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MENTAL HEALTH

"[Mental] health equity is the right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality… In conjunction with promoting access to high-quality services, mental health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity." - U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)

This document includes data points about items such as the prevalence of mental health issues for marginalized communities, as well as barriers to care, such as cultural stigma, accessibility issues, and medical racism. You can use this fact sheet to further build your understanding of mental health equity concerns, specific communities, and more, which can in turn be used to brief your staff, volunteers, donors, legislators, and other community members.

BIPOC and LGBTQ+ Mental Health Disparities

Mental health issues affect individuals at all ages, sexes, genders, income levels, racial and ethnic communities, sexual orientations, and religious orientations. However, due to deeply embedded structural inequities across economic opportunity, education, health care, and many other sectors, people of color have higher rates of some disorders and face higher barriers to accessing care. People of color must also navigate hate and violence against their communities in a way that white individuals do not, which can cause trauma responses that impact mental health and contribute to higher rates of mental health conditions.

- **Asian and Pacific Islander**
  - » While API adults report experiencing lower levels of mental health issues than other races (16.4%)[i], they also report receiving less assistance than any other race when it is needed. Of all API adults with a mental illness, 74.6% percent did not receive treatment compared to 52.8% of the overall population.[ii]
  - » Serious mental illness in the API community nearly doubled in people aged 18-25 between 2008 and 2018.[iii]

- Suicidal planning and attempts rose among API young adults (18-25) between 2008 (122,000) and 2018 (196,000).[iv] In 2019, suicide was the leading cause of death for Native Hawaiians/Pacific Islanders ages 15-24.[v]

- **Black**
  - 21.4% of Black individuals experience a mental illness annually, but less than 40% of those individuals receive any form of mental health treatment. This compares to 23.9% of white individuals who experience a mental illness annually, 52.9% of whom receive treatment.[vi]
  - Although overall rates of depression are lower in Black individuals (24.6%) than in white individuals (34.7%),[vii] depression among Black individuals is likely to be more disabling and persistent.[viii]
  - Black individuals have a higher prevalence rate for PTSD (9.1%) than white individuals (6.8%), Hispanic/Latinx individuals (5.9%), or API individuals (1.8%).[ix]
  - In 2019, suicide was the second leading cause of death for Black individuals aged 15-24.[x] Although Black individuals are less likely than white individuals to die from suicide at all ages, Black teenagers are more likely to attempt suicide than their white counterparts.[xi] In fact, Black female high schoolers are 60% more likely than non-Hispanic white female students to attempt suicide.[xii]

- **Hispanic/Latinx**
  - Only 36.1% of Hispanic/Latinx adults with mental illness receive assistance/treatment annually, compared to the U.S. average of 47.2%.[xiii]
  - While Hispanic/Latinx individuals have overall lower rates of mental illness (20.7%), research shows that rates are higher in young people and older generations, specifically linked to concerns about immigration and acculturation.[xiv]
  - Serious mental illness rates among young Hispanic/Latinx adults rose from 2.2% in 2009 to 6.8% in 2019.[xv]
  - Hispanic/Latinx high school students have higher rates of seriously considering, making a plan, and attempting suicide that requires medical attention than their white and Black counterparts.[xvi]

- **Native/Indigenous**
  - In 2021, Native/Indigenous individuals were more likely than any single racial or ethnic group to experience mental health concerns: 26.6% of Native/Indigenous people reported experiencing a mental health issue, including almost 7% who reported a serious mental health issue.[xvii]
  - Native/Indigenous people are more likely to screen positive or at-risk for post-traumatic stress disorder and bipolar disorder compared to other groups.[xviii]
  - Native/Indigenous people in the U.S. are 2.5 times more likely to report experiencing serious psychological distress than the general population.[xix]
  - While overall suicide rates are similar between Native/Indigenous populations and those of the general populations, there are significant differences between certain age groups. For instance, the suicide rates for Native/Indigenous youth ages 15-19 is nearly 3.5 times the national average[xx] and death rates for suicide in American Indian/Alaska Native females aged 15-19 were more than five times higher than that for white females of the same age.[xxi]

- Rates of major depressive episodes resulting in severe impairment decreased overall for adult Native/Indigenous individuals between 2016 and 2019 but increased significantly (from 4% to 12.3%) for young adult women, aged 18-25.[xxii]

- **Multiracial**
  - 25% of people who identify as being two or more races experience mental illness.[xxiii] People who identify as being two or more races are more likely than any single race to report a mental illness within the last year.[xxiv]
  - A study by Mental Health America found that multiracial people are most likely to screen positive or at-risk for anxiety, depression, psychosis, eating disorders, and alcohol/substance use disorders, compared to other races.[xxv]
  - The Substance Abuse and Mental Health Services Administration confirms that multiracial individuals are the most likely to report experiencing mental health issues (34.9% compared to 22.8 % overall); however, only 52% of those with a mental health condition receive any form of treatment.

