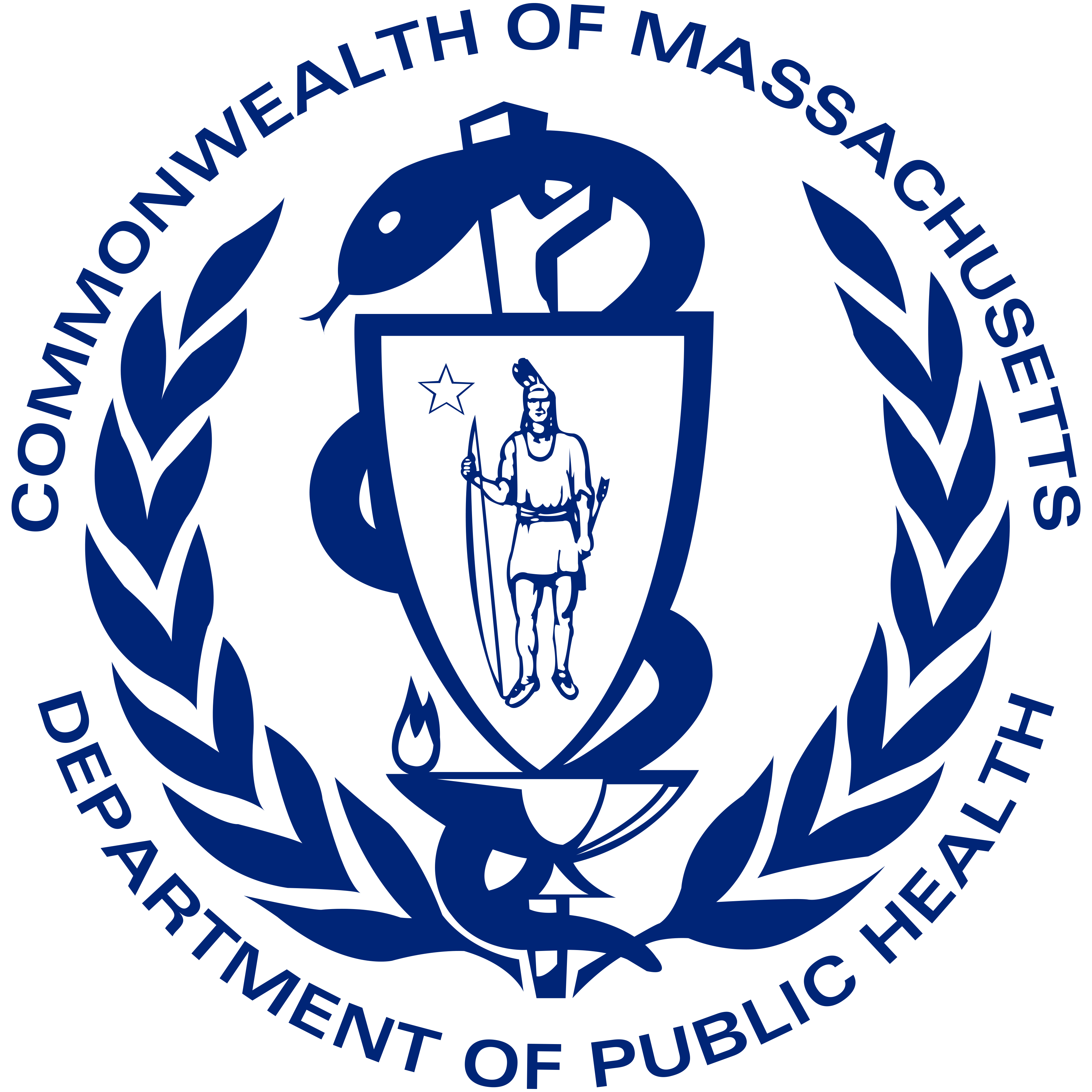


Massachusetts Department of Public Health

Bureau of Community Health and Prevention

August 2024



**2023 Community Health Equity Survey (CHES)**

Mental Health Report

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## Executive Summary

Mental health is integral to our overall health and affects nearly all aspects of our lives. The building blocks for positive mental health include many different factors at the individual, family, community, institution, and systems levels. However, not everyone has equal access to these building blocks and equal opportunities to achieve positive mental health. Systems of oppression, like systemic racism, drive differential access to important social resources and opportunities that shape exposures to key drivers of mental health. This creates unjust patterns of poor mental health within many communities.

**Mental Health in Massachusetts**

Data from the 2023 Community Health Equity Survey (CHES) show that the overall burden of poor mental health in Massachusetts is high.

* Nearly 1 in 3 adults and 1 in 2 youth reported having high or very high psychological distress.
* About 7% of adults and 15% of youth reported suicidal ideation.
* About 13% of adults and 16% of youth reported feeling socially isolated.
* The highest reported rates of psychological distress, suicidal ideation, and social isolation were among the young adult group.

Rates of poor mental health were particularly high within certain communities of focus. These include:

* Many **communities of color**, including those identifying as American Indian or Alaska Native, Hispanic or Latine/o/a, and Middle Eastern or North African.
* Members of the **lesbian, gay, bisexual, transgender, queer, questioning, asexual, plus (LGBTQA+) community.**
* **People with disabilities**, including those that are blind or vision impaired, deaf or hard of hearing, have a cognitive disability, have a learning or intellectual disability, have a mobility disability, and those that have a self-care or independent living disability.

**Drivers of Mental Health Inequity**

The drivers of poor mental health and mental health inequities include factors along the health inequity pathway. Data from the 2023 CHES help to illustrate the connections between various social drivers of health and mental health outcomes.

* **Economic Stability** is the ability of individuals, households, and communities to meet their basic needs. Adults that reported having trouble paying for basic needs were 4 times as likely to report psychological distress and social isolation compared to those that did not.
* **Employment** is an important contributor to economic stability and overall mental health. Adults that reported being out of work were nearly twice as likely to report psychological distress and over twice as likely to report suicidal ideation compared to those currently employed.
* **Social Networks and Supports** influence our physical and mental health in many important ways. Adults that reported having low levels of social support were 2.6 times as likely to report suicidal ideation compared to those that reported high levels of support. Approximately 7 in 10 youth that reported not having someone to talk to about personal problems had high or very high psychological distress.
* **Housing** is a key social determinant of health. There are many aspects of housing that influence mental health. Adults that reported having trouble paying for housing-related expenses were 2.6 times as likely to report psychological distress and 2.8 times as likely to report suicidal ideation compared to those that did not. Adults that reported not having a steady place to live had significantly worse mental health outcomes compared to those that did.
* **Access to Health Care** including mental health care is important for overall health. However, significant barriers exist that contribute to inequities in access and utilization. Barriers to health care access that were significantly associated with poor mental health outcomes include health care expenses, experiencing discrimination in the health care setting, and lack of health insurance coverage.
* **Environmental Exposures** include a wide range of external factors that influence health. Environmental exposures in the home, such as exposure to pests, mold, and unsafe drinking water were associated with psychological distress. Climate impacts such as extreme temperatures and flooding were also associated with poor mental health outcomes.
* **Violence** in its many forms can have a devastating impact on physical and mental health. Individuals that were exposed to intimate partner violence, household violence, sexual violence, or neighborhood violence had significantly higher rates of psychological distress, social isolation, and suicidal ideation.
* **Discrimination** experienced by individuals was associated with poor mental health. Respondents that reported experiencing discrimination in the past 12 months were 2.7 times as likely to have high or very high psychological distress, 4.1 times more likely to report suicidal ideation, and 4 times as likely to report social isolation compared to those that did not experience discrimination.

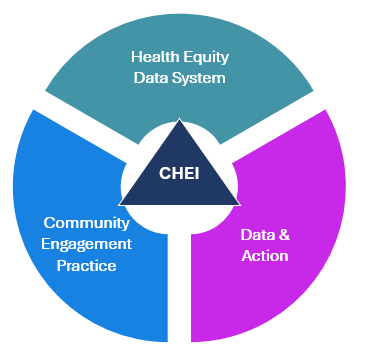
Communities of focus that experienced disproportionately high levels of poor mental health also reported experiencing inequities within these drivers of health. Members of communities of focus that had access to positive building blocks for mental health, such as economic stability, access to timely and quality health care, stable housing, and reduced exposures to discrimination and violence, had significantly better mental health outcomes.

**Action to Address Root Causes of Mental Health Inequities**

Solutions to promote mental health and address inequities must include strategies that address inequities across the various drivers of mental health. Data from the 2023 CHES highlighted potential areas of action to address root causes of inequities. For example, strategies and interventions to promote economic stability, increase access to affordable housing, and enact policies that create systems and environments that promote health equity are likely to have a positive impact on overall mental health and help bridge the equity gap. Critical work to promote mental health is being carried out by many groups and institutions across the state, including the Department of Public Health. More work and resources are still needed, however, to fully address the needs of Massachusetts residents.

## Background

### Community Health Equity Initiative Overview

The Community Health Equity Initiative (CHEI) is a health equity data and response system implemented by the Massachusetts Department of Public Health’s Bureau of Community Health and Prevention (BCHAP) in collaboration with community, the Massachusetts Department of Public Health (DPH), and other state agency partners.

The overarching goal of CHEI is to promote the health of Massachusetts residents and reduce health inequities that are shaped by systemic racism and other systems of oppression through its health equity data and response system. This system is centered around three foundational pillars: a data system rooted in health equity, authentic community engagement, and intentional focus on data & action.

A key component of the health equity data system is the Community Health Equity Survey (CHES). CHES is a population-based survey conducted to better understand the most pressing health needs facing Massachusetts residents and to help DPH, sister agencies, and communities across the state change conditions that get in the way of health. The survey is developed in collaboration with community members, community-based organizations, municipal partners, and internal partners within DPH and other state agencies.

The 2023 CHES was administered to Massachusetts residents ages 14 and older from July through October 2023. The survey was primarily administered online with a paper survey option available to individuals for which online surveys are not accessible. The survey gathers important information across various topic areas, including health outcomes, behaviors, and social drivers of health. The overall sample size for the 2023 CHES was 18,276, with representation across members of various communities of focus, including people of color, people with disabilities, rural residents, and more.

For more information about CHEI and CHES, visit the CHEI website: [www.mass.gov/CHEI](http://www.mass.gov/CHEI).

### About This Report

The 2023 CHES contributes to our understanding of mental health and inequities in Massachusetts by gathering important information on mental health indicators and the root causes of mental health inequities to inform public health solutions.

This report is part of a collection of resources intended to provide our partners and other interested users with important health equity data and frameworks that can be used to support policy and practice change to promote health equity.

The overall goals of this report are to provide an overview of the mental health data and findings from the 2023 CHES, highlight communities experiencing inequities in poor mental health, and identify potential areas of action to address the root causes of mental health inequities.

This report is organized into the following sections:

1. **Mental Health Equity Framing and Key Drivers**

This section introduces the CHEI Health Inequities Framework, which helps to illustrate the pathways between systems of oppression, key drivers of health inequities, and health outcomes.

1. **Mental Health in Massachusetts**

This section provides a brief overview of the state of mental health in Massachusetts with a focus on findings from the 2023 CHES. This section also highlights communities that have a disproportionately high burden of poor mental health.

1. **Drivers of Mental Health Equity**

This section provides an overview of the various drivers of health, using CHES data to illustrate their connection to mental health equity.

1. **Promoting Mental Health: Action to Address Root Causes of Mental Health Inequities**

This section highlights potential areas for action to address the root causes of mental health inequities supported by findings from the 2023 CHES. The section also provides examples of current work happening within communities and at the Department of Public Health to promote mental health.

Findings and recommendations presented in this report were informed by partners of CHEI through participation in the CHEI Collaborative Data Analysis (CDA) process.The CDA process creates opportunities for community, DPH, and state agency partners to inform data analysis planning, interpretation, and contextualization of results. Partners were invited to attend a series of mental health-specific CDA sessions to (1) identify important research questions and intersections for further analysis, (2) review and interpret analyzed results, (3) help develop dissemination materials and communication strategies, and (4) recommend data-driven action. Analyses and themes elevated during these sessions, as well as recommended framing, contextual information, and interpretation, have been incorporated into this report.

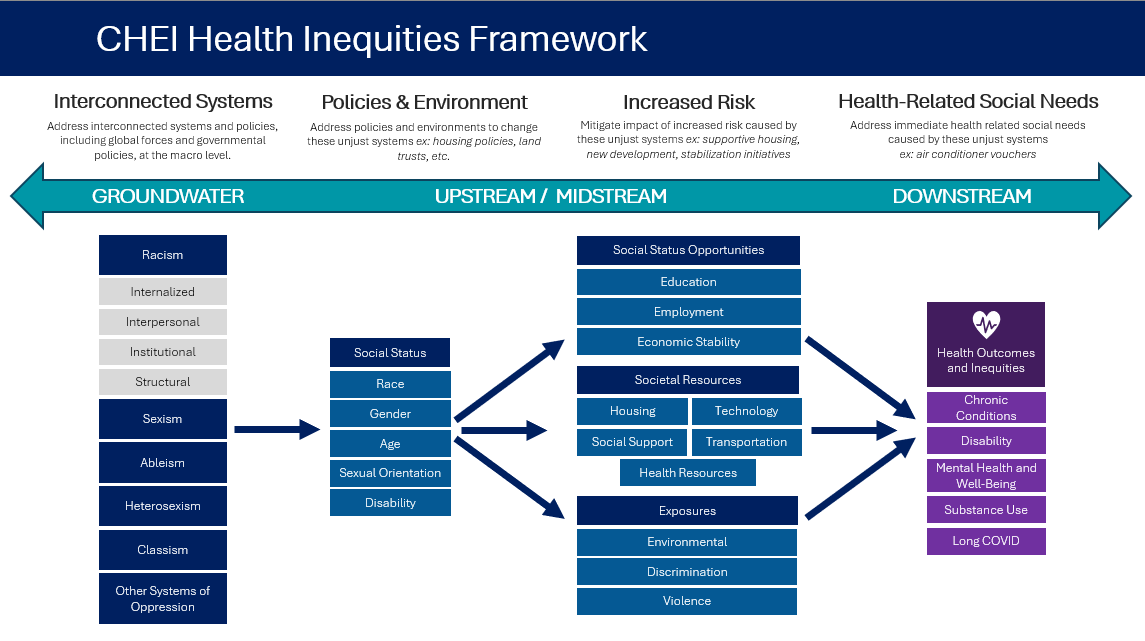
## Mental Health Equity Framing and Key Drivers

Mental Health is a core component of overall health and includes our emotional, psychological, and social well-being. Our mental health affects nearly all aspects of our lives and is important for maintaining meaningful relationships, coping with everyday stress, and making choices[[1]](#endnote-2). Our mental health exists on a continuum and is more than just the absence of mental illness[[2]](#endnote-3). Individuals living with a mental health condition can have high levels of mental well-being, just as those without a mental health diagnosis are not guaranteed to have positive overall mental health.

### CHEI Health Inequities Framework

The building blocks for positive mental health include factors at the individual, family, community, environment, institution, and systems levels[[3]](#endnote-4). However, not everyone has equal opportunities to achieve positive mental health. The CHEI Health Inequities Framework (Figure 1) helps to illustrate the various pathways that lead to poor health outcomes and health inequities, including mental health.

Figure 1. CHEI Health Inequities Framework



This framework shows that poor health outcomes and health inequities that exist within and across communities are driven by systemic racism and other systems of oppression. These systems create, maintain, and attribute value to various social status categories, such as race, which leads to differential access to social resources and opportunities and differential exposure to various proximal determinants of health. While individual-level biological factors and health-related behaviors play an important role in one’s mental health, the systematic and unjust patterns of poor mental health across populations are largely driven by interconnected systems that impact the social determinants of health[[4]](#endnote-5). The 2023 CHES gathers information along this health inequity pathway to help us better understand the root causes of health inequities, including mental health inequities.

