
Quality of LIFE
SPOKANE
MENTAL HEALTH
SECTION 6
CITY OF SPOKANE
PROVIDENCE Health Care
SPOKANE REGIONAL HEALTH DISTRICT
EMPIRE HEALTH FOUNDATION
Spokane County
WASHINGTON

SPOKANE COUNTY

Neighborhood Boundaries

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Nearly seven decades after a global shift in how "health" is accounted for, to include such aspects as mental and social well-being, most communities are still lacking in data specific to the social well-being of its members. Spokane Regional Health District and its partners organized Spokane County's first comprehensive Quality of Life survey in 2015 to confirm disparities in quality of life in the county and find areas for improvement. The survey was used to assess a series of domains and data that, together, measure all of the essential conditions that really matter for people's well-being.

Among several domains examined in this report is mental health, which is explored here in Section 6. To read the first section, which provides an introduction to quality of life as a whole, as well as several other sections that explore elements affecting quality of life in Spokane County, visit qolspokane.org.

Introduction

Health is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[1] Aspects of physical health and social well-being, related to social capital and quality of life, were examined in earlier sections of this report. This section describes select aspects of mental health using data from the Spokane County Quality of Life survey conducted in 2015.

Mental health is influenced by social determinants, which are defined as "the conditions in which people are born, grow, live, work and age."[2] Said another way, mental health is affected by income, employment, education, access to health care, and larger-scale circumstances like the built environment (see figure 1).

Earlier Spokane County reports clearly showed differences in mental health by social determinants.[3,4,5] The current report provides additional detail on the connection between social determinants and select aspects of mental health, as well as linkages between social capital and mental health.

Methods

Data on mental health in Spokane County were gathered as part of the Quality of Life (QOL) survey conducted by Spokane Regional Health District in 2015. The survey was administered following a "push-to-web" model used extensively within Washington state and other states. Survey invitations were mailed to a random sample of 12,000 addresses within Spokane County. Respondents were encouraged to respond to the survey online (pushed to web) before being given the option of completing a hardcopy survey. In total, 3,833 people responded (32%) and 3,334 records (28%) were valid for analysis. The survey was weighted to account for the sampling design and differential response rates among subgroups. Weights were created using iterative proportional fitting (raking) across five margins: age, race/ethnicity, sex, education, and home ownership. To capture mental health, several questions from CDC's Behavioral Risk Factor Surveillance System (BRFSS) were used in the QOL survey.[6] Please see Section 7, Technical Appendix for detailed methodology.

Figure 1. Social Determinants of Health

Poor Mental Health

Poor mental health was defined as 14 or more days of self-reported poor mental health in the last 30 days. Overall, 12% of residents surveyed reported poor mental health.

1 in 9 people had poor mental health.

Poor mental health was related to:

- *Age*
- *Race/ethnicity*
- *Income*
- *Employment*
- *And self-reported health*

Differences by demographic factors

Poor mental health was related to age, race/ethnicity, income, employment status, and self-reported health. Poor mental health was not related to sex, education, neighborhood, home ownership, marital status, health insurance, or children. There was no indication that education, home ownership, marital status, children under 18 in the home, or neighborhood were related to poor mental health. See figure 2 for more information.

By age

Poor mental health was highest among those ages 40-59 at 15%. Poor mental health was lowest among those ages 60 and over (6%). People ages 20-39 were twice as likely (12%) to experience poor mental health as those 60 and over.

By race/ethnicity

American Indian and Alaska Natives had the highest rates of poor mental health at 44% (five times more likely than whites). Asians (4%) were least likely to have poor mental health. Hispanics (8%) and blacks (9%) were also less likely than whites (12%) to have poor mental health.

By income

Those with higher incomes were less likely to have poor mental health. One in 10 people who earned $50,000 to $75,000 annually reported experiencing poor mental health compared to 1 in 6 people with an annual household income of under $25,000. Similarly, those with annual household incomes under $25,000 (16%) were twice as likely to have poor mental health as those with a household income of over $100,000 (5%).

By employment

Those who were unable to work had the highest rates of poor mental health at 40%. Students, homemakers, and retirees were half as likely (6%) to have poor mental health as those who were employed for wages (11%). Those who were out of work were over twice as likely (15%) as students, homemakers, and retirees to experience poor mental health and were also more likely than those who were employed for wages.