- **LGBTQ**
  - LGBTQ+ individuals are more than twice as likely as heterosexual individuals to have a mental disorder in their lifetimes.[xxvi]
  - LGBTQ+ teens are six times more likely to experience depression symptoms than their non-LGBTQ+ peers.[xxvii]

  - LGBTQ+ youth are more than twice as likely to feel suicidal and more than five times as likely to attempt suicide as their heterosexual peers.[xxviii]
  - In one study, nearly half (48%) of transgender adults reported considering suicide in the past year.[xxix] Black, Hispanic/Latinx, Native/Indigenous, and multiracial transgender individuals are at an increased risk of suicide attempts compared to white transgender individuals.[xxx]
  - According to one study, 45% of Hispanic/Latinx transgender women and 41% of Black transgender women experienced serious psychological distress.[xxxi] Further, 45% of Hispanic/Latinx transgender women and 47% of Black transgender women had attempted suicide at least once.[xxxii]

Racism and Mental Health

Our bodies carry the trauma that we experience with us. Microaggressions, discrimination, and witnessing or being a victim of racial violence can have a significant negative impact on the mental health of marginalized people.

- Microaggressions are everyday experiences of racism, sexism, homophobia, transphobia, ableism, etc., that come in the form of intentional or unintentional slights, insults, putdowns, invalidations, and offensive behaviors that people experience interacting with individuals.[xxxiii] They are a form of racial trauma that can harm a person of color's identity and sense of self-worth, potentially impacting their mental health,[xxxiv] and causing post-traumatic stress symptoms,[xxxv] depression,[xxxvi] anxiety,[xxxvii] loss of behavior control,[xxxviii] and avoidance,[xxxix] in addition to numerous physical health symptoms.[xl]
- Stress plays a crucial role in how racism can impact both physical and mental health. For instance, racial trauma can increase the risk of people of color developing post-traumatic stress disorder (PTSD).[xli]
- Racism places Black people at an increased risk of developing psychosis, in part due to extreme amounts of chronic stress and trauma.[xlii]
- 48% of Black people report discrimination as a stressor in their lives, the highest of any race.[xliii]
- In the spring of 2022, 22% of API students experienced COVID-related discrimination and/or hostility. This anti-API hate caused a 23% increase in severe anxiety, a 10% increase in moderate to severe anxiety, and a 9% increase in severe depression for API students.[xliv]

Medical Racism and Misdiagnosis

Implicit and explicit racial biases, missing data, a lack of trust from patients, lack of cultural understanding by health care providers, language differences between patients and providers, stigma of mental illness and mental health care, and cultural presentation of symptoms may all contribute to underdiagnosis and/or misdiagnosis of mental illness in people from racially/ethnically diverse communities.

- Black individuals are more likely than white individuals to be misdiagnosed with schizophrenia when exhibiting symptoms of major depressive or other mood disorders.[xlv]
- Even when controlling for adverse childhood experiences, prior juvenile offense, genetics, and sociodemographics, Black and Hispanic/Latinx youth are more likely than white youth to be diagnosed with disruptive behavior disorders (such as oppositional defiant disorder and conduct disorder) and with ADHD, and less likely to be diagnosed with mood disorders.[xlvi]
- Despite similar (or higher) rates of eating disorders among Hispanic/Latinx, Black, and Asian people in the U.S. compared to white people, people of color are significantly less likely to receive assistance for eating disorders.[xlvii] When clinicians were presented with identical case studies demonstrating disordered eating symptoms in white, Black, and Hispanic/Latinx women and asked to identify whether the behavior was problematic, they identified the actions as problematic in 44% of the cases for white women and 41% of the cases for Hispanic/Latinx women, but only 17% of the cases for Black women.[xlviii]
- The National Survey of American Life demonstrated that Black individuals are as likely to experience obsessive compulsive disorder (OCD) as the general population but are less likely to receive treatment. Among those who are able to access care, few are able to access specialized treatment and only 20% are using a serotonin reuptake inhibitor (SRI) medication.[xlix]