## Mental Health in Massachusetts

In this section, we provide a brief overview of the state of mental health in Massachusetts focusing on findings from the Community Health Equity Survey (CHES). The chapter also includes highlights from other Massachusetts statewide data systems, including the Behavioral Risk Factor Surveillance System (BRFSS) [[5]](#endnote-6), Youth Health Survey (YHS), and Youth Risk Behavior Survey (YRBS) [[6]](#endnote-7). We will then highlight communities in Massachusetts that experience inequities in poor mental health outcomes. It is important to note that the data in this chapter focuses primarily on mental illness and other poor mental health outcomes, which is only one component of mental health.

### Mental Illness and Poor Mental Health Outcomes

Mental illness includes health conditions that involve significant changes in our thinking, emotions, or behavior that disrupt our everyday life[[7]](#endnote-8). Mental illnesses are among the most common health conditions in the U.S., with more than 1 in 5 adults living with a mental illness[[8]](#endnote-9), nearly 1 in 2 adolescents having a current or past mental disorder, and over 1 in 5 youth having a seriously debilitating mental illness either currently or at some point in their lives[[9]](#endnote-10). Many mental illnesses are also closely linked to our physical health. People with a mental health condition have increased morbidity and mortality associated with a range of physical health conditions, including heart disease, diabetes, and stroke[[10]](#endnote-11). Individuals with a chronic condition such as cancer are also more likely to develop a mental health condition like depression[[11]](#endnote-12).

#### Psychological Distress

Psychological distress is defined as a state of emotional suffering characterized by symptoms of depression and anxiety, along with other somatic symptoms[[12]](#endnote-13). The 2023 CHES measures psychological distress using the Kessler Psychological Distress Scale, a widely used, validated scale to assess non-specific psychological distress in the past 30 days[[13]](#endnote-14). Respondents’ answers are scored and categorized into the following levels of psychological distress: low, medium, high, and very high.

Figure 2. 2023 CHES - Psychological Distress by Age Group (Years)

Overall levels of psychological distress for adult and youth respondents in the 2023 CHES were high. Nearly 1 in 3 adults (32%) aged 18 and older and 1 in 2 youth (46%) aged 14 to 17 had high or very high levels of psychological distress. Psychological distress was highest among youth and young adult age groups.

Trends in psychological distress from the 2023 CHES are consistent with data from other MA statewide surveys. Mental health data from the 2022 BRFSS showed that approximately 14% of MA adults have persistent poor mental health, with the highest rates among the 18-24 age group (22%) and lowest among those 75 and older (6.1%). Data from the 2022 YHS and YRBS show that among MA high school students, nearly 1 in 3 (32%) reported their mental health was not good always or most of the time.

#### Suicide

Suicide is one of the leading causes of death in the United States among all age groups and the second leading cause of death among people aged 10 to 34. In 2022, over 13 million US adults had serious thoughts of suicide in the past year[[14]](#endnote-15). The 2023 CHES included two questions related to suicide: (1) Suicidal Ideation – “In the past 12 months, did you ever think about doing something to end your life?” (2) Suicide Attempts – “In the past 12 months, how many times did you do something to try to end your life?”.

Figure 3. 2023 CHES - Suicidal Ideation by Age Group (Years)

Overall, 7.4% of adults aged 18 and older and 14.7% of youth aged 14 to17 reported suicidal ideation in the past year.

Young adults aged 18 to 24 had the highest reported rates of suicidal ideation (17.9%).

Data on suicidal ideation from the 2023 CHES are comparable to findings from other statewide surveys. Data from the 2022 YHS/YRBS showed that among MA high school students, 19.7% reported injuring oneself intentionally without wanting to die and 7.6% attempted suicide in the past year. The 2022 MA BRFSS estimates that approximately 3.9% of adults have seriously considered suicide in the past year, which is lower than the 2023 CHES estimate. This difference is likely due to methodological and sampling differences.

#### Social Isolation

Social relationships play an important role in mental well-being and social isolation can impact overall mental health. Persistent social isolation has been linked to several poor health outcomes, including depression, dementia, heart disease, suicidal behavior, and psychosis[[15]](#endnote-16),[[16]](#endnote-17). Social isolation likely increased as a result of the COVID-19 pandemic, particularly among older adults, leading to increased risk of associated mental health outcomes[[17]](#endnote-18).

Isolation in the 2023 CHES was defined as not having many people to talk to or spend time with on a regular basis and included the following question: “How often do you feel isolated from others?”. Social isolation within CHES is defined as those that reported feeling isolated from others “usually” or “always”.

Figure 4. 2023 CHES - Social Isolation by Age Group (Years)

Overall, 13.2% of adults aged 18 and older and 15.6% of youth aged 14-17 reported usually or always feeling isolated from others.

Social Isolated was highest among young adults aged 18 to 24. Older adults reported the lowest rates of social isolation.

National and statewide data on social isolation is limited. In the U.S., it is estimated that 1 in 3 adults aged 45 and older are lonely and nearly 1 in 4 adults 65 and older are socially isolated[[18]](#endnote-19). Estimates of social isolation from the 2023 CHES are generally lower than these national estimates, particularly among older adults. Differences in social isolation rates in this age group are likely due to methodological and sampling differences[[19]](#footnote-2).

#### Other Health Outcomes and Substance Use

Mental health is associated with other health outcomes, including chronic conditions and substance use. Research has consistently shown a bidirectional relationship between chronic conditions and mental health[[20]](#endnote-20). Mental health disorders are associated with higher incidences of chronic conditions such as diabetes, cardiovascular disease, cancer, and respiratory conditions. Additionally, the burden of managing chronic conditions can contribute to psychological distress[[21]](#endnote-21).

Poor mental health can also increase one’s risk for substance use and misuse. More than one in four adults living with a serious mental health disorder also has a substance use disorder[[22]](#endnote-22). Substance use can also contribute to and exacerbate poor mental outcomes. Outreach and services to individuals and communities affected by substance addiction and strategies that focus on prevention are critical for mental health promotion.

Findings from the 2023 CHES help to quantify the association between substance use and mental health. For example, tobacco use, medical marijuana use, and non-medical marijuana use were significantly associated with psychological distress, suicidal ideation, and social isolation (Table 1).

Table 1. 2023 CHES - Substance Use and Mental Health Indicators

|  | **Psychological Distress –  High / Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Tobacco Use** |  |  |  |
| Past Month Use | 54.1\*\*\* | 14.3\*\*\* | 24.7\*\*\* |
| No Use in Past Month (ref) | 30.8 | 7.4 | 12.1 |
| **Non-Medical Marijuana Use** |  |  |  |
| Past Month use | 49.1\*\*\* | 17.8\*\*\* | 20.2\*\*\* |
| No Use in Past Month (ref) | 30.2 | 6.5 | 12.4 |
| **Medical Marijuana Use** |  |  |  |
| Past Month Use | 56.6\*\*\* | 20.5\*\*\* | 26.8\*\*\* |
| No Use in Past Month (ref) | 31.3 | 7.2 | 12.6 |

\*\*\* p<.0001, \*\* p<.001, \* p<.05.

In addition to the substance use reported here, CHES also collects data on the use of other substances and respondents’ preferences for resources to help manage the use of alcohol or other drugs. More findings related to substance use will be made available in future CHEI resources.

### Communities Experiencing Inequities in Poor Mental Health

The Massachusetts Department of Public Health (DPH) envisions an equitable public health system that supports optimal well-being for all people in Massachusetts. This includes equitable opportunities for all to achieve mental health and emotional well-being. As summarized in the previous section, the overall burden of poor mental health in Massachusetts is high. However, this burden is not equal across all communities. Poor mental health outcomes are disproportionately concentrated within certain populations due to systems of oppression and other root causes of health inequities.

This section will further explore the mental health findings to highlight inequities in poor mental health experienced within certain communities of focus. The 2023 CHES provides important insights into mental health inequities within Massachusetts by allowing for disaggregation by populations that are often underrepresented or made invisible in other datasets. This section highlights several communities of focus that reported the highest burden of poor mental outcomes. Importantly, these are not the only communities that experience inequities in mental health. Future population spotlights will dive deeper into the needs, assets, and inequities experienced within each of our communities of focus.

#### People of Color

As illustrated in the CHEI Health Inequities Pathway (Figure 1), racism at the structural, institutional, interpersonal, and internalized levels contributes to inequities in health for people of color, including mental health. Mental illness and other poor mental health outcomes may be underdiagnosed and underreported within communities of color, likely due to cultural, institutional, and systemic factors [[23]](#endnote-23). Cultural norms around mental health, social stigma, and language differences may contribute to underreporting within these communities[[24]](#endnote-24). People of color are also more likely to experience barriers to accessing mental health services and more likely to receive poor quality mental health care leading to underdiagnosis of mental health conditions[[25]](#endnote-25). These factors contribute to the national data showing many people of color groups have equal or better outcomes compared to White, non-Hispanic/Latine/o/a (nH/nL) people[[26]](#endnote-26). Massachusetts data from the 2022 BRFSS show a similar trend with Black, Hispanic/Latine/o/a, and White adults having approximately equal rates of persistent poor mental health and Asian, Native Hawaiian and Pacific Islander adults reporting lower rates.

Findings from 2023 CHES show several communities of color disproportionately experienced poor mental health outcomes. As shown in Figure 5 and Table 2, many communities of color disproportionately experienced poor mental health outcomes, including those identifying as American Indian or Alaska Native, Hispanic or Latine/a/o, Middle Eastern or North African, and multiracial.

Figure 5. CHES 2023 - Adult Psychological Distress by Race and Hispanic or Latine/o/a Ethnicity

ANHPI=Asian, Native Hawaiian, Pacific Islander   
nH/nL=non-Hispanic/non-Latino-a-e

Table 2. 2023 CHES - Mental Health by Race/Ethnicity

|  | Psychological Distress –  High or Very High | | Suicidal Ideation | | Social Isolation | |
| --- | --- | --- | --- | --- | --- | --- |
|  | Adult (18+) Weighted % | Youth (14-17) Weighted % | Adult (18+) Weighted % | Youth (14-17) Weighted % | Adult (18+) Weighted % | Youth (14-17) Weighted % |
| Overall | 31.6 | 45.6 | 7.3 | 14.6 | 13.1 | 15.4 |
| Race/Ethnicity |  |  |  |  |  |  |
| American Indian / Alaska Native | 42.8\*\*\* | ^ | 12.6\* | ^ | 19.2\* | ^ |
| ANHPI1, nH/nL​2 | 24.6\*\*\* | 34.7\*\* | 3.7\*\*\* | 11.2 | 6.5\*\*\* | 8.4\* |
| Black, nH/nL | 32.6 | 38.2 | 6.3 | 8.1\* | 14.6\* | 20.1\* |
| Hispanic or Latine-o-a | 42.0\*\*\* | 46.6 | 6.6 | 13.4 | 18.2\*\*\* | 20.2\* |
| Middle Eastern or North African | 38.0\* | 62.2\* | 19.9\*\*\* | 11.3 | 12.6 | 20.3 |
| Multiracial, nH/nL | 49.6\*\*\* | 52.9 | 15.1\*\*\* | 19.0 | 25.7\*\*\* | 14.1 |
| White, nH/nL (*ref*) | 30.1 | 46.2 | 7.5 | 15.7 | 12.3 | 14.2 |

1 ANHPI=Asian, Native Hawaiian, Pacific Islander  
2 nH/nL=non-Hispanic/non-Latino-a-e  
^ Data from groups that have fewer than 30 survey respondents were suppressed.  
\*\*\* p<.0001, \*\* p<.001, \* p<.05. P-values from Pearson chi-square test comparing weighted responses from those identifying as specified race group and those identifying as White, nH/nL.

**Multiracial**

* 1 in 2 adults identifying as multiracial reported high or very high psychological distress, and 1 in 4 reported social isolation.

**Middle Eastern or North African (MENA)**

* Over 6 in 10 MENA youth aged 14-17 reported high or very high psychological distress, which is 34% higher than the rate for White, nH/nL youth.
* Approximately 2 in 5 MENA adults aged 18 and older reported suicidal ideation in the past year, which is over double the rate for White, nH/nL adults.

**Inequities Spotlight**

**American Indian/Alaska Native (AI/AN)**

* Approximately 2 in 5 AI/AN adults reported high or very high psychological distress, which is 42% higher than the rate for White, nH/nL adults.
* AI/AN adults have a 68% higher rate of suicidal ideation compared to White, nH/nL adults (12.6% vs 7.5%).

**Hispanic / Latine-o-a**

* Approximately 2 in 5 Hispanic / Latine-o-a adults reported high or very high psychological distress and 1 in 5 youth reported being socially isolated.

#### Sexual Orientation, Gender Identity, Transgender Identity

The Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Asexual, Plus (LGBTQA+) community includes individuals with a diverse range of identities and expressions of gender and sexual orientation and experiences. The LGBTQA+ community has experienced a long history of discrimination, violence, and denial of civil and human rights[[27]](#endnote-27). This has contributed to members of this community being at higher risk for many mental health conditions, including depression, anxiety, and substance misuse[[28]](#endnote-28). Existing data on mental health of the LGBTQ+ community in MA generally show higher rates of poor mental health compared to straight/heterosexual and cisgender people. For example, the MA BRFSS showed that MA adults who identified as LGBT had significantly higher rates of persistent poor mental health compared to straight/cisgender adults (30.2% vs 11.5%).

The 2023 CHES helps us to better understand the state of mental health within the LGBTQA+ community by allowing for disaggregation by gender identity, sexual orientation, and transgender identity. Overall, adults and youth who identify as LGBTQA+ had significantly higher rates of psychological distress, suicidal ideation, and social isolation compared to straight/cisgender respondents. Figure 6 and Table 3 highlight several inequities in mental health outcomes across specific sexual orientation, gender, and transgender identities.

Figure 6. 2023 CHES – Youth (14-17) Suicidal Ideation by Sexual Orientation and Transgender Identity

Table 3. 2023 CHES - Mental Health by Gender Identity, Sexual Orientation, and Transgender Identity

|  | Psychological Distress –  High or Very High | | Suicidal Ideation | | Social Isolation | |
| --- | --- | --- | --- | --- | --- | --- |
|  | Adult (18+) Weighted % | Youth (14-17) Weighted % | Adult (18+) Weighted % | Youth (14-17) Weighted % | Adult (18+) Weighted % | Youth (14-17) Weighted % |
| Overall | 31.7 | 45.8 | 7.4 | 14.7 | 13.2 | 15.6 |
| Gender Identity |  |  |  |  |  |  |
| Female (*ref*) | 31.8 | 48.5 | 6.2 | 11.4 | 12.0 | 15.8 |
| Male | 28.5\*\*\* | 39.8\*\*\* | 7.3\* | 14.2\* | 13.0\* | 13.2\* |
| Non-Binary | 72.6\*\*\* | 80.1\*\*\* | 39.4\*\*\* | 53.2\*\*\* | 39.8\*\*\* | 43.1\*\*\* |
| Questioning/Undecided | 68.6\*\*\* | ^ | 21.6\*\*\* | ^ | 22.5\* | ^ |
| Sexual Orientation |  |  |  |  |  |  |
| Asexual | 43.1\*\*\* | 57.2\*\* | 13.9\*\*\* | 28.4\*\*\* | 20.8\*\*\* | 28.8\*\*\* |
| Bisexual/Pansexual | 58.8\*\*\* | 68.5\*\*\* | 24.5\*\*\* | 33.6\*\*\* | 24.6\*\*\* | 29.6\*\*\* |
| Gay or Lesbian | 42.1\*\*\* | 72.5\*\*\* | 10.5\*\*\* | 34.6\*\*\* | 18.1\*\*\* | 23.0\*\*\* |
| Queer | 66.9\*\*\* | ^ | 33.1\*\*\* | ^ | 30.4\*\*\* | ^ |
| Questioning/Not Sure | 65.8\*\*\* | 52.3\* | 28.2\*\*\* | 23.1\*\*\* | 37.2\*\*\* | 26.3\*\* |
| Straight/Heterosexual (*ref*) | 27.3 | 38.0 | 5.2 | 8.4 | 11.0 | 11.8 |
| Transgender Identity |  |  |  |  |  |  |
| Transgender | 75.1\*\*\* | 84.8\*\*\* | 41.0\*\*\* | 60.1\*\*\* | 40.8\*\*\* | 40.7\*\*\* |
| Not Sure | 69.4\*\*\* | 76.9\*\*\* | 27.7\*\*\* | 39.3\*\*\* | 22.1\*\* | 36.7\*\*\* |
| Not Transgender (*ref*) | 30.3 | 41.9 | 6.3 | 10.8 | 12.2 | 13.7 |

^ Data from groups that have fewer than 30 survey respondents were suppressed.  
\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

**Inequities Spotlight**

**LGBTQA+ Youth (aged 14-17)**

* Youth identifying as **Asexual, Bisexual, Pansexual, Gay, Lesbian, or Questioning/Not Sure** were 3 to 4 times as likely to report suicidal ideation compared to youth identifying as straight/heterosexual.
* 6 in 10 youth identifying as **Transgender** reported suicidal ideation. That rate is over 5 times higher compared to youth that do not identify as transgender.
* 4 in 5 youth identifying as **Non-Binary** reported having high or very high psychological distress and over half reported suicidal ideation.