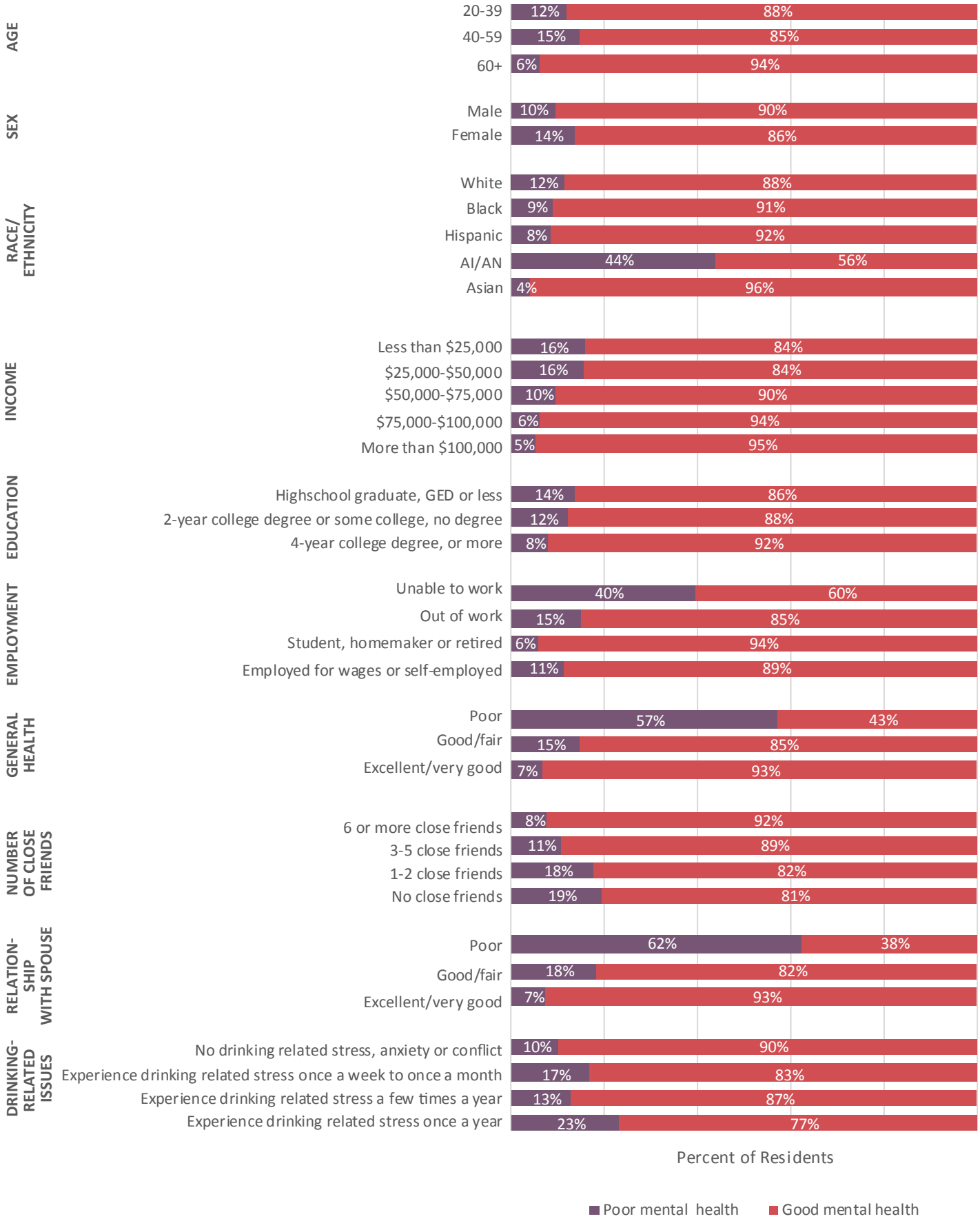
By general health

Over half of those who reported *poor* general health also reported poor mental health at 57%, compared to 7% of those who reported *excellent* or *very good* general health. Those in *good* or *fair* general health were two times more likely (15%) to report poor mental health than those with *excellent* or *very good* health.

By drinking-related issues

People who experienced stress, conflict, or anxiety related to drinking only once a year were twice as likely (23%) to report poor mental health than those who did not experience drinking-related stress (10%).

