MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Community Health Equity Initiative (CHEI)

Community Health Equity Survey 2023

Mental Health Spotlight

[Image: CHEI logo consisting of a circle divided into three equal sectors. In the center, the text reads 'CHEI.' Each sector of the circle contains one of the following phrases: 'Health Equity Data System,' 'Community Engagement Practice,' and 'Data & Action.']

CHEI

]

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CHEI COMMUNITY ENGAGEMENT ADVISORY COMMITTEE (CEAC)

CHEI would not have been possible without the collaboration of the CEAC. Member organizations collaborated with DPH to make decisions around survey development and outreach strategies.

* Allston Brighton Health Collaborative Asian Task Force Against Domestic Violence (ATASK) ​
* Authentic Caribbean Foundation ​
* Black Literacy and Arts Collaborative ​
* Boston Children's Hospital Office of Community Health ​
* Cambodian Mutual Assistance Association ​
* Casa Project of Worcester County ​
* Health Equity Partnership of North Central Massachusetts (CHNA 9) ​
* DEAF, Inc.​
* Dignity Alliance Massachusetts ​
* Disability Policy Consortium​
* Greater Lawrence Community Action Council ​
* Haitian Community Partners
* Immigrants’ Assistance Center ​
* Justice 4 Housing ​
* Massachusetts Alliance of Portuguese Speakers ​
* Massachusetts Councils on Aging ​
* Massachusetts Association of Community Development Corporations ​
* Multicultural AIDS Coalition ​
* New American Association of Massachusetts ​
* New England Rural Health Association​
* North American Indian Center of Boston ​
* Ohketeau Cultural Center ​
* Outer Cape Health Services ​
* PureSpark ​
* Quaboag Hills Substance Use Alliance ​
* Revitalize CDC ​
* Somali Parents Advocacy Center for Education​
* Springfield Family Resource Center ​
* Springfield Mass in Motion ​
* Stavros ​
* YMCA of Greater Boston ​

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CHES SURVEY DISSEMINATION MINI-GRANTEES

CHEI

CHES would not have been possible without the efforts of mini-grantees. These organizations received funding to conduct outreach to their community members, and their success is reflected in response rates among communities of focus.

* Advocates
* Authentic Caribbean Foundation Inc.
* Berkshire Area Health Education Center, Inc
* Black Autism Coalition
* Boston Chinatown Neighborhood Center
* Boston Lesbigay Urban Foundation
* Breaktime United, Inc.
* Cambiando el mundo de personas con Discapacidades
* Cambodian Mutual Assistance Association of Greater Lowell, Inc.
* Center for Living and Working
* Centro Comunitario de Trabajadores
* Chappaquiddick Tribe of The Wampanoag Indian Nation Corporation
* CHD's Big Brothers Big Sisters of Hampshire County
* Chelsea Black Community
* Coalition for a Healthy Greater Worcester
* Community Action Agency of Somerville
* Community Economic Development Center
* Developmental Evaluation and Adjustment Facilities, Inc. (DEAF, Inc.)
* Disability Policy Consortium
* Enlace de Familias de Holyoke/ Holyoke Family Network Inc.
* Greater Fall River RE-CREATION
* Haitian Community Partners Foundation
* Health Equity Partnership of North Central MA (CHNA9)
* Health Imperatives
* Herring Pond Wampanoag Tribe
* Hilltown CDC
* Immigrants' Assistance Center
* Islamic Society of Boston
* JAHAN Women and Youth Intercultural,  Inc
* Justice For Housing Inc
* La Colaborativa
* Latino Education Institute
* Latinx In Action
* Lawrence Prospera
* LEO Inc.
* LGBT Asylum Task Force
* Making Opportunity Count
* Mary Lyon Foundation
* Massachusetts Alliance of Portuguese Speakers (MAPS)
* Montague Catholic Social Ministries
* Mystic Valley YMCA
* Native American Lifelines
* New American Association of MA
* Nipmuc Nation Tribal Council
* North Quabbin Community Coalition
* Ohketeau Cultural Center
* Open Sky – Safe Homes Program
* Outer Cape Health Services
* Out at Home - The Home for Little Wanderers
* Out MetroWest
* Out Now
* Partners for Youth with Disabilities
* Pioneer Valley Workers Center
* PureSpark
* Quaboag Valley Community Development Corporation
* Quincy Asian Resources, Inc. (QARI)
* Roca Inc.
* Saheli
* Somali Parents Advocacy Center for Education (SPACE)
* Somerville Public Schools - Somerville Family Learning Collaborative
* Southeast Asian Coalition of Central MA
* Tan Chingfen Graduate School of Nursing at UMass Chan Medical School
* Tapestry Health Systems, Inc.
* The Association of Haitian Women in Boston
* The Care Center
* The Vietnamese American Civic Association
* Uhai for Health Inc
* Viability
* Vietnamese American Initiative for Development (VietAID)
* Vim Berkshires
* Voices of The Community
* Volunteers in Medicine
* Waltham Partnership for Youth
* WestMass ElderCare,  Inc.
* Wildflower Alliance (under the umbrella of the Western Mass Training Consortium)
* Youth on Fire
* YWCA Central Massachusetts