**Inequities Spotlight**

**LGBTQA+ Adults**

* Over 7 in 10 **Non-Binary Adults** reported having high or very high psychological distress, 2.3 times the rate of female adults. Nearly 4 in 10 non-binary adults reported suicidal ideation and being socially isolated, 6.4 times and 3.5 times the rate of female adults respectively.
* **Transgender** respondents reported some of the highest rates of poor mental health outcomes among all CHEI communities of focus. Adults who identify as transgender were 2.5 times as likely to report high or very high psychological distress, 2.0 times as likely to report suicidal ideation, and 6.4 times as likely to report being socially isolated compared to those not identifying as transgender.
* **LGBQA** adults had significantly worse mental health outcomes compared to heterosexual adults. Adults identifying as bisexual/pansexual, queer, or questioning had over twice the rate of high or very high psychological distress compared to adults identifying as heterosexual. Adults identifying as queer were 6.4 times as likely to report suicide ideation compared to adults identifying as heterosexual.

#### People with Disabilities

People with disabilities are a diverse group of individuals with a wide range of identities, abilities, and experiences. Disabilities are defined as conditions interacting with environmental and social barriers that make it more difficult for people to do certain activities and interact with the world around them[[29]](#endnote-29). Ableism is a system of oppression that discriminates against and creates disadvantages for people with disabilities. Ableism leads to structural, environmental, and social barriers that make it more difficult for people with disabilities to fully engage and interact with the world around them[[30]](#endnote-30). People with disabilities often experience more mental distress than people without disabilities. In the US, an estimated 17.4 million adults with disabilities experience frequent mental distress, which is 4.6 times as often as adults without disabilities[[31]](#endnote-31). Consistent with national data, the 2023 CHES show that people with disabilities are more likely to experience poor mental health outcomes.

Figure 7. 2023 CHES – Adult Psychological Distress by Disability Status

Overall, people with disabilities had significantly worse mental health outcomes compared to people without disabilities.

* Approximately 1 in 2 adults aged 18 and older with disabilities and 3 in 4 youth aged 14 to 17 with disabilities reported high/very high psychological distress.
* Approximately 15% of adults with a disability and 35% of youth with a disability reported suicidal ideation.
* Adults with a disability were over 3 times as likely to report social isolation compared to those without a disability.

The 2023 CHES intentionally sampled from individuals living with different types of disabilities, allowing for further disaggregation within the disability community. Unsurprisingly, mental health status was not uniform across disability type, highlighting the importance of data disaggregation within this community. As seen in Table 4, people with cognitive, learning/intellectual, and self-care/independent living disabilities reported particularly high rates of poor mental outcomes among all disability types.

Table 4. 2023 CHES Mental Health by Disability Type

|  | Psychological Distress –  High or Very High | | Suicidal Ideation | | Social Isolation | |
| --- | --- | --- | --- | --- | --- | --- |
|  | Adult (18+) Weighted % | Youth (14-17) Weighted % | Adult (18+) Weighted % | Youth (14-17) Weighted % | Adult (18+) Weighted % | Youth (14-17) Weighted % |
| People with Disabilities |  |  |  |  |  |  |
| At Least One Disability | 50.8\*\*\* | 74.4\*\*\* | 15.0\*\*\* | 34.6\*\*\* | 25.8\*\*\* | 33.1\*\*\* |
| Blind/Vision Impaired | 49.9\*\*\* | 63.0\*\*\* | 10.5\*\*\* | 34.6\*\*\* | 30.0\*\*\* | 39.6\*\*\* |
| Cognitive Disability | 73.3\*\*\* | 77.2\*\*\* | 24.4\*\*\* | 36.1\*\*\* | 39.5\*\*\* | 35.8\*\*\* |
| Deaf/Hard of Hearing | 28.0\* | ^ | 7.8\*\*\* | ^ | 15.2\*\*\* | ^ |
| Learning/Intellectual Disability | 65.9\*\*\* | 66.8\*\*\* | 25.4\*\*\* | 29.8\*\*\* | 40.3\*\*\* | 34.3\*\*\* |
| Mobility Disability | 44.0\*\*\* | 75.5\*\*\* | 10.4\*\*\* | 50.8\*\*\* | 21.3\*\*\* | 49.6\*\*\* |
| Self-Care/Independent Living Disability | 65.1\*\*\* | 86.7\*\*\* | 21.9\*\*\* | 55.3\*\*\* | 39.0\*\*\* | 53.4\*\*\* |
| No Disability (*ref*) | 24.4 | 36.3 | 4.5 | 9.0 | 8.4 | 10.3 |

^ Data from groups that have fewer than 30 survey respondents were suppressed.  
\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

**People with Cognitive Disability**

* About 3 in 4 adults and youth with a cognitive disability reported having high or very high psychological distress.
* 1 in 4 adults and over 1 in 3 youth with a cognitive disability reported suicidal ideation.

**Inequities Spotlight**

**People with a Learning / Intellectual Disability**

* Adults with a learning/intellectual disability were 2.7 times as likely to report high or very high psychological distress and 5.6 times as likely to report suicidal ideation compared to adults without a disability.
* About 4 in 10 adults and 1 in 3 youth with a learning/intellectual disability reported social isolation.

**People with a Self-Care / Independent Living Disability**

* Youth with a self-care/independent living disability were 2.4 times as likely to report high or very high psychological distress compared to youth without a disability.
* Youth with a self-care/independent living disability reported the highest rate of high or very high psychological distress (86.7%), suicidal ideation (55.3%) and social isolation (53.4%) of all disability types.

**Inequities Spotlight**

**Youth with a Mobility Disability**

* 1 in 2 Youth with a mobility disability reported social isolation, which is the second highest among all disability groups.
* 1 in 2 youth with a mobility disability reported suicidal ideation and 3 in 4 had high or very high psychological distress.

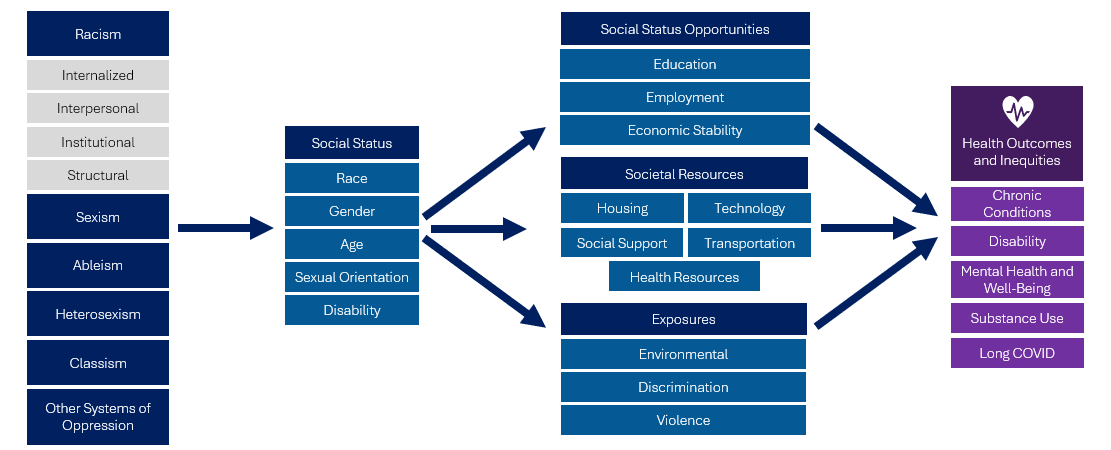
## Drivers of Mental Health Inequity

The previous chapter provided an overview of mental health in Massachusetts and highlighted several communities with disproportionately high levels of poor mental health. In this chapter, we will explore the drivers of poor mental health and health inequities using findings from the 2023 CHES.

As demonstrated by the CHEI Health Inequities Framework (Figure 1), there is no single pathway that leads to mental well-being and no single cause that fully explains why certain populations have worse mental health outcomes. Many individual-level, environmental, social, structural, and historical factors work together to influence overall mental health. This chapter will highlight findings from the 2023 CHES that help demonstrate how inequities in social opportunities, resources, and key exposures contribute to inequities in mental health outcomes.

### Social Status Opportunities

Social status opportunities, like education, employment, and economic stability, are important drivers of health equity. They serve as important facilitators of mental health and well-being, influencing a wide range of mid- and downstream factors that influence overall health.



Social status opportunities are closely connected to one another. At the individual level, having access to quality education and having safe and steady employment are important contributors to the economic stability of individuals and families. At the community level, overall economic stability contributes to neighborhood-level conditions that can lead to increased education and employment opportunities[[32]](#endnote-32). At the systems level, systems of oppression help shape social status opportunities, creating patterns of advantages and disadvantages that lead to inequities in health, including mental health. CHES 2023 gathers important information on various social status opportunities and their connections to mental health. The following sections will highlight findings related to two important social status opportunities: (1) Economic Stability and (2) Employment.

#### Economic Stability

Economic stability is the ability of individuals, households, and communities to meet their basic and essential needs sustainably. Having economic stability contributes to one’s ability to access important resources like housing, technology, transportation, health care, and healthy foods[[33]](#endnote-33). The absence of economic stability negatively impacts mental health by threatening the ability of individuals and groups to attain necessary health-related resources, influencing health-related behaviors, and increasing levels of psychological distress[[34]](#endnote-34).

Data from the 2023 CHES demonstrate a clear relationship between economic stability and mental health. The following economic indicators included in the survey were all significantly associated with various mental health outcomes:

* *Basic Needs:* Trouble paying for basic needs in the past 12 months, including food or groceries, childcare, health care, and housing.
* *Benefits:* Applying for or receiving governmental benefits, like housing or food assistance.
* *Economic Security:* Self-reported end-of-month finances.

Figure 8. 2023 CHES– Paying for Basic Needs and Mental Health Indicators

Adults that reported having trouble paying for basic needs in the past 12 months had significantly worse mental health outcomes. Those who reported trouble paying for basic needs were over 4 times as likely to report psychological distress and social isolation compared to those that did not. They were also nearly 3 times as likely to report suicidal ideation.

Table 5. 2023 CHES Economic Indicators and Adult Mental Health

|  | **Psychological Distress –**  **High/Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Paying for Basic Needs1** |  |  |  |
| Trouble Paying for Any Basic Needs in Past Month | 35.4\*\*\* | 13.6\*\*\* | 25.7\*\*\* |
| No Trouble Paying for Any Basic Needs in Past Month (*ref*) | 8.1 | 4.7 | 6.4 |
| **Applying For/Receiving Benefits Past Year2** |  |  |  |
| Applied For/Received Any Benefits | 50.9\*\*\* | 10.9\*\*\* | 23.4\*\*\* |
| Did Not Apply For/Receive Benefits Listed *(ref)* | 26.8 | 6.4 | 10.4 |
| **Finances At End of Month** |  |  |  |
| Not Enough to Pay for Things Needed | 61.0\*\*\* | 13.9\*\*\* | 31.9\*\*\* |
| Just Enough to Pay for Things Needed | 35.9\*\*\* | 7.4\*\*\* | 13.1\*\*\* |
| Having Money Left Over After Paying for Things Needed *(ref)* | 19.5 | 5.2 | 7.0 |

1 Basic needs include childcare or school, food or groceries, formula or baby food, health care, housing, technology, transportation, and utilities. 2 Benefits include cash assistance, disability assistance, food assistance, housing assistance, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)  
\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

Many of the communities of focus that experienced inequities in mental health also reported inequities in economic stability.

* People identifying as American Indian/Alaska Native, Black, nH/nL, Hispanic or Latine/o/a, Middle Eastern or North African, or Multiracial reported significantly higher rates of having trouble paying for basic needs compared to White, nH/nL adults. They also were significantly more likely to have applied for or received benefits and to have no money left over at the end of the month to pay for things they need.
* Members of the LGBTQA+ community experienced high rates of economic insecurity. For example, over 6 in 10 adults that identified as transgender reported having trouble paying for basic needs. Adults who identified as LGBQA were significantly more likely to report having trouble paying for basic needs compared to those who identified as straight/heterosexual.
* People with disabilities were nearly twice as likely to report trouble paying for basic needs, nearly 3 times as likely to have applied for or received benefits, and over twice as likely to have not enough money at the end of the month to pay for things they need compared to people without disabilities.

Table 6. 2023 CHES - Adult Economic Indicators by Communities of Focus

|  | Trouble Paying for Any Basic Needs in Past Month1  Weighted % | Applied For or Received Any Benefits2  Weighted % | Not Enough Money to Pay for Necessities at End of Month  Weighted % |
| --- | --- | --- | --- |
| **Race/Ethnicity** |  |  |  |
| American Indian / Alaska Native | 50.2\*\*\* | 27.1\*\*\* | 44.0\*\*\* |
| ANHPI1, nH/nL​2 | 26.6\*\* | 38.4\*\*\* | 25.2\*\*\* |
| Black, nH/nL | 55.5\*\*\* | 39.1\*\*\* | 51.1\*\*\* |
| Hispanic or Latine/a/o | 44.4\*\*\* | 39.3\*\*\* | 59.0\*\*\* |
| Middle Eastern or North African | 48.3\*\*\* | 30.8\*\*\* | 27.0\* |
| Multiracial, nH/nL | 48.7\*\*\* | 26.4\*\*\* | 30.7\*\*\* |
| White, nH/nL (*ref*) | 31.3 | 14.5 | 18.2 |
| **Sexual Orientation** |  |  |  |
| Asexual | 49.4\*\*\* | 32.6\*\*\* | 33.9\*\*\* |
| Bisexual/Pansexual | 53.5\*\*\* | 23.8\*\*\* | 29.3\*\*\* |
| Gay or Lesbian | 37.4\* | 20.4 | 23.8 |
| Queer | 55.7\*\*\* | 21.6\* | 29.9\*\*\* |
| Questioning/Not Sure | 42.8\* | 29.3\*\*\* | 29.6\* |
| Straight/Heterosexual (*ref*) | 33.0 | 18.4 | 22.1 |
| **Transgender Identity** |  |  |  |
| Transgender | 62.6\*\*\* | 33.4\*\*\* | 41.9\*\*\* |
| Not Sure | 55.7\*\*\* | 40.5\*\*\* | 45.4\*\*\* |
| Not Transgender (*ref*) | 35.0 | 19.5 | 23.6 |

Table 6 (continued)

|  | Trouble Paying for Any Basic Needs in Past Month1  Weighted % | Applied For or Received Any Benefits2  Weighted % | Not Enough Money to Pay for Necessities at End of Month  Weighted % |
| --- | --- | --- | --- |
| **People with Disabilities** |  |  |  |
| At Least One Disability | 54.3\*\*\* | 39.4\*\*\* | 45.4\*\*\* |
| Blind/Vision Impaired | 56.2\*\*\* | 48.5\*\*\* | 49.6\*\*\* |
| Cognitive Disability | 63.1\*\*\* | 51.0\*\*\* | 59.8\*\*\* |
| Deaf/Hard of Hearing | 38.7\* | 25.5\*\*\* | 19.1\*\*\* |
| Learning/Intellectual Disability | 60.1\*\*\* | 70.8\*\*\* | 68.1\*\*\* |
| Mobility Disability | 54.6\*\*\* | 46.5\*\*\* | 51.8\*\*\* |
| Self-Care/Independent Living Disability | 61.8\*\*\* | 62.2\*\*\* | 65.3\*\*\* |
| No Disability (*ref*) | 29.4 | 13.6 | 18.0 |

1 Basic needs include childcare or school, food or groceries, formula or baby food, health care, housing, technology, transportation, and utilities.   
2 Benefits include cash assistance, disability assistance, food assistance, housing assistance, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)  
\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

Figure 9. 2023 CHES - Psychological Distress by Trouble Paying for Basic Needs Within Communities of Focus

\*People of color include respondents that reported one of the following race/ethnicities: American Indian/Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.   
\*\*\* Basic needs include childcare or school, food or groceries, formula or baby food, health care, housing, technology, transportation, and utilities.

