

BEHAVIORAL HEALTH EQUITY

For people with mental health and/or substance use disorders, behavioral health equity enables recovery. This brief presents an approach for individuals and institutions working in healthcare and public health to engage people with behavioral health conditions around their health and social needs, preferences, and values.

Motivated by the conviction that prevention works, treatment is effective, and people recover, behavioral health equity is the process of ensuring the conditions for reducing [mental](#) health and substance use inequities* and improving health outcomes for communities that have historically suffered marginalization, victimization, and prejudicial injustices.

Health inequities exist between people with behavioral health conditions and people who do not have such illnesses, and also among the behavioral health population in the form of racial, ethnic, and socio-economic disparities.

People with serious mental illnesses experience significantly higher morbidity and mortality rates compared to those of a similar age (Martens, WHO) and are hospitalized at much higher rates (Mai). When coupled with social conditions such as poor living conditions or unstable housing, unmanaged physical and behavioral health conditions overwhelm health care systems that are unprepared to meet these complex needs.

The over-reliance on hospitals and nursing facilities in the behavioral health service delivery system reflects a dysfunctional system that fails to engage individuals

WHAT IS HEALTH EQUITY?

Health equity is a process of assurance of the conditions for optimal health for all people. It requires at least three things:

1. Valuing all individuals and populations equally
2. Recognizing and rectifying historical injustices
3. Providing resources according to need

-Camara Phyllis Jones, MD, MPH, PhD

* Differences in health that are avoidable, unfair, and unjust. Health inequities are affected by social, economic, and environmental conditions. (Health Equity Institute. Available from: <https://healthequity.sfsu.edu/content/defining-health-equity>)

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and their families in managing an illness and instead allows them to flounder with a disease that is interfering with their lives until a crisis leads to the local Emergency Department or jail.

According to the Chicago Health Atlas, the rate of inpatient behavioral health hospitalizations was highest among African American or Black residents (278 per 10,000) in 2014, which was more than double the rate of other race-ethnicity groups (See Figure 1).

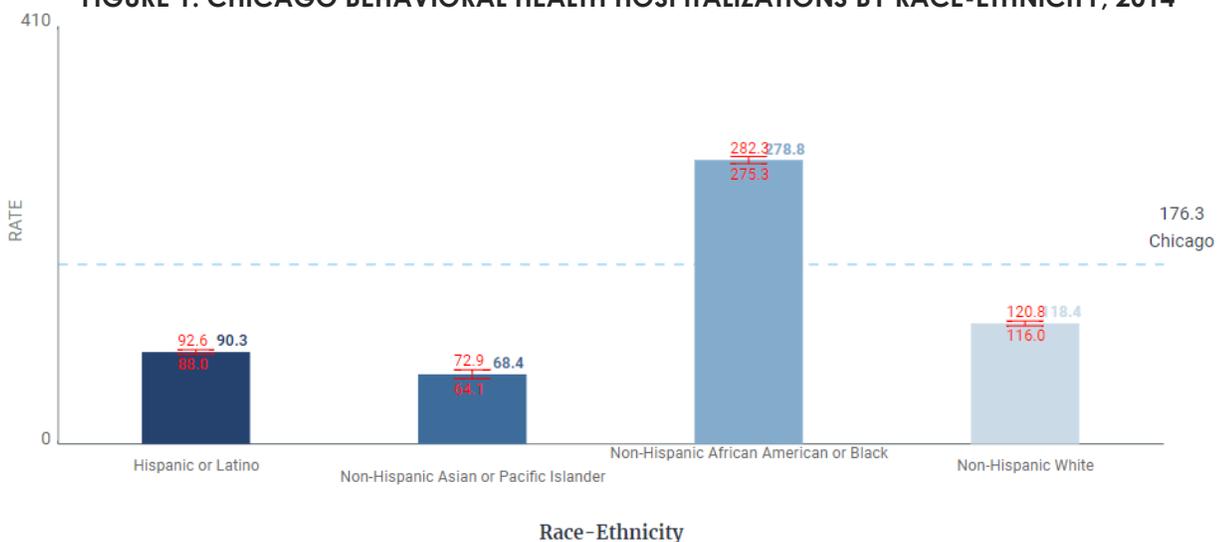
Due to effects of poverty and the higher likelihood of living in poverty—a long-term pattern attributable to historical and contemporary structural racism—African Americans are three times more likely to experience homelessness (HUD). With greater risk for homelessness, an individual's ability to tend to health issues is undermined (HUD). Oftentimes physical health issues go untreated until symptoms become an overwhelming crisis, resulting in using emergency rooms as primary care clinics (Corrigan). Thus, complex and chronic health needs become enormously difficult to manage as one's fundamental needs, such as stable housing, are not met.