Figure 2. Self-Reported Mental Health by Demographic Factors



Mental Health Treatment or Counseling

Overall 11% of residents reported receiving treatment or counseling for mental health issues. Factors not related to whether residents received treatment included age, race/ethnicity, education, employment status, general health, and having health insurance. As expected, receiving treatment was most clearly related to experiencing poor mental health.

Nearly half of people with poor mental health in the past month claimed they did not need treatment or counseling.

Of people in poor mental health, 29% received treatment or counseling in the past 12 months. Conversely, 71% of people with poor mental health had not received treatment or counseling in the past 12 months. Since poor mental health was assessed by resident's report specific to the last 30 days and treatment or counseling was asked regarding the past 12 months, there is possibility that some of these people planned to engage in treatment or counseling services but had not yet done so. Nevertheless, these data suggest a notable gap in mental health treatment. Among those in good mental health, 9% received treatment or counseling in the last 12 months.

Forty-five percent of those in poor mental health who had not received treatment or counseling indicated that they did not need treatment (see figure 3). Of those who did not receive treatment, important factors were identified that could inhibit them from receiving treatment—14% were concerned their counselor might not keep their information confidential, 17% were concerned about cost, and 12% were concerned they might be committed to a psychiatric hospital or might have to take medicine.

Factors including sex, income, neighborhood, marital status, and children under 18 in the home, were all related to receiving mental health treatment (figure 4). Even accounting for poor mental health and other factors, separated and divorced people were nearly three times as likely (22%) to receive treatment compared to married people (9%); those living together but unmarried or never married were twice as likely (18%).

71%

of people who indicated having poor mental health had not received treatment or counseling in the last 12 months.

Among those with poor mental health, there was some evidence that insurance, education, general health, and neighborhood were uniquely related to not receiving treatment; there was no evidence that sex, income, or race/ethnicity were related to not receiving treatment.

Figure 3. Reasons for Not Receiving Mental Health Treatment or Counseling Among People with Poor Mental Health Who Did Not Receive Treatment or Counseling

