**Slide 1**

Title: Identifying Suicidality and Mental Health Disparities in Massachusetts

Presented at the 24th Annual Massachusetts Suicide Prevention Conference on April 23rd, 2025.

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**Slide 2**

Title: Agenda

This presentation is in two parts. Part one will cover monitoring and identifying populations at risk. In this section, we will include suicide death data trends; suicide by mechanism that includes firearm suicides and a road transit spotlight; suicide by occupation that includes first responders and veterans; and suicidality in youth. Part two will cover social drivers of health and suicidality. In this section, we will give an overview of the Community Health Equity Initiative background, mental health equity framing, Community Health Equity Survey (CHES) 2023 data results that include communities experiencing mental health inequities and drivers of mental health inequities.

**Slide 3**

Title: Data to Action

Data and surveillance play an important role in public health. From using multiple indicators of mental health and suicidality we can identify populations at risk, and where there may be gaps in interventions. From partnering with experts in their own communities, these findings can be translated to useful interventions or modifications to existing interventions that help prevent suicide and promote well-being. These interventions can then be evaluated for effectiveness and trends in suicidality can be tracked over time to identify successes or additional gaps in intervention and so on.

**Slide 4**

Title: Massachusetts Suicide Death Trends

One of the sources we use to monitor suicide deaths is the Massachusetts Violent Death Reporting System. This database collects information from the medical examiner, law enforcement, and death certificate. Information is verified and reviewed by abstractors who enter data into the MAVDRS database. By collating and reviewing these data we are able to report on demographics, location, occupation, mechanism and circumstantial data from suicide deaths. Since this is a lengthy process, the suicide reports are usually a few years behind when the deaths occurred. We will likely release the 2023 report sometime in the Fall. Today, we are going to go over some suicide trends among sex, age, race and ethnicity and location from our 2022 report.

**Slide 5**

Title: Suicide Death Trends

On this slide you will see the number of suicides from MAVDRS over the 11 year period from 2012 to 2022. Between 2012 and 2017, age-adjusted suicide rates increased an average of 1.5% per year. From 2017 to 2022, rates decreased at an average of 4.2% per year. Between 2020 and 2022, age-adjusted suicide rates increased at a slower rate in Massachusetts compared to the U.S.  In Massachusetts, age-adjusted suicide rates increased by 0.43% while the U.S. age-adjusted suicide rate increased by an average of 3.0% per year. In 2022 the age-adjusted suicide rate in MA was 8.2, this rose by 5% from the rate in 2021. We have the third lowest suicide rate in the country and the national rate is almost double that of Massachusetts. However, suicide is still a public health problem in Massachusetts.

**Slide 6**

Title: 2021 and 2022 Suicide Death Data Trends by Age and Sex

When looking at suicide trends from 2021 to 2022 by age group we see a few notable differences.

From 2021 to 2022…

* The suicide rate for **45-54 and 54 to 64 year olds** i**ncreased**. This is still lower than rates seen in the past few years 2018-2020.
* The suicide rate among **65-74 year olds decreased.** The 2022 rate is the lowest reported rate in at least a decade.
* The suicide rate among **75-84 year olds increased.** The 2022 increase is similar to an increase seen in the year 2018 for this age group.
* These notable differences were mostly attributed to the change in male rates for the age groups mentioned above.
* All other age groups had similar rates in 2022 to rates observed in 2021.

When combining 2021 and 2022 rates, the age groups with the highest rates of suicide for males were individuals aged 85+ years and 55-64 years.

For females, groups with the highest rates of suicide were 45-54 and 55-64.

**Slide 7**

Title: 2021 and 2022 Suicide Death Data Trends by Race and Ethnicity

Trends from 2021 to 2022 also differed by race and ethnicity.

* Suicide rates for Hispanics increased. This 2022 rate is the highest since 2017.
* White, non-Hispanics had similar rates in 2022 to 2021.
* Suicide rates for Black, non-Hispanics increased. This 2022 rate is the highest recorded rate for this race/ethnicity group since MAVDRS began collecting data in 2003.
* Suicide rates for Asian, non-Hispanics increased. This 2022 rate is similar to rates seen in 2016-2017.

**Slide 8**

Title: Suicide Deaths by Race and Ethnicity and Age

However, when looking at suicide rates by race and ethnicity by age groups for the previous 5 years, we see a more nuanced story with suicide rates peaking at a much younger age.