Promoting economic stability within these populations may have a positive impact on health. Figure 9 demonstrates that members of communities of focus with more economic stability were more likely to have better overall mental health outcomes compared to those that were more economically unstable. For example, among people of color, the rate of psychological distress who did not report trouble paying for basic needs was 21.2% compared to 58.5% that did. This suggests that programs and interventions to improve economic stability within communities of focus may be effective in promoting overall mental health equity. It is important to note, however, that inequities still persist among members of these communities with higher levels of economic security. For example, 2 out of 3 adults that identified as transgender and reported not having trouble paying for basic needs still had high or very high psychological distress, suggesting that addressing economic insecurity alone is not sufficient to address inequities in mental health within these communities.

#### Employment

Having safe and steady employment is important for promoting physical and mental health. Employment is not only an important contributor to the economic security of individuals and families, but the nature and conditions of work have a large impact on overall health[[35]](#endnote-35). There are many factors related to employment that affect health. For example:

* *Workplace:* Employers have a responsibility of creating healthy and safe workplaces that not only provide protection from physical harm, but also provide opportunities for growth, connection and community, work-life balance, and a sense of meaning and dignity[[36]](#endnote-36). Healthy workplaces can help promote overall mental health and well-being as well as minimize stressors that can lead to poor mental health outcomes.
* *Wages and Benefits*: Employment that provides livable wages for individuals to be able to afford basic needs is tied closely to overall economic security and can help promote overall mental health[[37]](#endnote-37). In addition to wages, many individuals rely on their employers for access to important health-related benefits like paid sick leave and health insurance. In the United States, approximately 60% of people under age 65 had employment-sponsored health insurance in 2023[[38]](#endnote-38).
* *Job Security:* Job security is the ability and perception of an individual to maintain employment. Having sustained job security is important for economic stability and for mental health. Greater job security is associated with lower risk for psychological distress and anxiety[[39]](#endnote-39).

Because employment includes many factors, the overall relationship between employment and mental health is complex. While being employed is generally linked to economic stability and more positive health outcomes, not all jobs and workplaces are equally health-promoting. The nature of work, workplace environment, and other factors related to employment are important contributors to mental health.

The 2023 CHES helps us to better understand the relationship between employment and health by including several indicators related to employment:

* Employment status (including number of jobs) and past-year employment
* Industry and occupation
* Employment changes and reason for changes
* Telework
* Paid sick leave access and use

This report will highlight employment data related to employment status, job loss or reduction, and working multiple jobs and their connections to mental health. A future Employment Spotlight will focus on various other aspects of employment and explore inequities by industry, occupation, changes in employment, access to paid sick leave, and telework.

Table 7. 2023 CHES - Adult Employment and Mental Health Indicators

|  | **Psychological Distress –  High/Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Employment Status** |  |  |  |
| Currently Employed *(ref)* | 32.6 | 7.4 | 12.1 |
| Out of Work <1 Year | 61.6\*\*\* | 16.9\*\*\* | 24.8\*\*\* |
| Out of Work >1 Year | 60.2\*\*\* | 15.1\*\*\* | 33.1\*\*\* |
| Unable to Work | 57.0\*\*\* | 13.7\*\*\* | 31.6\*\*\* |
| **Working Multiple Jobs** | 39.1\*\*\* | 10.4\*\*\* | 15.4\*\*\* |
| **Job Loss/Reduction** | 47.3\*\*\* | 14.4\*\*\* | 20.8\*\*\* |

1 Includes those that reported leaving their job, taking unpaid leave, and working fewer hours in the past year.   
\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group. For working multiple jobs, the reference group is those that reported having one job. For job loss or reduction, the reference group is those that did not report any change in employment status in the past year.

Data from 2023 CHES demonstrates a strong connection between employment and mental health. Individuals that reported being out of work were nearly twice as likely to report high or very high psychological distress and over twice as likely to report suicidal ideation and social isolation compared to those that reported being currently employed.

The relationship between employment and health was more pronounced within certain communities of focus. Among adults who reported being unemployed[[40]](#footnote-3):

* Individuals identifying as gay, lesbian, bisexual/pansexual, or asexual had significantly higher rates of psychological distress than those who identify as straight/heterosexual (Figure 10).
* People with disabilities were significantly more likely to report high or very high psychological distress (62.0% vs 48.7%) and suicidal ideation (17.0% vs 8.1%) compared to people without disabilities.

Figure 10. 2023 CHES - Psychological Distress Among Unemployed Adults by Sexual Orientation\*

\*Respondents identifying as queer or questioning are not included in this figure due to small numbers.

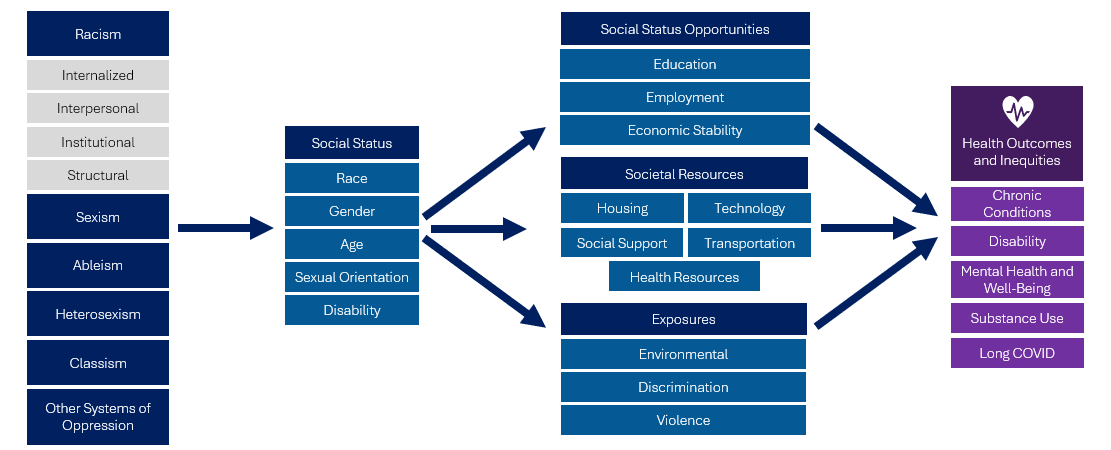
Increased access to safe and stable employment with adequate wages and benefits may be an effective strategy to promote mental health equity. Individuals within communities of focus that reported being employed had better mental health outcomes overall compared to those that were unemployed. For example, within the LGBQA community, rates of psychological distress among employed adults were significantly lower compared to unemployed adults (79.1% vs 52.2%) (Figure 11). This suggests that investments in promoting employment within these communities may be important to address mental health inequities.

Figure 11. 2023 CHES – Psychological Distress by Employment Status Within Communities of Focus

\*People of color include respondents that reported one of the following race/ethnicities: American Indian / Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.  
\*\*\* Not employed includes individuals that reported being out of work or unable to work.

### Societal Resources

Equitable access to important societal resources, such as housing, social support, technology, and transportation, are necessary to promote health equity. Access to these resources is closely connected to many of the social status opportunities described in the previous section. Economic stability, employment, and education can promote access and utilization of these resources to promote health. Policies, systems, and institutions create patterns of advantage and disadvantage that help shape inequities in resource access. CHES 2023 gathers important information on these key resources and connects them to mental health outcomes. The following sections will highlight findings related to three important societal resources: (1) Social Networks and Support, (2) Housing, and (3) Health Care Access.



#### Social Networks and Support

The relationships and interactions that we share with others have a strong connection to our health and the health of our communities. Social networks influence our physical and mental health in many important ways, including[[41]](#endnote-40):

* Providing *social support* in the form of emotional support, assistance with tangible needs, and information[[42]](#endnote-41).
* Providing *social influence* that reinforces social norms and constrain or enable certain behaviors[[43]](#endnote-42).
* Our *social engagements* with others define and reinforce social roles and influence our participation in various activities[[44]](#endnote-43).
* Shaping *person-to-person contact* which restricts and promotes exposure to infectious disease[[45]](#endnote-44).
* Impacting our *access to resources* like job opportunities, educational opportunities, access to health care, and housing[[46]](#endnote-45).
* Influencing exposure to *negative social interactions* like conflict and abuse[[47]](#endnote-46).

The 2023 CHES gathers important data on social networks and social supports, including:

* Among Youth (aged 14-17 years):
  + Someone to talk to if you needed help with a personal problem.
  + Sense of safety and belonging at school.
  + Family/caregivers that support interests.
* Among Adults (aged 18 years and older):
  + Level of social support[[48]](#footnote-4) (Having someone you can count on for favors, to take care of you if sick, for money for emergencies, to talk to about family relationships, and to help find housing).

**Social Support Among Adults**

* Among adults who reported not having anyone they could count on for any of the types of social support included in the survey, over half reported high or very high psychological distress (57.2%) and over a third reported social isolation (38.5%).
* Adults with low levels of social support were 2.6 times as likely to report suicidal ideation compared to adults with high social support.

**Connection Between Social Support and Mental Health**

**Social Support Among Youth**

Youth who reported having someone to talk to about a person problem had lower rates of psychological distress compared to youth who did not (44.6% vs. 70.2%). They were also nearly half as likely to report suicidal ideation (12.3% vs. 22.9%).

As seen in Tables 8 and 9 on the following page, there is a strong association between social support and mental health. Adults and youth who reported lower levels of social support were more likely to have worse mental health outcomes.

*Table 8. 2023 CHES - Adult Social Support and Mental Health*

|  | **Psychological Distress –  High or Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Social Support1**  Have someone to count on: |  |  |  |
| For favors (e.g., a ride, borrowing a little money, errands)1 | 27.3\*\*\* | 6.4\*\*\* | 9.1\*\*\* |
| To take care of you when sick1 | 25.2\*\*\* | 5.8\*\*\* | 7.7\*\*\* |
| To lend you money for an emergency1 | 23.7\*\*\* | 5.9\*\*\* | 7.7\*\*\* |
| To talk to if you were having trouble with family relationships1 | 27.0\*\*\* | 6.3\*\*\* | 8.7\*\*\* |
| To help you find housing1 | 23.4\*\*\* | 5.6\*\*\* | 6.9\*\*\* |
| For all of the above social supports (High Social Support) 2 | 19.2\*\*\* | 4.8 \*\*\* | 4.6 \*\*\* |
| For none of the above social supports (Low Social Support) | 57.2 | 12.7 | 38.5 |

\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.  
1Reference group is those that reported not having that type of social support.   
2Reference group is “none of the above social supports”.

Table 9. 2023 CHES - Youth (aged 14-17 years) Social Support and Mental Health

|  | **Psychological Distress –**  **High/Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Support with Personal Problems** |  |  |  |
| Have someone to talk to about personal problems | 44.6\*\*\* | 13.7\*\*\* | 14.4\*\*\* |
| Do not have someone to talk to about personal problems *(ref)* | 70.2 | 46.3 | 49.5 |
| **Sense of Safety and Belonging** |  |  |  |
| Very much feel safe with family/caregivers1 | 42.4\*\*\* | 11.6\*\*\* | 12.9\*\*\* |
| Very much feel that I belong at school1 | 33.5\*\*\* | 8.5\*\*\* | 6.7\*\*\* |
| Very much feel family/caregivers support interests1 | 39.2\*\*\* | 10.5\*\*\* | 11.4\*\*\* |
| Very much feel all of the above2 | 29.8\*\*\* | 6.1\*\*\* | 4.9\*\*\* |
| Do not feel any of the above very much | 84.4 | 52.6 | 53.6 |

\*\*\* p<.0001, \*\* p<.001, \* p<.05   
P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.  
1Reference group is those that reported somewhat or not at all for that question.   
2Reference group is those that “do not feel any of the above very much”.

Figure 12. 2023 CHES High or Very High Psychological Distress by Social Support Levels\* Among Communities of Focus

*\*Social support levels were calculated from the social support module included in the 2023 CHES. This module asked survey takers if they had someone to count on for five different types of social support. High social support is defined as having someone to count on for all types of social support. Medium social support is defined is defined as having someone to count on for 1 to 4 types of social support. Low social support is defined as not having someone to count on for any type of social support.*\*\*People of color include respondents that reported one of the following race/ethnicities: American Indian/Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.

Within communities of focus, increased levels of social support were associated with overall better mental health outcomes (Figure 12). For example, adults with disabilities with high levels of social support were half as likely to report having high or very high psychological distress compared to adults with disabilities with low levels of social support. This suggests that work to build and maintain community connections and increase access to social supports within community and school settings may be effective in promoting mental health and mitigating some of the impacts of the inequities experienced within these groups.

#### Housing

As a key social determinant of health, housing plays a critical role in health and health equity. There are many aspects of housing that have important connections to mental health, as summarized in the figure below.

Figure 13. Housing and Mental Health Pathways

Figure 13 shows a framework that connects various aspects of housing and mental health. Systems and policies impact the cost, supply, and distribution of housing. This in turn impacts neighborhood level housing factors, like neighborhood-level exposures and community resources, housing-level factors like quality and accessible design, and individual-level factors like housing affordability and housing stability. 

These factors in turn impacts various mid and downstream determinants of health, including environmental exposures, social networks & supports, access to resources & opportunities, exposure to violence, chronic stress, health-related behaviors, sleep quality, and access to basic needs. These mid and downstream determinants of health impacts health outcomes and health equity. 

##### Systems Level

Federal, state, and local regulations and policies, and macroeconomic factors shape the overall housing landscape, influencing the cost, supply, distribution, and quality of homes. These systems and policies create patterns of advantage and disadvantage, resulting in inequitable access to safe and affordable housing within and across communities resulting in inequities in access to intergenerational wealth-building, impacting long-term family security and community stability[[49]](#endnote-47). As an example, historical laws, policies, and institutional practices that enforced racial segregation in the U.S. created and maintained racially distinct neighborhoods and communities and led to unjust home devaluation and neighborhood disinvestment within communities of color[[50]](#endnote-48). Past and present-day laws, policies, and practices related to segregation continue to drive economic inequity, patterns of violence and crime, and concentrations of poor health across communities.

##### Neighborhood Level

Where we live strongly influences our level of access to community resources that influence our health, such as transportation, green space, and educational and job opportunities. Our neighborhoods also influence our social networks and levels of social support, which serve as important facilitators for positive mental health and well-being. Key exposures at the neighborhood level, such as violence, crime, and environmental hazards, also increase our risk for poor health outcomes. Exposure to neighborhood violence and crime, which are shaped by systemic racism, segregation, land use, and social control, can lead to poor mental health outcomes like chronic and post-traumatic stress[[51]](#endnote-49). Environmental risk factors like air pollution, water quality, hazardous waste, noise, extreme temperature, and weather events strongly influence our physical and mental health[[52]](#endnote-50). Inequities in environmental exposures that disproportionately impact specific populations and groups, including many communities of color, are likely to worsen as a result of climate change[[53]](#endnote-51).

