error of the estimate)	1.834		
Source: Roanoke College Institute for Policy and Opinion Research May 2020 Survey * p<.05			

Mean Comparisons:

Table 3: Mean Comparison Age & Attitudes on Government Intervention in Public Mental Health Insurance			
Age	**Mean**	**N**	**Std. Deviation**
18-29	5.2174	23	1.70445
30-44	5.0000	48	1.84506
45-64	4.4293	184	2.03934
65+	4.3984	256	1.91522
Total	4.5029	511	1.95425

Table 4: Mean Comparison Education & Attitudes on Government Intervention in Public Mental Health Insurance			
Education	**Mean**	**N**	**Std. Deviation**
Less than HS	5.4545	11	1.75292
HS	4.2603	73	2.07517
Some College	4.4622	119	1.99911
Associate’s Degree	4.6071	28	2.18309
Bachelor’s Degree	4.1560	141	1.90219
Advanced Degree	4.9348	138	1.79296
Total	4.5059	510	1.95504

Table 5: Mean Comparison Party & Attitudes on Government Intervention in Public Mental Health Insurance			
Party	**Mean**	**N**	**Std. Deviation**

Democrat	5.1745	149	1.65518
Independent/Other	4.2953	193	2.05417
Republican	4.0331	151	1.96101
Total	4.4807	493	1.96570

Table 6: Mean Comparison Ideology & Attitudes on Government Intervention in Public Mental Health Insurance

Ideology	Mean	N	Std. Deviation
Liberal	5.5195	77	1.69838
Moderate	4.6587	208	1.81880
Conservative	3.8629	197	1.94477
Total	4.4710	482	1.93989

Table 7: Mean Comparison Income & Attitudes on Government Intervention in Public Mental Health Insurance

Income ($)	Mean	N	Std. Deviation
Less than 20k	5.3103	29	1.69249
20k-35k	4.3478	46	1.95752
35k-50k	4.4909	55	1.84464
50k-75k	4.6811	94	1.93831
75k-100k	4.7162	74	1.83960
100k+	4.3540	161	2.06280
Total	4.5120	459	1.94952

Table 8: Mean Comparison Nonwhite & Attitudes on Government Intervention in Public Mental Health Insurance

Nonwhite	Mean	N	Std. Deviation
No	4.3333	405	1.96756
Yes	5.1800	100	1.77741
Total	4.5010	505	1.95903

Table 9: Mean Comparison for do You Know Someone with a Mental Health Disorder & Attitudes on Government Intervention in Public Mental Health Insurance

Know Someone	Mean	N	Std. Deviation
No	4.4100	100	1.93894
Yes	4.5281	409	1.96285
Total	4.5049	505	1.95684

Table 10: Mean Comparison Mental Health Awareness & Attitudes on Government Intervention in Public Mental Health Insurance

# of Disorders Known	Mean	N	Std. Deviation
0	4.3333	15	2.31969
1	5.3000	10	1.82878
2	4.0833	24	2.01983

3	4.8205	39	1.91767
4	4.2540	63	2.14000
5	4.4000	110	1.94040
6	4.5754	252	1.88680
Total	4.5010	513	1.95069

Crosstabs

	Table 11: Crosstab Analysis Between Ideology and Attitudes on Government Intervention in Public Mental Health Insurance				
Survey Response		**Liberal**	**Moderate**	**Conservative**	**Total**
1	**Count**	**3**	**18**	**36**	**57**
	%	**3.9%**	**8.7%**	**18.3%**	**11.8%**
2	**Count**	**3**	**9**	**17**	**29**
	%	**3.9%**	**4.3%**	**8.6%**	**6.0%**
3	**Count**	**4**	**22**	**27**	**53**
	%	**5.2%**	**10.8%**	**13.7%**	**11.0%**
4	**Count**	**7**	**43**	**40**	**90**
	%	**9.1%**	**20.7%**	**20.3%**	**18.7%**
5	**Count**	**17**	**48**	**39**	**104**
	%	**22.1%**	**23.1%**	**19.8%**	**21.6%**
6	**Count**	**10**	**21**	**11**	**42**
	%	**13.0%**	**10.1%**	**5.5%**	**8.7%**
7	**Count**	**33**	**47**	**27**	**107**
	%	**42.9%**	**22.6%**	**13.75**	**22.2%**
Total	**Count**	**77**	**208**	**197**	**482**
	%	**100.00%**	**100.00%**	**100.00%**	**100.00%**

	Table 12: Crosstab Analysis Between Nonwhite and Attitudes on Government Intervention in Public Mental Health Insurance			
Survey Response		**Nonwhite No**	**Nonwhite Yes**	**Total**
1	**Count**	54	**7**	**61**
	%	**13.3%**	**7.0%**	**12.1%**
2	**Count**	**27**	**3**	**30**
	%	**6.7%**	**3.0%**	**5.9%**
3	**Count**	**50**	**3**	**53**
	%	**12.3%**	**3.0%**	**10.5%**
4	**Count**	**73**	**18**	**91**
	%	**18.0%**	**18.0%**	**18.0%**
5	**Count**	**83**	**24**	**107**
	%	**20.5%**	**24.0%**	**21.2%**
6	**Count**	**36**	**11**	**47**
	%	**8.9%**	**11.0%**	**9.3%**
7	**Count**	**82**	**34**	**116**
	%	**20.2%**	**34.0%**	**23.0%**
Total	**Count**	**405**	**100**	**505**
	%	**100.00%**	**100.00%**	**100.00%**