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CHEI MENTAL HEALTH ADVISORY GROUP

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This Mental Health Spotlight was developed in partnership with members of the CHEI Mental Health Advisory Group who informed the analyses and findings highlighted within this report.

CHEI Mental Health Advisory Group Members represent various programs and divisions across DPH, including:

* Culturally and Linguistically Appropriate Services 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
* Office of Statistics and Evaluation - Bureau of Community Health and Prevention
* Pregnancy, Infancy, and Early Childhood Division
* State Office of Rural Health
* Women, Infants, & Children Nutrition Program

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COMMUNITY HEALTH EQUITY INITIATIVE (CHEI) BACKGROUND

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CHEI MODEL: FOUNDATIONAL PILLARS

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CHEI promotes the health of Massachusetts residents and reduces health inequities through a

Health Equity Data and Response System.

This public health system is built upon Three Foundational Pillars:

[Image: CHEI logo with text: “CHEI: Health Equity Data System. Community Engagement Practice. Data & Action”.]

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CHES 2023 METHODOLOGY OVERVIEW

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CHES is an innovative, community-based survey administered to residents aged 14 and older

Utilizes a non-probability quota sampling methodology

Sample goals were set for Communities of Focus to ensure representation and sufficient sample sizes for granular and intersectional analyses.

Non-random sampling with community outreach strategies to meet sample goals.

Sample weights were created using propensity score model weights to better align the survey sample to statewide race & ethnicity, gender, age, and education distribution.

Data collection was open from July 31 through October 31, 2023.

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CHES 2023 SAMPLE GOAL ACHIEVEMENTS

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CHES engagement & dissemination strategies were effective in reaching nearly all CHES sample goals.

[Image: Bar chart showing number of participants in CHES 2023 Sample (n=18276) compared to Sample Goal (n=12,000).]

Overall Participation exceeded CHES 2023 sample goal by 65%.

Sampling goals were exceeded for nearly all Communities of Focus, including:

* American Indian/Alaska Native, Asian American & Pacific Islander, Black, and Hispanic/Latine-o-a groups
* Overall, residents of color represented a greater proportion of participants in CHES 2023 compared to CCIS 2020 (29.7% vs. 18.7%)
* Youth, age 14-17 (n=2,070)
* All people with disability groups
* Pregnant and postpartum people (n= 307)
* Foreign-born residents (n=2,800)
* LGBTQA+ residents (n=2962)
* Transgender and/or nonbinary residents (n=676)
* Rural residents (n= 3023)

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CHES 2023 METHODOLOGY OVERVIEW

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For more information about the Community Health Equity Initiative (CHEI) and more information about the Community Health Equity Survey (CHES) please visit our website.

www.mass.gov/CHEI

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MENTAL HEALTH EQUITY FRAMING

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MENTAL HEALTH EQUITY FRAMING

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Mental Health Is A Core Component Of Our Overall Health

Our mental health impacts nearly all aspects of our lives and is important for maintaining meaningful relationships, coping with everyday stress, and making choices.

Mental Health Is More Than Just the Absence of Illness

Mental health exists on a continuum and having positive mental health is more than just the absence of mental illness.

Individuals living with a mental health condition can have high levels of mental well-being just as individuals without a mental health diagnosis are not guaranteed to have positive overall mental health.

Promoting Mental Health Equity Goes Beyond Focusing on Individuals

The building blocks for positive mental health include factors at the individual, community, environment, institution, and systems levels.

Promoting mental health equity will require strategies across all levels, including addressing systems and structures that drive health inequities.

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CHEI Health Inequities Framework​

[Image: "A flow chart illustrating how systems and structures lead to health outcomes and inequities. The left side represents 'Interconnected Systems,' listing forms of oppression such as racism (internalized, interpersonal, institutional, structural), sexism, ableism, heterosexism, classism, and other systems of oppression. These systems influence 'Social Status' categories such as race, gender, age, sexual orientation, and disability, represented by arrows pointing to the middle section labeled 'Upstream/Midstream,' which includes 'Social Status Opportunities' (education, employment, economic stability) and 'Societal Resources' (housing, technology, social support, transportation, health resources). Exposures (environmental, discrimination, violence) are also factors in this section. All of these factors lead to the 'Health Outcomes and Inequities' section on the right, which includes chronic conditions, disability, mental health and well-being, substance use, and long COVID."]