##### Housing Level

Housing conditions, quality, and design impact health-related household exposures that individuals may experience in their homes. Household-level hazards like lead and carbon monoxide[[54]](#endnote-52), extreme hot and cold temperatures, and exposures such as pests and mold can lead to or exacerbate chronic conditions, infectious diseases, and chronic stress[[55]](#endnote-53). Poor housing quality and inaccessible housing design can also inhibit physical access and mobility within the home and can increase risk of physical injury, especially for individuals with disabilities[[56]](#endnote-54).

##### Individuals and Families

Individual and family-level dimensions of housing also play an essential role in health. Housing affordability is closely tied to overall economic stability and access to basic needs. Individuals and families that spend a high percentage of their income on rent, mortgage, and other housing-related costs are at higher risk for food insecurity and poor health outcomes[[57]](#endnote-55). Housing unaffordability can also lead to overcrowding, which can negatively impact relationships and lead to poor sleep quality and chronic stress[[58]](#endnote-56).

Housing stability has also been shown to be an important facilitator of overall health. People in unstable or uncertain living arrangements are at higher risk for depression, anxiety, substance use, psychological distress, and suicide[[59]](#endnote-57). Acute and chronic homelessness, the most extreme forms of housing instability, has a dramatic impact on physical and mental health. People who experience homelessness die nearly 30 years earlier than the average American[[60]](#endnote-58). Children are particularly vulnerable to the negative health impacts related to housing instability and can experience higher rates of malnutrition, vaccine-preventable infectious diseases, asthma, obesity, and dental and vision problems, as well as emotional, behavioral, and developmental issues. Consequently, these children miss more school and are less successful academically. Families with children with special health care needs are more likely to fall behind in rent or mortgage payments and experience homelessness, creating a cycle of poor health, housing insecurity, and poverty from an early age.

The 2023 CHES collected important information related to housing, including affordability, neighborhood-level violence, and environmental exposures within the home. These include:

* Trouble paying for housing and housing-related expenses.
* Housing stability, or having a steady place to live.
* Current living arrangements.
* Problems in the home (including lead paint or pipes, mold or water leaks, too hot during the summer, not enough heat in the winter, and pests).

Table 10. 2023 CHES - Adult Housing and Mental Health Indicators

|  | **Psychological Distress –**  **High/Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Expenses (past year)** |  |  |  |
| Trouble Paying for Housing Expenses | 63.9\*\*\* | 16.2\*\*\* | 30.1\*\*\* |
| No Trouble Paying for Housing Expenses *(ref)* | 25.0 | 5.7 | 9.2 |
| **Housing Stability** |  |  |  |
| Steady Place to Live *(ref)* | 28.8 | 6.8 | 10.7 |
| Steady Place to Live but Worried About Losing | 70.4\*\*\* | 20.3\*\*\* | 37.4\*\*\* |
| No Steady Place to Live | 72.0\*\*\* | 20.5\*\*\* | 41.1\*\*\* |
| **Problems in Home1** |  |  |  |
| One or more problems in the home | 49.6\*\*\* | 14.2\*\*\* | 22.9\*\*\* |
| No problems in the home *(ref*) | 24.7 | 5.2 | 8.8 |

1Problems in the home include lead paint or pipes, mold or water leaks, noise from the neighborhood, not enough heat during the winter, pests (e.g., bugs, roaches, mice, rats), poor air quality or air pollution, too hot during the summer, too many people living in the space, and water is not safe to drink.  
\*\*\* p<.0001, \*\* p<.001, \* p<.05   
P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

**Housing Expenses and Economic Security**

* Adults who reported having trouble paying for housing-related expenses were 2.6 times as likely to report high or very high psychological distress, over 2.8 times as likely to report suicidal ideation, and 3.3 times as likely to report social isolation compared to those who did not have trouble.

**Connection Between Housing and Mental Health**

**Housing Stability**

* Adults who reported having a steady place to live had significantly lower levels of psychological distress, suicidal ideation, and social isolation compared to those who did not have a steady place to live.
* Adults who had a steady place to live but were worried about losing their housing had similar rates of psychological distress, suicidal ideation, and social isolation compared to those who reported not having a steady place to live.

Figure 14.CHES 2023 – Adult High or Very High Psychological Distress by Housing Stability within Communities of Focus

\* Data within category suppressed due to small numbers.   
\*\*People of color include respondents that reported one of the following race/ethnicities: American Indian/Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.

Promoting access to safe, stable, affordable housing is a key strategy to promote mental health and health equity. Within communities of focus, those who have access to stable, affordable housing were more likely to have better mental health outcomes. For example, the rate of high or very high psychological distress within residents of color who reported having a steady place to live were significantly lower than residents of color who reported not having a steady place to live (29.0% vs 69.9%).

#### Access to Quality Health Care

Having access to affordable, quality health care is important for overall health. However, significant barriers to health care access exist within many communities that contribute to inequities in health, including mental health. Economic barriers and affordability of health care are major contributors to inequitable health care access, but financial hurdles are not the only hurdles that individuals and families face. Inadequate health insurance coverage, language access barriers, provider shortages, transportation barriers, lack of or insufficient paid sick leave policies, and racial bias and discrimination are some examples of non-financial barriers to health care[[61]](#endnote-59). Provider shortages are a particular challenge within mental health care, with more than half the U.S. population living in a Mental Health Professional Shortage Area[[62]](#endnote-60). These barriers to health care are largely driven by systems and policies that systematically promote access within some communities and obstruct access for others, namely communities of color[[63]](#endnote-61).

The 2023 CHES gathered important information related to health care access, including:

* Health insurance coverage and type
* Usual sources of health care
* Access to needed care in the past 12 months and reasons for not receiving care
* Access to telehealth visits

Table 11. 2023 CHES - Health Care Access and Mental Health Indicators

|  | **Psychological Distress –**  **High/Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Expenses - Adult** |  |  |  |
| Trouble Paying for Health Care Expenses | 60.7\*\*\* | 16.4\*\*\* | 28.6\*\*\* |
| No Trouble Paying for Health Care Expenses (*ref*) | 27.7 | 6.2 | 10.7 |
| **Experiences of Discrimination** |  |  |  |
| Experienced Discrimination While Getting Health Care | 64.8\*\*\* | 24.5\*\*\* | 39.1\*\*\* |
| Did Not Experience Discrimination While Getting Health Care (*ref*) | 57.2 | 18.5 | 26.7 |
| **Receiving Needed Health Care** |  |  |  |
| Did Not Receive Needed Health Care | 72.2\*\*\* | 23.8\*\*\* | 42.5\*\*\* |
| Did Not Receive Needed Mental Health Care | 64.2\*\*\* | 22.0\*\*\* | 30.0\*\*\* |
| Received Needed Mental Care (*ref*) | 23.8 | 4.3 | 9.1 |
| **Health Insurance - Adult** |  |  |  |
| No Health Insurance Coverage (*ref*) | 57.0 | 14.4 | 29.7 |
| Health Insurance Coverage | 30.0\*\*\* | 6.9\*\*\* | 12.0\*\*\* |

\*\*\* p<.0001, \*\* p<.001, \* p<.05   
P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

**Health Insurance Coverage**

* Adults that reported not having health insurance coverage were nearly twice as likely to have high or very high psychological distress, 2.1 times as likely to have suicidal ideation, and 2.5 times as likely to report social isolation.

**Health Care Expenses**

* Adults that reported having trouble paying for health care expenses were significantly more likely to report having an unmet health care need in the past year compared to those that did not have trouble (40.5% vs. 12.8%). They were also 2.2 times as likely to have high or very high psychological distress, 2.6 times as likely to report suicidal ideation, and 2.7 times as likely to report social isolation.

**Connection Between Health Care Access and Mental Health**

**Discrimination in Health Care**

* Adults that reported experiencing discrimination while getting health care were over twice as likely to report not receiving health care that they needed in the past year compared to those that did not report experiencing discrimination while getting health care (50.5% vs 24.4%). They also reported significantly higher rates of psychological distress, suicidal ideation, and social isolation compared to those that did not experience discrimination while getting health care.

As seen in Table 12, many communities of focus experience barriers to accessing health care. A high percentage of residents from communities of color, the LGBTQA+ community, and the disability community reported not receiving the health care that they needed in the past year. Adults that identify as queer or transgender and adults with disabilities also reported significantly higher rates of experiencing discrimination while receiving health care.

Table 12. 2023 CHES– Adult Health Care Access and Barriers by Communities of Focus

|  | **Trouble Paying for Health Care Expenses**  **Weighted %** | **Experienced Discrimination While Receiving Health Care**  **Weighted %** | **Did Not Receive Needed Health Care1**  **Weighted %** |
| --- | --- | --- | --- |
| Race/Ethnicity |  |  |  |
| American Indian/Alaska Native | 17.9 | 19.6 | 24.2\*\* |
| ANHPI1, nH/nL​2 | 8.8 | 14.1\*\* | 12.6 |
| Black, nH/nL | 19.3\*\* | 23.6 | 21.9\*\*\* |
| Hispanic or Latine/a/o | 15.7 | 15.0 | 21.3\*\*\* |
| Middle Eastern or North African | 14.7 | 22.1 | 27.7\*\*\* |
| Multiracial, nH/nL | 25.2\*\*\* | 22.1 | 21.8\*\*\* |
| White, nH/nL (*ref*) | 14.7 | 24.0 | 13.0 |
| Sexual Orientation |  |  |  |
| Asexual | 18.7\* | 14.5\* | 22.2\*\*\* |
| Bisexual/Pansexual | 23.4\*\*\* | 18.9 | 22.6\*\*\* |
| Gay or Lesbian | 14.5 | 20.0 | 18.6\*\*\* |
| Queer | 36.7\*\*\* | 33.6\*\*\* | 33.3\*\*\* |
| Questioning/Not Sure | 27.3\*\*\* | ^ | 15.9 |
| Straight/Heterosexual (*ref*) | 13.6 | 21.7 | 12.1 |
| Transgender Identity |  |  |  |
| Transgender | 33.7\*\*\* | 30.4\*\*\* | 34.9\*\*\* |
| Not Sure | 29.0\*\*\* | 20.0 | 26.1\*\*\* |
| Not Transgender (*ref*) | 14.7 | 20.8 | 13.7 |

Table 12 (Continued)

|  | **Trouble Paying for Health Care Expenses**  **Weighted %** | **Experienced Discrimination While Receiving Health Care**  **Weighted %** | **Did Not Receive Needed Health Care1**  **Weighted %** |
| --- | --- | --- | --- |
| People with Disabilities |  |  |  |
| Blind/Vision Impaired | 23.6\*\*\* | 30.4\*\*\* | 23.6\*\*\* |
| Cognitive Disability | 30.7\*\*\* | 32.9\*\*\* | 30.7\*\*\* |
| Deaf/Hard of Hearing | 16.9 | 35.9\*\*\* | 16.9 |
| Learning/Intellectual Disability | 28,5\*\*\* | 35.7\*\*\* | 28.5\*\*\* |
| Mental Health Disability | 31.3\*\*\* | 33.3\*\*\* | 31.3\*\*\* |
| Mobility Disability | 26.8\*\*\* | 40.2\*\*\* | 26.8\*\*\* |
| Self-Care/Independent Living Disability | 27.5\*\*\* | 39.4\*\*\* | 27.5\*\*\* |
| One or More Disabilities | 25.1\*\*\* | 30.0\*\*\* | 25.1\*\*\* |
| No Disability (*ref*) | 12.0 | 16.5 | 12.0 |

1 Includes respondents that reported having some form of health care need that was unmet in the past 12 months.   
\*\*\* p<.0001, \*\* p<.001, \* p<.05   
P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

Improving access to health care services, including mental health care, within communities of focus is important to promote mental health equity. As seen in Figure 15, rates of psychological distress within people of color, those identifying as LGBTQA, and people with disabilities were significantly lower among those that received the health care that they needed compared to those that did not. Within communities of color, the rate of psychological distress was 53% lower for those that received the health care they needed compared to those that did not. This suggests that eliminating barriers to health care access can be an effective step towards health equity promotion.

Figure 15. CHES 2023 – Adult High or Very High Psychological Distress by Unmet Health Care Needs Among Communities of Focus

\*People of color include respondents that reported one of the following race/ethnicities: American Indian / Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.

### Key Exposures

Our social and physical environments are inseparably linked to our health. The health promoting and health impairing exposures we interact with in our daily lives have an important impact on our mental well-being and overall health. As illustrated in the CHEI Health Inequities Framework, patterns of exposures to these determinants of health are shaped by systems of oppression, leading to inequities in health. The 2023 CHES gathered information from residents on their experiences with many key exposures within their physical and social environments. The following sections will highlight findings related to three key exposure categories and their connections to mental health: (1) Environmental exposures, (2) Discrimination, and (3) Violence.

This figure displays the CHEI Health Inequities Framework, which shows the connection between systems of oppression and health outcomes and inequities. 

On the left side of the diagram are systems of oppression, like racism, sexism, ableism, heterosexism, classism, and other systems of oppression, These systems help shape and attribute value to social status categories, which in turn shape important drivers of health, including social status opportunities, societal resources, and key exposures. 

There is a red square surrounding the exposures box to show that the following section will be focused on key exposures such as environmental exposures, discrimination, and violence. 

#### Environmental Exposures

Environmental health is centered on the relationship between people and their environment and is an integral component of public health[[64]](#endnote-62). Environmental exposures include a wide range of external factors commonly classified as chemical, physical, biological, mechanical, or psychosocial hazards[[65]](#endnote-63). Systemic and structural inequities strongly influence our community characteristics and our levels of exposure to various environmental hazards[[66]](#endnote-64). For example, policies and institutional practices that enforce and maintain racial segregation have led to higher median blood lead levels in Black children compared to White children, impacting cognitive development and functioning[[67]](#endnote-65).

The 2023 CHES gathered information related to several important environmental exposures, including exposures in the home, air quality, water quality, and extreme temperatures. This section will highlight findings related to these environmental exposures and their connection to mental health.

Table 13. 2023 CHES– Adult Environmental Exposures in Home and Psychological Distress

|  | **Psychological Distress –**  **High/Very High**  **Weighted %** |
| --- | --- |
| **Problems in Home** |  |
| Lead paint or pipes | 47.9\*\*\* |
| Mold or water leaks | 54.0\*\*\* |
| Noise from neighborhood | 53.7\*\*\* |
| Not enough heat during the winter | 67.9\*\*\* |
| Pests (e.g., bugs, roaches, mice, rats) | 52.3\*\*\* |
| Poor air quality or air pollution | 65.4\*\*\* |
| Too hot during the summer | 58.9\*\*\* |
| Water is not safe to drink | 50.7\*\*\* |
| No reported problems in the home | 24.7 |
| **Environmental Impacts Experienced in Past 5 Years** |  |
| Feeling unwell due to poor air quality, very hot days, or allergies | 45.5\*\*\* |
| Flooding in my home or on my street | 46.2\*\*\* |
| More ticks or mosquitoes | 37.5\*\*\* |
| Unable to get to work or do my job due to weather | 49.0\*\*\* |
| Very cold or very hot temperatures at home, work, or school | 47.2\*\*\* |
| None of these | 21.9 |

\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

As seen in Table 13, adults who reported having issues with various environmental exposures in their home had higher rates of high or very high psychological distress compared to those that did not.

**Extreme temperatures**

* Adults who reported having problems dealing with extreme temperatures, like being too hot in the summers or not having enough heat in the winters, were significantly more likely to report psychological distress and suicidal ideation.

**Biological Exposures**

* Adults who reported having problems with pests in the home were 2.1 times as likely to report high or very high psychological distress compared to adults who did not.