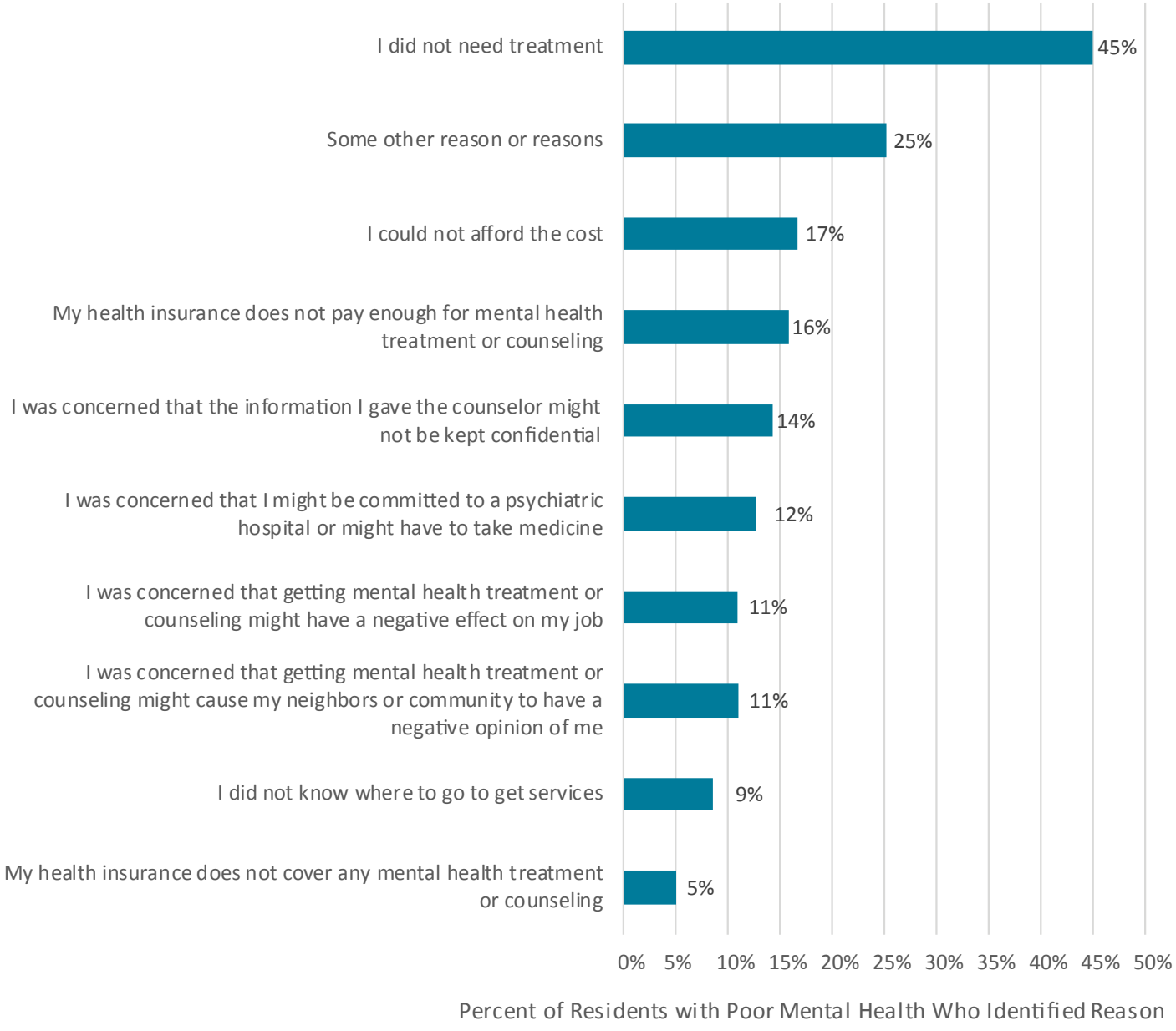


Figure 4. Mental Health Treatment or Counseling by Demographic Factors, Spokane County 2015