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MENTAL HEALTH IN MASSACHUSETTS

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2023 CHES MENTAL HEALTH INDICATORS

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Psychological Distress

2023 CHES used the Kessler Psychological Distress Scale\*.

Scores from the Kessler Scale were used to categorize levels of psychological distress.

Psychological distress in this spotlight is defined as having “high” or “very high” levels of psychological distress.

\* The Kessler Psychological Distress Scale is a validated scale to assess non-specific psychological distress. The 2023 CHES used a 5-question version of the scale.

Suicidal Ideation

2023 CHES gathered information on suicidal ideation and suicide attempts.

Suicidal ideation is defined as thinking about doing something to end your life in the past 12 months.

Social Isolation

Social isolation is defined as not having many people to talk to or spend time with on a regular basis.

2023 CHES asked respondents how often they feel isolated from others. Those who reported feeling isolated “usually” or “always” were considered socially isolated.

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MENTAL HEALTH IN MASSACHUSETTS

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The overall burden of poor mental health in MA is high and inequities exist

Nearly 1 in 3 adults and 1 in 2 youth reported psychological distress.

Youth and younger adult age groups reported the highest rates of psychological distress.

[Image: "Bar chart titled 'Psychological Distress by Age Group (Years)' showing the percentage of psychological distress across age groups: 14-17 at 45.8%, 18-24 at 59.0%, 25-34 at 50.8%, 35-44 at 41.9%, 45-65 at 28.6%, 65-74 at 14.0%, and 75+ at 10.3%."

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MENTAL HEALTH IN MASSACUSETTS

CHEI

The overall burden of poor mental health in MA is high and inequities exist

Overall, 7.4% of adults aged 18 and older and 14.7% of youth aged 14-17 reported suicidal ideation in the past year.

Young adults aged 18-24 had the highest reported rates of suicidal ideation.

"Bar chart titled ‘ Suicidal Ideation by Age Group (Years)' showing the percentage of suicidal ideation across age groups: 14-17 at 14.7%, 18-24 at 17.9%, 25-34 at 14.4%, 35-44 at 8.7%, 45-65 at 6.0%, 65-74 at 2.7%, and 75+ at 1.9%."

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MENTAL HEALTH IN MASSACUSETTS

CHEI

The overall burden of poor mental health in MA is high and inequities exist

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.

“Bar chart titled ‘Social Isolation by Age Group (Years)’ showing the percentage of social isolation across age groups: 14-17 at 15.6%, 18-24 at 25.0%, 25-34 at 21.1%, 35-44 at 15.7%, 45-65 at 12.3%, 65-74 at 6.1%, and 75+ at 4.7%."

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: People of Color

Racism and Mental Health

Communities of color continue to experience racism at the structural, institutional, interpersonal, and internalized levels, which lead to poor outcomes and inequities in mental health.

Barriers to Quality Mental Health Care & Resources

People of color are more likely to experience barriers to accessing mental health services and more likely to receive poor quality mental health care.

Mental Health Inequities Hidden within Data

Poor mental health outcomes, including mental illness, are often underdiagnosed and underreported within many communities of color.

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: People of Color

People 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.

[Image: "Bar chart titled ‘Psychological Distress by Race and Hispanic or Latine/a/o Ethnicity' showing the percentage of psychological distress across race/ethnicity groups: American Indian/Alaska Native at 42.8%, ANHPI, nH/nL at 24.6%, Black nH/nL at 32.6%, Hispanic or Latine/a/o at 42.0%, Middle Eastern or North African at 38.0%, Multiracial, nH/nL at 49.6%, and White nH/nL at 30.1%."

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

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: People of Color

American Indian / Alaska Native

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

1 in 5 youth reported being socially isolated.

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.

Multiracial

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

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: LGBTQA+

Diversity within the LGBTQA+ Community

The Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Asexual (LGBTQA+) community includes individuals with a diverse range of identities and expressions of gender and sexual orientation and experiences

History of discrimination, violence, oppression

The LGBTQA+ community have experienced a long history of discrimination, violence, and denial of civil and human rights.

Mental Health Inequities within the LGBTQA+ Community

Structural and social drivers of health contribute to members being at higher risk for many poor mental health outcomes, including depression, anxiety, and substance misuse.

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: LGBTQA+

Overall, adults and youth who identify as LGBTQA+ had significantly higher rates of psychological distress, suicidal ideation, and social isolation compared to straight and cisgender respondents.

