

The Economic Burden of Mental Health Inequities in the United States Report

Satcher Health Leadership Institute



MOREHOUSE
SCHOOL OF MEDICINE



*“There is no health
without mental health.”¹*

-Dr. David Satcher, 16th U.S. Surgeon General

While need may necessitate a transformation, it does not begin without a vision, a passion, and a will to execute. This work is dedicated to a change agent, Dr. David Satcher, whose vision for a different and healthier future sparked the beginning of an equity movement in mental health.

As 16th U.S. Surgeon General and 10th Assistant Secretary for Health, Dr. David Satcher’s lifelong career in addressing the underrated issues of health policy and advancing mental health equity has helped forge the path for current health equity champions to continue paving.

Thank you, Dr. Satcher for challenging us to become part of the struggle so that we can make a positive difference and continue transforming the future of America.

Foreword

Over twenty years ago, the Surgeon General of the United States, David Satcher, MD, PhD, issued a seminal report, *Mental Health: A Report of the Surgeon General*,¹ which demonstrated that mental health is fundamental to our systemic health, and mental health conditions are equally worthy of our focus and investments. In that report, Dr. Satcher stated, “The past century has witnessed extraordinary progress in our improvement of the public health through medical science and ambitious, often innovative, approaches to health care services. Through much of this era of great challenge and greater achievement, however, concerns regarding mental illness and mental health too often were relegated to the rear of our national consciousness.” More than two decades later, after the release of this landmark report, just about every sentiment continues to ring true. We have made even greater strides in the improvement of our public health, unfathomable achievements that overcame unimaginable challenges have occurred in just the past few years, and yet we still find ourselves relegating mental and behavioral health to the rear of our national consciousness. Mental and behavioral health equity is health equity, and if we are to ever achieve a more equitable tomorrow, then starting today, we must begin acknowledging, addressing, and alleviating the economic burden of mental and behavioral health inequities.

My vision and quest for advancing mental and behavioral health equity and developing a report on the *Economic Burden of Mental Health Inequities in the United States* came three years after the release of the

President’s New Freedom Commission on Mental Health report,² which underscored the complexity and fragmentation of our mental health system, the unfair treatment the system offers in its delivery of care, the stigma behind mental illness, and how mental health illness ranked first in causing disability in the United States. Compelled by these facts, I was convinced that more could be done but more importantly, I knew that more had to be done to change the narrative for mental health. For 15 years, I have been interested in examining the reasons why our country has stalled on substantively addressing the barriers to mental and behavioral health equity and investing resources needed for us to move the health equity needle in a meaningful direction.

Building upon three landmark reports (*Mental Health: A Report of the Surgeon General*,¹ the *President’s New Freedom Commission on Mental Health*,² and the *Economic Burden of Health Inequalities in the United States*³), this study is intended to help us shed a light on an issue that we, as a country, have not before been able to wrap our arms around: understanding the economic impact of our failure of over 165 years since the passage of the *Bill for the Benefit of the Indigent Insane*⁴ to invest in equity-focused behavioral health interventions, services, treatments, supports, and programs. We know that there is a reason for the dearth of mental and behavioral health policies in this country and a dearth of investments by our government and commercial interests in this arena. We also understand, from a political determinants of health standpoint, that

health equity-focused policies, especially equity-focused mental and behavioral health policies have not ever been prioritized in the United States unless they are tied to an economic or national security argument.

While previous studies have attempted to highlight how health disparities affect economic, health, and lifespan outcomes for indigenous populations and racial and ethnic minoritized groups, none have specifically analyzed the economic burden of mental and behavioral health inequities. With this report we aim to close an important gap in behavioral health and health equity research relative to mental health inequities. We intend for this report to speak to the existential threat of mental health inequities for these specific populations, especially as the United States becomes a more racially pluralistic country, and to chart a path forward toward a more healthy, equitable, and inclusive tomorrow.

This study, which was performed by the Satcher Health Leadership Institute at Morehouse School of Medicine, in conjunction with the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Anschutz Medical Campus, and the Robert Graham Center, attempts to answer two core and vitally important questions: *how many lives and how many dollars could be saved if the mental and behavioral health care system became more equitable?* These are complex questions, that necessitate difficult conversations and require nuanced context to chart a path forward. But I am certain

that these are precisely the types of answers we should be seeking now among others, to push the health equity movement onward.

I believe that health equity requires not only tailored solutions to the unique problems that we face, but also requires innovative approaches and cross-collaboration to make certain that those solutions are indeed equitable and sustainable. In that vein, I wish to thank Otsuka America Pharmaceutical, Inc. for providing financial support and other consideration for this study, but more importantly for agreeing to support a project that took over a decade and a half to realize. I know that this report, by attempting to quantify both the dollars and the lives that could be saved, is applying a compelling perspective to this thorny issue that we have all long battled with. The time is now to make certain that the next century will witness even greater progress in the improvement of our public health, health care and behavioral health systems, and that all begins with asking these key questions and ensuring fewer precious lives are lost along the way.



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The Satcher Health Leadership Institute (SHLI) aims to be the leading transformational force for health equity in policy, leadership development, and research. Rooted in the legacy of our founder, 16th U.S. Surgeon General Dr. David Satcher, SHLI's mission is to create systemic change at the intersection of policy and equity by focusing on three priority areas: the political determinants of health, health system transformation, and mental and behavioral health. In conjunction with key strategic partners, SHLI enhances leadership among diverse learners, conducts forward-thinking research on the drivers of health inequities, and advances evidence-based policies; all in an effort to contribute to the achievement of health equity for all population groups.

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The National Advisory Panel for Economic Burden of Mental Health Inequities Study

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Contents

Executive Summary.....	7
Introduction.....	9
Framing the Findings.....	11
Quantitative Findings.....	12
Drivers of Mental/Behavioral Health Inequities.....	18
How to Successfully Improve Equity: Critical Policy Considerations.....	21
Investment in Behavioral Health Systems.....	21
Culturally Centered Mental and Behavioral Healthcare.....	27
Political and Social Determinants of Behavioral Health.....	32
Conclusion.....	38
References.....	39
Appendix A. Quantitative Methodology.....	45
Appendix B. The Excluded 5.8 Million.....	47
Appendix C. Grounding Assumptions and Policy Principles.....	48
Appendix D. Policy Recommendations to Improve Behavioral Health Equity.....	49
Appendix E. Reports with Additional Detailed Recommendations.....	59
Appendix F. The Political Determinants of Health.....	60

Executive Summary

“There is no health without mental health.”

-Dr. David Satcher, 16th U.S. Surgeon General

We are at a tipping point within the United States of a broader acknowledgement that this statement is not only true, but our decades-long lack of focus and resources on mental health has had a significant and negative impact on overall health outcomes. We are also at a long overdue awakening of how decades of systemic health inequities have yielded significantly worse outcomes for indigenous, racial and ethnic minoritized, marginalized, and medically under-resourced populations, which has led to generations of poor outcomes and reduced value of every life.

In the United States, the decline of the overall population’s general health and life expectancy is evidenced by increased morbidity and mortality rates.⁴⁻⁶ In addition to this decline in the nation’s systemic health is the alarming deterioration of mental and behavioral health across the country, which has been exacerbated by the deleterious impact of the COVID-19 pandemic and ongoing syndemic.⁷ These mental and behavioral health outcomes are significantly more adverse and unparalleled when visualized through the lens of indigenous populations and racial and ethnic minoritized, marginalized, and

medically underserved populations; *but what is the impact from a health outcomes and economic standpoint?*⁸ Previous studies have attempted to highlight how health disparities affect economic and lifespan outcomes for indigenous populations and racial and ethnic minoritized groups, but none have specifically analyzed the economic burden of mental and behavioral health inequities.^{9,10} This first-of-its-kind report is designed to inform all stakeholders on the ramifications of a chronically underfunded and siloed system of mental health care, with a particular focus on underserved and under-represented communities.



There is a demonstrated need to gain a better understanding of the complexities and severity of the economic burden that mental health concerns have among indigenous populations and racial and ethnic minoritized groups. To address this need, the Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine in conjunction with the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Anschutz Medical Campus (Farley Center) and the Robert Graham Center conducted a first-of-its-kind investigation to examine the economic and mortality burden of mental health inequities in the United States. Building upon three national landmark reports that were published more than two decades ago,¹⁻³ this report is intended to shed light on the impact of economic disinvestment in behavioral health prevention, treatment, service delivery access, and the inequities generated from limited action or inaction.

The results are alarming, but the answers are remarkably simple. Access to mental health services saves dollars and lives.^{11,12} This report provides empirical evidence to answer the following: (1) How many lives could be saved and (2) how many dollars could be saved, if access to mental and behavioral services becomes more equitable? Through a comprehensive literature review, analysis of public data sets, and case study examination

of state and national policies, the findings of this study demonstrate a relationship between economic status, mental health status, and racial and ethnic status.

- Between 2016 and 2020, the total number of excess premature mental and behavioral health-related deaths among indigenous populations and racial and ethnic minoritized groups was 116,722.
- Between 2016 and 2020, the total excess cost burden from premature mental and behavioral-related deaths among indigenous populations and racial and ethnic minoritized groups owing to mental illness, substance use, and suicide by race and ethnicity is \$278 billion dollars.
- The national estimates underrepresent the actual burden of mental and behavioral health conditions: 5.8 million people are excluded from traditional sampling frames and national surveys used for these estimates, including those who live in prison or jail, nursing home residents, residents of assisted living facilities, the unhoused, active military, and people who are institutionalized in psychiatric facilities. The ecological analysis of this excluded group reveals the following: \$23 billion annual excess burden in terms of years of life lost among the unhoused, and \$63 - \$92 billion annual

excess costs due to mental illness and substance use disorder among incarcerated and unhoused populations.

Although these findings reflect a significant underestimate, they demonstrate an alarming “call to action” for equitable policy change to combat the devastating impact mental health inequities have on national progress. In an effort to provide policymakers a myriad of policy proposals that can address these significant gaps in access to mental health care in the U.S., this report provides policy proposals, from the very large-scale investments needed, to smaller-scale ideas that can be immediately implemented to address the current and future needs across three domains:

- Sustainable and long-term investment in mental and behavioral health infrastructure
- Adoption of culturally centered mental and behavioral healthcare
- Addressing both the Political and Social Determinants of Health

The findings of this investigation aim to inform conclusions on how policies and programs affect equitable access to care, treatment, and support for indigenous, racial and ethnic minoritized populations in the United States with the goal of improving economic and health outcomes for all.





Introduction

The Brenner Study was the first of its kind to examine and analyze the relationship between economic status and mental and behavioral health services utilization, and established that inpatient psychiatric hospitalizations decrease when the national economy is performing well.¹³ In 1999, Dr. David Satcher, 16th Surgeon General of the United States, released the first ever *Mental Health: A Report of the Surgeon General*,¹ catapulting mental wellness to the forefront of the national healthcare agenda. The report also acknowledged the reality of stigma, disparities, and barriers to care for those who suffer from mental illness and launched a movement of better understanding the burden of behavioral health conditions in the United States. In 2009, Thomas LaVeist, PhD, Darrell Gaskin, PhD, and Patrick Richard, PhD broke ground when they released their seminal work investigating the economic burden of health inequalities in the United States.³ This study quantified the impact healthcare disparities have on the United States' economy by quantifying the overall cost in lives and dollars saved if the healthcare system were able to be more equally accessed

by all. However, the study was not inclusive of mental or behavioral health.

Why This Study and Why Now?

Overall, the burden of mental health concerns in the United States has worsened since the publication of these seminal works. Mounting historical evidence has further shown that a disproportionate number of Asian Americans, Black/African Americans, Native Americans, Alaska Natives, Native Hawaiians, and Hispanic/Latin(o)(a)(x) Americans, experience mental and behavioral health issues, and these groups make up the bulk of Americans living in poverty.¹⁴ There is a need to better understand the economic burden of mental and behavioral health issues on indigenous populations and racial and ethnic minoritized groups and the impact to society as a whole. This understanding would inform conclusions about how the social and political determinants of health address, as well as hinder or advance, equitable access to care, treatment, and support for these populations.

By applying an equity lens and comprehensive analysis of public quantitative data and existing policies, this report answers two research questions:

1. How many lives could be saved if the mental/behavioral healthcare system became more equitable?
2. How many dollars could be saved if the mental/behavioral healthcare system became more equitable?

It is important to emphasize that this report has a strong focus on the economic impact which has been calculated in dollar amounts as it relates to excess premature deaths, for indigenous populations and racial and ethnic minoritized groups who have historically and currently endure disproportionate and inequitable health outcomes: Asian Americans, Black/African Americans, Hispanic/Latin(o)(a)(x) Americans, and Native Americans, Alaska Natives, and Native Hawaiians. When investigating the impact of race, ethnicity, and income on overall health, a recurring theme is that socioeconomic status and racial inequities adversely affect the overall health of communities. It is also



evident that geographical differences have a significant impact in quality and access to mental and behavioral health services, treatments, and supports, and several parts of the country are experiencing prolonged and elevated mental and behavioral health crises in communities of color.

A Special Note on COVID-19

It is evidenced that the COVID-19 pandemic has exacerbated the burden of mental health distress in the United States.⁷ There is a clear need to discern how mental and behavioral health inequities can be better addressed to replenish the economy and ultimately save lives. As the COVID-19 pandemic continues to unfold, forthcoming research and

policy will have to re-conceptualize its variables related to issues like disability and chronic conditions, which is particularly salient to health equity given the disproportionate impact the pandemic has had on low-income families and communities of color.²¹ It is worth noting that the data here are representative of mental health outcomes prior to the onset of the pandemic as more recent data was not available at the time of the study.