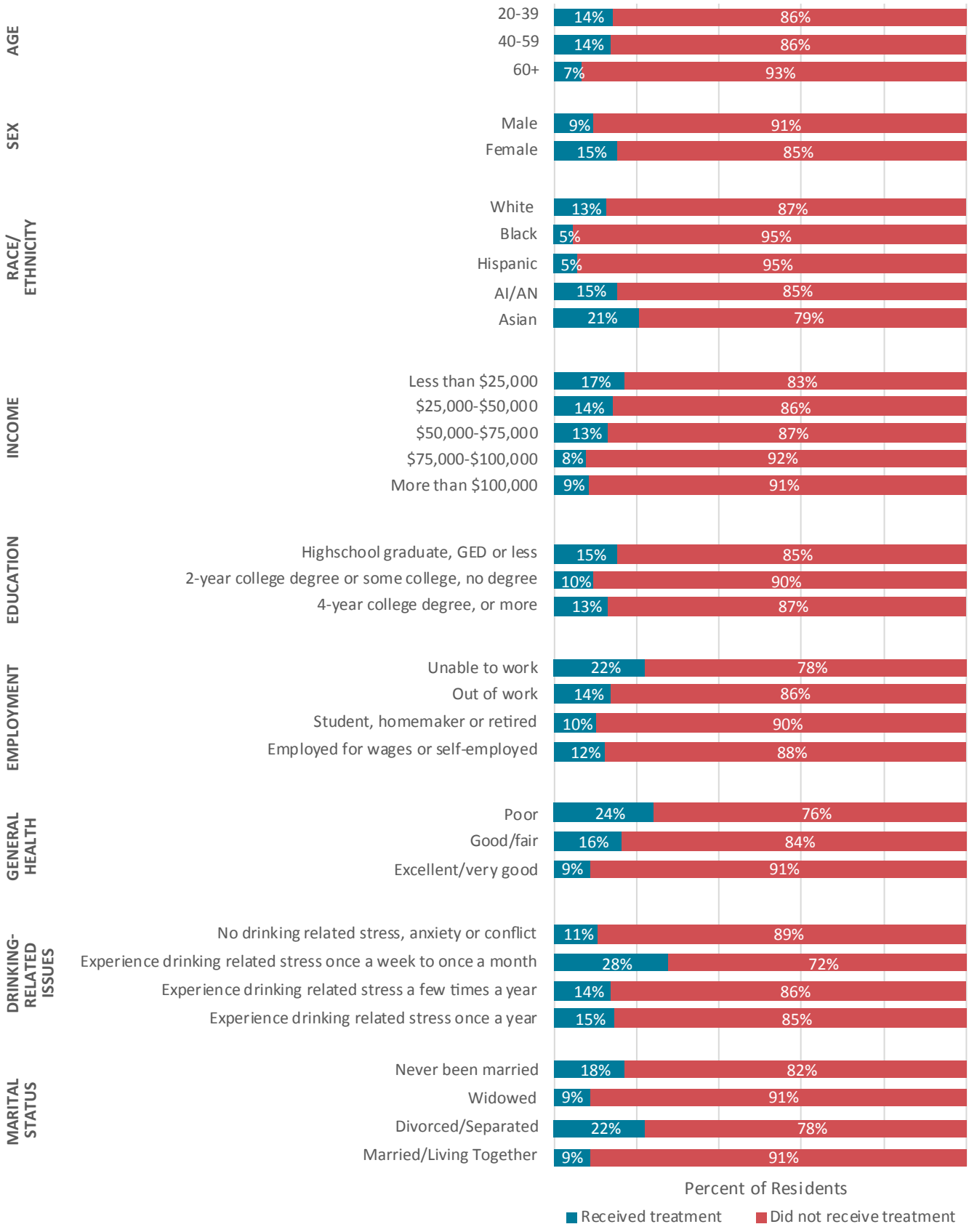
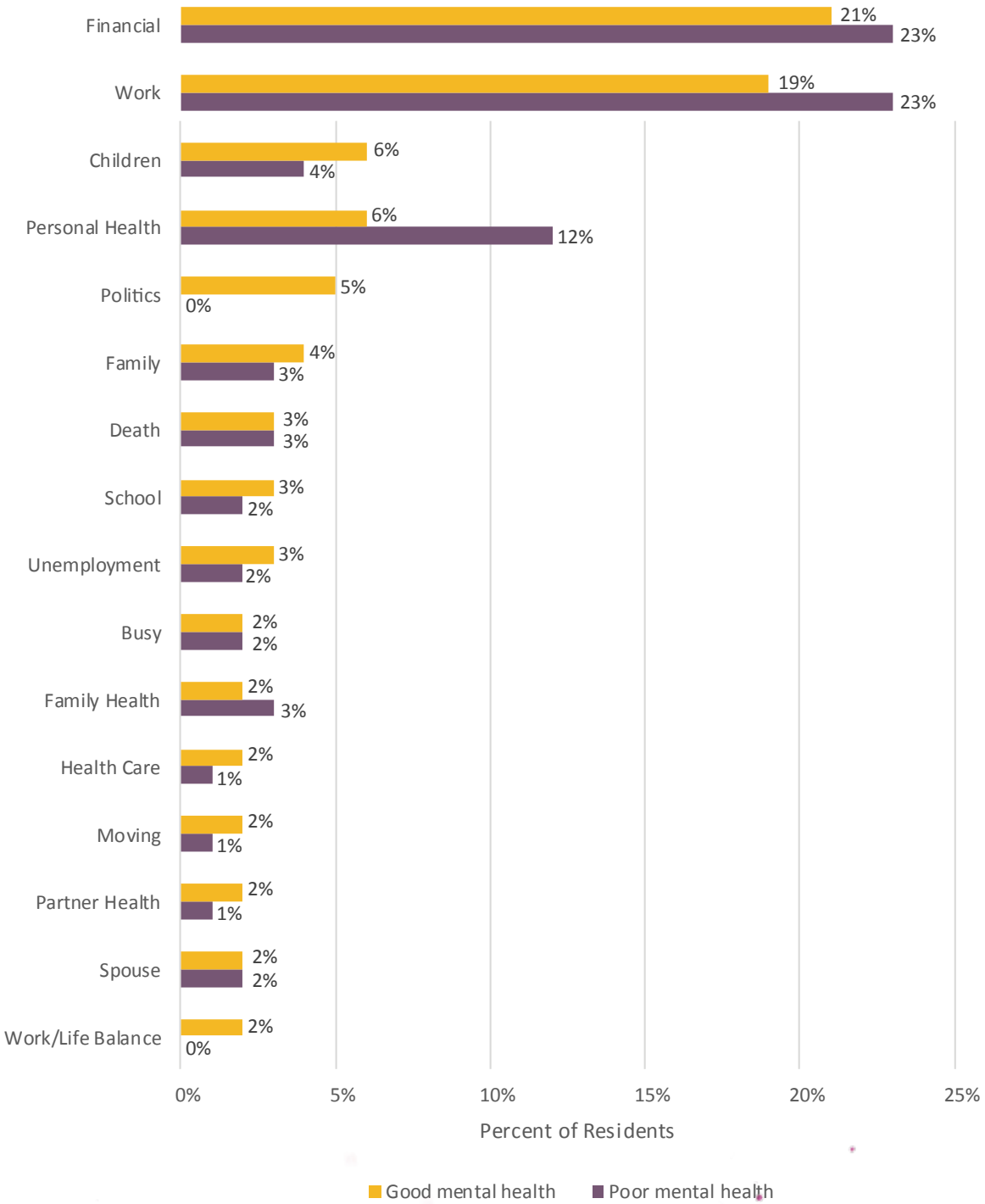