Among all age groups White, non-Hispanics had the highest suicide rate in all but two age groups.

* Among Black, non-Hispanics, suicide rates peaked among individuals aged 25-34 years. This rate increased by 17.6% from the 2016-2020 rate.
* Among Hispanics, suicide rates also peaked among individuals aged 25-34 years. This rate increased by 5% from the 2016-2020 rate.
* Among Asian, non-Hispanics, suicide rates peaked at the earliest age, among individuals aged 15-24 Years old. This rate increased by 4.3% from the 2016-2020 rate.

**Slide 9**

Title: 2021 and 2022 Suicide Death Data Trends by County

We can also look at these trends on a county level. From 2021 to 2022 we saw the biggest increases in some of the more rural counties across the state.

* The suicide rate in Barnstable County increased. This is the highest rate for this county since 2018.
* The suicide rate in Berkshire County increased. This is the highest rate reported for this county since MAVDRS began collecting data in 2003.
* The suicide rate in Franklin County increased (the suicide count was under 20; therefore, the rate can be unstable). This is similar to 2019-2020 rates.

**Slide 10**

Title: 2021 and 2022 Suicide Death Data by County

* When combining 2021 and 2022 suicide rates in Massachusetts the highest rates of suicide were:
* Berkshire County (17.8/100,000 persons, n=46),
* Dukes County (17.0/100,000 persons, n=7), and
* Barnstable County (14.9/100,000 persons, n=68) .

These counties all had a higher suicide rate than the national crude suicide rate.

* Middlesex County had the highest number of suicides (n=226) but also had one of the lowest suicide rates (6.9/100,000 persons).
* The county with the lowest measurable suicide rate from 2021-2022 was Norfolk County (6.9/100,000 persons, n=100) and Middlesex County (6.9/100,000 persons, n=226).  In general, the urban counties in and around Boston had the lowest suicide rates in Massachusetts.

**Slide 11**

Title: Suicide by Mechanism

We know in suicide prevention work that restricting access to lethal means can be an important intervention in reducing suicides. Knowing this, we can look at trends in suicide among different mechanisms.

**Slide 12**

Title: Firearm Suicide

Firearms are one of the most lethal means of suicide. Research has shown that states that have stricter laws around firearm licensure and storage have fewer suicides by firearm and access to firearms is associated with increased suicide risk, so having an understanding of how suicide by firearm is impacting different populations in MA can be important for intervention work.

Firearm suicide deaths made up more than half of all firearms in the state between 2016 to 2022. The overall suicide by firearm yearly rate from 2016 to 2022 was consistent, with an average of 2.03 suicide deaths by firearm per 100,000 people. Males accounted for the majority of suicide death by firearm (92.3%) and had 3 times the firearm suicide rate of females.

The seven-year average rate of suicide by firearm increased as age increased. Individuals aged 65 and older had the highest average rate. Suicide by hanging had the highest mechanism rate for most age groups, except 65 and older, where suicide by firearm had the highest mechanism rate (3.29 per 100,000 people).

This age group had the highest yearly rate of suicide by firearm for all years except 2022. In 2022, the age groups 25-34 (2.56) and 35-44 (2.65) had a higher rate than the 65 and older group (2.5 per 100,000 people).

**Slide 13**

Title: Mechanisms of Suicides by Race and Ethnicity

When looking at firearm suicides by race and ethnicity, from 2016 to 2022, White, non-Hispanics had the highest average suicide by firearm rate of 2.52 per 100,000. However, the annual suicide by firearm rate for White, non-Hispanics stayed consistent across the seven years, while rates for Black, non-Hispanics and Hispanic/Latinx have been slightly increasing.

**Slide 14**

Title: Firearm Suicide

When breaking down firearm suicides among men by race and ethnicity and age we see a different pattern. For White, non-Hispanic men the rate of firearm suicides increases as age increases, which is what we saw when looking at overall age differences. For Black, non-Hispanic men, firearm suicides peak at a younger age in the 25 to 34 year old range before decreasing in middle age and rising again in 65 and older men. A similar pattern exists for Hispanic Latino men with a spike in firearm suicides among young men. Among all young men, Black, non-Hispanic men have the highest firearm suicide rate compared to other race and ethnicities. One note of caution with interpretation is the small sample sizes in this analysis. Over the seven years there were 21 firearm suicides among Black, non-Hispanic young men aged 25-34.