Contributions for the National Advisory Panel

To ensure that findings were contextually relevant to the current state of mental health in the United States, a National Advisory Panel (NAP) of experts was invited to function as a sounding

board for this study. The ten members selected to participate in the NAP are subject matter experts in policy, public health, culture, and lived experience, and have dedicated their life's work to advancing mental and behavioral health. The panel reviewed, informed, and vetted recommendations during the study's inception, data collection, and summation of findings, as well as provided ethical considerations and helped minimize assumptions and biases. Over the course of three convenings, the NAP offered the research team feedback related to study methods and the intended audience, specifically "whose lives" and "what kind of dollars" could be saved.

— DEFINITIONS —

Indigenous populations: any group of people native to a specific region, who lived there before colonists or settlers arrived and began to occupy the land¹⁵

Racial and ethnic minoritized groups: racial and ethnic minoritized groups are numerically smaller than the rest of the population; not in a dominant position; these populations have culture, language, religion or race that is distinct from that of the majority; and its members have a will to preserve those characteristics¹⁶

Historically marginalized: groups who have been relegated to the lower or peripheral edge of society. Many were and continue to be denied full participation in mainstream cultural, social, political, and economic activities. Marginalized communities can include people of color, women, LGBTQIA+, individuals with low incomes, prisoners, people with disabilities, the elderly, and many more.¹⁷ These communities were ignored or misrepresented in traditional historical sources, and may also be described as racialized, invisible, and medically under-resourced.

Mental and behavioral health: mental health and substance use concerns, life stressors and crises, stress-related physical symptoms, and health behaviors;¹⁸ mental and behavioral health diagnoses and psychological distress may also be described as illness, conditions, concerns and disorders

Health equity: known obstacles to equity, also known as inequities, include experiences like poverty, discrimination, power differentials, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare¹⁹

Behavioral health equity: the right to access high-quality and affordable behavioral health care services and supports for all populations²⁰

Equality: as a process means providing the same amounts and types of resources across populations

Disparities: measurable differences in health outcomes



Framing the Findings

Quantitative Methodology

The framework for this study was based on LaVeist et al's groundbreaking health disparities research of the 2009 report *The Economic Burden of Health Inequalities in the United States*.³ However, that study excluded the investigation of mental and behavioral health wellness as it relates to inequality. In this study, the focus was changed to equity (versus equality), because equity addresses social and political determinants of status in society, whereas equality solely looks at observed outcomes related to status in society. Also noted was the importance of understanding the relationship between health and mental and behavioral health, per Dr. David Satcher's Surgeon General Report on Mental Health.¹ Four methodologies were applied in this study to estimate:

- National prevalence of mental illness using survey weights
- Service use and healthcare costs
- Additional medical costs attributable to mental health inequities
- Premature deaths with a focus on indigenous populations and racial and ethnic minoritized groups: Asian Americans, Black/African Americans, Native Americans, Alaskan Natives and Native Hawaiians, and Hispanic/Latin(o)(a)(x) Americans

Literature Review Methodology

More than 365 articles were reviewed and coded for this analysis, and 65 citations were included as sources. To best respond to the research questions, the researchers analyzed the relationship between three primary data variables to inform their findings:

- "economic status" AND
- "racial/ethnic disparities" AND
- "behavioral health status"

The analysis developed by this literature review was a result of several stages of academic database searches that focused on identifying existing literature addressing these themes. PubMed was used as the primary database during the data collection process. With "race/ethnicity" being the stratifying variable throughout the analysis, the team utilized an intersectionality-based policy analysis (IBPA) approach when relating

results to the research questions.²² For the purposes of conducting and achieving the most inclusive and expansive breadth of search results, the team conducted nine separate search queries that incorporated secondary IBPA variables into the original variables referenced above ("behavioral health status" AND "economic status" AND "racial/ethnic disparities"). Those results were used to establish the total number of academic literature citations applied to this review.

Policy/Case Study Methodology

The analysis of policies that impact behavioral health and equity began with relevant case studies and recently enacted state policies that demonstrate a balancing of inequities. The National Conference of State Legislatures (NCSL) has a database of such initiatives across all 50 states. While these listings of policies are not exhaustive, they are comprehensive and

— DEFINITIONS —

Premature death: the number of deaths before life expectancy due to mental and behavioral health. For this report, the number of deaths among the four reported indigenous populations and racial and ethnic minoritized groups are due to (1) suicides (2) substance use disorders and (3) mental illness as the underlying cause of death due to inadequate treatment and/or associated with comorbid illness.

Excess premature death: the number of premature deaths among indigenous and racial and ethnic minoritized groups calculated by taking the difference between the actual number of deaths and the "expected" number of premature deaths based on the lowest death rate across the indigenous and racial and ethnic groups.

Economic burden (of mental and behavioral health inequities): healthcare expenditures for office-based care, emergency department visits, hospitalizations, prescription medications, and costs of loss of life due to mental and behavioral health



were informative in identifying common policy levers and recent attempts to address mental and behavioral health disparities across state legislatures and executive agencies. In addition, peer-reviewed and non-peer-reviewed targeted searches were conducted to identify policy recommendations based on the identified levers at the state and national jurisdiction levels. These searches led to primary and secondary research articles with evidence to support the mental and behavioral health and equity implications of these policy or programmatic changes. Subsequently, additional literature that was referenced in seminal publications from government agencies or national advocacy groups were reviewed. Additional targeted searches were conducted to identify policy recommendations and case studies for specific populations from known associations and nonprofits (e.g., report by the National Alliance for Caregiving to identify policy recommendations to address mental and behavioral health needs of caregivers).

Quantitative Findings

- Between 2016 and 2020, the total number of excess premature mental and behavioral health-related deaths among indigenous populations and racial and ethnic minoritized groups was 116,722.
- Between 2016 and 2020, the total excess cost burden from premature mental and behavioral health-related deaths among indigenous populations and racial and ethnic minoritized groups due to **mental illness, substance use, and suicide** is \$278 billion dollars.

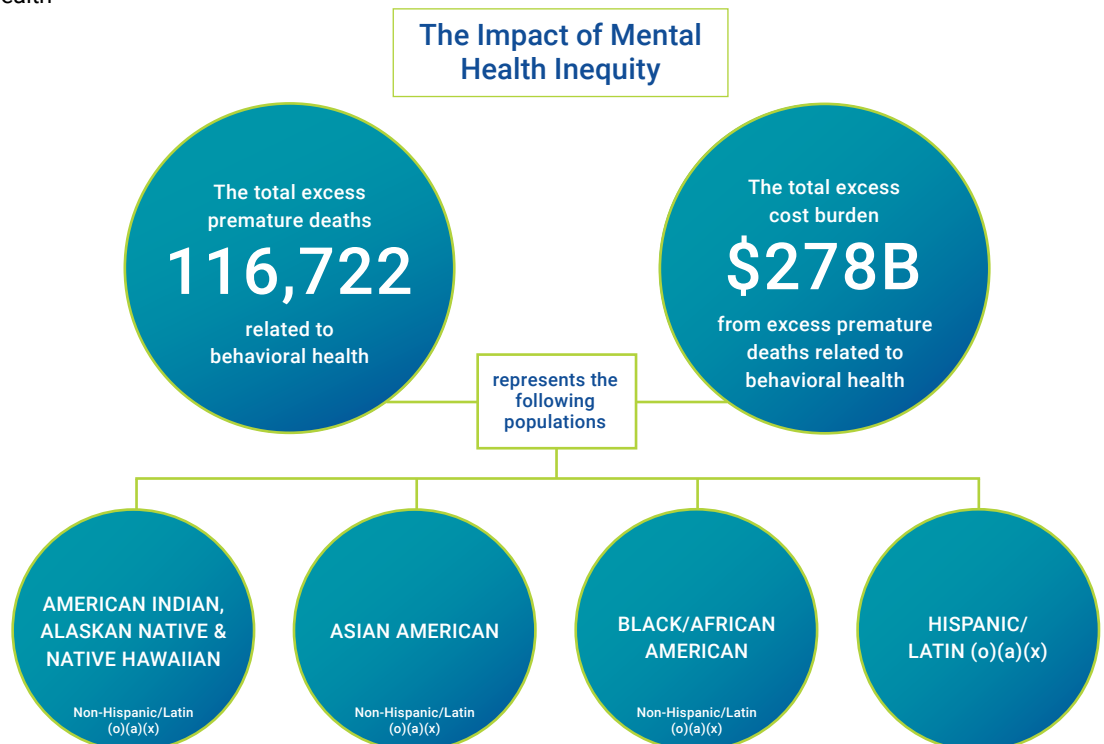
Purpose of the Quantitative Analysis

To answer the two questions posed by this study 1) *how many lives* and 2) *how many dollars could be saved if mental health services become more equitable*, the study examined the prevalence of mental illness among adults, youth and

children in the last five years prior to 2021 (2016-2020) specifically disaggregating the data by indigenous populations and race and ethnicity. Of note, mortality data for 2021 had not been completed at the time of this study and therefore was not included. The study assessed the use of mental and behavioral healthcare services and expenditures across four serious psychological distress and mental illness diagnosis categories:

- Death due to Suicide
- Death associated with Substance Use Disorders
- Death due to Inadequate Mental Health Treatment
- Death due to Mental Illness associated with Comorbid Illness

This report aims to elevate the loss of life and costs due to mental and



behavioral health inequities, which are disproportionately experienced by historically marginalized and under-resourced communities. The loss of life and cost analysis examines the indigenous and racial and ethnic inequities among communities of greatest impact: American Indian, Alaskan Native and Native Hawaiians, Asian Americans, Black/African Americans, and Hispanic/Latin(o)(a)(x) Americans.

Following the LaVeist et al. 2009 methodology,³ the excess premature deaths and economic burden were calculated. Please refer to Appendix A for more specific information regarding calculations and methodology.

Understanding the Number of Lives Lost

When discussing mortality rates for any given population, there is an assumption and expectation that a percentage of the population will die (for various reasons) “prematurely” or prior to the average age of death for that population. People dying “in excess” or beyond what was already expected for a given population, are considered excess premature deaths. While 116,722 by itself may not appear to be a large number, this conservative

figure represents the excess number of premature deaths as it relates to mental and behavioral health. **Understanding then, that this number operates from a baseline of an already larger number of deaths for the United States, it is imperative that the 116,722 deaths are looked at with great interest to discern root causes and more importantly, for prevention.** These deaths are undue and are related to [reversible] inequities that persist within and beyond the United States’ healthcare and behavioral health systems.



Understanding the Amount of Dollars Lost

Directly related to the total number of excess premature deaths, is the total excess cost burden which quantifies a dollar amount for each life lost prematurely. While it is understood that there is no amount of dollars that can be placed on the value of human life, this study (unlike previous studies) sought to better quantify the inequity in suffering, death and cost of deaths related to underlying mental illness which was estimated at \$278 billion. From the

literature review, multiple sources indicate that individuals affected by mental wellness concerns will have their pathway to economic thriving lessened. If that mentally unwell person is representative of an indigenous population or racial or ethnic minority, the economic burden of behavioral health conditions is even greater. This is due to a hindered ability to participate in economic activities such as employment or workforce training and exacerbated by having a historically disadvantaged socioeconomic status because of indigenous or racial or ethnic status.

The findings also demonstrated that there are inconsistencies, issues, and limitations in the way this reality is being captured and addressed by the behavioral health system. Specific themes and potential consequences of these limitations are mentioned throughout the report.

Who is missing from this?

The study revealed that an estimated 5.8 million Americans (i.e. the incarcerated, nursing home residents, residents of assisted living facilities, the unhoused, active military, and those who are institutionalized in psychiatric facilities)



Simply put, the national estimates are underrepresenting the actual burden of mental and behavioral illness.

are excluded from the traditional sampling frame used by the United States Department of Health and Human Services and federal surveys for mental and behavioral health. See Appendix B. Simply put, the national estimates are underrepresenting the actual burden of mental and behavioral illness.

Understanding that lack of accurate data representation is detrimental to improving outcomes for any population. The researchers of the study were compelled to do an ecological analysis estimating the premature deaths and excess cost burden of this excluded group. The data set used for this portion of the study consisted of published literature from multiple federal and state agencies and national advocacy organizations on mental illness and substance use disorder among the unhoused and incarcerated populations. The analysis revealed the following alarming figures:

Excess burden of mental illness and lower life expectancy among unhoused in the U.S.:

- **\$23 billion annual excess burden in terms of years of life lost**

Excess burden of mental illness among the incarcerated population in the U.S.:

- **\$15 billion - \$44 billion excess cost** among those with substance use disorder
- **\$19 billion excess cost** among those with mental illness

- **\$6 billion excess cost** in potential averted crime

This leads to a total of \$63 - \$92 billion annual excess costs due to mental illness and substance use disorder among the incarcerated and unhoused.

To put meaning behind these numbers, American Indian, Alaskan Native and Native Hawaiians, Black/African Americans, and Hispanic/Latin(o)(a)(x) Americans were the populations most over-represented in both the unhoused and incarcerated populations. Based on shorter life expectancy among the unhoused, the United States suffers a greater than \$23 billion annual burden due to years of life lost. Incarceration

of those suffering mental illness or substance use disorder results in an annual cost burden of over \$50 billion related to high cost of incarceration compared to mental illness treatment, substance use treatment, and averted post incarceration crime. The unhoused and incarcerated suffer from undertreatment of mental illness and substance use disorder. In many instances, incarceration may replace community treatment. The prominent racial disparities among the unhoused and incarcerated lead to serious inequity in mental health outcomes and costs.