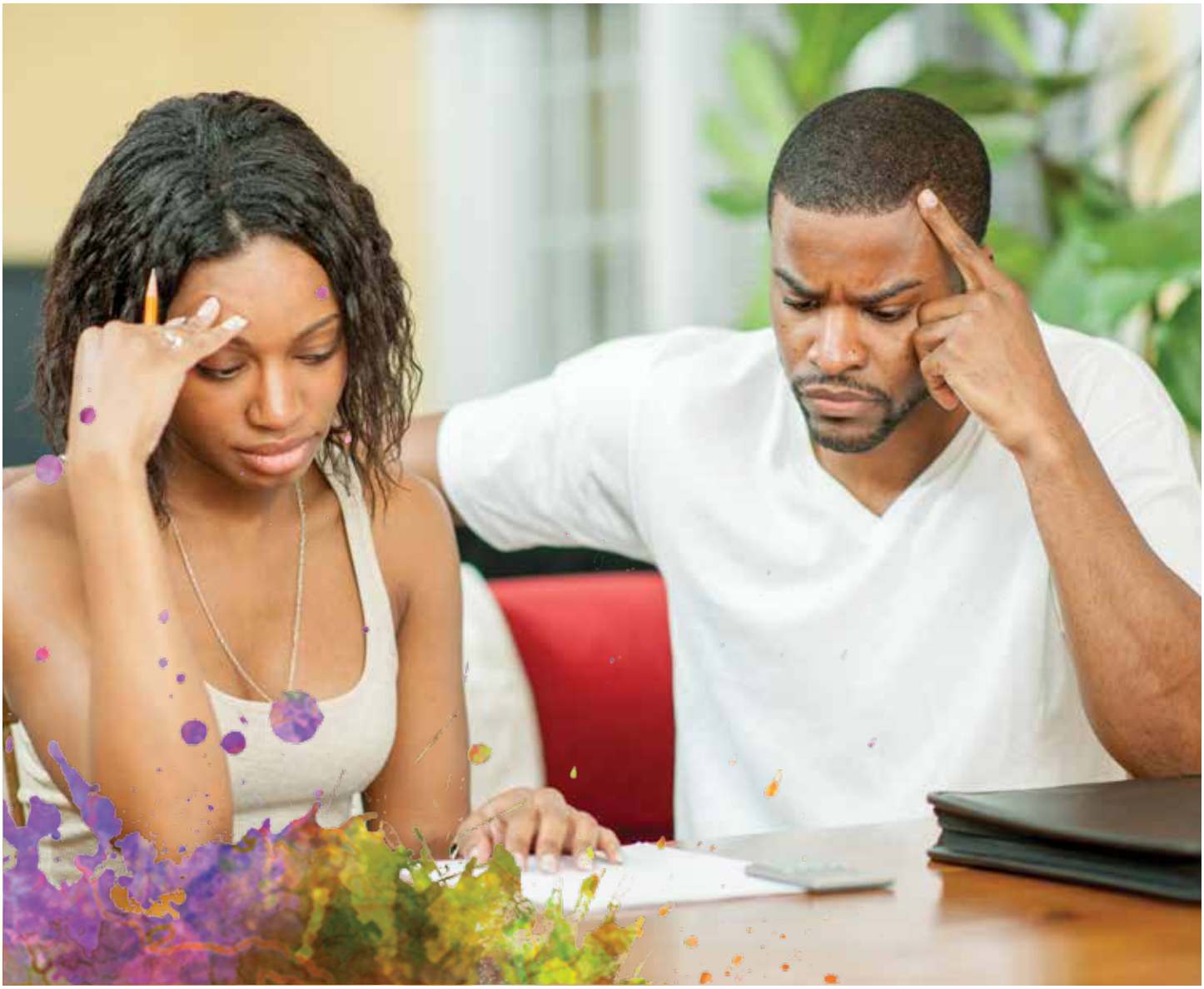