6 in 10 youth identifying as Transgender reported suicidal ideation. That rate is over 5 times higher compared to youth who do not identify as transgender.

[Image: "Bar chart titled ‘Youth (Aged 14-17) Suicidal Ideation by Sexual Orientation and Transgender Identity’ showing the percentage of psychological distress across sexual orientation and transgender identity groups: asexual at 28.4%, bisexual/pansexual at 33.6%, gay or lesbian at 34.6%, questioning/not sure at 23.1%, straight/heterosexual at 8.4%, transgender at 60.1%, and not transgender at 10.8%."]

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: LGBTQA+

LGBTQA+ Adults

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 suicial ideation, and 6.4 times as likely to report being socially isolated compared to those not identifying as transgender.

Over 7 in 10 Non-Binary Adults reported having high or very high psychological distress, 2.3 times the rate of female adults.

Adults identifying as Bisexual. Pansexual, Queer, or Questioning had over twice the rate of 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.

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: People with Disabilities

Diversity Among People with Disabilities

People with disabilities are a diverse group of individuals with a wide range of identities, abilities, and lived experiences.

Ableism is a System of Oppression

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.

Disability and Mental Health Inequities

The discrimination and barriers people of disabilities face often lead to increased mental distress and risk for other poor mental health outcomes. In the U.S., an estimated 17.4 million adults with disabilities experience frequent mental distress.

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: People with Disabilities

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 14-17 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 adults and youth without a disability.

[Image: "Bar chart titled ‘Psychological Distress by Disability Status Among Adults’ showing the percentage of psychological distress indicators of those with at least one disability compared to those with no disabilities: 50.8% of those with one disability reported psychological distress compared to 24.4% of those with no disability; 15.0% of those with at least one disability reported suicidal ideation compared to 4.5% of those without a disability; 25.8% of those with at least one disability reported social isolation compared to 8.4% of those with no disability”.]

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MENTAL HEALTH IN MASSACUSETTS

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Communities Experiencing Inequities in Mental Health: People with Disabilities

Mental Health Inequities Among People with Disabilities

People with a Self-Care / Independent Living Disability

Youth with a self-care/ independent living disability reported the highest rate of suicidal ideation (55.3%) and the highest rate of social isolation (53.4%) of all disability types.

People 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.

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.

People with a Learning / Intellectual Disability

Adults with a learning / intellectual disability were 2.7 times more likely to report high or very high psychological distress and 5.6 times as likely to report suicidal ideation compared to adults without a learning / intellectual disability.

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DRIVERS OF MENTAL HEALTH INEQUITES

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DRIVERS OF MENTAL HEALTH INEQUITIES

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[Image: "A flow chart illustrating how systems and structures lead to health outcomes and inequities. The left side represents 'Interconnected Systems,' listing forms of oppression such as racism (internalized, interpersonal, institutional, structural), sexism, ableism, heterosexism, classism, and other systems of oppression. These systems influence 'Social Status' categories such as race, gender, age, sexual orientation, and disability, represented by arrows pointing to the middle section labeled 'Upstream/Midstream,' which includes 'Social Status Opportunities' (education, employment, economic stability) and 'Societal Resources' (housing, technology, social support, transportation, health resources). Exposures (environmental, discrimination, violence) are also factors in this section. All of these factors lead to the 'Health Outcomes and Inequities' section on the right, which includes chronic conditions, disability, mental health and well-being, substance use, and long COVID." The ‘Social Status Opportunities’ area of the flowchart is framed by a red rectangle.”]

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Social Status Opportunities: Economic Stability

Economic Stability is the ability of individuals, households, and communities to meet their basic and essential needs sustainably.

Economic stability is important for accessing important resources like housing, technology, transportation, health care, and healthy foods.

Absence of economic stability leads to poor mental health outcomes by impacting your ability to attain necessary resources and increasing psychological distress.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Social Status Opportunities: Economic Stability

Adults who 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 4x as likely to report psychological distress and social isolation compared to those who did not. They were also nearly 3x as likely to report suicidal ideation.

[Image: "Bar chart titled ‘Paying for Basic Needs and Mental Health Indicators’ showing the percentage of psychological distress indicators of those reporting trouble paying for basic needs compared to those reporting no trouble paying for basic needs: 35.4% of those reporting trouble paying for basic needs reported psychological distress compared to 8.1% of those reporting no trouble paying for basic needs; 13.6% of those reporting trouble paying for basic needs reported suicidal ideation compared to 4.7% of those reporting no trouble paying for basic needs; 25.7% of those reporting trouble paying for basic needs reported social isolation compared to 6.4% of those reporting no trouble paying for basic needs”.]