**Environmental Exposures Associated with Worse Mental Health Outcomes**

Table 14. 2023 CHES - Environmental Exposures by Communities of Focus

|  | Not Enough Heat During the Winter in Home  Weighted % | Pests in Home  Weighted % | Flooding in Home or Street in Past 5 Years  Weighted % |
| --- | --- | --- | --- |
| Race/Ethnicity |  |  |  |
| American Indian/Alaska Native | 9.2\* | 17.8\* | 13.8 |
| ANHPI1, nH/nL​2 | 4.7 | 10.7\* | 5.0\*\*\* |
| Black, nH/nL | 8.4\*\*\* | 15.1\* | 9.3\* |
| Hispanic or Latine/a/o | 7.1\*\*\* | 16.9\*\*\* | 7.5\*\*\* |
| Middle Eastern or North African | 11.3\*\*\* | 12.9 | 18.5\*\* |
| Multiracial, nH/nL | 11.4\*\*\* | 20.1\*\*\* | 16.6\*\*\* |
| White, nH/nL (*ref*) | 5.1 | 12.7 | 11.3 |
| Sexual Orientation |  |  |  |
| Asexual | 7.7\* | 20.9\*\*\* | 12.4\* |
| Bisexual/Pansexual | 9.6\*\*\* | 20.7\*\*\* | 16.7\*\*\* |
| Gay or Lesbian | 5.5 | 15.2\*\* | 12.2\* |
| Queer | 14.2\*\*\* | 23.7\*\*\* | 24.2\*\*\* |
| Questioning/Not Sure | 13.3\*\*\* | 24.9\*\*\* | 17.3\*\* |
| Straight/Heterosexual (*ref*) | 5.1 | 11.9 | 9.5 |
| Transgender Identity |  |  |  |
| Transgender | 14.0\*\*\* | 23.8\*\*\* | 21.7\*\*\* |
| Not Transgender (*ref*) | 5.4 | 12.8 | 10.3 |
| People with Disabilities |  |  |  |
| At Least One Disability | 11.2\*\*\* | 18.9\*\*\* | 12.7\*\*\* |
| Blind/Vision Impaired | 10.4\*\*\* | 21.6\*\*\* | 14.0\* |
| Cognitive Disability | 13.3\*\*\* | 20.9\*\*\* | 15.2\*\*\* |
| Deaf/Hard of Hearing | 8.4\*\*\* | 12.6 | 9.7 |
| Learning/Intellectual Disability | 11.8\*\*\* | 19.4\*\*\* | 11.0 |
| Mobility Disability | 12.2\*\*\* | 19.8\*\*\* | 11.3 |
| Self-Care/Independent Living Disability | 13.7\*\*\* | 20.8\*\*\* | 12.0 |
| No Disability (*ref*) | 4.0 | 11.4 | 9.7 |

\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

As seen in Table 14, many communities experiencing disproportionately high poor mental health outcomes also reported high rates of environmental exposures.

**LGBTQA+**

* Respondents that identified their sexual orientation as asexual, bisexual or pansexual, queer, or questioning or not sure reported significantly higher rates of not having enough heat in their homes during winter, having pests in their home, and experiencing flooding in their home or street in the past 5 years compared to respondents that identified as straight or heterosexual.
* A high percentage of respondents that identified as transgender reported having not enough heat in their homes (14.0%), pests in the home (23.8%), and experiencing flooding in their homes and streets in the past 5 years (21.7%).

**People with Disabilities**

* Respondents who reported having 1 or more disabilities had significantly higher rates of not having enough heat in their homes during winter, having pests in their home, and experiencing flooding in their home or street in the past 5 years compared to respondents that did not report having a disability.

**Many Environmental Exposures Are Higher Within Communities of Focus**

**People of Color**

* Respondents that identified as Black, Hispanic, Hispanic or Latine/a/o, Middle Eastern or North African, or Multiracial reported significantly higher rates of not having enough heat in their homes during winter, having pests in their home, and experiencing flooding in their home or street in the past 5 years compared to respondents that identified as White, nH/nL.
* Respondents that identified as Middle Eastern or North African reported some of the highest rates of not having enough heat in their homes during winter (11.3%) and experiencing flooding in their homes or streets (18.5%) compared to all other race and ethnicities.
* Respondents that identified as American Indian or Alaska Native reported high rates of not having enough heat in their homes during winter (9.2%) and pests in home (17.8%).

Reducing levels of negative environmental exposures can be an important part of an overall strategy to promote mental health equity. As seen in Figure 16, members of various communities of focus that did not report having pests in their home were significantly less likely to have high or very high psychological distress compared to those that did report having pests in their home. Among people with disabilities, the rate of psychological distress was lower among those that did not have pests in their home compared to those that did (50.9% vs 68.0%).

Figure 16. 2023 CHES– Adult High or Very High Psychological Distress by Exposure to Pests in the Home within Communities of Focus

\*People of color include respondents that reported one of the following race/ethnicities: American Indian/Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.

#### Violence

Many of the social and structural determinants of health highlighted within the CHEI Health Inequities Framework are also drivers of violence exposure. Patterns of socioeconomic disadvantage, diminished social opportunities, and resource deprivation driven by systems of oppression place certain communities at higher risk for and more vulnerable to violence[[68]](#endnote-66).

Exposure to violence in its many forms can have a devastating impact on physical and mental health. Children who are exposed to violence and other adverse childhood experiences (ACEs) are at greater risk for many immediate and long-term impacts such as mental disorders, substance use, and chronic conditions[[69]](#endnote-67),[[70]](#endnote-68). Exposure to violence during adulthood can lead to physical health issues, cardiovascular disease, premature mortality, and poor mental health outcomes, including depression, anxiety, and posttraumatic stress disorder[[71]](#endnote-69). Violence among older adults, including elder abuse, can increase the risk for stress, depression, fear, and anxiety [[72]](#endnote-70).

CHES 2023 captures information related to community violence, intimate partner violence, household violence, and sexual violence.

Table 15. 2023 CHES - Experiences of Violence and Mental Health Indicators

|  | **Psychological Distress –** **High/Very High**  **Weighted %** | **Suicidal Ideation**  **Weighted %** | **Social Isolation**  **Weighted %** |
| --- | --- | --- | --- |
| **Intimate Partner Violence** |  |  |  |
| Ever | 50.9\*\*\* | 15.2\*\*\* | 23.4\*\*\* |
| In Last 12 Months1 | 69.1\*\*\* | 26.1\*\*\* | 34.1\*\*\* |
| Never (*ref*) | 25.6 | 5.6 | 9.5 |
| **Household Violence** (Youth) |  |  |  |
| Ever | 80.6\*\*\* | 52.2 | 41.4\*\*\* |
| In Last 12 Months1 | 88.3\*\*\* | 53.7\*\*\* | 51.1\*\*\* |
| Never (*ref*) | 38.1 | 7.6 | 10.5 |
| **Sexual Violence** |  |  |  |
| Ever | 53.8\*\*\* | 19.1\*\*\* | 24.8\*\*\* |
| In Last 12 Months1 | 83.5\*\*\* | 12.6\*\*\* | 47.3\*\*\* |
| Never (*ref*) | 27.0 | 5.4 | 10.1 |
| **Neighborhood Violence2** |  |  |  |
| Ever | 44.1\*\*\* | 12.0\*\*\* | 20.2\*\*\* |
| Very Often1 | 61.3\*\*\* | 19.1\*\*\* | 36.8\*\*\* |
| Never (*ref*) | 25.8 | 6.1 | 8.9 |

\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.  
1Reference group is those who reported experiencing that form of violence but not in the last 12 months.   
2Reported ever seeing or hearing someone getting physically attacked, beaten, stabbed, or shot in the neighborhood they were living.

**Exposure to Violence Associated with Poor Mental Health**

* Nearly 7 in 10 respondents who reported experiencing intimate partner violence in the last 12 months reported high or very high psychological distress, over 1 in 4 reported suicidal ideation, and over 1 in 3 reported social isolation.
* Youth who reported experiencing household violence in the last 12 months had very high levels of high or very high psychological distress (88.3%), suicidal ideation (53.7%), and social isolation (51.1%).
* Over 6 in 10 respondents who reported experiencing neighborhood violence very often reported high or very high psychological distress.

Table 16. 2023 CHES - Experiences of Violence by Communities of Focus

|  | Ever Experienced Neighborhood Violence1  Weighted % | Ever Experienced Intimate Partner Violence  Weighted % | Ever Experienced Sexual Violence  Weighted % |
| --- | --- | --- | --- |
| **Race/Ethnicity** |  |  |  |
| American Indian/Alaska Native | 61.7\*\*\* | 43.6\*\*\* | 27.9\* |
| ANHPI1, nH/nL​2 | 38.9\* | 12.7\*\*\* | 6.7\*\*\* |
| Black, nH/nL | 63.7\*\*\* | 31.5\* | 14.6\*\*\* |
| Hispanic or Latine/a/o | 57.9\*\*\* | 29.8 | 15.3\*\*\* |
| Middle Eastern or North African | 49.6\*\*\* | 37.0\*\* | 32.1\*\*\* |
| Multiracial, nH/nL | 53.0\*\*\* | 31.6\* | 26.6\*\* |
| White, nH/nL (*ref*) | 35.4 | 28.6 | 21.6 |
| **Sexual Orientation** |  |  |  |
| Asexual | 52.9\*\*\* | 30.9\* | 22.8\*\*\* |
| Bisexual/Pansexual | 51.7\*\*\* | 46.2\*\*\* | 46.4\*\*\* |
| Gay or Lesbian | 49.7\*\*\* | 32.9\*\*\* | 27.6\*\*\* |
| Queer | 51.6\*\*\* | 52.5\*\*\* | 53.9\*\*\* |
| Questioning/Not Sure | 40.0 | 36.2\*\*\* | 34.3\*\*\* |
| Straight/Heterosexual (*ref*) | 39.3 | 25.6 | 16.4 |
| **Transgender Identity** |  |  |  |
| Transgender | 52.4\*\*\* | 50.8\*\*\* | 54.5\*\*\* |
| Not Transgender (*ref*) | 40.5 | 27.3 | 18.7 |
| **People with Disabilities** |  |  |  |
| Blind/Vision Impaired | 50.5\*\*\* | 38.3\*\*\* | 26.7\*\*\* |
| Cognitive Disability | 50.4\*\*\* | 44.0\*\*\* | 38.1\*\*\* |
| Deaf/Hard of Hearing | 41.1 | 31.5\*\* | 21.3 |
| Learning/Intellectual Disability | 44.7\* | 30.7\* | 28.5\*\*\* |
| Mobility Disability | 49.2\*\*\* | 34.4\*\*\* | 27.2\*\*\* |
| Self-Care/Independent Living Disability | 46.5\*\*\* | 34.9\*\*\* | 32.5\*\*\* |
| One or More Disabilities | 48.1\*\*\* | 37.6\*\*\* | 30.0\*\*\* |
| No Disability (*ref*) | 38.4 | 24.5 | 16.2 |

1Reported ever seeing or hearing someone getting physically attacked, beaten, stabbed, or shot in the neighborhood they were living.   
\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

As seen in Table 16, many communities of focus reported disproportionately high levels of exposure to various forms of violence.

* Many members of the LGBTQA+ community reported experiencing significantly high rates of violence. Over half of respondents who identified as transgender reported ever experiencing neighborhood violence, intimate partner violence, and sexual violence. Over half of respondents who identified as queer reported ever experiencing neighborhood violence, intimate partner violence, and sexual violence.
* People with one or more disabilities were 1.3 times as likely to report experiencing neighborhood violence, 1.5 times as likely to report experiencing intimate partner violence, and 1.9 times as likely to report sexual violence compared to people without a disability.
* Black, nH/nL respondents reported the highest rates of experiencing neighborhood violence compared to all other race and ethnicity groups (63.7%).

Figure 17. CHES 2023 – Adult High or Very High Psychological Distress by Frequency of Exposure to Neighborhood Violence in Current Neighborhood1 within Communities of Focus

**Frequency of Exposure to Neighborhood Violence**

1 Neighborhood violence in the current neighborhood is defined as reporting seeing or hearing someone get physically attacked, beaten, stabbed, or shot in your current neighborhood.   
\*People of color include respondents that reported one of the following race/ethnicities: American Indian/Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.

Strategies to prevent exposure to violence are critical for overall health equity promotion. As seen in Figure 17, less frequent exposure to neighborhood violence within communities of focus was associated with lower rates of psychological distress. For example, among people of color, rates of psychological distress were significantly lower among those that reported never or rarely experiencing violence in their current neighborhood compared to those that reported experiencing violence somewhat or very often. This suggests that strategies that address root causes of violence, such as socioeconomic disadvantage, diminished social opportunities, and resource deprivation, could help to promote mental health equity across communities.

#### Discrimination

Discrimination is differential treatment experienced by stigmatized groups and is the result of systems of oppression that shape our communities and environments. Within communities of color, discrimination is the result of institutional and cultural racism that help generate negative stereotypes[[73]](#endnote-71). Discrimination has been shown to be a risk factor for adverse mental and physical health outcomes and contributor to health disparities[[74]](#endnote-72). For example, internalized and interpersonal racism has been linked to psychosocial trauma, stress, and maladaptive coping behaviors[[75]](#endnote-73).

Despite being an important driver of health inequity, there is a general lack of public health data sources that quantify and qualify experiences of discrimination. The 2023 CHES helps to fill this surveillance gap by gathering data on experiences of discrimination and connecting them to mental health outcomes.

Figure 18. CHES 2023 - Experiences of Discrimination and Mental Health Indicators

Individuals who reported experiencing some form of discrimination had worse mental health overall compared to those who reported never experiencing discrimination. Those who reported experiencing discrimination in the past 12 months were 2.7 times as likely to have high or very high psychological distress, 4.1 times as likely to report suicidal ideation, and 4 times as likely to report social isolation compared to those who did not experience discrimination.

Table 17. 2023 CHES - Experiences of Discrimination by Communities of Focus

|  | Ever Experienced Discrimination  Weighted % | Experienced Discrimination in the Past 12 months  Weighted % |
| --- | --- | --- |
| **Race/Ethnicity** |  |  |
| American Indian/Alaska Native | 75.9\*\*\* | 35.8\*\*\* |
| ANHPI1, nH/nL​2 | 43.7\*\*\* | 14.5 |
| Black, nH/nL | 69.2\*\*\* | 30.2\*\*\* |
| Hispanic or Latine/a/o | 60.9\*\*\* | 24.9\*\*\* |
| Middle Eastern or North African | 75.1\*\*\* | 34.8\*\*\* |
| Multiracial, nH/nL | 73.4\*\*\* | 31.5\*\*\* |
| White, nH/nL (*ref*) | 51.6 | 15.6 |
| **Sexual Orientation** |  |  |
| Asexual | 62.7\*\*\* | 26.1\*\*\* |
| Bisexual/Pansexual | 75.9\*\*\* | 28.1\*\*\* |
| Gay or Lesbian | 81.4\*\*\* | 35.0\*\*\* |
| Queer | 88.6\*\*\* | 51.5\*\*\* |
| Questioning/Not Sure | 69.1\*\*\* | 29.1\*\*\* |
| Straight/Heterosexual (*ref*) | 50.4 | 15.3 |
| **Transgender Identity** |  |  |
| Transgender | 90.2\*\*\* | 60.6\*\*\* |
| Not Transgender (*ref*) | 53.5 | 17.0 |
| **People with Disabilities** |  |  |
| Blind/Vision Impaired | 69.3\*\*\* | 33.6\*\*\* |
| Cognitive Disability | 72.1\*\*\* | 38.4\*\*\* |
| Deaf/Hard of Hearing | 57.1\* | 20.6\*\*\* |
| Learning/Intellectual Disability | 67.7\*\*\* | 40.3\*\*\* |
| Mobility Disability | 64.7\*\*\* | 28.9\*\*\* |
| Self-Care/Independent Living Disability | 72.3\*\*\* | 39.3\*\*\* |
| One or More Disabilities | 66.3\*\*\* | 29.7\*\*\* |
| No Disability (*ref*) | 50.1 | 14.6 |

1Reported ever seeing or hearing someone getting physically attacked, beaten, stabbed, or shot in the neighborhood they were living.   
\*\*\* p<.0001, \*\* p<.001, \* p<.05 P-values from Pearson chi-square test indicate whether weighted responses from those identifying as specified group significantly differ from those identifying as the noted reference group.