Adequate treatment could save \$60-\$90 billion dollars each year. Policies that address mental illness leading to improved diagnosis and treatment among these historically marginalized and under-resourced populations represent equitable strategy making, equitable health care delivery, and forge a path towards economic improvement for our healthcare system and for the overall output of this country.



Data Limitations and Assumptions

The purpose of this analysis was to determine whether there is a concerted need to understand the economic burden of mental and behavioral health inequities across indigenous, racial and ethnic populations. The researchers utilized both inductive and deductive approaches in their analysis. An inductive approach was used to identify themes and patterns that directly emerged from the data. Utilization of the National Advisory Panel was to ensure that these potential bias limitations were addressed appropriately to develop analysis that was as objective as possible.

Recurring limitations observed throughout the literature review and the study were related to data, data collection practices, and data reporting. Repeatedly, examples abound where data were not disaggregated by gender, race or ethnicity, and other ways of identifying specific populations. In general, there is inconsistency in how indigenous, racial and ethnic groups are coded and classified (e.g., it was noted that American Indian, Alaskan Native and Native Hawaiian persons are often subjected to listing themselves as “other” when their own ethnic category is not included in survey tools, and that Asian Americans are often left out of data sets as a demographic entirely, both of which are vastly underrepresented groups in these findings).

Sixteen indigenous, racial and ethnic categories were aggregated to five for analysis. Aggregating indigenous, racial and ethnic groups for analysis results in generalized findings for unique communities and individuals that are unable to see themselves

represented in the data. Most national surveys use the minimum standard for race and ethnicity categories for data collection or often have to aggregate data for analysis. Limited data collection and sampling prohibits data disaggregation. Federal efforts to increase indigenous, racial and ethnic data disaggregation and increased sampling will allow for more precise and meaningful analysis reflective of the country’s diversity.

Other limitations observed include behavioral health being excluded in many measures of overall burden of disease; lack of data available for youth and particularly youth under

the age of 12; restricted behavioral health data based on state preference due to interpretation of parity laws; discrepancy and inconsistency in use of terms associated with behavioral health issues (e.g. one author referred to alcohol related challenges as “heavy drinking,” while another called it “alcohol use disorder,” and a third measured respondents by tracking “alcohol misuse”);²³⁻²⁵ lack of representation of certain communities in data. Collectively, these provide challenges in accurately and equitably displaying the whole of the situation in the behavioral and mental health domain for all populations, limiting what influential leaders can learn

Black/African American	Black/African American
Native American/Alaska Native	Native American/Alaska Native
Native Hawaiian	Native Hawaiian/ Other Pacific Islander
Other Pacific Islander (Guamanians/ Chamorro's and Samoans)	
Native Hawaiian/Other Pacific Islander (selected both categories)	
Asian Indian	Asian
Chinese	
Filipino	
Japanese	
Korean	
Vietnamese	
Other Asian (other than Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)	
Asian multiple categories (multiple Asian categories selected)	
Multi-race (more than one race selected)	Multi-race
Hispanic/Latin(o)(a)(x)	Hispanic/Latin(o)(a)(x)
White	White





about the experiences of their respective communities including prioritizing historically invisible and resource-needy populations.

The study findings are not representative of the entire United States population, or the totality of lives lost or totality for every indigenous, racial and ethnic category, but the excess compared to the lowest losses among indigenous, racial and ethnic minoritized groups (which for this study, was identified to be the Asian American category). Additionally, the calculated figures are inherently limited given that the study included data from four national mental and behavioral health surveys, that data and data collection standard practices vary widely, and that data for mental and behavioral health are largely under captured.

An illustrative example is the Asian American population which is found in the literature to be under-reported, under-represented, and incorrectly

aggregated in available data. The use of the Asian American racial and ethnic category for having the lowest expected premature death rates was precisely modeled after LaVeist's study. However, to say that this group has the "best" outcomes is incorrect, given that the literature review demonstrated an under-reported burden of mental and behavioral health concerns in this group. Additionally, recommendations later in this report will refer to the disaggregation of the Asian American racial and ethnic category, as classifying over 100 different ethnicities into one category is inequitable. Further, the existence of an "other" racial and ethnic category, which may be inclusive of other populations due to a number of inequities that exist in accepted data collection structures, is a further compounding limitation i.e. overlap may exist between the "other" category and those presented in the findings. The diversity across established groups and emerging groups in aggregate obscures underlying

realities in mental and behavioral health outcomes and inequities. It is worth noting that these inequities are including but not limited to self-reporting, exclusive terminology, and forced racial identification due to institutional policies, and are all representative of the types of systemic inequities that this report exists to highlight and address.

— TAKE AWAY —

Input from the National Advisory Panel

Conversations with the National Advisory Panel focused on finding the common language and equitable terminology used in this report for defining/categorizing different race/ethnic groups as well as groups identified by health status, socioeconomic status, sexual and gender identity, and differences in ability.



Drivers of Mental and Behavioral Health Inequities

The burden of mental health needs is high and varies by indigenous population, race and ethnicity due to multiple, intersecting factors. Structural barriers to accessing care, cultural differences to pursuing behavioral healthcare, biased delivery of care, and social and political determinants of health, including poverty and having health care insurance, all perpetuate systemic inequities. Additionally, racism and racial incongruencies influence the collection of data and must be considered when interpreting the findings.

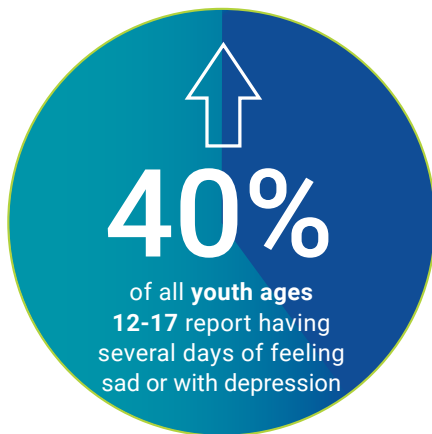
Over 40% of all youth ages 12-17 report having several days of feeling sad or with depression, the highest reporting among Native American and multiracial youth.²⁶ Nearly 20% of all adults report any mental illness, with Native American and multiracial adults reporting at the highest rates.²⁶

Children and adults who experience poverty are at an increased risk for poor mental health outcomes, including depression, anxiety, post-traumatic stress, and psychosis, in addition to poorer outcomes for overall health.^{10,27} Youth of color are disproportionately affected by mental health conditions and poverty, and the bidirectional relationship between these two indicators reveals alarming realities. Adverse childhood experiences (ACEs) are known to be a strong predictor of mental health concerns later in life.²⁸ Nationally, 61% of Black/African American children and 51% of Hispanic/Latin(o)(a)(x) children have experienced at least one ACE, compared with 40% of White and 23% of Asian American children.²⁹ The prevalence of ACEs is highest among Black/African American children and lowest among Asian American children

across all regions of the U.S. Black/African American, Native American, and Latin(o)(a)(x) youth are three times more likely than White and Asian children to be poor.³⁰ Further, children raised by single parents and children raised in the South or West regions of the U.S. are also more likely to be poor or low income compared to children residing in the Northeast.³⁰ Per the the Centers for Disease Control and Prevention (CDC), 7.4% of youth between the ages of 3 and 17 (approximately 4.5 million) are diagnosed with a mental health

— DEFINITION —

Adverse childhood experiences (ACE): potentially traumatic events that occur in childhood (ages 0 - 17 years)



Highest reporting among Native American and multiracial youth.²⁶



Highest reporting among Native American and multiracial adults.²⁶



condition, and Mental Health America's key findings from 2021 indicate that over 2.5 million youth in the U.S. have severe depression, with youth of color being at the greatest risk.^{31,32}

Poverty and unemployment also disproportionately affect communities of color, women and sexual and gender minorities, which parallels the higher rates of poor mental health observed in those communities.³³ American Indian, Alaskan Native and Native Hawaiian people experience both lower economic and lower behavioral health outcomes when compared with all other Americans.³⁴ Low-income Hispanic/Latino(o)(a)(x) families had the highest numbers of full families in poor health, followed by Black/African American low-income families.³⁵ Asian Americans seem to rank the best compared to other indigenous, racial and ethnic minoritized groups when it relates to behavioral health outcomes, but also show the lowest rates of treatment engagement.³⁶ This ranking order holds true for mental health outcomes as well. The findings also provided insight into what is known about the relationship between behavioral health diagnosis and race/ethnicity. Data indicate that Black/African American women experience depression at almost twice the rate of Black/African American men.³⁷⁻³⁹ They are, however, less likely to seek mental health help.^{40,41}

There are vast disparities seen in how people are connected to care due to structural barriers as well as historical and contemporary mistrust and misdiagnosis in the U.S. healthcare system. An estimated 43% of all people with mental health concerns are connected to care. White Americans and Americans who identify as two or more races receive care at

rates of 48% and 46%, respectively.³⁶ Black/African American and Hispanic/Latino(o)(a)(x) Americans receive mental healthcare at rates of 31%, and Asian Americans are least likely to be connected with care, at just 22%.³⁶ Black/African Americans often receive poorer quality of care, lack access to culturally competent care,^{11,42} and are more likely to use emergency rooms or primary care, rather than mental health specialists.⁴³⁻⁴⁵ As a result, the National Association on Mental Illness (NAMI) recommends that "a primary care professional is a good place to start" when seeking culturally responsive care. This stresses efforts necessary to improve integrated behavioral health and primary care spaces to include better assessment training for primary care and emergency room physicians on mental health symptoms in patients. But it is important to also recognize that care is sought outside of traditional treatment services and care settings such as faith-based interventions. Due to historic mistrust and misdiagnosis, Black/African Americans tend to seek support from their faith community rather than seeking a medical diagnosis.⁴³ Indigenous men and women are significantly more likely to seek help from traditional/spiritual healers than from other sources.^{42,46,47} Asian Americans/Pacific Islanders are least likely to seek mental health services than any other racial/ethnic group and 33% less likely to access mental health services than non-Hispanic/Latino(o)(a)(x) White Americans.^{42,48,49} Approximately 1 in 10 Hispanics/Latino(o)(a)(x) with a mental disorder use mental health services from a general healthcare provider, while only 1 in 20 receive such services from a mental health specialist.^{42,45} Black/African American

and Hispanic/Latino(o)(a)(x) children are generally found to have lower mental health service utilization compared with White children. Black/African American, Hispanic/Latino(o)(a)(x), and American Indian, Alaskan Native and Native Hawaiian children in rural and urban areas are less likely to be connected to mental healthcare compared to White children.³⁰

Health insurance enables people to access mental/behavioral healthcare. The Affordable Care Act created new health coverage options to narrow (but not eliminate) disparities in health coverage.⁵⁰ Some of the gains in health care coverage began to erode in 2017 due to policy changes by the Trump administration that contributed to reduced access and enrollment in coverage, and uninsurance rates increased for Hispanic/Latino(o)(a)(x), Black/African American, and White populations. Nonelderly American Indian, Alaskan Native, Native Hawaiian, Asian American and other Pacific Islander, Black/African American, and Hispanic/Latino(o)(a)(x) people remain more likely to lack health insurance than their White counterparts.⁵⁰ The Executive Order Strengthening Medicaid and the Affordable Care Act (January 2021) established a special open enrollment period for the federal insurance marketplace, restored funding for navigators, and implemented initiatives to increase enrollment among Black/African American and Hispanic/Latino(o)(a)(x) individuals to mitigate coverage losses due to the COVID-19 pandemic.⁵¹ Additionally, it reversed changes to public charge policies and reversed waivers that implemented work requirements for Medicaid coverage. Despite these policy actions, disparities in health insurance access remain.



The most devastating outcome of systemic failures to care for mental and behavioral health needs is suicide. Black/African American and multiracial groups with suicidal thoughts attempt suicide at higher rates than other indigenous populations and racial and ethnic minoritized groups with suicidal thoughts.⁵² When broken down by age, youth with suicidal thoughts attempt suicide at higher rates than adults with suicidal thoughts, with the largest proportion of suicidal thoughts and attempts in multiracial groups.⁵² Age-adjusted suicide rates are highest among non-Hispanic/Latin(o)(a)(x) American Indian/Alaska Native, as suicide is the 9th leading cause of death among American Indian/Alaska Native people, and the second leading cause of death in native youth.⁵³