However, this is something to note when thinking about lethal means, firearm safety and other interventions. Earlier, when looking at suicides across all mechanisms we noted that Black, non-Hispanic men had the highest suicide rate among 25-34 year olds. This may be driven by firearm suicides but points to the underlying need of suicide prevention tailored for young Black men in Massachusetts.

**Slide 15**

Title: Suicide by Firearm

One subpopulation in MA where we saw the highest firearm suicide rate is among current or former military personnel. Suicide by firearm was four and a half times higher in current or former military and veterans compared to the suicide by firearm rate in civilians. The civilian rate of firearm suicide (1.7 per 100,000 people) was similar to the civilian poisoning rate of suicide (1.66 per 100,000 people) during the 7 years.

**Slide 16**

Title: Data to Action Spotlight: Road Transport Suicide

Earlier in 2025 we had a data request from the Department of Transportation to look at suicide deaths that took place on the roadways or bridges in MA. The purpose of this request was to build interagency collaboration, brainstorm new interventions and prevent suicide deaths on MA roadways. This was a good example of how we used data to action in suicide prevention.

Within 11 years there were 123 suicide deaths that fell into these three categories of road transport: bridges, pedestrians and drivers. Due to small numbers, we did not calculate rates for this project. The three different types of road transport suicides had different key findings. For example, we saw that those who died by bridge suicide were more educated than the other road transport mechanisms. They tended to be younger and centered around MA’s most urban areas. For pedestrians who died by suicide, most of these deaths took place on a highway with a common theme being a driver pulling over into a breakdown lane and running into traffic, a truck or tractor trailer. Those who died by suicide in this category had a higher percentage of an alcohol or substance use problem and disclosing suicide intent compared to what we typically see in suicide deaths across MA. Finally, among cases that involved drivers who died by suicide over half were aged 15-34 and the majority took place in Worcester and Middlesex counties. Most of these cases involved driving into a stationary object such as a traffic median, tree, or parked truck.

**Slide 17**

Title: Data to Action Spotlight: Road Transport Suicide

Based on these main findings we worked with the suicide prevention program and assessed the literature on interventions already used in road transport. These are the recommendations we provided to the DOT that we grouped into 4 main themes.

We recommended a focus on creating safer environments and advertising help is available. This includes reviewing 988 signage and barriers for bridges and overpasses in MA, with a particular focus on the areas that we saw the most bridge suicides. We provided location data of deaths to the DOT for this review. We also recommended that this review be a recurring practice to assess if barriers and signage are working and identify any new areas that need barriers or signage. Since we saw a common theme in pedestrian suicides was pulling over in the breakdown lane and running into the highway, we suggested a potential campaign to expand the use of the existing Move Over law in MA.

The largest subgroup of suicides in this analysis were suicides by bridge. We saw these centered around urban areas close to universities, decedents were young and highly educated. One example of identifying and assisting persons at risk was offering QPR or mental health first aid training at universities or other locations surrounding these bridges.

For connecting to postvention services we wanted to ensure the DOT had the tools to connect those impacted by these suicides to trauma response centers. Truck drivers were commonly involved in pedestrian suicides, so making sure this population knew how to be connected to resources was important.

Finally, we suggested education and promotion on safe messaging. Since these suicides do not happen too frequently, they do tend to show up in media. We suggested connecting any media outlet that contacts the DOT with safe suicide prevention messaging to mitigate further harm.

**Slide 18**

Title: Suicide by Occupation

We know that occupational hazards and stressors can play a factor in suicide risk and certain occupations have higher risk for suicide. We have been focusing on high risk occupations with our Comprehensive Suicide Prevention grant from the CDC. In the past we looked at suicide among construction workers. During 2025 we published a spotlight on suicide among First responders.

**Slide 19**

Title: Suicides Among First Responders

Our analysis focused on first responder suicides over a 5-year period (2018-2022) among those aged 18-64 years old. There were 40 suicides over 5 years and the yearly rate varied among this group. On average the suicide rate was 1.5 times higher than the rate among the general population. About a quarter of these deaths involved first responders who were also current or former military personnel. Over half of these deaths were among law enforcement officers, a quarter were among firefighters, 17% were among EMTs and paramedics and 3% were among emergency telephone operators. When looking at the mechanism of suicide among this group, 65% of deaths were by firearm which is 45% higher than what we see in the general MA public. The majority of these firearm suicides were among law enforcement officers. They had 70% higher firearm by suicide proportion than the general public.