**Discrimination Within Communities of Focus**

**Communities of Color**

* Respondents who identified as American Indian/Alaska Native, Black, Hispanic/Latine/o/a, Middle Eastern or North African, or Multiracial reported significantly higher rates of discrimination in their lifetime compared to White respondents.
* Approximately 3 in 4 respondents who identified as American Indian/Alaska Native, Middle Eastern or North African, or Multiracial reported experiencing discrimination in their lifetime.
* 7 in 10 respondents who identified as Black reported experiencing discrimination in their lifetime, with 3 in 10 experiencing it in the past year.

**LGBTQA+ Community**

* Respondents who identified as asexual, bisexual, pansexual, gay, lesbian, queer, or questioning were significantly more likely to experience discrimination compared to respondents who identified as heterosexual.
* Nearly 9 in 10 respondents who identified as queer reported experiencing discrimination in their lifetime, with over half reporting experiencing discrimination in the past 12 months.
* 9 in 10 respondents who identified as transgender reported experiencing discrimination in their lifetime, 6 in 10 in the past 12 months.

**People with Disabilities**

* Respondents who reported having one or more disabilities were over twice as likely to report experiencing discrimination in the past 12 months compared to those who reported not having disabilities.

Figure 19. CHES 2023 – Adult High or Very High Psychological Distress by Experiences of Discrimination within Communities of Focus

\*People of color include respondents that reported one of the following race/ethnicities: American Indian / Alaska Native, Asian, Native Hawaiian, Pacific Islander, Black, Hispanic/Latine/a/o, Middle Eastern/North African, or Multiracial.   
\*\*LGBQA includes respondents that reported their sexual orientation as being lesbian, gay, bisexual, queer, asexual, or other.

Reducing exposure to discrimination within communities of focus through addressing root causes of interpersonal and cultural racism and providing support to victims of discrimination are integral for mental health equity promotion. As seen in Figure 19, members of various communities of focus that reported either never experiencing discrimination or not experiencing discrimination in the past 12 months had significantly lower rates of psychological distress compared to those who did experience discrimination in the past 12 months. For example, among people with disabilities, over 72% of those who experienced discrimination in the past 12 months had high or very high psychological distress compared to 50% who experienced discrimination but not in the past 12 months. This provides evidence that strategies to reduce exposure to discrimination may be effective in promoting mental health.

## Promoting Mental Health: Action to Address Root Causes of Mental Health Inequities

### Potential Areas of Action to Address Root Causes of Mental Health Inequities

Section 3 of this report showed that mental health outcomes and inequities are associated with many social and structural factors beyond individual-level determinants. A person’s genetics, behaviors, or biology play a role but are not the only contributors to mental health outcomes. Solutions to promote mental health and address inequities must include strategies along the health inequity pathway, including providing social opportunities, promoting access to key societal resources, and reducing exposure to harmful drivers of poor health. Below is a summary of potential areas of action based on 2023 CHES findings.

* **Implement Community-led Approaches for Direct Mental Health Support and Outreach**

Tailored approaches are needed to support those who are currently suffering from poor mental health and mental health conditions, particularly those representing communities that are disproportionately impacted. Direct support and outreach strategies that are led by and created for communities of focus are necessary to meet the needs and preferences of communities of color, members of the LGBTQA+ community, people with disabilities, youth, and other communities of focus are important to promote mental health equity. Examples of direct mental health support and outreach include:

* + **Suicide Prevention Programs and Resources**Suicide is one of the leading causes of death in the United States and Massachusetts. The 2023 CHES demonstrated that rates of suicidal ideation are particularly high within the LGBTQA+ community, youth and young adult populations, and people with certain disabilities. Suicide prevention outreach and resources are critical to address this important public health crisis.
  + **Substance Use Treatment and Prevention**Mental health and substance use are closely linked. Poor mental health can increase one’s risk for substance use disorder. Substance use can also contribute to and exacerbate poor mental outcomes. Outreach and services to individuals and communities affected by substance addiction and strategies that focus on prevention are critical for mental health promotion.
* **Address Root Causes of Violence and Discrimination and Provide Support to Survivors**Adults and youth exposed to violence are at high risk for poor mental health outcomes. Data from the 2023 CHES demonstrated that individuals exposed to violence and discrimination in various forms were more likely to experience psychological distress, suicidal ideation, and social isolation. The data also showed that reduced exposure to violence and discrimination within communities of color and other communities disproportionately impacted was associated with better mental health. Programs and interventions to support survivors and address root causes of violence and discrimination are key for overall mental health promotion.
* **Promote Employment, Economic Stability, and Healthy Workplaces**Findings from the 2023 CHES show that promoting economic stability within communities of focus may be effective in promoting overall mental health. Economic stability can help improve access to basic needs and resources and decrease overall levels of psychological distress. Increasing opportunities for steady and safe employment that offers livable wages and benefits is one of the key pathways to economic stability. It is also important to ensure that workplaces across different industries and occupations have safe working conditions and are health-promoting. Safe and healthy workplaces offer protection from injuries and illnesses and help promote overall mental health.
* **Improving Access to Quality Health Care**Access to quality and timely health care is important to promote and maintain physical and mental health. Addressing barriers to health care access, particularly among communities of focus, is important to ensure more equitable utilization of needed health care resources, including mental health care. Some examples of barriers to health care access highlighted from the 2023 CHES include lack of insurance coverage, unaffordable health care costs, and experiences of discrimination while getting health care.
* **Increase Access to Quality, Affordable Housing**Health and health equity are not possible without equitable access to quality and affordable housing and neighborhoods that provide access to essential health-promoting resources and opportunities. Inequities in housing due to unjust historical and current policies and practices have led to inequities in housing that contribute to inequities in overall mental health across various communities. Work to promote access to affordable housing and improve neighborhoods within communities of focus are essential for mental health equity.
* **Build Resiliency to the Impacts of Climate Change on Communities of Focus**

The impacts of climate change are already having a disproportionate impact on communities of focus. Work to build community resiliency to present and future impacts of climate change, including extreme temperatures, flooding, and other natural disasters, is critical for health equity.

* **Build Community Capacity to Address Root Causes of Health**

Community organizations play a key role in promoting the overall health of communities across Massachusetts. Community organizations provide essential resources, opportunities, and information needed to address drivers of health equity across the health equity pathway and promote overall physical and mental health. They also help build social support and community connections across communities. Investments in community organizations are important to promote mental health at the individual, neighborhood, community, and state-wide levels. Resources to build the capacity of these organizations to address root causes of health are important for overall health equity promotion.

* **Enact Policies and Practices that Promote Health Equity**

Addressing the systems of oppression that drive health inequities will not be possible without changes to our policies, systems, and environments that help shape our health. In order to achieve mental health equity, we must have local, statewide, national, and institutional policies and practices that actively promote equity within communities that are denied equal access to opportunities and resources needed for health.

### Examples of Community Partner Programs and Initiatives to Promote Mental Health

One of the most vital areas of action to promote mental health is to support existing community-based organizations and the infrastructure that they have developed. It is critical for public health organizations and agencies to defer to partners working with and in communities with lived experiences of health inequities on solutions to address root causes of poor mental health and support them through funding and capacity-building.

The CHEI community partnership network includes hundreds of community partners across Massachusetts, including community-based organizations, hospitals and health systems, tribal governments, local boards of health, service providers, community colleges and universities, and regional coalitions. Many of these partners lead critical work to promote mental health and address the root causes of mental health disparities within their communities. The following table highlights a few examples of work from community partners that are part of the CHEI.

Table 18. Highlights of CHEI Community Partners Promoting Mental Health

|  |
| --- |
| **PureSpark** |
| PureSpark is a digital directory for people seeking mental health support from Black therapists throughout Greater Boston and Massachusetts. National data reflects that only 4% of psychologists, 2% of psychiatrists, and 7% of marriage and family counselors identify as Black. This gap creates disparities in access to culturally competent care, leaving many individuals feeling unheard and unseen. To address the lack of support and infrastructure to support Black people with their mental health needs, PureSpark curates a free digital directory of licensed Black therapists and free wellness events, fostering access to culturally relevant care. PureSpark is also a group of advocates, working with our local leaders on broader insurance coverage, ensuring cost isn't a barrier to well-being. PureSpark actively reaches out and engages community members through initiatives like story sharing sessions and free educational wellness events, including popular wellness walks. These programs create trust and understanding, ensuring people feel heard and represented within the healthcare system. |
| **Quaboag Hills Substance Use Alliance** |
| Quaboag Hills Substance Use Alliance works collaboratively to prevent and reduce substance misuse, especially among youth; to break down the stigma associated with substance use disorder; to reduce health problems resulting from substance use disorder; to contribute to community efforts to expand access to treatment services; and to value all pathways to recovery. Quaboag Hills Substance Use Alliance is a partnership of local hospitals, school districts, behavioral health agencies, religious organizations, police departments, town administrations, mental health professionals, fire & rescue departments, businesses, youth groups and organizations, substance use treatment service providers, and community members who care about community-based substance use prevention, treatment and recovery supports. |
| **Revitalize Community Development Corporation (CDC)** |
| Revitalize CDC works with homeowners, community members, and city officials to renovate, repair, and modify unhealthy homes to improve the well-being of residents in Springfield, Holyoke, and Chicopee. Revitalize CDC provides free critical repairs, modifications, and rehabilitation on the homes of low-income families with children, the elderly, veterans, and individuals with disabilities; helps bridge food insecurity gaps through delivery of fresh foods; and positions community members toward healthier lives through education and support for chronic conditions like asthma and diabetes. |
| **We Thrive** |
| We Thrive is a community-based LGBTQ and Ally program serving young people on Cape Cod and the Islands since 1996. It is a center where people 22 and under can enjoy meetings, drop-in times, field trips, special events, and more where there is camaraderie and support in a peer-led, adult advised environment, free from judgment based on inherent differences. We Thrive understands that mental health is facilitated when young people have meaningful roles, a sense of belonging and an opportunity to contribute within their community. The We Thrive Homes project, comprised of three buildings with shared living rentals, provides LGBTQ youth residents a space with manageable living costs and decreased isolation. We Thrive follows an 80/20 guideline to for resource allocation: dedicating 80 percent of resources of time and funds to outreaching to and supporting people who hold nine priority identities. |

### Highlighted Examples of DPH Programs and Initiatives to Promote Mental Health

The following table provides examples of DPH programs and initiatives to promote mental health outcomes and equity by addressing various drivers of health. While this table is not a comprehensive list of all work carried out by DPH to promote mental health, it helps to illustrate work being done across the health inequity pathway.

Table 19. DPH Programs and Initiatives to Promote Health Care Access, Services, & Resources

|  |  |  |
| --- | --- | --- |
| Program or Initiative | Bureau | Description |
| Division of Sexual and Domestic Violence Prevention and Services (DSDV) | Bureau of Community Health and Prevention (BCHAP) | The Division of Sexual and Domestic Violence Prevention and Services centers all its work around reaching those with the least access to services, who are disproportionately impacted by sexual assault (SA) and domestic violence (DV), and who experience worse outcomes. Although physical health outcomes are not uncommon, virtually all survivors of sexual and domestic violence (SDV) experience a range of mental health impacts, a normal reaction to the abnormal experience of being victimized by violence, abuse, and coercive control. The disproportionately impacted groups include communities of color, people who identify as LGBTQ+, immigrants, people with disabilities, rural residents, and those experiencing poverty and housing instability. Some of the ways the SDV Division addresses these needs are:   * Two clinical program models, Children Exposed to DV for children, youth, and their non-offending parents, and DV, Substance Misuse, and Trauma Shelter, for survivors dealing with both substance abuse and mental health challenges in addition to abuser-generated challenges * Specialized Rape Crisis Center hotlines for underserved communities, specifically Spanish-speaking survivors, Deaf or hard of hearing survivors, and survivors who are now or have recently been incarcerated * Requirements that DV or SA programs applying for prevention funding develop and maintain formal working partnerships with community organizations designed to serve the underserved population on which the prevention project is focused * The SDV Services for Communities Experiencing Inequities (SDVEI) program model, which funds SDV programs for tailor services and outreach to a specific underserved community that data demonstrate are disproportionately impacted by SDV * The SDVEI legal services program, which provides a range of legal services to SA or DV survivors who are immigrants * A new program, Culturally Specific Initiatives to Address SDV, designed to build the capacity of culturally-specific and/or BIPOC-led or -serving organizations to provide, or continue to provide, SDV prevention and intervention services * The Human Trafficking Grant program, in which grantees serve survivors of sex and/or labor trafficking, almost all of whom identify as part of at least one disproportionately impacted community |
| Division of Children and Youth with Special Health Needs (DCYSHN) | Bureau of Family Health and Nutrition (BFHN) | The Division of Children and Youth with Special Health Needs (DCYSHN) is dedicated to addressing the mental health needs of its population of focus. Some programs and initiatives include: - The DCYSHN Health Transition Toolkit includes a module dedicated to mental health for youth and young adults. This module is based on a mental health survey administered for their parents and caregivers, aiming to inform the toolkit and DCYSHN practices when working with young people and their families.  - Community Support Line Resource Specialists inquire about mental health needs as part of their assessment with families and provide who call the Line. They provide technical assistance, information, and referrals to services, including behavioral health services such as applied behavior analysis. - The DCYSHN Director was designated by the Commissioner of the DPH to chair the legislatively established DPH Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections and Pediatric Acute Neuropsychiatric Syndrome (PANDAS/PANS) Advisory Council. This council is charged with advising the Commissioner and MA General Court about research, diagnosis, treatment, and education related to Pediatric Autoimmune Neuropsychiatric Disorder Associated with PANDAS/PANS.  - DCYSHN “Learning Thursdays” sets aside time each month for staff to learn about emerging topics of importance to children and youth with special health needs (CYSHN). Family-led community organizations are invited to present on mental health and trauma-informed/healing-centered care for the PANDAS/PANS population and CYSHN with fetal alcohol syndrome disorder.  - A DCYSHN program support specialist sits on the Sexual Assault Response Teams that includes mental health on the Disabled Persons Protection Commission. |
| Maternal Child Health (MCH) Program | BFHN | The Maternal Child Health (MCH) program is in the process of procuring funds for a grant program to increase access to maternal and reproductive health services in MA. Community-based organizations will be able to submit proposals for mental health workforce development and hospital-based inpatient treatment programs for pregnant and postpartum people experiencing perinatal mental health mood disorders. |
| Perinatal-Neonatal Quality Improvement Network (PNQIN) | BFHN | The Perinatal-Neonatal Quality Improvement Network (PNQIN) will be launching the Alliance for Innovation on Maternal Health in Perinatal Mental Health Bundle in September 2024. Through this project, PNQIN will work with hospital obstetric teams to streamline integration of mental health care into obstetric care and the postpartum period, enhance the coordination and follow-up care for pregnant and postpartum individuals referred to mental health treatment, and identify and address racial inequities in obstetric mental health care. |
| Comprehensive School Health Services (CSHS) | BCHAP | The Comprehensive School Health Services (CSHS) program understands the important link between health and education. The CSHS grant programs help to support schools and school districts to provide a case management model in order to better address increasing student and family needs. They support the delivery of quality, comprehensive health services, including response and referral for mental health needs, in all school districts across Massachusetts. |
| Health Care Workforce Center (HCWC) | BCHAP / Office of Healthcare Strategy and Planning | The Health Care Workforce Center (HCWC) aims to improve the supply and distribution of the health care workforce, including the mental health workforce, in turn increasing access to health care services. The HCWC collects and provides data on healthcare providers, makes recommendations for policies and practices that strengthen the healthcare workforce, and administers programs which address workforce shortages and support providers. This includes a focus on augmenting the behavioral health workforce within mental health professional shortage areas, loan repayment for behavioral health providers, and monitoring emerging trends. |
| Massachusetts Child Psychiatry Access Program’s (MCPAP) | BFHN | The Massachusetts Child Psychiatry Access Program’s (MCPAP) early childhood behavioral health evaluation services aim to meet the needs of young children ages birth to 6 and their families, focusing on relational health, extended evaluations, and specialized resources. MCPAP’s behavioral health consultants receive comprehensive training in early childhood behavioral health, enabling them to effectively triage cases and address the child’s needs. After successfully piloting the program in Central-Western Massachusetts from 2022-2023, MCPAP for Early Childhood Behavioral Health Evaluation and Consultation Services have expanded statewide as of February 2024. |
| School Based Health Center Program | BCHAP | The School Based Health Center Program supports the hiring of full-time behavioral health clinicians, nurse practitioners, and community health workers in school-based health centers across Massachusetts. School-Based Health Centers fortify kids by providing comprehensive care, building on strengths and protective factors, and creating connections with trusted adults. This creates a safe space where providers can help students gain the confidence and skills they need to maximize their learning, successfully navigate school, and understand that they have what it takes to reach their full potential. |
| School Behavioral Workforce and Service Expansion | BCHAP | The School Behavioral Health Workforce and Service Expansion Program funds the hiring and retention of behavioral health personnel, expands services by partnering with community-based organizations, and helps to build overall behavioral health infrastructure. |
| State Office of Rural Health | BCHAP | The Massachusetts State Office of Rural Health (SORH) was established in 1994 to build partnerships to increase access to health services, develop better systems of care, and improve the health status of rural communities. The program has developed a successful institutional framework that links rural communities with state and federal resources to help create solutions to rural health problems. |
| Transforming Massachusetts Pediatrics for Early Childhood (TMPEC) Project | BFHN | Transforming Massachusetts Pediatrics for Early Childhood (TMPEC) Project provides infants and young children with social emotional/behavioral health screening and access to integrated behavioral health clinicians for consultation and interventions to meet the child's unique needs. TMPEC is currently supporting two cohorts of primary care practice partners to form integrated teams, which may include a parent or caregiver with lived experience and a behavioral health clinician. DPH issued a competitive procurement to select the second cohort of 5 practices and anticipates announcing awards in early May 2024. |
| Universal Postpartum Depression (PPD) Screening at Community Health Centers (CHCs) | BFHN | In the FY24 state budget, there was an increase in funding for the Universal Postpartum Depression (PPD) Screening at Community Health Centers (CHCs) program, leading to the expansion of PPD screenings from five to eight CHCs. This program supports the development of a robust system of maternal health care at CHCs, providing social support for pregnant and postpartum people, educating providers, and standardizing procedures for universal screening, assessment, treatment, and referral. |