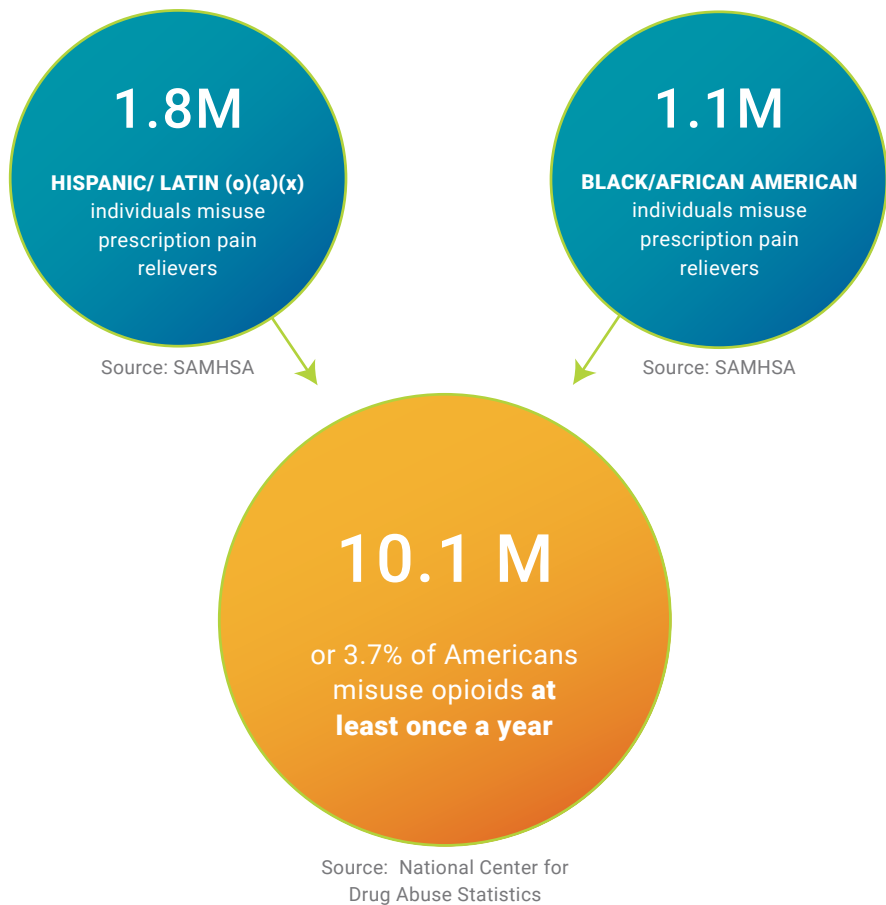
Native youth, particularly those living on reservations, have higher suicide rates due to social segregation and isolation.⁵⁴ Additionally, assimilation and acculturation are recognized as factors contributing to Native adolescents' suicide and suicidal behaviors.⁵⁴ Native youth residing on reservations are also at increased risk for "suicide clustering," wherein suicide attempts are likely to be mirrored by peers.⁵⁴ For Black/African American and Asian/Pacific Islander groups, the rates of suicide began to increase in 2014 and between 2014 - 2019, the suicide rate increased by 30% for Black/African American individuals and 16% for Asian or Pacific Islander individuals.^{53,55}

Opioid Epidemic

Over 10 million Americans misuse opioids at least once over a 12-month period.⁵⁶ The CDC estimates the total economic burden of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.^{12,57}

Per CDC findings, the opioid epidemic impacts both rural and urban communities. Throughout the 2000s, rural (nonmetropolitan) drug overdose mortality rates rose faster

than urban (metropolitan) rates and exceeded urban rates by the end of the decade. While rural rates continued to rise in the 2010s, the urban rates jumped even more.⁵⁸ In 2017, more than 47,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin, and illicitly manufactured fentanyl, a powerful synthetic opioid. That same year, an estimated 1.7 million people in the U.S. suffered from substance use disorders related to prescription opioid pain relievers, and 652,000 suffered from a heroin use disorder (not mutually exclusive).⁵⁷



How to Successfully Improve Equity:

Access to mental and behavioral health services in the right place at the right time is insufficient across the U.S., and indigenous populations and racial and ethnic minoritized groups experience additional barriers to obtaining access to care they need. To ensure more equitable access to care, policy action in three interrelated domains is needed:

- Investment in mental and behavioral health infrastructure
- Culturally centered mental and behavioral health care
- Addressing the political and social determinants of mental and behavioral health.⁴

Fundamental Policy Principles to Advance Equity

The fundamental policy principles are essential and applicable to all policy recommendations. These principles ensure the proposed policy solutions overcome inequities and focus impact specifically for communities of color that are disproportionately affected by inequities. The principles include the importance of community informed and led research; truth, reconciliation, and healing; and long-term investment with accountability. All policy recommendations are supported with evidence, and when implemented, the benefits of advancing mental and behavioral health equity have the potential to be realized by all populations.

Investment in Behavioral Health Systems

Equity Recommendation 1.

Mental and behavioral health equity will lead to benefits in economic and health outcomes with impact that have not been fully explored.

Policies must invest sufficiently and sustainably in rebuilding and maintaining equitable mental and behavioral health systems creating infrastructure for the long-term, to ensure access to the right care at the right place and the right time.

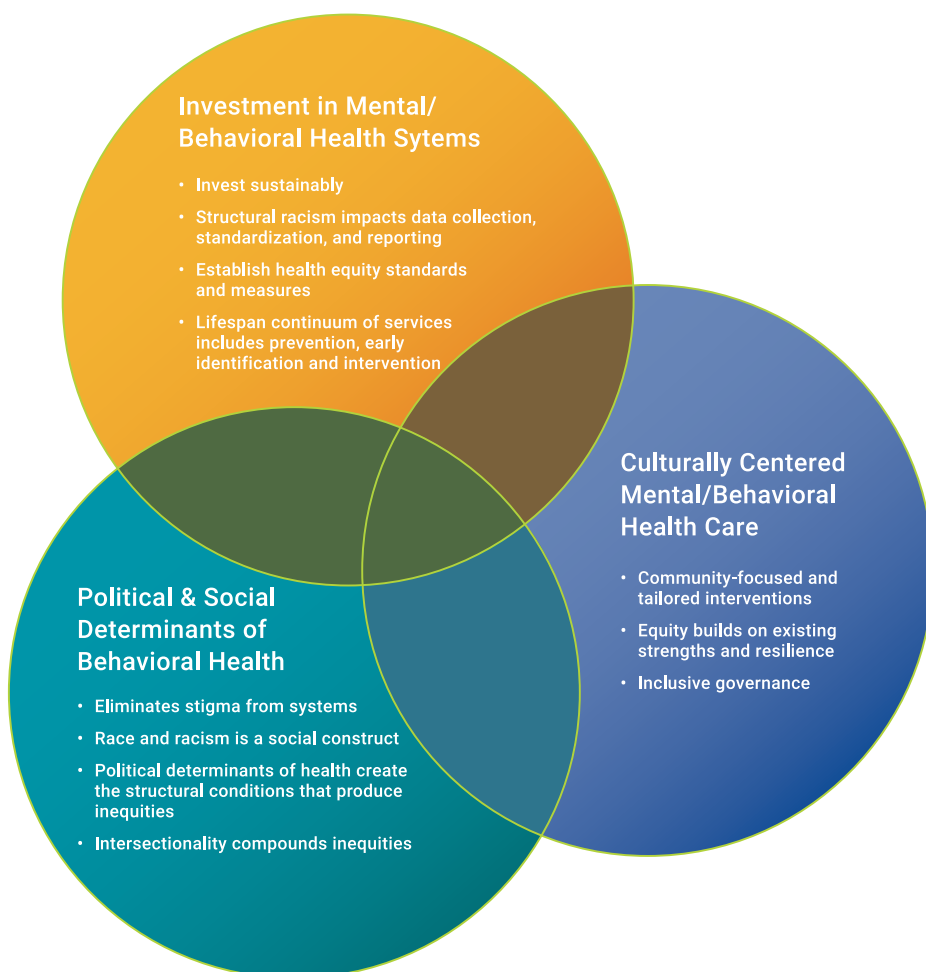
Equity Recommendation 2.

Mental and behavioral health equity across the lifespan is influenced by intergenerational and multigenerational experiences of racism and trauma. Policies must begin with prevention and early

intervention and identification to offer a continuum of services also inclusive of treatment and crisis needs.

Equity Recommendation 3.

Understanding equity requires metrics and measures that matter to unique communities. Policies must establish inclusive standards of health equity and quality measures for accessible health systems, and fund research to study mental and behavioral health equity including evaluation of policies and tracking of these measures to identify progress and ongoing needs.



— TAKE AWAY —

Input from the National Advisory Panel

Discussions with the National Advisory Panel centered on what kind of data should be collected, from where and whom data should be collected, current gaps in the data, and data (dis)aggregation. The panel recommended creating a case for specific studies of subpopulation groups across race and ethnicity to convince stakeholders of the value in proactive investment into promotion and prevention. For example, studying the burden of mental health disorders on women – particularly women of color and mothers – and children, as well as people from other marginalized groups including incarcerated people and people living with HIV.

Policy Recommendations

Investment in mental and behavioral health infrastructure requires a multi-prong approach to expanding and re-training the behavioral health workforce to better meet the behavioral health needs of historically marginalized communities, expansion of insurance coverage and enforcement of parity in both public and private insurance programs, funding and payment reform, and expanding services and care sites for the full continuum of behavioral health services.

Behavioral Health Workforce

Our behavioral health workforce is not currently equipped to address behavioral health needs at a population level, much less to provide equitable behavioral health services. The shortages are particularly pronounced in rural and underserved urban communities, and for individuals with intersectional identities. The workforce needs to be equitably trained, funded, and employed in the settings where there is the greatest need and that are the easiest for individuals to access. This includes addressing the current workforce shortage in rural and historically under-resourced communities by increased funding and training, re-training the existing

workforce to better serve these same communities in the settings in which they present (e.g., primary care and schools), and expanding the health care team to include diverse expertise among community-based providers. A well-trained and representative workforce will be better equipped to provide services to underserved communities, which could lead to improved health outcomes and therapeutic alliances between patients and providers.⁵⁹ Patients who might be averse to seeking care may view programs with a diverse workforce more favorably.⁶⁰ In addition, training to reduce bias is crucial in achieving equal treatment of minority patients.⁶¹

Mental/Behavioral Health Workforce

- 1.1 Develop and disseminate health professional educational programs, best practices, or core competencies addressing mental health disparities and culturally responsive care.
- 1.2 Improve and expand recruitment through pipeline programs, scholarships, loan repayment, and retention incentives for clinicians who are culturally and linguistically concordant with the populations they serve.

- 1.3 Participate in interstate licensure compacts to increase access to behavioral health services: the Interstate Licensed Professional Counselors Compact; Psychology Interjurisdictional Compact (PSYPACT); and Interstate Medical Licensure Compact (IMLC).

Insurance and Parity

Insurance is a primary driver of access to behavioral healthcare. As Medicaid plays a large role in insurance coverage for historically marginalized communities, policy to expand and improve coverage and reimbursement in Medicaid is an essential lever to support equity. Health equity will not be achieved unless there is adequate coverage and payment for behavioral health services among all public and private insurance programs, including enforcement of parity law to cover behavioral health services in line with physical health services. Specifically, this includes expanding Medicaid in all states to align with provisions of the Affordable Care Act, to all pregnant women through 1 year postpartum, and to all people without documentation; granting the Department of Labor authority, oversight and the ability to pursue penalties for parity violations and non-compliance with coverage mandates; addressing payment disparity among and between insurances to ensure that providers have an incentive to accept all insurances for behavioral healthcare; and requiring insurance carriers to submit annual reports on compliance with parity legislation. Due to inadequate payment, many behavioral health providers opt out of insurance networks to maintain financial sustainability; as a result, many patients are unable to access



behavioral health care except for costly out-of-network care.⁶³ Policies such as the Medicare Improvements for Patients and Providers Act (MIPPA) parity provision that reduced cost sharing have led to greater utilization of mental health services and psychotropic medications.⁶⁴ Stronger state parity laws and coverage mandates have been associated with increased alcohol treatment rates for diverse racial/ethnic groups⁶³ and narrowed differences in outcomes by racial and socioeconomic subgroups in adolescents.⁶⁵

Insurance Policy Recommendations

1.4 Expand available billing and reimbursement by unlicensed practitioners, including community health, care coordination, and peer support workers as essential team members under Medicaid State Plan Amendments.

Policies such as the Medicare Improvements for Patients and Providers Act (MIPPA) parity provision that reduced cost sharing have led to greater utilization of mental health services and psychotropic medications.⁶⁴

- 1.5 Expand Medicaid in all states to align with provisions of the Affordable Care Act.
- 1.6 Expand Medicaid coverage for pregnancy to 1 year postpartum.
- 1.7 Eliminate copayments for prescription drugs and visits for behavioral health conditions.
- 1.8 Eliminate disparities in Medicaid funding for U.S. Territories by permanently increasing federal allotments and matching rates.

Parity

- 1.9 Grant the Department of Labor authority to assess civil monetary penalties for parity violations.
- 1.10 Amend the Employee Retirement Income Security Act of 1974 (ERISA) to provide the Department of Labor authority to directly pursue parity violations by entities that provide administrative services to ERISA group health plans.
- 1.11 Amend ERISA to provide that beneficiaries may recover amounts lost for claims denied in violation of Mental Health Parity and Addiction Equity Act (MHPAEA).
- 1.12 Amend MHPAEA to ensure that mental health and substance use disorder benefits are defined uniformly based on nationally recognized standards.
- 1.13 Require insurance carriers to submit annual reports on compliance with parity legislation and empower regulatory agencies to enforce parity laws.

— SPOTLIGHT —

Workforce Diversity: Pipeline Program with State Funding and Community Accountability⁶²

A pipeline program can increase diversity in the health care workforce when paired with state funding and community accountability. In 1978, the Illinois General Assembly created and provided funding for the Urban Health Program (UHP) at the University of Illinois at Chicago with the goal of increasing recruitment and retention of minorities in health professions. UHP is a comprehensive pipeline program providing academic support and mentoring to middle school, high school, undergraduate, and health profession students. Between 1978 and 2011, University of Illinois at Chicago had the highest graduation rate for minority health care professionals in the country, after Historically Black Colleges and Universities (HBCUs) and Latino-serving institutions. Key factors contributing to success is the UHP Community Advisory Council, include: inclusion of which consists of business and community leaders, educators, and health professionals who together advocate for the mission of the UHP and hold both the university and state legislature accountable; early outreach and academic pipeline to increase interest in health-related careers among underrepresented minority elementary and secondary students; and change in culture and commitment of health professions colleges and the University.



- 1.14 Define mental health and substance use disorders broadly in statute to include all disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD).
- 1.15 Require parity in coverage for mental health and substance use disorders with physical conditions across insurance benefit management processes, quantitative and non-quantitative treatment limitations, co-pays, and out-of-pocket costs.