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Social Status Opportunities: Economic Stability

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, the rate of psychological distress among people of color who did report trouble paying for basic needs was 21.2% compared to 58.5% for people of color that did report trouble paying for basic needs.

[Image: "Bar chart titled ‘Psychological Distress by Paying for Basic Needs Among Communities of Focus’ showing the percentage of those reporting psychological distress by those reporting trouble paying for basic needs compared to those reporting no trouble paying for basic needs within four communities of focus: People of color, LGBQA Sexual Orientation, Transgender Identity, and people with disabilities. Among people of color, 58.5% of those reporting trouble paying for basic needs reported psychological distress compared to 21.2% of those reporting no trouble paying for basic needs; among LGBQA Sexual Orientation, 77.6% of those reporting trouble paying for basic needs reported psychological distress compared to 39.1% of those reporting no trouble paying for basic needs; among those identifying as transgender, 88.9% of those reporting trouble paying for basic needs reported psychological distress compared to 66.0% of those reporting no trouble paying for basic needs; ; among people with disabilities, 72.9% of those reporting trouble paying for basic needs reported psychological distress compared to 35.0% of those reporting no trouble paying for basic needs”.]

\*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.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Social Status Opportunities: Employment

Having safe and steady employment is important for promoting physical and mental health.

Employment promotes economic stability of individuals and families, which is important for accessing important health-promoting resources.

The nature and conditions of work also have a large impact on health. Having healthy and safe workplaces, livable wages, and job security are important for our overall health, including mental health.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Social Status Opportunities: Employment

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%).

[Image: "Bar chart titled ‘Psychological Distress by Employment Status Among Communities of Focus’ showing the percentage of those reporting psychological distress by employed status compared to unemployed status within four communities of focus: People of color, LGBQA Sexual Orientation, Transgender Identity, and people with disabilities. Among people of color, 50.7% of those employed reported psychological distress compared to 34.1% of those unemployed; among LGBQA Sexual Orientation, 79.1% of those employed reported psychological distress compared to 52.2% of those unemployed; among those identifying as transgender, 90.4% of employed reported psychological distress compared to 74.4% of those unemployed ; among people with disabilities, 62.0% of those employed reported psychological distress compared to 55.5% of those unemployed”.]

\*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.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Social Status Opportunities: Employment

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.

For example, among adults who reported being unemployed, individuals identifying as Gay, Lesbian, Bisexual, Pansexual, or Asexual had significantly higher rates of psychological distress than those who identify as straight/heterosexual.

[Image: "Bar chart titled ‘Psychological Distress Among Unemployed Adults by Sexual Orientation’ showing the percentage of psychological distress among unemployed adults by sexual orientation groups. Among unemployed adults, 65.5% of asexual, 83.0% of bisexual/pansexual, 76.1% of gay or lesbian, and 54.2% of straight/heterosexual adults reported psychological distress.”]

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DRIVERS OF MENTAL HEALTH INEQUITIES

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[Image: "A flow chart illustrating how systems and structures lead to health outcomes and inequities. The left side represents 'Interconnected Systems,' listing forms of oppression such as racism (internalized, interpersonal, institutional, structural), sexism, ableism, heterosexism, classism, and other systems of oppression. These systems influence 'Social Status' categories such as race, gender, age, sexual orientation, and disability, represented by arrows pointing to the middle section labeled 'Upstream/Midstream,' which includes 'Social Status Opportunities' (education, employment, economic stability) and 'Societal Resources' (housing, technology, social support, transportation, health resources). Exposures (environmental, discrimination, violence) are also factors in this section. All of these factors lead to the 'Health Outcomes and Inequities' section on the right, which includes chronic conditions, disability, mental health and well-being, substance use, and long COVID." The ‘Societal Resources’ area of the flowchart is framed by a red rectangle.”]

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Societal Resources: Social Networks and Supports

The relationships and networks 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 ways, including:

Providing us with emotional support, information, and help with tangible needs.

Reinforcing social norms and influencing behaviors.

Influencing our access to resources like job opportunities, educational opportunities, access to health care, and housing.

Shaping person-to-person contact, which influences our exposure to infectious diseases

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Societal Resources: Social Networks and Supports

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.

Social Support Among Youth

70.2% of youth who reported not having someone to talk to about a personal problem had high or very high psychological distress compared to 44.6% of youth who did have someone to talk to. They were also nearly twice as likely to report suicidal ideation (22.9% vs 12.3%).

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Societal Resources: Social Networks and Supports

Within communities of focus, increased levels of social support were associated with overall better mental health outcomes.

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.