This speaks to the availability and familiarity with firearms as a risk factor in suicide death and points to a need for lethal means intervention and mental health support among this population.

We published these findings and additional analyses in a three page spotlight for first responders and their support systems. The third page of the document lists resources and links to the Mass men website which has a page specifically for first responders.

**Slide 20**

Title: Suicides Among Veterans and Military Personnel

Another subpopulation that has a high risk of suicide is the military and veteran population. In the MAVDRS dataset, we can only see if someone is current military or a veteran so this is how we analyzed the data. The 5-year average suicide rate was similar to the rate for first responders. However, there are differences in this rate when looking at age groups. Younger military personnel or veterans and veterans over the age of 85 had the highest suicide rates. Age alone may not be a driving factor in suicide rates, but age can potentially be a proxy for different deployment eras. Each deployment or even military branch can come with its own factors influencing suicide risk. However, this is not something we can look at currently in MAVDRS.

3% of veteran suicides were among females, 3% were among Black, non-Hispanics and 3% were among Hispanic/Latinx veterans and military personnel. Although these numbers are a small percentage of deaths, these subpopulations may face increased risk factors due to discrimination and less representation in the military and should be considered when creating interventions.

**Slide 21**

Title: Suicides Among Veterans and Military Personnel

We can look at different circumstances surrounding a military or veteran suicide death. Over half of decedents had a current identified mental health problem and a quarter had an alcohol or substance use problem, but only 38% had treatment at time of death. This shows a gap in treatment for military and veterans who need mental health care. This could indicate an opportunity for evaluating mental health treatment at the VA for protocols on following up with care and who is eligible for care. Veterans and military personnel had more than twice the likelihood of having a physical health problem be a circumstance of suicide death compared to the general population. Alcohol/substance use problems were less likely in military and veterans compared to the general population that died by suicide.

Additionally, higher education was protective against suicide with military and veterans who had an education above a high school diploma having 3 times lower suicide rates than those who only had a GED or high school diploma. Being married was also protective, with married military personnel having 2 times lower suicide rates than those who were never married and three times lower than those who were widowed. An area for intervention here may include increased social support and connectiveness for military and veterans who are single or recently widowed.

The suicide prevention program at DPH has been working with other state agencies and experts on veterans to create a suicide mortality board to further look at this unique population, which has a higher risk of suicide. This project will individually review veteran suicide deaths and look for similar patterns and unique opportunities for interventions.

**Slide 22**

Title: Suicidality in Youth

As we saw earlier, in Massachusetts suicide rates among youth are slightly lower than the suicide rates in adults. Racial disparities in rates also present differently at younger ages. Understanding and monitoring suicide indicators in youth is important to improve the mental health and well-being of our young people, but also prevent suicide further upstream and at a younger age to reduce suicide further down the life course. Beyond suicide deaths in this population, we will use the Youth Risk Behavioral Survey to identify disparities and trends in mental health and suicidality in MA youth.

**Slide 23**

Title: Youth Risk Behavioral Survey (YRBS), 2021 and 2023

The YRBS is administered biannually in randomly selected MA high schools and answers are weighted to represent all 9-12th grade public students in Massachusetts. However, it is important to note that students with disabilities and chronic absenteeism may be underrepresented. In the 2021 and 2023 surveys, students were asked questions regarding suicidal ideation, plan and attempt in the last 12 months. They were also asked about poor mental health in the last month, persistent feelings of sadness or hopeless for two weeks at a time in the last year and self-harm without suicidal intent in the last 12 months.

When looking at 2021 and 2023 combined, more than a third of students reported feeling persistent sadness or hopelessness. When looking at trend data, reporting yes to this question has increased from 2013 to 2023 but has decreased from 38.5% to 34% between 2021 and 2023. Over the two years, 31.3% of students reported poor recent mental health. In 2021 and 2023 combined, 17% of students reported suicidal ideation and 13% reported having a suicide plan which have both increased in the past 10 years. 7.4% of students reported experiencing a suicide attempt which has not changed over time. Additionally, one-fifth of students reported they did something to hurt themselves without wanting to die in the past year (20.2%).

Additionally, the percentage of students who reported asking for help before a suicide attempt significantly increased from 11.3% to 18.2% from 2021 to 2023.