Funding and Payment Reform

The dual problems of increasing health care costs and poorer health outcomes points to funding and payment reform as levers for smarter investment in health, better outcomes, and advancing equity. For example, the Indian Health Services (IHS) is chronically underfunded resulting in significant deficiencies in care for tribal communities. Designating IHS as an entitlement program with a commitment for increased funding will provide resources to address existing behavioral health disparities.⁶⁷ Innovative payment models for behavioral health and primary care will support greater access to care.

A Special Note on the Indian Health Services

There are over 570 federally recognized tribes and a population of more than 5.6 million individuals identifying as American Indian or Alaska Native (AI/AN).⁶⁸ The political sovereignty and structure of tribal communities presents its own behavioral health care system and unique opportunities for community-

tailored behavioral services in order to address health disparities. Behavioral health concerns and related morbidities are a significant contributor to mortality, with estimates ranging from 1.7-7 times higher rates of mortality in the AI/AN communities.⁶⁸ The IHS, a federal government agency, appropriates federal funds that can be used to provide direct services by tribes to tribal members. However, the budget for IHS has been persistently underfunded.⁶⁹ In recent years, the IHS operates on 50% of what is needed to provide adequate level of services.⁷⁰ This is also insufficient to provide needed care for individuals who reside outside of reservations (almost 80% of individuals who identify as American Indian or Alaska Native).⁷⁰

- 1.16 Guarantee adequate and stable federal funding for the Indian Health Services, increasing funding over time and shifting from discretionary to mandatory.
- 1.17 Base funding practices, oversight of programs, and evaluation of programs on tribal self-determination in order to better fulfill the federal trust responsibility to American Indian/Alaskan Native (AI/AN) populations.
- 1.18 Develop incentives and accountability mechanisms under available value-based payment mechanisms to support behavioral health integration in primary care, such as through Accountable Care Organizations, Health Homes, Medicaid managed care, Medicare Advantage Plans and Delivery System Reform Incentive Payment (DSRIP) programs.

— SPOTLIGHT —

Parity Enforcement⁶⁶

State investigations of behavioral health claims reveal mental health parity violations. The New York Attorney General's Office investigations revealed insurers were using protocols that either were not in place for other medical care or were applied more stringently to behavioral health benefits than other covered services. These protocols involved use of fail-first policies (e.g., needing to "fail" out of one level of care to be approved for a higher, needed level of care), more onerous prior authorization procedures, more frequent and rigorous utilization review, and categorical exclusions of residential treatment and neuropsychological testing. The Attorney General's Office has reached settlements with numerous insurers and levied over \$3 million in penalties and ordered reprocessing of claims that resulted in payment of millions of dollars in previously withheld reimbursement to enrollees and providers. Nearly half of denials re-reviewed as part of settlements were overturned on appeal and health plans continue to be monitored to ensure parity compliance is reached and maintained.



Our mental health system is not set up to serve those who need the most help.

- 1.19. Implement a risk-adjusted population-based payment model for behavioral health integration in primary care to include funding for prevention and health promotion and intervention.
- 1.20. Expand the behavioral health provider types able to bill for services, including care coordination and family/behavioral health navigation.
- 1.21. Allow billing and reimbursement for available codes for behavioral health integration including all Health and Behavior Assessment and Intervention, and Collaborative Care, health and well-being, Current Procedural Terminology (CPT), and crisis/risk assessment codes.
- 1.22. Reimburse behavioral health services without site, provider, or patient restriction, or the need for prior authorization or diagnostic eligibility.

For additional funding and payment reform policy recommendations to support families, individuals with substance use concerns, and to address social media use concerns in youth, see table of policy recommendations in Appendix D.

Behavioral Health Service Continuum and Sites of Care

Comprehensive mental and behavioral health services encompass a continuum of care beginning with prevention and early intervention and identification, spanning treatment, recovery and crisis management. Care should be equitable and accessible at all points on this continuum. Behavioral health providers need to meet patients in settings and locations based in their own communities, speak the patient's preferred language, and provide access to all appropriate treatment options and providers.

Investment in prevention and equitable intervention will save dollars and lives for indigenous populations and racial and ethnic minoritized communities.

Our mental health system is not set up to serve those who need the most help. Policies can support clinical, school and community-based settings to integrate behavioral health care delivery in places where individuals are most commonly being seen (e.g., primary care and schools). States with mandated school-based mental health centers, social-emotional curricula, and school professional development in suicide prevention have reported significantly lower adolescent and young adult suicide and substance abuse rates. These programs offer accessibility to youth that would otherwise lack access and are known to improve academic performance as well as symptoms of behavioral health conditions. School-based programs also provide more equitable levels of access for youth of color.⁷¹ Studies of school-based services report higher utilization of mental health services and were rated as more acceptable to parents compared to receiving care at other locations.⁷²



- 1.23 Additional resources and funding to provide sustainable, school-based psychosocial support and mental health intervention, particularly in schools with a majority of youth of color.
- 1.24 Invest and expand access to online screening, treatment, and referral to in-person treatment to reach underserved students of color with mental health needs on college campuses.
- 1.25 Permanently allow and expand billing for telebehavioral health services, including in primary care and school settings.
- 1.26 Fund additional research on the effects of social media use on youth and adolescents, and on strategies to encourage healthy social media use.
- 1.27 Fund substance abuse prevention centers for individuals who are at greater risk of abusing substances due to intergenerational trauma, racism, and health inequities.
- 1.28 Establish Employee Assistance Programs and develop procedures to increase employee control and flexibility over schedules and decisions that impact job stress.
- 1.29 Provide funding for forgivable loans for primary care practices and multidisciplinary providers for the up-front costs of practice transformation to integrate behavioral health.
- 1.30 Establish a national system for locally delivered and tailored technical assistance through funding the Primary Care Extension Program authorized in the Affordable Care Act.
- 1.31 Expand funding for safety-net service providers and establish a grant program for Federally Qualified Health Centers and Rural Health Clinics to establish interprofessional behavioral health care teams in primary care settings.
- 1.32 Embed equity in the implementation of the national 988 system to enhance behavioral health crisis response and suicide prevention services.
- 1.33 Fund crisis walk-in centers and mobile crisis units staffed by peer support and community health workers.
- 1.34 Expand crisis stabilization services, short-term respite facilities, peer respite centers, behavioral health urgent care walk-in centers and the crisis hotline center.

For additional detailed recommendations for behavioral health workforce, mental health parity, and 988 implementation see Appendix E.

— SPOTLIGHT —

Community Mobile Response Teams & 988 Implementation

The new national 3-digit suicide prevention and behavioral health crisis hotline went live as of July 2022. While the National Suicide Hotline Designation Act of 2020 was monumental in designating ‘988’ as the universal number, more just and robust behavioral health crisis systems, and equitable support for the service, are needed. The American Rescue Plan Act’s new Medicaid state option to provide qualifying community-based mobile crisis intervention services with an enhanced federal matching rate of 85% for the first three years, are critical for state planning and implementation needs. The new Medicaid option requires crisis response teams to include one qualified behavioral health care professional who can provide an assessment within scope of practice requirements under state law.

Evaluations are proving the effectiveness of community mobile response teams in decreasing law enforcement involvement and improving behavioral health outcomes. In Eugene, Oregon, the Crisis Assistance Helping out the Streets (CAHOOTS) program responded to 24,000 calls in 2019, and only 319 required law enforcement. The program has an annual budget of roughly \$2 million and saves the city of Eugene an estimated \$8.5 million annually in public safety costs, in addition to \$14 million in ambulance trips and emergency room costs.⁷³



— SPOTLIGHT —

Ho'opono Mamo Program (Hawaii)

Individuals with untreated mental illness experiencing a crisis are much more likely to be killed in police encounters; in one study, individuals with severe mental illness were 16 times more likely to be killed in a police encounter than other civilians.⁷⁴ Crisis services will also need to be expanded to reduce the mortality rates of individuals with severe mental illness, especially in marginalized communities.⁷⁵ Culturally sensitive diversion programs such as Ho'opono Mamo in Hawaii have focused on proactively intervening and preventing youth from entering the criminal justice system. The program has led to significant reductions in juvenile incarceration rates and numbers of youth on probation.⁷⁶

Culturally Centered Mental and Behavioral Health Care

Equity Recommendation 1.

Communities are strong and resilient; tailored interventions should build on strengths that match solutions to each community, not employ the same solutions for all. Policies and programs must target interventions, building on community strengths and resiliency in addition to meeting unmet needs. Policymaking for inclusive governance should recognize community members' expertise, involving those who will be impacted by the policy to achieve more equitable outcomes.

Equity Recommendation 2.

Intersectionality compounds inequity when people suffer discrimination based on race/ethnicity and other identities such as gender, sexuality, or legal status. Policies must ensure that services are offered in a person and community-centered, language-concordant, and culturally-centered manner.

It is crucial to address the unmet needs of each community by including community leaders in identifying areas of need and development of tailored interventions. Community-led solutions that build on the strengths

of each community will allow for interventions to be culturally centered and accessible. Community workers and programs that honor the history of the communities being served can be effective in reducing barriers. In addition, significant improvements can be made by considering the sites of care that various communities rely on for mental and behavioral healthcare and how barriers to accessing care can be reduced by expanding partnerships with faith-based organizations, school-based treatment centers, integration of mental and behavioral health into primary care, and tele-behavioral health services.

- 2.1 Establish an agenda of priorities for the White House Office of Faith-Based and Neighborhood Partnerships and federal agency Centers for Faith-Based and Neighborhood Partnerships to address mental health equity.
- 2.2 Establish sustainable funding mechanisms to scale peer and community-driven programs that provide culturally specific and culturally responsive behavioral health services to people of color, tribal communities, and people with lived mental health experience.

— DEFINITION —

culturally-centered care: care that is person-centered, values cultural humility among providers, and is implemented in environments that appreciate diversity and represented cultures. It conceptualizes the patient/client-clinician relationship as a partnership that emerges from person-centeredness, it is empowerment oriented, and does not presume that any clinician can have "competence" in a client's culture, but rather focuses on culture as strength, not pathology.^{77,78}



- 2.3 Co-develop safe and inclusive public spaces for all ages that values the cultural history of a community.
- 2.4. Certify both community health workers and peer support specialists with best practices and core competencies in mental health and substance use, as well as accessing resources and coordinating care.

Regardless of the site of care or provider, training based on anti-racism and culturally centered care can reduce biases and reduce distrust from patients. In school settings, such training can reduce the discipline gap affecting students of indigenous populations and racial and ethnic minoritized groups.

- 2.5 Implement anti-racist training for clinicians to decrease personal and systemic biases in health care institutions.
- 2.6 Require training with culturally informed and anti-racist principles to decrease the discipline gap in schools experienced by students of color.
- 2.7 Mandate socio-emotional curricula and school professional development in suicide prevention in schools.
- 2.8 Develop and launch anti-stigma campaigns with collaboration from community leaders or community-based organizations to change public attitudes toward mental illness.

“Community-based organizations (CBOs) know their communities, their cultures and are often trusted entities within marginalized communities. Being able to elevate a focus on these CBOs and the services and leadership they provide in their communities would reflect a community-asset driven approach.”

- Dr. Larke Huang, National Advisory Panel Member

A Special Note on Native American, Alaskan Natives, and Native Hawaiians

A greater number of culturally adapted interventions that integrate cultural practices and traditions are needed to address health disparities and behavioral health needs of the Native American, Alaskan Native, and Native Hawaiian populations. Such interventions have been implemented with noted reductions in symptoms for various tribal populations. Key adaptations of services in such programs have been the flexibility in utilizing school-based services, using culture as treatment, involving the community, or adapting a pre-existing intervention to a tribal community.⁷⁰ In addition to cultural adaptations of interventions, training and employment of native community mental health

workers is crucial in increasing cultural appropriateness of the interventions and in reducing barriers posed by stigma. Incorporation of native community mental health workers have shown positive outcomes related to mental health promotion, reduced substance use, and improved attitudes toward healing mental health issues.⁶⁸

- 2.9 Integrate traditional and cultural practices in prevention and intervention programs.
- 2.10 Promote programs aimed at creation of a coalition of native mental health professionals, including native community mental health workers.



— SPOTLIGHT —

Mental Health Promotion -- Sawubona Healing Circles⁷⁹

The Association of Black Psychologists created Sawubona Healing Circles in response to the significant stress and psychological toll experienced by Black communities due to recent and ongoing events of the COVID-19 pandemic, police brutality, 2020 presidential election, and the January 6, 2021 insurrection at the Capitol. The Sawubona (a KiKonga term for “I/we see you”) Healing Circles are a culturally grounded practice to connect and affirm values and healing strategies that have long-term protective benefits. Sawubona Healing Circles are a rapid response program designed to interrupt stress and trauma, while offering a supportive healing opportunity to learn culturally affirming wellness strategies. The program aims to strengthen self-care and activate self-healing and empowerment in participants. By training mental health professionals and community leaders to become Sawubona Healing Circle leaders, the program also expands the capacity of the mental wellness workforce and grassroots efforts to meet the unique needs of the Black/African American community. It accomplished such by promoting cultural awareness and optimal ethnic identity formation and increasing functioning and cultural resilience to address in countering the exposure to complex cultural

Intersectional Approaches to Understanding Mental Health Inequities

Intersectionality can lead to different and compounded experiences of discrimination and disadvantage. The experiences of a Black woman, for example, are not the same as a Black man; the experiences of a straight Black man are not the same as a gay Black man. A concerted effort is needed to examine how disparities and inequities further expand when intersectionality is considered, as people of color who represent other marginalized and minoritized groups are even more at risk for poor economic and behavioral health outcomes. It is therefore recommended that intersectionality be considered alongside the unique strengths and needs of patients. Specifically, we highlight policy recommendations that can reduce

disparities for patients who are geriatric, veterans, LGBTQIA+, individuals with disability, or family caregivers.