- Cultural differences can also lead to misdiagnoses. For instance, Hispanic/Latinx individuals may talk about depression symptoms in terms of nervousness, tiredness, or other physical ailments. These are all consistent with depression, but physicians who are unaware of cultural influences on mental health may not recognize these as signs of depression.[l]
- Black people are significantly less likely to receive lithium and SSRI antidepressants and significantly more likely to receive first-generation antipsychotics (generally regarded as less effective, or as having more undesirable side-effects), as well as antipsychotics, in general, than patients of any other racial group.[li]
- When people of color are able to receive treatment for mental health conditions, they have less access to appropriate medications and treatments for their mental health conditions. For example, they: receive more prn medication (medication that is only given as needed), receive higher doses of psychotropic medication; receive more different medications; receive more injections of medication; are more likely to receive depot medications (injectable versions of medications given to ensure patient compliance); are less likely to receive antidepressants; are less likely to receive psychotherapy; and are more likely to be prematurely terminated from psychotherapy.[lii]
- Hispanic/Latino adolescents and youth are half as likely than their white counterparts to use antidepressants.[liii] Hispanic/Latinx children are also half as likely as white children to use appropriate medication—such as stimulants—to treat disorders such as attention deficit disorder.[liv]

Mental Health Stigma

Mental health stigma has been used throughout history as a tool to justify violence, discrimination, and oppression against people marginalized because of their race, sex, gender identity, and sexuality. Bias was built into our mental health care systems from their beginning and these biases continue to show up and impact the health outcomes of marginalized people.

- 19.1% of Black young women and 16.1% of Hispanic/Latinx young women report that they did not seek mental health treatment because of confidentiality concerns.[lv]
- Hispanic young women also reported that they avoided mental health treatment because they "did not want others to find out" (14.5%) or because they "feared negative impact on their job" (17.8%) at high rates. [lvi]
- API adults are the group least likely to seek out mental health services — 3 times less likely than white adults.[lvii]
- In a 2021 survey, 54% of Black respondents and 47% of Hispanic/Latinx respondents reported that individuals with mental health conditions in their communities "are looked down upon." Only 38% of white respondents responded similarly.[lviii]
- More than 80% of Black individuals are very concerned about the stigma associated with mental illness, which discourages them from seeking treatment; these effects are concentrated most heavily in young men, and in older men and women.[lix]

Trauma and Mental Health

Experiencing trauma can make individuals more vulnerable to developing mental and physical health problems and can directly cause post-traumatic stress disorder (PTSD). Historical trauma, disproportionate poverty levels, community and state violence, racism, and discrimination place marginalized communities at greater risk of experiencing trauma and developing related mental health concerns.

- Adverse Childhood Experiences (ACEs) are potentially traumatic experiences during childhood (such as abuse, neglect, or witnessing violence) that can undermine a child's sense of safety, stability, and bonding. ACEs can have negative long-term impacts on a child's physical, mental, emotional, and behavioral development, including increasing the risk for mental health conditions such as depression, suicide, and attempted suicide.[lx]
- Children of color face an increased risk of exposure to traumatic events. According to studies, 64% of Black children and 51% of Hispanic/Latinx children have family histories that include ACEs, compared to 40% of white children.[lxi] Across all income levels, 21.8% of Hispanic girls, 30.7% of Black girls, and 43.9% of Native girls have experienced two or more Adverse Childhood Experiences (ACEs).[lxii] When factoring in poverty, these percentages increase to 30% of Hispanic girls, 43.6% of Black girls, and more than half of Native girls (53.4%).[lxiii]
- The cultural assimilation of Native and Indigenous people through forced relocation away from families to distant residential facilities was traumatic, leading to historical, multi-generational trauma. The effects of this trauma continue to manifest through the high rates depression, suicide, and other issues impacting the mental health of Indigenous people. [lxiv]
- Vicarious trauma refers to the psychological response to second-hand exposure to difficult or disturbing experiences, information, images, and stories. Marginalized communities are repeatedly exposed to graphic news and social media reports depicting discrimination, racism, and state and police violence, which increases their vulnerability to vicarious trauma and the attendant mental health issues, including anxiety, hopelessness, depression, and more. [lxv]

Justice System Involvement

Mental and behavioral health issues increase the risk of justice system involvement, and these conditions are common among individuals in both the adult and juvenile justice systems, where BIPOC individuals are vastly overrepresented.

- Marginalized youth with mental and behavioral health issues are more likely to be referred to the juvenile justice system than to mental health care when compared to white youth.[lxvi, lxvii]
- Approximately 50%-75% of youth in the juvenile justice system meet the diagnostic criteria for a mental illness. [lxviii]
- Students of color, students with disabilities, and students who are displaying trauma responses are disproportionately disciplined and arrested instead of receiving the support and mental health services that allow them to remain in the classroom and continue to make educational progress.[lxix] This effect is particularly noticeable among girls of color. For instance, Black girls are seven times more likely to be suspended from school and four times more likely to be arrested at school, compared to white girls.[lxx] Hispanic/Latina girls are 1.6 times more likely than white girls to receive an out of school suspension.[lxxi] Native/Indigenous youth make up just one percent of students in school, yet Native/Indigenous girls are three times more likely to be suspended than white girls. [lxxii]