**Slide 24**

Title: Disparities in Youth Risk Behavioral Survey (YRBS) Results

When looking at these 6 measures of mental health and suicidality across sex, females were 2x more likely to report having poor mental health and suicidality compared to male students.

Hispanic/Latinx students reported twice the likelihood of experiencing a suicide attempt compared to White, non-Hispanic students. Differences in feelings of persistent sadness and hopelessness were reported across race and ethnicity, but no other significant differences were observed.

The greatest disparity in responses were among those who identified as Lesbian, Gay, Bisexual, Transgender, Queer or Other (LGBTQ+). LGBTQ+ identifying students were 4-6 times more likely to report poor mental health and suicidality measures compared to heterosexual and cisgender peers

Additionally, students who reported either a long-term learning or physical disability had higher reports of poor mental health measures and twice the likelihood of reporting suicidality measures compared to students without a disability.

MA released a trends report on these measures by sex and race/ethnicity.

Black, non-Hispanic students were the only group in this report who reported worse mental health from 2021 to 2023 and an increase in suicide attempts over 10 years from 3% to 15%.For comparison, in 2023 5% of white, non-Hispanic students reported experiencing a suicide attempt and 9% of Hispanic/Latinx students reported a suicide attempt. The opposite effect is being seen nationally, where Black, non-Hispanic students are reported a decrease in suicide attempts from 14% to 10%.

Overall, these trends show there is worse mental health and suicidality across the board in MA youth compared to 10 years ago, but there is some recovery from the mental health crisis of the pandemic. However, this is not consistent across all groups, most notably Black, non-Hispanic students are not seeing the same bounce back. Programming focusing on suicide prevention and mental health in youth needs to ensure it is reaching all youth.

**Slide 25**

Title: Additional Findings from the YRBS (2021 and 2023)

We examined additional factors reported in the YRBS and how they relate to mental health and suicidality. Students who reported bullying due to race and ethnicity, and discrimination based on sexual orientation and gender identity had worse mental health and suicidality. Additionally, students who reported being the victim of cyberbullying or bullying on school property had worse mental health and suicidality outcomes. Female students, LGBTQ+ students and students with a disability were significantly more likely to report being a victim to both types of bullying. Other adverse factors including recent or current use of alcohol, start of alcohol use before 13 years old, current use of marijuana or if they ever or currently used electronic vaping products had significantly worse mental health and suicidality measures.

There were also factors that showed to be protective for youth’s mental health. Students who reported having a trusted adult at school had better mental health and less suicidality. Students who were more likely to report having a trusted adult in school included older students, White, non-Hispanic students, heterosexual/cisgender and students with a disability. Students had significantly better mental health and suicidality measures if they reported receiving mostly A’s and B’s in school and if they had plans to attend a 4-year college. Students who reported at least 60 minutes of physical activity for 5 days in the past week also had significantly better mental health and suicidality measures.

These are just a few of the adverse and protective factors shown in the YRBS. Interventions and programming for youth should focus on reducing adverse factors and strengthening protective factors to reduce poor mental health and suicidality.

**Slide 26**

Title: Community Health Equity Initiative (CHEI) Background

The second half of the presentation will cover data and framing from the Community Health Equity Initiative. The Community Health Equity Initiative (CHEI) collects data on the social and structural causes of health experienced by Massachusetts residents, specifically among communities impacted by structural racism and other drivers of inequity. CHEI collaborates with community, state and local partners in using data to drive funding, programming and policy change to advance health equity.

**Slide 27**

Title: CHEI Model: Foundational Pillars

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: health equity data system, data and action and community engagement practice.The main goals of the data system are to capture data on root causes of health and ensure findings are reaching communities that have been historically left out of our data systems. Community engagement is aimed for all stages of the process from development to dissemination to analysis.

**Slide 28**

Title: CHES 2023 Methodology Overview

CHES is an innovative, community-based survey administered to residents aged 14 and older. It 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 were also used 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 and ethnicity, gender, age, and education distribution. Data collection was open from July 31 through October 31, 2023.

**Slide 29**

Title: CHES 2023 Sample Goal Achievements

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

Overall participation exceeded CHES 2023 sample goal by 65%. The sample goal was 12,000 responses and the final CHES sample reached 18,276 responses.

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%).