PARTICIPANT WITH LIVED EXPERIENCE

“Unfortunately unless it’s an emergency, they’re not going to do it [seek care], they don’t want to leave because they’re terrified if they leave someone’s going to come and steal their stuff or the city’s going to do a sweep and take their stuff. We’ve had people who even if they’re three blocks from here, they’re afraid they’re going to lose their blankets so they can’t come and access medical care.”

(Corrigan)

FIGURE 1: CHICAGO BEHAVIORAL HEALTH HOSPITALIZATIONS BY RACE-ETHNICITY, 2014



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Fundamental to wellbeing is the need for security and safety. However, many families and children experience trauma prior to becoming homeless. More than 90% of sheltered and low-income mothers have experienced physical and sexual assault over their lifespan (NCTSN).

Studies show that as of 2016, 33% of people experiencing homelessness in the U.S. were identified as having untreated serious mental illness. **Besides mortality rates of four to nine times higher than the general population, the rate of victimization for people who are homeless with a serious mental illness is 74%-87% and the rate of arrest is 63%-90% (TAC).**

This regular form of victimization along with an increased likelihood of entering into the criminal justice system can only lead to a vicious cycle of street to institution to street. Living without stable housing itself can be traumatic causing additional mental health problems. Moreover, the stigma and disrespect of experiencing homelessness worsens participation and engagement in healthcare systems (Corrigan).

The experience of homelessness results in a loss of community, routines, possessions, privacy, and security. Children, mothers, and families who live in shelters need to make significant adjustments to shelter living and are confronted by other problems, such as the need to reestablish a home, interpersonal difficulties, mental and physical health problems, and child-related difficulties such as illness. Homelessness also makes families more vulnerable to other forms of trauma such as physical and sexual assault, witnessing violence, or abrupt separation. The stress related to these risks comes in addition to the stress resulting from homelessness itself and can impede recovery due to ongoing traumatic reminders and challenges.

A CALL FOR BEHAVIORAL HEALTH EQUITY

The U.S. needs preventive approaches and healthcare systems equipped to handle the level of trauma and magnitude of suffering that people with serious mental illness (SMI) and substance use disorders (SUD) are likely to encounter. In Illinois, as of 2014, 363,000 adults over the age of 18 had experienced serious mental illness in the last year prior to being surveyed. Of adults that had experienced any type of mental illness between 2010-2014, **55.4% received no type of mental health treatment or counseling within the year prior to being surveyed** (SAMHSA Behavioral Health Barometer Illinois, 2015).

The healthcare system treats people for symptoms of illness and disease and should not be viewed as the only system that needs to transform to keep people healthy. Adverse physical, social, and economic exposers, as well as maladaptive coping and stereotyped threats (i.e., increased substance use or stigma of inferiority leading to physiological arousal and impaired provider-patient relationships) occur over time and can accumulate across generations and over the life course (Bailey). When the social conditions in which people live are stacked against them in regards to their financial resources and opportunities for stable housing, quality education, well-paid employment, accessible transportation, and nutritious food—unfortunately, mainly

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among poor people of color—we must critically look at the larger structures that create these conditions and change them.

Public health promotes and protects the health of people and their communities by focusing on prevention of illness and supporting wellness. Public health officials along with healthcare providers, policy makers, and advocates can facilitate the analysis needed to recognize and change the structural racism that is pervasive in institutional policies and systems.

WHERE ARE THE INEQUITIES AMONG PEOPLE WITH BEHAVIORAL HEALTH ISSUES?