- Implicit and explicit racial bias often prevents Black and Hispanic/Latinx defendants from qualifying for diversion programs that could keep them out of jail or permit them to receive mental health treatment in jail.[lxxiii]
- Inmates of color with mental health disabilities are disproportionately punished and placed in solitary confinement, compared to white individuals, who are often sent to mental health units. Solitary confinement has been shown to exacerbate mental illness and many individuals experience their first psychotic episode in these conditions.[lxxiv]
- Incarcerated individuals with mental health disabilities of all races suffer mistreatment and medical neglect and have high rates of suicide and self-harm. But people of color with mental health disabilities are less likely than white individuals to receive the necessary mental health services.[lxxv]

Mental Health Care Accessibility

Marginalized communities are less likely to be able to access mental health care and often have difficulty finding health care professionals of color or providers trained in addressing racial trauma. Barriers to care by members of diverse race, sex, gender, and gender identity groups can include: a lack of insurance/being underinsured; stigma of mental illness; a lack of diverse health care providers; a lack of culturally competent providers; language barriers; and a distrust of the health care system overall. Lack of access and other barriers to care only worsen mental health disparities.

- People from marginalized groups are disproportionately affected by lack of access to quality health care, health insurance, and/or linguistically and culturally responsive health care.[lxxvi]
- One of the most prominent barriers to mental health care is affordability, including health care coverage. While 93% of women in 2021 had some form of health insurance, more than 12 million women and girls remained uninsured and rates of uninsurance varied by race and ethnicity: Hispanic/Latinx women and girls (16.4%) were the most likely to be uninsured, followed by Black women and girls (7.5%), Asian women and girls (6%), and white women and girls (4.4%).[lxxvii]
- While nearly a quarter (23.3%) of young white women living at or below the poverty line reported receiving mental health services in the last year, young women of color received mental health care at less than one third of that rate—young Black women at 8.1%, young Hispanic/Latinx women at 7.1%, and young Native/Indigenous women at 1.1%.[lxxviii]
- Language barriers contribute to difficulties in finding mental health care and receiving services. Overall, 30.9% of API individuals do not speak English fluently,[lxxix] and Spanish-speaking individuals have a difficult time finding mental health care services; only 5.5% of psychologists say they're able to provide mental health care services in Spanish.[lxxx]
- A lack of diverse health care providers also acts as a barrier to mental health care access, as cultural competency is crucial to successful care. In 2015, 86% of psychologists in the U.S. were white, 5% were Asian, 5% were Hispanic/Latinx, 4% were Black, and 1% were multiracial or from another race/ethnicity.
- Although Black families have more contact with mental health providers, Black individuals are less likely to seek out family psychoeducation and other crucial aspects of the treatment process due to historic mistrust in the system.[lxxxi] Only 37.1% of Black adults and 43% of multiracial adults pursue treatment for mental health conditions, compared to 51.8% of white adults.[lxxxii]

Maternal Mental Health

Maternal mental health is a major public health concern. Maternal mental conditions in the postpartum period—defined as up to one year after childbirth—account for approximately 9% of the maternal mortality rate.[lxxxiii] *National estimates of mood and anxiety disorders and serious mental illness - such as anxiety, antenatal and postnatal depression, perinatal obsessive-compulsive disorder, postpartum depression, postpartum psychosis, and birth-related post-traumatic stress disorder (PTSD) among delivering persons have increased from 18.4% in 2006 to more than 40%.*[lxxxiv] *Of the pregnant individuals impacted, 75% do not get the help they need.*[lxxxv] *Pregnant and perinatal women of color are more likely to experience many of these conditions and are also disproportionately underserved by the mental health profession and relevant support services.*

- Women of color experience postpartum depression at a rate of nearly 38% compared with approximately 13% to 19% for all postpartum women.[lxxxvi]
- Mental health conditions (including deaths due to suicide and overdose/poisoning related to substance use disorder) are the leading cause of maternal death for Native/Indigenous women and Hispanic/Latinx women.[lxxxvii]
- One study showed particularly low levels of treatment for postpartum depression among low-income Black women (4%) and Latinas (5%).[lxxxviii] The same study showed that white women were twice as likely to initiate mental health care after delivery than Black women or Latinas, in spite of evidence of similar rates of underlying illness.[lxxxix] Further, among those who initiated care, the time from delivery to treatment initiation was significantly longer for Black women and Latinas than for white women.[xc] In addition, Black women and Latinas who started treatment had lower chances of receiving follow-up or continued care compared with white women who initiated treatment, and Black women and Latinas who initiated antidepressant use had much lower chances than white women of refilling a prescription.[xci]

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