The final samples for communities of focus are as follows:

* + 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)

**Slide 30**

Title: Mental Health Equity Framing

**Slide 31**

Title: Mental Health Equity Framing

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.

**Slide 32**

Title: CHEI Health Inequities Framework

This framework shows how the health outcomes and inequities on the right side of this figure are driven by systemic racism and other systems of oppression on the left side. These systems cause inequitable access to opportunities (like education and employment) and resources (like housing and transportation), and inequitable exposures to factors like violence and discrimination that impact health. The Community Health Equity Initiative uses this framework to guide our understanding of the causes of health inequities, the design of our health equity data system, and the development of data & action strategies.

To address health equity, we must reduce social and structural barriers that lead to poor health. To transform the systems that maintain racial and social inequities, our focus spans the entire health equity pathway, including:

Interconnected Systems: Address interconnected systems and policies, including global forces and governmental policies, at the macro level.

Policies and Environment: Address policies and environments to change these unjust policies ex: housing policies, land trusts, etc.

Increased Risk: Mitigate impact of increased risk caused by these unjust systems. For example: supportive housing, new development, stabilization initiatives.

Health-Related Social Needs: Address immediate health related social needs caused by these unjust systems. For example: air-conditioner vouchers.

**Slide 33**

Title: Community Health Equity Survey 2023 Results

**Slide 34**

Title: 2023 CHES Mental Health Indicators

For this analysis CHEI results focused on three main areas broken down by age, race, gender and sexual orientation, disability and veteran status. The three main areas are:

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.

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.

**Slide 35**

Title: Mental Health in Massachusetts

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

*Psychological Distress by Age Group (Years):*

* Nearly 1 in 3 adults aged 18 and older and 1 in 2 youth (aged 14-17) reported psychological distress.
* Youth and younger adult age groups reported the highest rates of psychological distress.

**Slide 36**

Title: Mental Health in Massachusetts

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

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

**Slide 37**

Title: Mental Health in Massachusetts

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

*Suicidal Ideation by Age Group (Years):*

* 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.

In surveys, youth consistently report higher rates of suicidal ideation and attempts. Yet we know that suicide death rates among older adults are higher. Some of that is due to the differences in means of suicide between younger and older adults

**Slide 38**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People of Color

Racism in 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 and 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.

**Slide 39**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People of Color

*Psychological Distress by Race and Hispanic or Latine/a/o Ethnicity:*

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.

**Slide 40**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People of Color

*Adults (18+): Past Year Suicidal Ideation by Race/Ethnicity:*

* 1 in 5 MENA adults reported suicidal ideation in the past year
* Multiracial adults were 2 times as likely to report suicidal ideation in the past year compared to White adults
* 12.6% of AI/AN adults reported suicidal ideation in the past year

**Slide 41**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People of Color

*Youth (14-17): Past Year Suicidal Ideation by Race/Ethnicity:*

* Nearly 1 in 5 multiracial youth reported past year suicidal ideation
* Suicidal ideation was lower among ANHPI, Black and Hispanic/Latine youth compared to white youth

**Slide 42**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People of Color

*Young Adults (18-24): Past Year Suicidal Ideation by Race/Ethnicity:*

* Over 1 in 4 AI/AN and multiracial young adults reported past year suicidal ideation
* Suicidal ideation was lower among AI/AN, ANHPI, Black and Hispanic/Latine young adults compared to white young adults

**Slide 43**

Title: Mental Health in Massachusetts

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 has 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.

**Slide 44**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: LGBTQA+

*Adults (18+) Suicidal Ideation by 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 and cisgender respondents.
* 2 out of 5 adults who identify as transgender reported suicidal ideation in the past year.
* Adults who identify as queer were 6.4 times as likely as straight adults to report past-year suicidal ideation

**Slide 45**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: LGBTQA+

*Adults (18+) Suicidal Ideation by Gender Identity:*

* Nearly 1 in 5 adults who identify as nonbinary reported suicidal ideation in the past year.
* Adults who identified as men reported suicidal ideation at a slightly higher rate than those who identified as women.

**Slide 46**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: LGBTQA+

*Youth (Aged 14-17) Suicidal Ideation by Sexual Orientation and Transgender Identity:*

* 3 in 5 youth identifying as transgender reported suicidal ideation in the past year
* Youth who identify as gay or lesbian were 4.1 times as likely to report past year suicidal ideation compared to straight youth.