[Image: "Bar chart titled ‘Psychological Distress by Social Support Levels\* Among Communities of Focus’ showing the percentage of those reporting psychological distress by low, medium, and high social support levels within four communities of focus: People of color, LGBQA Sexual Orientation, Transgender Identity, and people with disabilities. Among people of color, 53.5% with low social support, 41.8 with medium social support, and 22.3% with high social support reported psychological distress; among LGBQA Sexual Orientation, 70.2% with low social support, 61.1% with medium social support, and 39.5% with high social support reported psychological distress; among those identifying as transgender, 91.0% with low social support, 77.1% with medium social support, 68.7% with high social support reported psychological distress; among people with disabilities, 71.3% of those with low social support, 56.4% with medium social support, and 34.5% with high social support reported psychological distress”.]

\*Social support levels were calculated from the social support module in the 2023 CHES. 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 types 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.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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[Image: A flowchart titled "Societal Resources: Housing," depicting the relationship between housing systems and policies and mental health outcomes. At the top is "Systems & Policies," including "Housing-related Policies" and "Macroeconomic Factors." This level affects three components: "Housing Cost," "Housing Supply," and "Housing Quality." Each of these components feeds into subsequent levels.

Under "Housing Cost," the "Neighborhood Level" includes "Neighborhood Violence" and "Community Resources." "Housing Supply" connects to the "Housing Level," represented by "Household Environmental Exposures." "Housing Quality" leads to "Individual & Family Level," with factors like "Housing Affordability" and "Housing Stability."

The next section, "Mid and Downstream Determinants of Health," lists factors such as "Access to Basic Needs," "Sleep Quality," "Chronic Stress," "Social Networks & Support," "Exposure to Violence," "Access to Resources," and "Health-Related Behaviors."

Finally, all determinants converge into "Mental Health Outcomes" at the bottom of the chart.]

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Societal Resources: Housing

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.

Housing Stability

Adults who reported having a steady place to live had significantly lower rates 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.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Societal Resources: Housing

Within communities of focus, those that have access to stable, affordable housing were more likely to have better mental health outcomes.

For example, among residents of color, the rate of high or very high psychological distress among those that reported having a steady place to live was significantly lower than those that reported not having a steady place to live (29.0% vs 69.9%).

\* 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.

[Image: "Bar chart titled ‘Psychological Distress by Housing Stability Among Communities of Focus’ showing the percentage of those reporting psychological distress by housing stability status within four communities of focus: People of color, LGBQA Sexual Orientation, Transgender Identity, and people with disabilities.

Among people of color, 29.0% with a steady place to live, 67.3% with a steady place but worried about losing, and 69.9% with no steady place to live reported psychological distress; among LGBQA Sexual Orientation, 47.7% with a steady place to live, 78.5% with a steady place but worried about losing, and 87.1% with no steady place to live reported psychological distress; among those identifying as transgender, 71.1% with a steady place to live, 91.5% with a steady place but worried about losing, and a percentage not reported due to small sample size with no steady place to live reported psychological distress; among people with disabilities, 43.5% with a steady place to live, 81.6% with a steady place but worried about losing, and 81.4% with no steady place to live reported psychological distress”.]

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Societal Resources: Access to Quality Health Care

Significant barriers to health care access exist within many communities that contribute to inequities in health.

Economic Barriers and Affordability

Inadequate Health Insurance Coverage

Language Access Barriers

Provider Shortages

Transportation Barriers

Insufficient Paid Sick Leave Policies

Racial Bias and Discrimination

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Societal Resources: Access to Quality Health Care

Health Care Expenses

Adults who 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 who did not have trouble (40.5% vs. 12.8%). They were also 2.2x as likely to have high or very high psychological distress, 2.6x as likely to report suicidal ideation, and 2.7x as likely to report social isolation.

Discrimination in Health Care

Adults who reported experiencing discrimination while getting health care were over twice as likely to report not receiving the health care that they needed in the past year compared to those who 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 who did not experience discrimination while getting health care.

Health Insurance Coverage

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

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Societal Resources: Access to Quality Health Care

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 people 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.

[Image: "Bar chart titled ‘Psychological Distress by Unmet Health Care Needs Among Communities of Focus’ showing the percentage of those reporting psychological distress by unmet healthcare needs status within four communities of focus: People of color, LGBQA Sexual Orientation, Transgender Identity, and people with disabilities.

Among people of color, 34.3% who did not receive needed healthcare compared to 72.7% who received needed healthcare reported psychological distress; among LGBQA Sexual Orientation, 49.6% who did not receive needed healthcare compared to 80.0% who received needed healthcare reported psychological distress; among those identifying as transgender, 71.3% who did not receive needed healthcare compared to 87.4% who received needed healthcare reported psychological distress; among people with disabilities, 46.7% who did not receive needed healthcare compared to 81.0% who received needed healthcare reported psychological distress”.]