Maternal Mental Health

Factors that contribute to racial and ethnic-based disparities in maternal mental health include poverty, employment issues, interpersonal relationships, lack of transportation and childcare options, marital problems, racism, and gender discrimination.⁸⁰⁻⁸³ Women of color disproportionately lack the time and flexibility required to regularly attend doctor’s appointments, which can be critical for addressing mood disorders. Women in this situation have to choose between neglecting their health because they lack access to these supports—potentially exacerbating health concerns—or losing pay or their jobs as a result of taking time off.⁸⁴

Maternal depression is associated with child maltreatment and foster care placement.⁸⁵⁻⁸⁷ Children with mothers who have had a depression diagnosis are more likely to report feelings of loneliness, guilt, sadness, and being nervous, along with acting out behaviors such as aggression.^{85,88} High levels of parenting stress are linked to compromised parent-child interactions and child development. Parents who report high levels of parenting stress are more likely to exhibit harsh discipline and less parental responsiveness and warmth. Children whose parents report high levels of parenting stress display more internalizing and externalizing behaviors, insecure attachment, and decreased social competence.^{85,89} These realities are even more dire for mothers of color.

Investments in community-based programs for maternal behavioral health are needed to address the stigma associated with these conditions and raise awareness about warning signs for maternal behavioral health conditions. Community-based and culturally centered programs can address the expected widening of maternal health disparities.

— DEFINITION —

Intersectionality: the complex and cumulative way in which the effects of multiple forms of discrimination—including racism, sexism, and classism—combine, overlap, or intersect to produce and sustain complex inequities



Model Adolescent Suicide Prevention Program (MASPP)⁷⁰

The MASPP is a suicidal behavior prevention program conducted through an extensive community planning process which began with solicitation of active involvement from tribal leadership, healthcare providers, parents, elders, youth, and clients in a total of more than 50 community workgroup sessions. As a result of these planning sessions, the community ultimately concluded that suicide cannot be addressed in isolation and is often compounded by substance use or domestic violence concerns. The MASPP integrated multiple program components across the 15-year timespan, including constant surveillance, screening, and outreach.

The MASPP utilized programs such as social services, school-based prevention programs, and community education for adults to widen the scope of the intervention. The MASPP benefitted from neighborhood volunteers, known as natural helpers, who worked alongside mental health professionals throughout the study. During the timespan the tribe also benefited from capacity building as a result of involvement with the Bureau for Indian Affairs and the Indian Health Service. Results of the MASPP indicated a substantial decrease in suicidal gestures, characterized by self-destructive behavior warranting intervention and a decrease in suicide attempts. However, the intervention did not yield either a significant increase or decrease in suicidal deaths. The MASPP demonstrates efficacy in reducing suicidal behaviors.

opportunities for social participation and community leadership, and accessible health and wellness services. The projected growth of the older population over 65 by 2030 is much lower for the White (non-Hispanic/Latin(o)(a)(x)) population, projected to increase by 39% compared to 89% for older indigenous, racial and ethnic minoritized population groups.⁹³ The growth rate exceeds the number of behavioral health providers that are trained in geriatric care, and the workforce is not routinely trained in how to recognize or effectively treat the mental health needs of this population.⁹³

For families, parents and caregivers, funding and support is needed for community and family health navigators to support the entire family with connecting to support services related to racism, minority stress, caregiver isolation/burden, and behavioral health needs. The emotional burden of caregiving is significant across racial/ethnic groups. While White and Hispanic/Latin(o)(a)(x) caregivers report higher rates of distress, nearly 40% of caregivers identify as Black, Indigenous, or People of Color (BIPOC). Within each BIPOC racial/ethnic group, the rates of caregiving are higher than in White demographics.⁹⁴

- 2.11 Invest in community-based programs for maternal behavioral health and initiatives to raise awareness of maternal behavioral health conditions.
- 2.12 Expand funding sources to support family-based intervention programs including parenting programs.

disparities in financial capacity exist among patients with memory loss concerns.⁹²

- 2.13 Implement initiatives aimed at educating police departments on responding effectively to crises and to people with serious mental illnesses (SMI) and intellectual/developmental disabilities (I/DD).

People Living with Disability

A study by Triebel and colleagues⁹² explored the impact of “mild cognitive impairments” on financial capacity and observed different outcomes based on race between the patients interviewed. They found that Black/African American patients with mild cognitive impairments performed below White patients with the same impairments. They also found that significant racial

Geriatric and Elder Populations

Specific to geriatric and elder populations, funding is needed to incentivize providers to seek specialization or re-specialization in geriatric mental health with a focus on social determinants of health through the lifespan, including affordable housing, safe outdoor spaces, convenient transportation options,

- 2.14 Conduct a comprehensive, systematic effort to identify and disseminate information about family caregiver strategies tested by states.
- 2.15 Measure the number, demographics, contributions, and needs of the family caregivers who assist Medicaid enrollees.



— FACTS —

- Black/African American and Hispanic/Latin(o)(a)(x) women who experience maternal depression have higher rates of adversities compared with their White counterparts.^{80, 81}
- Sixty-four percent of Black/African American children, 52% of American Indian, Alaskan Native and Native Hawaiian children, and 40% of Hispanic/Latin(o)(a)(x) American children live in single-parent households;⁹⁰
- The added stress of running a household increases the likelihood that single women of color will experience postpartum mood disorders.⁹¹
- Black/African American women are half as likely to receive mental health treatment and counseling as White women.⁹¹

- 2.16 Provide assistance for both caregivers and patients in navigating the mental health system, with active outreach to caregivers to offer information and care coordination.
- 2.17 Appropriate funds to incentivize new providers to seek specialization in geriatric mental health and improve training for health care workers, including registered nurses (RNs).

- 2.18 Establish a national hub in partnership with a coordinating organization to support communities with the planning and implementation of Aging Friendly Communities with culturally distinctive programming.

LGBTQIA+ Population

For LGBTQIA+ populations, effective policy measures include opposing any legislation that criminalizes or discourages gender-affirming care. Black/African American and Hispanic/Latin(o)(a)(x) American sexual and gender minorities experience significant disparities in economic status and behavioral health status, and also face many challenges regarding exposure, susceptibility, and access to providers and treatment. A study by Crossman, Stroumsa, Kobernik and Berger⁹⁵ highlighted deficiency observed in access to affirming spaces for care for LGBTQIA+ communities of color. The authors described severe challenges that trans and non-binary people have with acquiring insurance and being able to afford the expensive costs attached to gender-affirming care. They also noted that one must be designated as “mentally ill” (gender dysphoria) in order to be approved for gender-confirmation treatment, which can influence negative mental health outcomes in this population. Gender-affirming care is considered suicide prevention.⁹⁶

- 2.19 Protect the rights to, and/or oppose or veto any legislation that criminalizes, gender-affirming care.

- 2.20 Enact laws and organizational policies to include gender identity and expression as protected classes under non-discrimination clauses.
- 2.21 Allow changing pronouns and legal names on government-issued documents consistent with an individual’s gender identity.

Veterans

Specific to veterans, effective policy measures include reducing barriers to care by expanding allowable benefits outside of the VA and increasing training, recruitment, and funding for providers within the Veterans Choice program. Veterans experience higher rates of mental illness and earlier mortality rates as compared to civilians without mental illness.⁹⁷

- 2.22 Expand access to mental health services outside of the Veterans Administration through the Veterans Choice program and increase recruitment for mental health providers in this program.
- 2.23 Examine weaponization of military discharges that prevent veterans from accessing vital behavioral health services.
- 2.24 Increase resources to help with homelessness, trauma, and behavioral health concerns.

For additional detailed recommendations and seminal reports on culturally and linguistically appropriate services, youth suicide prevention, primary care integration, school-based mental health, and crisis response services, see Appendix E.



Political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities.⁴

Political and Social Determinants of Behavioral Health

Today, it is commonly understood in the field of public health that health outcomes hinge on more than our genetics and behavioral choices. Environmental conditions including the places where people live, learn, work, and play have wide-ranging effects of health risks and outcomes.⁹⁸ Compounding this impact is the political system of the United States which historically has not valued all ethnicities and sub-populations equally, much less addressed the long-term implications of policies on different groups of people. Direct correlations exist between political decisions, government action or inaction, and health outcomes.⁴ While the social determinants of health drive towards the root cause of variable outcomes, the real instigators lie even further upstream, and are called the Political Determinants of Health (PDOH). Political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either

advance health equity or exacerbate health inequities.⁴ Due to these existing structures, it is impossible to entirely capture the true burden of distress experienced by communities that have been historically neglected in our system.

Equity Recommendation 1.

Race and racism are social constructs and markers for racism. Structural racism is embedded in policy and impedes accurate data collection, data standardization and data reporting. Policies must rebuild data collection systems to dismantle biased reporting structures, improve disaggregation, and examine the impact of racism to more clearly understand mental and behavioral health inequities.

Equity Recommendation 2.

Stigmatizing language entrenched in laws, policies, and systems perpetuates and codifies inequitable treatment. Federal, state, and local policymakers must systematically examine existing policies and laws for removal of stigmatizing language and ensure that new legislation excludes further stigmatization.

Equity Recommendation 3.

Policies focusing on social determinants of mental and behavioral health offer upstream solutions and wrap around support. Recognizing the impact of political and systemic power differentials on historically marginalized communities will facilitate policy actions toward equitable culture shifts.

— TAKE AWAY —

Input from the National Advisory Panel

The NAP called for applying a social and political determinants of health approach to improve critical equity concerns related to basic education in health literacy, fear- and stigma-based barriers to help-seeking, considerations for mental health therapy and wraparound services, and insurance and telehealth policies.



Embedding Behavioral Health Equity in Data and Policy

It bears repeating that current data collection mechanisms aggregate data across and among ethnicities that result in over generalization and a loss of accuracy connecting mental and behavioral health conditions to specific populations. Thus, inequities are systematized as well as stigmatized. To improve our understanding of behavioral health equity, we must rebuild data collection systems to dismantle biased reporting structures and identify inclusive and disaggregated categories that will inform targeted and tailored interventions and policies. Accuracy of indigenous, racial, ethnic and gender-related data is essential to fully understand social and political influences on mental and behavioral health.

— DEFINITIONS —

Racism: the relegation of people of color to inferior status and treatment based on unfounded beliefs about innate inferiority, as well as unjust treatment and oppression of people of color, whether intended or not⁹⁹

Systemic racism: the involvement of whole systems, and often all systems—for example, political, legal, economic, health care, school, and criminal justice systems—including the structures that uphold the systems¹⁰⁰

Structural racism: the role of the structures —laws, policies, institutional practices, and entrenched norms that are the systems’ scaffolding¹⁰¹

Stigma and policy intersect when policy is used as an expressive function of the bias held by the authors of those policies. Language used in policy can advance stigma through socially acceptable means of reinforcing human distinction, applying labels, and creating cultural “norms” with respect to “in” and “out” groups. There is abundant documentation of stigma-advancing language in laws and policies that relate to substance use. Knowing that the law can be a vehicle which creates and exploits power differentials, laws that inhibit stigma (i.e., antidiscrimination laws) have been implemented to correct this offense. Unfortunately, many of these laws and policies are not tailored to the specific group being stigmatized and are therefore rendered ineffective.¹⁰³

Addressing societal inequities that contribute to mental and behavioral health concerns

Political and social determinants of health are the main drivers of inequity in our society, directly affecting one’s behavioral health, and are often the reason that those who need mental and behavioral health treatment are unable to receive needed treatment without additional support and coordination from the health care system. Improving behavioral health equity requires universal screening for political and social determinants of health; the integration and funding for coordination of care with services such as community health navigators and medical-legal partnerships to offer support in the community; funding permanent supportive housing; desegregating housing; expansion of anti-poverty programs such as the Earned Income Tax Credit (EITC); and mandated family and sick leave.

— SPOTLIGHT —

Developing Behavioral Health Advocates for Social and Community Policy¹⁰²

To address the structural mental health inequities that plague the United States, we need leaders who understand the social and political determinants of health and mental health. To that end, the Hogg Foundation for Mental Health created and launched the Hogg Foundation Mental Health Policy Academy & Policy Fellow Initiative in 2010, with the aims of 1) increasing the number of knowledgeable and skilled mental health or substance use policy advocates; 2) building a workforce capacity capable of engaging in mental health and substance use policy development and advocacy; and 3) strengthening collaboration and effectiveness of the mental health and substance use policy advocacy community. Evaluation of the program found:

- 90% of policy fellows agreed that they now can effectively engage in the policy process and advocate for change.
- 89% percent of alumni are still involved in mental health or substance use policy engagement.
- 100% percent of host organizations agreed that the program increased collaboration and strengthened the network of mental health advocates.





Clinical care and screening

- 3.1 Incentivize universal screening for social determinants of health, including experiences of perceived and experienced racism.
- 3.2 Provide funding for community health navigators across settings of care to coordinate connections to social services.
- 3.3 Expand alternative payment models to include social services including transportation, connection to public benefits.

Addressing legal needs: Medical-Legal Partnerships (MLP)

- 3.4 Add new Medicare quality metrics in medical homes, Accountable Care Organizations (ACO) and Automatic Clearing House (ACH) payment models to incentivize providers to incorporate MLP services in privately managed care contracts.
- 3.5 Finance MLPs as an “enabling” or “wrap-around” service under section 330 of the Public Health Services Act.

- 3.6 Review Department of Housing and Urban Development and Department of Health & Human Services’ programs and policies for funding permanent supportive housing to maximize flexibility and coordinate use of funding streams for supportive services, health-related care, housing-related services, the capital costs of housing, and operating funds such as Housing Choice Vouchers.