Table 20. DPH Programs and Initiatives to Address Substance Use

|  |  |  |
| --- | --- | --- |
| Program or Initiative | Bureau | Description |
| Bureau of Substance Addiction Services (BSAS) Programs and Initiatives | Bureau of Substance Addiction Services (BSAS) | The Bureau of Substance Addiction Services (BSAS) oversees the statewide system of prevention, intervention, treatment and recovery support services for individuals, families, and communities affected by substance addiction. Some examples of important work include: - Peer Recovery Support Centers (PRSC) are free peer-led spaces that provide individuals in recovery, as well as families and loved ones affected by addiction, the opportunity to offer and receive support in their community environment. PRSC’s help to support social connectedness and well-being among people with histories of substance use.  - Funding for school-based programs that support young people who are beginning to struggle with substance use.  - Funding municipalities to develop plans and implement evidence-based primary prevention of substance misuse.  - Continuum of treatment and recovery support services as well as substance-use related harm reduction. |
| Division of Sexual and Domestic Violence Prevention and Services (DSDV) | Bureau of Community Health and Prevention (BCHAP) | Data show that substance use and sexual and domestic violence frequently overlap. Substance addiction can lead to people being victimized by unscrupulous people, and many survivors cope with the mental health sequelae of SDV by self-medicating. The Division of SDV funds a residential program model for DV survivors managing both trauma and substance misuse, and also works closely with BSAS on cross training our funded providers about how these issues intersect. Ideally, the two units would like to explore co-location of services, possibly including SDV-funded services for those who have used violence or coercive control in their intimate relationships. |
| FIRST Steps Together | BFHN | The FIRST Steps Together program is completing its sixth Mothering from the Inside Out (MIO) training cohort for clinicians and peer staff in the state. This evidence-based intervention for parents with substance use disorders improves parent-child relationship health by increasing parents’ reflective capacities. FIRST Steps Together is also running multiple Circle of Security-Parenting groups, an attachment-based intervention designed to strengthen the parent-child dyad, for program participants and community members. |
| Massachusetts Tobacco Cessation and Prevention (MTCP) Program | BCHAP | The Massachusetts Tobacco Cessation and Prevention (MTCP) Program provides funding to technical assistance organizations to build capacity among healthcare systems, behavioral health and mental health systems, and community-based organizations to implement tobacco prevention and cessation programming using trauma-informed approaches. They also implement a statewide Quitline that offers free confidential coaching and access to free quit tobacco/nicotine medications such as nicotine replacement therapy (NRT) to help individuals quit or reduce their tobacco/nicotine use. The Quitline also offers tailored programs such as the Behavioral Health Program for individuals with select self-identified mental or behavioral health conditions to support their unique needs |
| Rural Vaccine Equity Initiative | BCHAP | The Rural Vaccine Equity Initiative provides technical assistance to community organizations around substance use disorder prevention and harm reduction, promotes access to behavioral health care in rural areas, and provides funding to support interventions to promote behavioral health. |

Table 21. DPH Programs and Initiatives to Promote Healthy Work

|  |  |  |
| --- | --- | --- |
| **Program or Initiative** | **Bureau** | **Description** |
| Occupational Health Surveillance Program | BCHAP | The Occupational Health Surveillance Program (OHSP) works to promote the health, safety, and well-being of all working people in Massachusetts by using occupational health data for action. OHSP collects, analyzes, and disseminates information about work-related injuries, illnesses, and hazards and uses this information guide and prioritize interventions such as developing policies and programs to address workplace risks. OHSP places a special emphasis on reaching worker populations that have been affected by persistent systemic racism and related inequities. |
| Division of Sexual and Domestic Violence Prevention and Services (DSDV) | BCHAP | Survivors of DV are often methodically prevented from becoming or remaining economically self-sufficient as a way for the abusive partner to prevent them from leaving. Lack of access to money, education, or job training, sabotaging a survivor’s success in the workplace, and ensuring bankruptcies, evictions, bad credit, and even arrests are on the survivor’s record are tools commonly used by abusers. The community-based DV programs funded by the Division address these economic security issues in various ways to support survivors in having life choices other than returning to an abusive environment.  Additionally, the Division supports the Massachusetts Women of Color Network, which comprises people of color working in SA and DV programs in the Commonwealth, in their initiatives to support the SDV workforce in managing job and life stress, self-care, professional development with an eye toward promotion and increasing income, and so on. |

Table 22. DPH Programs and Initiatives to Prevent Suicide

|  |  |  |
| --- | --- | --- |
| Program or Initiative | Bureau | Description |
| Suicide Prevention Program | BCHAP | The Suicide Prevention Program provides support to community agencies, education and training for professionals and caregivers, and funds programs working with youth, veterans, and older adults to reduce suicides and promote mental health and well-being among Massachusetts residents. The program provides licenses to middle and high schools to implement the Signs of Suicide Program, a three-lesson curriculum that encourages student help-seeking by instructing students how to ACT (Acknowledge, Care, and Tell) in the face of a mental health emergency. The Suicide Prevention Program also implements 988, a suicide and crisis lifeline to support those in emotional distress or suicidal crisis. |
| Division of Sexual and Domestic Violence Prevention and Services (DSDV) | BCHAP | A tragic number of domestic violence cases end in homicide/suicide, sometimes with one or more other victims in addition to the intended target or targets, in the case of murder of the partner and children. The Division of SDV funds and certifies Intimate Partner Abuse Education Programs (IPAEP), formerly known as Batterer Intervention Programs. The Department’s *Guidelines and Standards for the Certification of Intimate Partner Abuse Education Programs* require these programs to continually assess program participants’ risk of re-assault of their partner, child abuse, and/or suicide, and have protocols in place for managing those risks. |

Table 23. DPH Programs and Initiatives to Prevent Violence and Support Survivors

|  |  |  |
| --- | --- | --- |
| Program or Initiative | Bureau | Description |
| Division of Sexual and Domestic Violence Prevention and Services | BCHAP | The Division of Sexual and Domestic Violence Prevention and Services works to eliminate sexual and domestic violence and support the health of those impacted by such violence. The Division funds a comprehensive array of programs and services for survivors of sexual and domestic violence and their children or other dependents. Intervention services funded by the Division of SDV include residential programs, community-based programs providing advocacy and support, 24-hour accompaniment of sexual assault victims to hospital exams and/or criminal legal system proceedings, housing advocacy, legal services, individual and group support, several crisis hotlines, specialized programs for children exposed to domestic violence, and services for immigrants and other communities experiencing inequities. Prevention-focused programs and activities include a statewide social media campaign about healthy relationships among youth, programs for youth working with community-based organizations by and for the specific populations of youth on which the prevention program is focused, community education and awareness aimed at changing social norms, training of professionals whose work brings them in contact with survivors, and services designed to support those who have used violence and coercive control in their intimate relationships in recognizing and changing their harmful behaviors and the belief systems that led to those behaviors. |
| Gun Violence Prevention Program | BCHAP | The Gun Violence Prevention program works with grantees across 15 communities to help youth avoid conflict and injury. Grantees work directly with individuals affected by gun violence by delivering evidence-based prevention, intervention, treatment, and recovery services across six core domains: street outreach, comprehensive social needs assessment and referral, mentoring, mental and behavioral health services, workforce development, and community engagement. |
| Healing, Equity, & Leadership (HEAL) Grant | BCHAP | The Health Equity Leadership Grant (HEAL) coordinates state and local efforts to address social determinants of health, the root causes of violence, and makes connections to address individual behavioral health needs through contracted vendors. The initiative is made up of three programs: Primary Violence Prevention, Safe Spaces for LGBTQIA+ youth, and Opportunity Youth. |

Table 24. DPH Programs and Initiatives to Promote Policy, Systems, and Environment Change

|  |  |  |
| --- | --- | --- |
| Program or Initiative | Bureau | Description |
| Community Health Training Institute (the Training Institute) | BCHAP | The Community Health Training Institute (the Training Institute) provides targeted skills development to individuals and teams working to build healthy communities in Massachusetts. They customize in-person trainings and webinars around core competencies that include: Coalition Building; Leadership; Policy and Systems Change; Communications; Health Equity; Youth Development; Strategic Planning and Evaluation. Behavioral Health Coalitions are supported in this space and there are many trainings that bridge into BH and root cause BH work. |
| Equitable Approaches to Public Safety (EAPS) | BCHAP | The Equitable Approaches to Public Safety (EAPS) program looks to identify and implement alternative approaches to traditional public safety models that are effective and equitable to the residents of the Commonwealth that best serve their community. EAPS works with different municipalities to develop and implement comprehensive public safety reform. Using a public safety reform partnership and broad stakeholder involvement to explore various types of alternative response models ranging from co-response with law enforcement to stand alone clinical response. |
| Mass in Motion (MiM) | BCHAP | Mass in Motion uses a root cause framework to inform selection of strategies and activities to enact policy and practice change at the local level, Grantees have identified strategies to address root causes related to these health outcomes, these include strategy work in the areas of crime and safety, housing, active transportation, economic development, and access to open space. |
| Root Cause Solutions Exchange | BCHAP | The Root Cause Solutions Exchange is a unique center for excellence building capacity to improve community conditions that build resilience and reduce vulnerability for Covid-19, chronic disease, climate change, and other conditions, with an explicit focus on structural racism. The Exchange centers interaction and helping participants take action using a manageable and accessible library of quality resources relevant to a Massachusetts context. The Exchange is a dynamic initiative where participants contribute and learn from DPH and each other, rather than a static website or standalone resource hub. These investments in increasing community capacity through the Exchange create improved physical and social conditions, more multi-sectoral partnerships, more dollars invested in communities where it may not have occurred otherwise, and healthier communities with increased resilience. |

# Conclusion

Mental health is a core component of our overall health and the building blocks for overall mental well-being include factors at the individual, family, community, institution, and systems levels.

Data from the 2023 CHES and other statewide data sources show that the overall burden of poor mental health in Massachusetts is high. The data also show that rates of poor mental health outcomes are disproportionately high within certain communities. Communities of color, members of the LGBTQA+ community, people with disabilities, and school-aged youth were among the communities that reported the highest burden of poor mental health outcomes, including psychological distress, social isolation, and suicidal ideation.

There is no single cause for poor mental health outcomes. Findings from the 2023 CHES help to demonstrate the connection of mental health outcomes with factors along the health inequity pathway. Social and structural drivers such as employment, economic stability, housing, health care access, social support, experiences with violence and discrimination, environmental exposures, and others were shown to be closely tied to mental health outcomes. Unsurprisingly, communities of focus that experience disproportionately high levels of poor mental health were also shown to experience inequities within these various drivers of health.

Addressing inequities within these various drivers of health is important for promoting mental health equity. The 2023 CHES showed that members of communities of focus that had access to positive building blocks for mental health, such as economic stability, access to timely and quality health care, stable housing, and reduced exposures to discrimination and violence, had significantly better mental health outcomes.

Critical work to promote mental health is being carried out by different groups and institutions, including community organizations, resident leaders, health care organizations, academic institutions, and government agencies. More work and resources are still needed, however, to fully address the mental health needs of Massachusetts residents. No single solution or strategy alone can provide us all with equal opportunities for mental well-being. However, a deeper understanding of the root causes of mental health inequities combined with a firm commitment to work together to implement solutions to address these root causes can help to bridge the equity gap and promote health and well-being for all residents.

# Resources

One of the primary goals of the Community Health Equity Initiative is to support state, local and community partners in using data to better understand resident experiences and take action to advance health equity. This mental health report is part of a collection of resources to help fill important gaps of information and inform policy and inform policy and practice change to promote health equity. This report and other resources are available on the CHEI website. Additional resources include an overview of the Community Health Equity Initiative, detailed data tables, data dashboards, and racial justice framing resources.

Data & Action is one of the foundational pillars of CHEI. The purpose of the Data & Action Support model is to share CHES data and findings back with community-based organizations, municipalities, health systems, and other partners and support their use of the data for action. CHEI has partnered with regional Data & Action Support Providers across Massachusetts to offer capacity building and assistance to community partners. These providers offer a wide range of services, including providing customized data analyses and supporting the use of data to inform programming, apply for grant funding, and advocate for policies that reduce health inequities.

For more information, please visit our website or contact the CHEI team.

Website: [www.mass.gov/CHEI](http://www.mass.gov/CHEI)

Contact: [CHEI@mass.gov](mailto:CHEI@mass.gov)

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**Community Engagement Advisory Committee (CEAC)**

Our CEAC was instrumental in helping us make key decisions during survey development, community outreach, and survey dissemination. Member organizations include:

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**2023 CHES Survey Dissemination Mini Grantees**

Our 2023 survey mini grantees conducted important outreach within communities across Massachusetts, including many communities that are often underrepresented in public health data.

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**CHEI Mental Health Advisory Group**

The CHEI Mental Health Advisory Group helped to design and make decisions on survey questions related to mental health. The advisory group also helped to support the analysis, interpretation, and development of key findings seen within this report. Members of this advisory group comprise volunteers that represent various programs and initiatives across the Department, including: the Culturally and Linguistically Appropriate Services (CLAS) Initiative, Division for Children and Youth with Special Health Care Needs, Division for Pregnancy, Infancy, and Early Childhood, Division of Child/Adolescent Health and Reproductive Health, Bureau of Community Health and Prevention’s Office of Statistics and Evaluation, Pregnancy, Infancy, and Early Childhood Division, Division of Community Health Planning and Engagement, and Women, Infants, & Children Nutrition Program.

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