\*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.

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[Image: "A flow chart illustrating how systems and structures lead to health outcomes and inequities. The left side represents 'Interconnected Systems,' listing forms of oppression such as racism (internalized, interpersonal, institutional, structural), sexism, ableism, heterosexism, classism, and other systems of oppression. These systems influence 'Social Status' categories such as race, gender, age, sexual orientation, and disability, represented by arrows pointing to the middle section labeled 'Upstream/Midstream,' which includes 'Social Status Opportunities' (education, employment, economic stability) and 'Societal Resources' (housing, technology, social support, transportation, health resources). Exposures (environmental, discrimination, violence) are also factors in this section. All of these factors lead to the 'Health Outcomes and Inequities' section on the right, which includes chronic conditions, disability, mental health and well-being, substance use, and long COVID." The ‘Exposures’ area of the flowchart is framed by a red rectangle.”]

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Key Exposures: Environmental Exposures

Healthy Environments Are Critical for Health

Systems and Structures Drive Inequities in Environmental Health

Environmental exposures come in many forms and influence our health in many ways, including our mental health. Systemic and structural inequities strongly influence our community characteristics and our levels of exposures to various environmental hazards, contributing to inequities in mental health.

Biological Exposures

Biological exposures are one type of environmental exposure that can have an impact on our mental health. For example, adults who reported having problems with pests in the home were 2.1x as likely to report high or very high psychological distress compared to adults who did not.

Extreme temperatures

Our climate also contributes to our overall mental health. For example, adults who reported having problems dealing with extreme temperatures, like being too hot in the summer or not having enough heat in the winter, were significantly more likely to report psychological distress and suicidal ideation.

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DRIVERS OF MENTAL HEALTH INEQUITIES

CHEI

Key Exposures: Environmental Exposures

Many Environmental Exposures are Higher Among Communities of Focus

People of Color

Respondents who identified as Black, 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.

LGBTQA+

Members of the LBTQA+ community reported high rates of environmental exposures. For example, a high percentage of respondents who 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 who did not report having a disability.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Key Exposures: Environmental Exposures

Members of communities of focus who did not report having pests in their homes were significantly less likely to have high or very high psychological distress compared to those who did report having pests in their homes.

Among people with disabilities, the rate of psychological distress was lower among those who did not have pests in their home compared to those who did (50.9% vs 68.0%).

[Image: "Bar chart titled ‘Psychological Distress by Exposure to Pests in the Home Among Communities of Focus ’ showing the percentage of those reporting psychological distress by exposure to pets in the home status within four communities of focus: People of color, LGBQA Sexual Orientation, Transgender Identity, and people with disabilities.

Among people of color, 55.4% who reported pests in the home compared to 34.3% who reported no pests in the home reported psychological distress; among LGBQA Sexual Orientation, 71.0% who reported pests in the home compared to 52.8% who reported no pests in the home reported psychological distress; among those identifying as transgender, 91.7% who reported pests in the home compared to 75.8% who reported no pests in the home reported psychological distress; among people with disabilities, 68.0% who reported pests in the home compared to 50.9% who reported no pests in the home reported psychological distress”.]

\*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.

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DRIVERS OF MENTAL HEALTH INEQUITIES

CHEI

Key Exposures: Violence

Exposure to violence can have a devastating impact on physical and mental health

Systems of Oppression Place Communities at Higher Risk for Violence

Patterns of socioeconomic disadvantage, diminished social opportunities, and resource deprivation driven by systems of oppression make certain communities more vulnerable to violence.

Exposure to Violence Can Have a Devastating Impact on 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. 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. Violence among older adults, including elder abuse, can increase the risk for stress, depression, fear, and anxiety.

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DRIVERS OF MENTAL HEALTH INEQUITIES

CHEI

Key Exposures: Violence

Violence and 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 (46.6%), and social isolation (51.1%).

Over 6 in 10 respondents who reported experiencing neighborhood violence very often reported high or very high psychological distress.

Inequities in Violence Exposure

Many members of the LGBTQA+ community reported experiencing significantly high rates of violence. For example, over half of respondents that identified as transgender reported ever experiencing neighborhood violence, intimate partner violence, and sexual violence.

People with one or more disabilities were 1.3x as likely to report experiencing neighborhood violence, 1.5x as likely to report experiencing intimate partner violence, and 1.9x as likely to report sexual violence compared to people without a disability.

Black respondents reported the highest rates of experiencing neighborhood violence compared to all other race and ethnicity groups (63.7%).

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Key Exposures: Violence

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.