- 3.7 Clarify Centers for Medicare & Medicaid Services (CMS) policies and procedures for states to request reimbursement for allowable housing-related services; states should pursue opportunities to expand the use of Medicaid reimbursement for housing-related services to beneficiaries whose medical care cannot be well provided without safe, secure, and stable housing.

- 3.8 Develop multi-sector partnerships to increase the supply of permanent supportive housing utilizing a Housing First approach.

- 3.9 Expand tax incentives that encourage low-income housing in affluent areas and enact low-income community revitalization policies that encourage residential and commercial development in low income and primarily communities of color.

Immigration

The literature indicates that immigrants, refugees and asylum seekers are more likely to develop post-traumatic stress disorder (PTSD) and other mental disorders as a result of the trauma experienced pre- and post-migration. Hynie’s¹⁰⁴ systematic review demonstrated a critical relationship between low socioeconomic status, PTSD, distress, and/or depression in these populations. The author also highlighted frequent challenges this population has securing insurance, education, and gainful employment. These income and employment-related experiences are reflective of social and political determinants of mental health in immigrant, refugee, and asylum-seeking populations.¹⁰⁴

Housing



- 3.10 Expand access to health insurance coverage to undocumented persons through expansion of Medicaid and ability to purchase insurance on the marketplace.
- 3.11 Make marketplace subsidies available to people with incomes under 100 percent of the poverty level or otherwise fill the Medicaid coverage gap.

Employment

Supported employment (SE) presents opportunities for individuals with serious mental illness to obtain and sustain competitive employment through supportive services such as identifying employment opportunities, integration of vocational and clinical services, and on the job development post-attainment of employment.¹⁰⁵ International Placement and Support (IPS) is an evidence-based approach to SE that has been noted to lead to significant improvements in vocational outcomes and non-vocational outcomes such as quality of life and psychiatric hospitalization.¹⁰⁵ Randomized clinical trials and routine implementation programs of SE services have led to significant improvements in gaining employment¹⁰⁶ resulting in improvements that may persist for years.¹⁰⁷ Studies demonstrate SE programs are effective within Black/African American and Latin(o)(a)(x) populations.¹⁰⁸ In addition, a study comparing SE programs for Hispanic/Latin(o)(a)(x) populations with non-Hispanic/Latin(o)(a)(x) populations showed that despite higher baseline levels of symptom severity, these participants achieved comparable levels of vocational outcomes as the non-Hispanic/Latin(o)(a)(x) Black/African American and White participants of the SE program.¹⁰⁹

— SPOTLIGHT —

Case Study: The Mental Health Treatment Study (MHTS)¹¹¹

The Mental Health Treatment Study (MHTS) was an SSA demonstration that provided intervention services for a 2-year period to Social Security beneficiaries with psychiatric conditions. A total of 2,238 beneficiaries who were between the ages of 18 and 55, had a primary impairment of schizophrenia or affective disorder, expressed interest in working, and were randomly assigned to a treatment or control group. The treatment group received IPS and behavioral health services.

The control group did not receive any study-provided services or benefits. During the study period, beneficiaries in the MHTS treatment group were significantly more likely to be employed at any point (60.5% vs. 40.2% in the control), were employed more total months (6.23 vs. 3.65 in the control) and had higher average past month's earnings (\$148.16 vs. \$97.41 in the control).

Although IPS has demonstrated benefits in improvements in vocational and clinical outcomes and many states implement IPS programs, there continues to be a lack of availability of IPS programs for individuals with mental health concerns who want to work.¹¹⁰ The Social Security Administration's SE program, part of The Mental Health Treatment Study (MHTS), showed that these individuals were able to attain employment and continue to benefit from these positive outcomes.¹¹¹ There is another promising SAMHSA SE demonstration program funded by the Social Security Administration (SSA) underway with almost 3000 participants enrolled.¹¹²

Supported Employment

- 3.12 Expand funding, interagency collaboration, and early intervention efforts to increase access to supported employment programs and the use of International Placement and Support (IPS) model.

- 3.13 Streamline Medicaid funding of SE programs in order allow states to fund SE more conveniently.
- 3.14 Expand Medicaid income eligibility criteria to ensure that individuals with SE and mental health concerns will continue to have access to care.
- 3.15 Train diverse SE program personnel able to implement SE initiatives in linguistically and culturally centered ways to ensure various communities can utilize and benefit from SE programs.

Workers who lack access to sick leave report higher levels of distress and are 1.45 times more likely to report that their distress interfered with their work.¹¹³ It has also been reported that a disproportionate number of workers who lack access to sick leave are Hispanic/Latin(o)(a)(x) American or Black/African American.¹¹⁴ As many as 7 out of 10 low-income workers do not have a single day of sick



leave.¹¹⁵ State-funded EITC programs are associated with significant reductions in mental distress, poor physical health, and unhealthy levels of alcohol use. In addition, EITC programs are also associated with improvements in birth outcomes and a reduction in the probability of low birth weight and preterm birth in Black/African American mothers. EITC programs benefit a higher proportion of households of color.¹¹⁶ Mandated family leave is likely to reduce the symptoms of fatigue, anxiety, and depression in new mothers.¹¹⁷ Ensuring that workers have sick leave could reduce levels of psychological distress and absenteeism.

3.16 Expand EITC programs to adults without children and people who are undocumented.

3.17 Enact paid family and medical leave.

3.18 Mandate paid sick leave.

3.19 Extend Supplemental Security Income (SSI) to American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands.

The Forensic-Involved

The carceral health system has arguably become one of the largest mental health systems in the country. The literature indicates that involvement with the criminal justice system results in long-term negative effects on an individual's social, health, and economic well-being. There is also a disproportionate number of people who are living with mental health conditions behind bars, as the U.S. Department of Justice reports that over 50% of men and women who are incarcerated report a history of mental distress or a serious mental health condition.¹¹⁸ When

someone is released from prison, the inequities become even more disparate. Formerly incarcerated people (particularly women and people of color) are almost 10 times more likely to experience homelessness and unemployment.^{119,120} Drug-related convictions can also limit access to jobs, housing, health benefits, and financial assistance for higher education.^{25,121} Further, adults on probation experience "limited economic potential" with fewer support systems that consistently place them in high-risk environments with increased risk for recidivism.¹²¹ All of these realities present social and political risk factors for mental distress and poor socioeconomic outcomes in this population.

Reentry Services and Supports

3.20 Fund programs to provide reentry services and support for persons scheduled for release from county jail.

3.21 Expand inclusion criteria for diversion programs to include individuals with felony charges, as this excludes many individuals with serious mental illness (SMI) from diversion programs.

3.22 Enroll individuals in prison with behavioral health conditions into SSI or Medicaid benefits pre-release so they have access to the medical and behavioral benefits they need to remain stabilized as well as supports and connections to housing, food, and other essentials.

For additional detailed recommendations for community-based solutions, caregivers, military and veterans, and geriatric populations, see Appendix E.

— FACT —

- Black/African American, Hispanic/Latin(o)(a)(x), and Indigenous people are five times more likely to be incarcerated than their White counterparts.
- Indigenous and racial and ethnic minoritized youth with behavioral health issues are more readily referred to the juvenile justice system than to specialty primary care, compared with White youth.^{42, 122}
- Approximately 50% to 75% of youth in the juvenile justice system meet criteria for a mental health disorder.^{42, 123}

A Special Note on 2022 Policy Updates

Recent political and societal influences on policy change will have a dramatic impact on behavioral health and the potential for historically marginalized populations to achieve advances in health equity. In addition to the COVID-19 pandemic's continued amplification of health and structural inequities, in June 2022, both the Supreme Court's decision to overturn *Roe v. Wade* and the passage of the Bipartisan Safer Communities Act shifted the course of behavioral health. Resources to be allocated through the Bipartisan Safer Communities Act, as well as local and state policies and programs developed to buffer the adverse impact of policies must be guided by the equity recommendations/policy principles to ensure resources are optimized to advance behavioral health equity.



Bipartisan Safer Communities Act of 2022

Passage of the Bipartisan Safer Communities Act of 2022 is intended to address gun violence and provide communities that are impacted by these shootings with the resources to recover from grief and trauma. The bill takes significant steps in improving community mental healthcare by expanding the community mental health services demonstration program so that additional states and sites can take part in the program with the aim of ensuring these sites deliver high quality care. The bill also expands behavioral health services within schools to expand access to services and encourages the expansion of and delivery of culturally competent care via telehealth services. Towards that aim, it establishes technical assistance centers and instructs the appropriate agencies in distribution of guidance and best practices for providing services at schools, streamlining of payments to these school-based services under Medicaid or Children's Health Insurance Program (CHIP), and to ensure that the appropriate federal departments are coordinating with one another in assessing ongoing needs.

While the initiatives in the Bipartisan Safer Communities Act address gun violence and behavioral healthcare, it is worth noting that mental illness should not be attributed as the cause of mass shootings. Ninety-three percent of violent crimes are committed by individuals without a history of psychiatric disorders and only 3% of crimes committed by individuals with a psychiatric diagnosis involve the use of a gun.^{124,125} Organizations such as the American Psychological Association (APA) and National Alliance on Mental Illness (NAMI) emphasize the need for

focusing on overall risk and not just mental illness.¹²⁶ Therefore, the bill's initiatives to address the expansion of criminal background checks, especially for those under the age of 21, and curbing illegal trafficking of firearms are positive steps toward addressing gun violence risk rather than purely mental illness. Children are particularly at risk of being victims of gun violence as gun violence has become the leading cause of mortality for children in the United States.^{127,128} In addition, there are racial disparities in firearms homicide rates that place young Black/African American males at much higher risk, nearly 21 times higher than their White male counterparts.¹²⁹ This law takes other positive steps such as establishing a clearinghouse for the investigation, dissemination, and implementation of evidence-based measures for improving school safety. These are all positive steps towards the prevention of gun violence and improving school safety, but additional measures could be taken to improve firearm safety.

- 3.23 Increase and expand firearms suicide prevention research.
- 3.24 Amplify education on lethal means and suicide prevention.
- 3.25 Authorize Extreme Risk Protection Orders (ERPOs), also referred to as "Red Flag" laws.
- 3.26 Pass legislation enabling persons to voluntarily place themselves on "do not sell" lists for firearms.
- 3.27 Clarify and refine existing mental health firearm disqualification criteria relating to involuntary hospitalization.

U.S. Supreme Court Decision to Overturn Roe v. Wade

The recent U.S. Supreme Court decision to overturn Roe v. Wade makes access to abortion dependent on state legislation. In effect, abortion has and may continue to become illegal or highly restricted in many states. Even prior to the recent verdict by the Supreme Court, some states had placed restrictions on abortion. Studies suggest that these provider restrictions led to delayed access and by extension increased the risk of maternal mortality. Other consequences are continuation of unwanted pregnancy, pregnancy complications, reliance on self-managed or illegal abortion, or added costs related to traveling to a less-restricted state.^{130,131} Many of these difficulties lead to significant emotional distress. In addition, women from rural areas or of marginalized communities are impacted to a greater degree and find access to abortion to be even more inaccessible.^{130,132,133} A 5-year longitudinal study indicated that women who were denied abortions experienced significant levels of anxiety and reduced levels of life satisfaction in the week following denial.¹³⁴ In addition, women with unwanted pregnancy experience higher levels of mood disorders.¹³⁵ There is also no reliable evidence that abortion can be attributed as the cause of mental health issues after considering pre-existing risk factors.¹³⁶ State laws restricting abortion place undue burden on a

— DEFINITION —

carceral health system: the medical specialty in which healthcare providers care for people in prisons and jails





few especially vulnerable populations that include pregnant minors, women with significant mental or cognitive disorders, and women with limited freedom of movement (e.g. women in volunteer armed services, medically dependent women, women with limited or low resources).¹³³

Intentional investments in community-based programs for maternal behavioral health including group prenatal and postpartum models, collaborative maternity care models, initiatives to address stigma and raise awareness about warning signs for maternal behavioral health conditions may address the expected widening of maternal health disparities resulting from anti-choice policies. Additionally, regulatory approaches that may reduce the number of willing providers to provide reproductive health services will limit access to health care and may impact efforts to increase diversity and representation among health care providers.

3.28 Regulations that may reduce the number of willing abortion providers or that pose implications for the availability and accessibility of abortion require significant justification on the part of the state.

3.29 As in the Supreme Court case *Hellerstedt v. Whole Woman's Health*, the health benefits of abortion restrictions must conclusively outweigh the burdens they impose on women and should be considered in the context of all available scientific evidence and other existing restrictions.

Conclusion

Access to mental and behavioral health services in the right place at the right time is insufficient across the U.S., and indigenous populations and racial and ethnic minoritized groups experience additional barriers to obtaining access to and receipt

of the care they need. Policy action in three interrelated domains is needed to ensure more equitable access to care and improve health and economic outcomes: investment in mental and behavioral health infrastructure, culturally centered mental and behavioral health care and addressing the political and social determinants of mental and behavioral health. Examples of specific policy levers include those focused on the behavioral health workforce, insurance and parity, funding and payment reform, intersectional and whole-person approaches, community-led solutions, uplifting intersectional populations, embedding equity in behavioral health data collection, and addressing social/political determinants of health. Cumulatively, this report provides policy opportunities and recommendations to help the United States advance equity within mental and behavioral health for all populations.