**Slide 47**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: LGBTQA+

*Youth (Aged 14-17) Suicidal Ideation by Gender Identity:*

* Over half of youth who identify as nonbinary reported past year suicidal ideation
* Youth who identified as men or boys reported suicidal ideation at a slightly higher rate than those who identified as women or girls.

**Slide 48**

Title: Mental Health in Massachusetts

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 with 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.

**Slide 49**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People with Disabilities

*Psychological Distress by Disability Status Among Adults:*

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.

**Slide 50**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People with Disabilities

*Adults (18+) Suicidal Ideation by Disability Type:*

* Approximately 15% of adults with a disability and 35% of youth with a disability reported suicidal ideation in the past year
* Over 1 in 3 adults with a mental health disability reported past year suicidal ideation
* Adults with a learning/intellectual disability were 5.4 times as likely to report past year suicidal ideation compared to those without a disability

**Slide 51**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: People with Disabilities

*Youth (14-17) Suicidal Ideation by Disability Type:*

* Over half of youth with a mental health disability reported suicidal ideation in the past year
* Youth with a self care/independent living disability and those with a cognitive disability were 4 times as likely to report past year suicidal ideation compared to youth with no disability.

**Slide 52**

Title: Mental Health in Massachusetts

Communities Experiencing Inequities in Mental Health: Veterans

*Adults (18+) Suicidal Ideation by Veteran Status and Age Group:*

* Overall, past year suicidal ideation was only slightly higher for veterans compared to non-veterans
* Among those aged 35-44, veterans were 2.9 times as likely to report past year suicidal ideation compared to non-veterans

Among those aged 45-64, veterans were 2.7 times as likely to report past year suicidal ideation compared to non-veterans

**Slide 53**

Title: Drivers of Health Inequities

Revisiting the CHEI framework, we can focus on opportunities, resources, exposures that impact mental health.

**Slide 54**

Title: Drivers of Mental Health Inequities

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.

**Slide 55**

Title: Drivers of Mental Health Inequities

Social Status Opportunities: Economic Stability

*Paying for Basic Needs and Mental Health Indicators:*

* 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.

**Slide 56**

Title: Drivers of Mental Health Inequities

Societal Resources: Access to Quality Health Care

Having access to affordable, quality health care is important for overall health, including mental health.

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

**Slide 57**

Title: Drivers of Mental Health Inequities

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.

**Slide 58**

Title: Drivers of Mental Health Inequities

Societal Resources: Access to Quality Health Care

*Psychological Distress by Unmet Health Care Needs Among Communities of Focus:*

* As seen among all respondents, 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.

**Slide 59**

Title: Drivers of Mental Health Inequities

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.

**Slide 60**

Title: Drivers of Mental Health Inequities

Societal Resources: Housing

*Psychological Distress by Housing Stability Among Communities of Focus:*

* As with respondents as a whole, 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%).

**Slide 61**

Title: Drivers of Mental Health Inequities

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.

**Slide 62**

Title: Drivers of Mental Health Inequities

Key Exposures: Violence

*Psychological Distress by Frequency of Exposure to Neighborhood Violence1 Among Communities of Focus:*

* Less frequent exposure to neighborhood violence among all respondents and 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.

**Slide 63**

Title: Drivers of Mental Health Inequities

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.

**Slide 64**

Title: Drivers of Mental Health Inequities

Key Exposures: Discrimination

*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 2.7x 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.

**Slide 65**

Title: Resources and Next Steps

**To learn more about CHES and explore our updated data dashboard:**

* Visit our website: [www.mass.gov/chei](http://www.mass.gov/chei)
* CHEI data dashboard: [Community Health Equity Initiative Data Dashboard | Mass.gov](https://www.mass.gov/info-details/community-health-equity-initiative-data-dashboard)

**To submit a request for customized data analyses and support:**

* Fill out this form: <https://forms.office.com/g/7pxW24Yc5K> to be connected with a Regional Data & Action Support Provider

**To request a custom analysis of death data:**

* Email: [**DPH-NVDRS@mass.gov**](mailto:DPH-NVDRS@mass.gov)
* Other data reports can be found here: [Suicide data & reports | Mass.gov](https://www.mass.gov/info-details/suicide-data-reports)

**Slide 66**

Title: Connect with DPH

X: @MassDPH

Linkedin: Massachusetts Department of Public Health

Website: mass.gov/dph