- Women are more likely to have a reported mental illness
- Highest rates of mental illness are found in Native Americans (28.3%) and African Americans (18.6%) (NAMI).
- LGBTQ individuals are two or more times more likely than straight individuals to have a mental health condition (NAMI).
- Of the 1.16 million veterans registered for VA healthcare, 57.2% received a diagnosis of mental illness (Pickett et al., 2017).
- 20% of the 744,600 people with mental illness incarcerated in U.S. county and city jails have a serious mental illness (TAC, 2014).
- 1,561,500 people incarcerated in state jails have a mental illness, of which 15% are serious mental illness (TAC, 2016).
- First generation immigrants to the U.S. have lower rates of mental illness diagnoses in comparison to native-born Americans. The number of diagnoses increases in the second generation, a finding which is seen consistently across different countries of origin (Salas-Wright, 2014), and health issues.
- Among refugees, studies have shown ranges of PTSD diagnoses from 10-40% and depression from 6-40%. The rates are highest in children (5-90% and 6-40% for PTSD and depression, respectively) (Giacco, 2018).

VALUING ALL INDIVIDUALS EQUALLY: IN HEALTHCARE, SOCIETY, AND CULTURE

Access to care has improved overall through Medicaid expansion and the ACA, but people with a serious mental illness—which may result in substantial impairment in carrying out major life activities—still face significantly lower life expectancy, social and legal barriers to treatment, and are at a much greater risk for complex, and oftentimes, preventable health problems such as diabetes, heart disease, high blood pressure, and asthma (Parks et al., 2006; SAMSHA; Corrigan).

Recognizing that the stigma of mental illness and substance use is also reflected in the budgets and regulations of programs that address them, Health & Medicine's Center for Long-Term Care Reform chose to launch the [Behavioral Health-Primary Care Integration Learning Collaborative](#) to guide a local advocacy agenda and facilitate practice-level changes to improve the lives of people with SMI/SUD. A community-based participatory research study of African Americans who were homeless with mental illness conducted focus groups and key informant interviews which yielded solutions at the agency or community-level. Prominent among these was the call to integrate behavioral and primary care (Corrigan). When Health & Medicine designed

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its Learning Collaborative, we were careful to include people with lived experience and sought to maximize the geographic diversity of the providers at the table to reflect the different experiences and perspectives of Chicago's neighborhoods on the North, South, and West Sides.

PART OF THE PROCESS

To advance behavioral health equity, we recommend that providers, policy makers, public health practitioners, and advocates should align with the SAMHSA strategic plan "Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018," focused on meeting the behavioral health care needs of individuals, communities, and service providers. The Six Key Strategic Initiatives include:

1. Prevention of Substance Abuse and Mental Illness
- 2. Health Care and Health Systems Integration**
3. Trauma and Justice
4. Recovery Support
5. Health Information Technology
6. Workforce Development

Health equity is a process of assurance of the conditions for optimal health for all people. As allies working to advance behavioral health equity, providers, payers, policy makers, and advocates need to partner with the Recovery Movement and other social justice movements, grassroots campaigns, and legislative advocacy efforts to bolster an interdisciplinary and intersectoral policy platform. A coordinated, unified, and collective approach is required to move the needle on health inequities of those with behavioral health needs.

HEALTH CARE & HEALTH SYSTEMS INTEGRATION

Integrated care – the coordination of mental health, substance abuse, and primary care services – is just one health systems solution to improve outcomes for people with SMI/SUD and reduce the highest costs to the system (i.e., ED and in-patient utilization, institutional care). Integrated care has demonstrated the best outcomes and is the most effective approach to caring for people with complex healthcare needs (SAMHSA).

ABOUT HEALTH & MEDICINE POLICY RESEARCH GROUP

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Health & Medicine's mission is to promote social justice and challenge inequities in health and health care. We have successfully developed health policy recommendations and implementation strategies for different public and private entities, earning the trust of the legislature, advocates, the media, researchers and policymakers to become the region's "honest broker" on healthcare policy matters. Learn more at www.hmprg.org.

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BEHAVIORAL HEALTH EQUITY STARTS BY:

1. Valuing people with serious mental illness and those who have experienced homelessness equally.
 2. Recognizing and rectifying historical injustices that social stigma, housing discrimination, and disease-oriented frameworks that have segregated mental health from the rest of medical care.
 3. Providing resources in the form of permanent and supportive housing, supportive employment, supportive education, and quality integrated care and prevention and wellness services according to need.
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