[Image: "Bar chart titled ‘Psychological Distress by Frequency of Exposure to Neighborhood Violence1 Among Communities of Focus ’ showing the percentage of those reporting psychological distress by frequency of exposure to neighborhood violence within three communities of focus: People of color, LGBQA Sexual Orientation, and people with disabilities.

Among people of color, 34.8% who reporting ‘never’, 31.5% reporting ‘rarely’, 60.4% reporting ‘somewhat often’, and 63.6% reporting ‘very often’ being exposed to neighborhood violence reported psychological distress; among LGBQA Sexual Orientation, 54.6% who reporting ‘never’, 62.2% reporting ‘rarely’, 76.2% reporting ‘somewhat often’, and 77.0% reporting ‘very often’ being exposed to neighborhood violence reported psychological distress; among people with disabilities, 57.8% who reporting ‘never’, 60.7% reporting ‘rarely’, 74.3% reporting ‘somewhat often’, and 75.9% reporting ‘very often’ being exposed to neighborhood violence reported psychological distress”.]

1 Neighborhood violence in 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.

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DRIVERS OF MENTAL HEALTH INEQUITIES

CHEI

Key Exposures: Discrimination

Discrimination is a key driver of mental health inequities

Discrimination and Systemic Racism

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.

Driver of Health Inequities

Discrimination has been shown to be a risk factor for adverse mental and physical health outcomes and contributor to health disparities. For example, internalized and interpersonal racism has been linked to psychosocial trauma, stress, and maladaptive coping behaviors.

Lack of Public Health Data on Discrimination

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.

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DRIVERS OF MENTAL HEALTH INEQUITIES

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Key Exposures: Discrimination

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 2.7x as likely to have high or very high psychological distress, 4.1x as likely to report suicidal ideation, and 4x as likely to report social isolation compared to those who did not experience discrimination.

[Image: "Bar chart titled ‘Experiences of Discrimination and Mental Health Indicators’ showing the percentage of those reporting mental health indicators by recency of exposure to discrimination.

7.4% of those who never experienced discrimination, 13.1% of those who experienced discrimination but not in the past year, and 29.7% of those who experienced discrimination in the past year reported social isolation. 4.4% of those who never experienced discrimination, 7.7% of those who experienced discrimination but not in the past year, and 18.1% of those who experienced discrimination in the past year reported suicidal ideation. 21.2% of those who never experienced discrimination, 34.9% of those who experienced discrimination but not in the past year, and 57.5% of those who experienced discrimination in the past year reported high/very high psychological distress.]

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DRIVERS OF MENTAL HEALTH INEQUITIES

CHEI

Key Exposures: Discrimination

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 that did experience discrimination in the past 12 months.

For example, among people with disabilities, over 72% that experienced discrimination in the past 12 months had high or very high psychological distress compared to 50% that experienced discrimination but not in the past 12 months.

[Image: "Bar chart titled ‘Adult Psychological Distress by Experiences of Discrimination Among Communities of Focus ’ showing the percentage of those reporting recency of exposure to discrimination within four communities of focus: People of color, LGBQA Sexual Orientation, and people with disabilities.

Among people with disabilities, 33.4% reported never having experienced discrimination, 49.8% reported having experienced discrimination but not in the past year, and 72.1% reported having experienced discrimination in the past year; among people identifying as transgender , 53.7% reported never having experienced discrimination, 70.3% reported having experienced discrimination but not in the past year, and 80.5% reported having experienced discrimination in the past year; among people with LGBQa sexual orientation, 33.3% reported never having experienced discrimination, 49.7% reported having experienced discrimination but not in the past year, and 69.6% reported having experienced discrimination in the past year; among people of color, 21.3% reported never having experienced discrimination, 36.0% reported having experienced discrimination but not in the past year, and 55.7% reported having experienced discrimination in the past year”.]

\*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.

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Promoting Mental Health: Action to Address Root Causes of Inequities

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PROMOTING MENTAL HEALTH EQUITY

CHEI

Potential Areas of Action to Promote Mental Health Equity

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

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 needed support and outreach include Suicide Prevention Programs and Resources and Substance Use Treatment and Prevention.

Address Root Causes of Violence and Discrimination and Provide Support to Survivors

CHES data 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

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.

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PROMOTING MENTAL HEALTH EQUITY

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Potential Areas of Action to Promote Mental Health Equity

Improve 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.

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PROMOTING MENTAL HEALTH EQUITY

CHEI

Potential Areas of Action to Promote Mental Health Equity

Build Resiliency to 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, are 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. They 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 the 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.

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WANT TO KNOW MORE?

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Visit www.mass.gov/CHEI for more information about the Community Health Equity Initiative and more resources on how to use these data for action.

Contact: CHEI@mass.gov