Figure 5. Major Stressors by Mental Health Status, Spokane County 2015





Major Stressors

The most common stressors for all residents were financial situation and work (see figure 5). People with poor mental health identified the same stressors as those with good mental health, with exception to personal health and politics. Those with poor mental health more frequently cited personal health as a major stressor than those in good mental health. Also, a number of people in good mental health regarded politics as a major stressor, whereas those with poor mental health did not.

Social capital and risk factors for mental illness

Generally, risks factors for mental illness include family history of mental illness, major stressors, chronic diseases, traumatic experiences including combat, use of alcohol or drugs, child abuse, and limited social network.[7] Support for several of these risk factors was seen in Spokane County's QOL survey results. For example, people with one to two close friends were twice as likely to have poor mental health than those with six to 10 close friends. Individuals who did not trust others were 1.4 times more likely to have poor mental health compared to those who trusted others. People who had a *poor* relationship with their spouse or partner were nine times more likely to have poor mental health days than those with *excellent* relationships. As discussed previously, those with drinking-related stress, conflict or anxiety were twice as likely to have poor mental health as those without. While mental health was related to aspects of social capital, it was not related to overall social capital as measured by the social capital score (see section 2, Social Capital for more detail on the social capital score).

Conclusion

Mental health was associated with previously described social determinants. Said another way, there were marked disparities between different groups. For example, poor mental health was highest among those 40 to 59 years of age, American Indian and Alaska Natives, people with incomes under $50,000, people unable to work, and people with poor general health.

These results, taken in context with other studies and policies, support the following conclusions.

First, health inequities are present in Spokane County.

This survey, in addition to SRHD's report on inequities in Spokane County, *Odds Against Tomorrow*, clearly show that mental health and other aspects of life in the county differ by social determinants. This should serve as a reminder that inequities are present in Spokane County. Thus, efforts to improve mental health in Spokane County should account for the social, physical, and economic environment in which people live.

For example, American Indian and Alaska Natives were six times more likely to be in poor mental health as compared to whites, even when accounting for differences in income, employment, and other factors. Thus, efforts to improve mental health in Spokane County should consider inequities by race and ethnicity specifically.

Second, these results can guide interventions to improve mental health.

This survey provides a wealth of data, not all of which were presented here, that allows interventions to be tailored to specific subpopulations with poor mental health. These results do not identify which programs are likely to improve mental health in the Spokane community.[8] However, there is extensive evidence tying social determinants of health to key health outcomes even if the mechanisms of action are often unknown. There is sufficient evidence and rational in many areas to support taking action.[9,10] Identifying effective interventions is best done through a systematic decision-making process that considers the information in this report together with best-practice solutions, other data, available resources, and organizational and community contexts. For reference, a resource table of best-practice solutions related to quality of life is included below and select research studies are presented in figure 9.[11,12,13]

Issues involving mental health and inequities are complex and inter-related; they are also complicated to resolve. Given the nature of the issues, a cross-sector, collective action approach is recommended, as are interventions that change policy, systems, or the environment.[14,15] Residents, non-profit organizations, and government agencies all have a role in using this information to pursue strategies to improve health in Spokane County.

Figure 6. Select Compilations of Best Practices Related to Health and Social Determinants

SECTOR	TITLE	ORGANIZATION	URL
Public Health	Healthy People 2020	US Department of Health and Human Services	www.healthypeople.gov/2020/topics-objectives
	The Community Guide	US Centers for Disease Control and Prevention	www.thecommunityguide.org
Clinical Preventive Services	US Preventive Services Task Force	US Preventive Services Task Force	www.uspreventiveservicestaskforce.org
Poverty and Community Development	What Works for America	Federal Reserve Bank of San Francisco and the Low Income Investment Fund	www.whatworksforamerica.org
	Social Programs that Work	Coalition for Evidence-Based Policy	evidencebasedprograms.org
	The Campbell Library of Systematic Reviews	The Campbell Collaboration	www.campbellcollaboration.org
Education	The Best Evidence Encyclopedia	Johns Hopkins University	www.bestevidence.org
	What Works Clearinghouse	US Department of Education	ies.ed.gov/ncee/wwc
	Blueprints	State of Colorado; University of Colorado, Boulder	www.colorado.edu/cspv/blueprints/index.html

Endnotes

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