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Appendix

Appendix A. Quantitative Methodology

Data Sources

To evaluate the state of mental health inequities in the U.S., data were extracted from the following publicly available data sets:

1. National Survey of Drug Use and Health (NSDUH) restricted data
2. National Survey of Children's Health
3. Medical Expenditure Panel Survey
4. National Vital Statistics Systems Mortality data

Description of Data Sources

1. [The National Survey of Drug Use and Health](#) (2015-2018) restricted data through the Restricted Data Analysis System (RDAS). The NSDUH provides national estimates on mental health, tobacco, alcohol, and drug use of the civilian and non-institutionalized populations. The data are self-reported, or model-based. The model-based estimates were derived using clinical interview data from a subset of the NSDUH adult respondents from 2008 to 2012.
2. [The National Survey of Children's Health](#) (2016-2019) and the [Children's Data Resource Center](#) provide national estimates of the physical and mental health of children (0-17 years) and factors that influence their health and well-being. Data are based on parents or guardians reporting about their child's health.
3. [The Medical Expenditure Survey \(MEPS\)](#) (2016-2019). The MEPS is a survey of U.S. civilian non-institutionalized populations. The survey provides national estimates of health care use in the U.S. The data were derived from the "consolidated, office-based, and medical conditions" file. The data are self-reported.

4. [The Centers for Disease Control and Prevention, National Center for Health Statistics Mortality Multiple Cause Files](#) (2016-2020) identifies the underlying cause of death using ICD-codes for any mental illness. It includes a national registry containing data on vital events (births, deaths, marriages, divorces, and fetal deaths).

Constructs

Analysis focused on mental health, mortality, and economic outcomes, specifically the following codes and terms derived from the data sources:

1. Diagnosis based on ICD-10 codes for:
 - any mental illness (F10-69, F60-69, F90-99)
 - for suicide (X60-X64, X65-X66, X68-X69, X70, X72-X74, U03, X71, X75-X79, X80, X81-X84, X87.0)
 - for substance overdose category (F10, F11-19, X40-X44, Y10-Y14, G31.2, G62.1 I42.6 K29.2, K70, R78.0, X45, and Y15)
 - for chronic conditions, such as, asthma (J45), kidney disease (N18), cancer (C18 C34 C44 C50 C53C54 C55 C61 C64 C76 C80 C85 C95), hypertension (I10), congestive heart failure (I50), hyperlipidemia (E78), arthritis (M19), COPD (J44) diabetes (E11), coronary artery disease (I25), stroke (I63), hepatitis (K75), HIV (B20), and osteoporosis (M81)
2. Serious psychological distress
3. Access to health services
4. Costs of health services
5. Deaths attributable to mental illness

The mental illness measures included:

1. Any mental illness - defined as any mental, behavioral, or emotional disorder in the past year of sufficient duration meeting DSM-V criteria (excluding developmental disorders and SUDs).¹³⁷

2. Depression - defined as having five out of the nine symptoms on the PHQ-9 questionnaire with at least one of them being depression or loss of interest in daily activities.¹³⁸
3. Severe psychological distress - defined based on adults scoring 13 or greater on the Kesslers-6 index.¹³⁹
4. Behavior/conduct problems - behavior or conduct problems, depression, or anxiety in children was based on parents' report of being told by the health professional, an educator, or a physician that the child has given problem.^{140,141}

Four causes of premature deaths from mental illness were identified:

1. Suicide - Individuals with serious thoughts or attempts to self-harm with the intent to die anytime in the past 12 months.¹³⁷
2. Substance use disorders - defined as recurrent use of alcohol or other drugs affecting health, functioning, and daily activities.¹³⁷
3. Inadequate treatment for mental illness - receipt of mental health treatment or counseling was based on the response to the survey question whether respondents received treatment for any problem with emotions, nerves, or mental health in the past year.¹⁴²
4. Chronic disease management (mental illness and comorbidities) - Chronic comorbidity included the chronic conditions concomitant with mental illness diagnosis.¹⁴³

To identify measures related to access and expenditures contributing to an estimate of the economic burden of mental illness, the following variables were also assessed:

1. Healthcare service utilization - inclusive of the number of office-based visits, emergency department visits, and hospitalizations were examined.



- Healthcare service expenditures - inclusive of office-based care, emergency room/department (ED) visits, hospitalizations, prescription medications, and costs associated with loss of life.

Stratifying Variables

The data was stratified primarily in three ways across mental/behavioral health and identifying demographics, inclusive of:

- Age - the prevalence of mental illness was examined across the lifespan among children 3-5 years (preschool) and 6-11 years (school-aged); youth (12-17 years); and adults (18-100 years).
- Race-ethnicity - seven race categories were used: (1) Non-Hispanic/Latin(o)(a)(x) White, (2) Non-Hispanic/Latin(o)(a)(x) Black/African American, (3) Non-Hispanic/Latin(o)(a)(x) American Indian/Alaska Native, (4) Non-Hispanic/Latin(o)(a)(x) Other Pacific Islander (5) Non-Hispanic/Latin(o)(a)(x) Asian, (6) Non-Hispanic/Latin(o)(a)(x) Multi-race, and (7) Hispanic/Latin(o)(a)(x). However, wherever the data was inadequate or unavailable, fewer than seven groups were used
- Self-reported mental health status, psychological distress, and mental illness - Kessler's Psychological Distress index was used to identify individuals reporting severe psychological distress. Severe Psychological Distress is defined as a score of 13 or greater. Mental illness diagnosis was based on ICD-10 codes (F10-69, F60-69, F90-99). Depending on the presence or absence of severe psychological distress and mental illness, the MEPS respondents were categorized into four groups:
 - no severe psychological distress and no mental illness (NDNMID) diagnosis
 - severe psychological distress and no mental illness diagnosis (DNMID)
 - no severe psychological distress and mental illness diagnosis (NDMID)
 - both severe psychological distress and mental illness diagnosis (DMID)

Analyses

Four methodologies were applied to estimate:

- national prevalence of mental illness using survey weights
- service use and healthcare costs
- additional medical costs attributable to mental health inequities
- premature deaths with a focus on the most vulnerable (three race categories).

Calculating the Estimate of Mental and Behavioral Health National Prevalence

Data was extracted from the National Survey of Drug Use and Health (2015-2018) Online Restricted Data Analysis System (RDAS) to assess the prevalence of mental illness among adults and youth. Estimates were derived from the prevalence of any mental illness, depression, and severe psychological distress (non-specific symptoms of stress, depression, and anxiety) among both a sampling of all adults and a sampling of adults in each of the racial groups separately. For youth, data assessed the prevalence of any mental illness, depression, and feelings of sadness in the total sample and again, separately for each of the racial groups. The National Survey of Children's Health (2016-2019) was used to calculate the prevalence of depression or anxiety, behavior, or conduct problems among children comparing the total sample and with each of the racial groups separately. The proportion of the adult population that did not receive mental health treatment or counseling was included. The data on the proportion of adolescents who received treatment or counseling was included. The proportion of children with mental illness that reported difficulty in obtaining mental health treatment was included.

Analyzing and incorporating ICD-10 codes, chronic conditions relevant to the data sampling were identified (recommended by the Office of Assistant Secretary of Health, Health & Human Services, Multiple Chronic Conditions Work Group).¹⁴⁴ A measure of comorbidities (defined as 1, 2, 3 or more co-occurring chronic conditions) was created using ICD-10 codes for hypertension, diabetes, asthma, hyperlipidemia, arthritis,

stroke, coronary artery disease, congestive heart failure, cancer (breast, lung, colon, and prostate), chronic kidney disease, chronic obstructive pulmonary disease, HIV-AIDS, hepatitis, osteoporosis.

Based on the number of chronic conditions associated with mental illness diagnosis, the MEPS respondents were grouped into:

- mental illness diagnosis alone
- mental illness diagnosis and one chronic condition
- mental illness diagnosis and two or more chronic conditions

Estimating Healthcare Service Utilization and Costs

The Medical Expenditure Panel Survey (MEPS 2016-2019)¹⁴⁵ data were used to estimate the healthcare services use and expenditures. Based on the self-reported race-ethnicity of the respondent, a five-category race/ethnicity measure was established:

- Non-Hispanic/Latin(o)(a)(x) White
- Non-Hispanic/Latin(o)(a)(x) Black/African American
- Non-Hispanic/Latin(o)(a)(x) Asian American
- Non-Hispanic/Latin(o)(a)(x) Other (American Indian or Alaskan Native, and Non-Hawaiian or Other Pacific Islander, multiracial)
- Hispanic/Latin(o)(a)(x)

First, the number and percentage of adults in each of the four severe psychological distress groups for the total and each of the separate racial groups were calculated. Second, calculations were done to establish the mean number of office-based visits, ED visits, and hospitalizations among adults for the total and each of the racial groups across the four severe psychological distress categories. Third, expenditures were combined for office-based care, prescription medications, ED use, and hospitalizations separately for the total and each of the racial categories to obtain total expenditures across the four severe psychological distress categories.



Estimating the Additional Costs Attributable to Mental Health Inequities

Using MEPS data (2016-2019) practice-based estimate was applied for additional costs attributable to mental health inequities, done in a six-step process:

1. Using tabular data structured to the personal level, to obtain actual total expenditures annual expenditures were summed from office-based care, prescription medications, ED use, and hospitalizations for all adults and adults in each of the racial groups across the four severe psychological distress and mental illness categories (NDNMID, DNMMID, NDMID, DMID).
2. The mean total expenditure for all adults and adults in each of the racial/ethnic groups was calculated separately across the four distress/ diagnosis categories.
3. The mean expenditure for all adults in the NDNMID (“no psychological distress and no mental illness”) category was then multiplied by

the number of adults in each of the racial/ethnic groups in the remaining distress/diagnosis categories (DNMID, NDMID, DMID) to obtain expected population-level expenditures.

4. The difference between actual and expected expenditures was calculated to estimate additional expenses that could be attributed to mental health inequities for all adults and adults in each of the separate racial/ethnic groups across the three distress/diagnosis categories (DNMID, NDMID, DMID).
5. The additional costs were then summed across each of the three distress/ diagnosis categories (DNMID, NDMID, DMID) to obtain aggregated excess expenditures for the three distress/ diagnosis categories separately.
6. The additional costs from the three categories that included distress/ diagnosis (DNMID, NDMID, DMID) were aggregated to obtain the total excess burden from healthcare services attributable to mental health inequities.

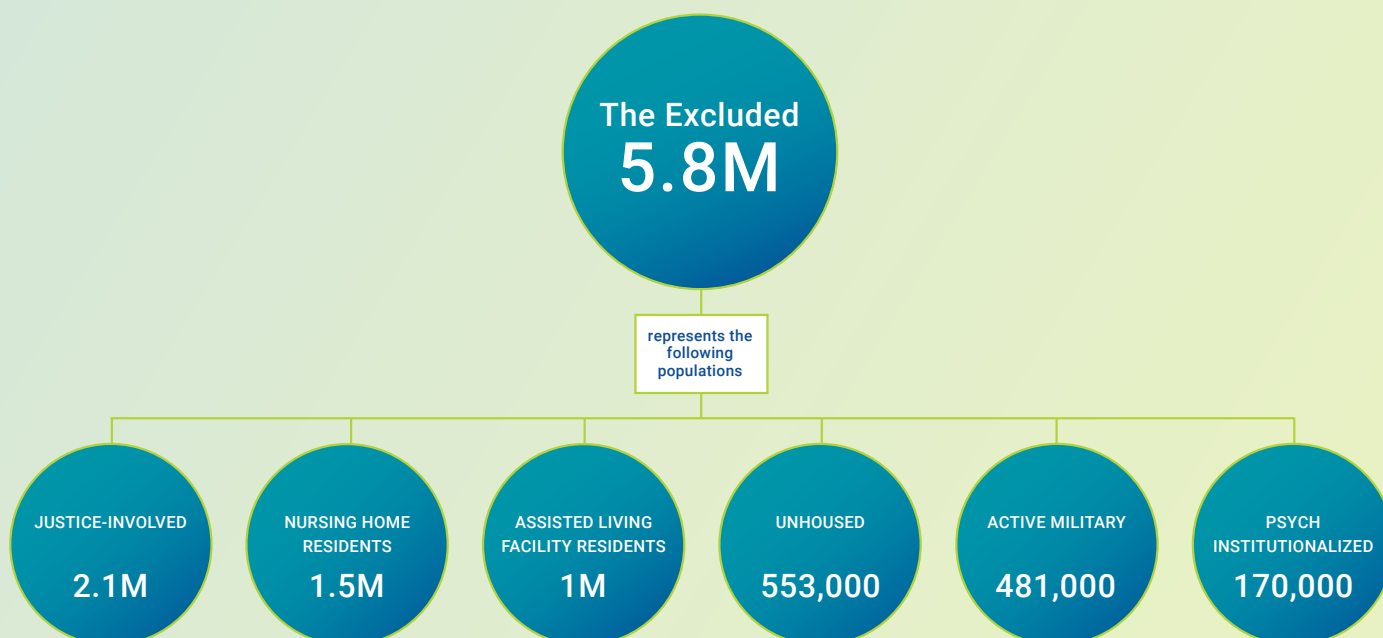
Estimating the Number and Costs of Premature Deaths

The Centers for Disease Control and Prevention, National Center for Health Statistics Mortality Multiple Cause Files¹⁴⁶ were used to identify the underlying cause of death using ICD-codes for any mental illness, suicide, and substance overdose category.

Modeled after the LaVeist et al.³ methodology, the number of premature deaths for each racial/ethnic group was calculated by taking the difference between the actual number of deaths and the “expected” number of deaths based on the lowest death rate across the racial/ethnic group (Non-Hispanic/Latin(o)(a) (x) Asian American or other Pacific Islanders) within the ten-year age group. Then, the number of premature deaths was summed up across age groups. The ten-year age groups were ages 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, and 85 and over. \$64,000 was identified as the annual value of life lost to calculate the excess burden due to premature deaths from the underlying cause of death (mental illness). Costs were adjusted for inflation rates applicable to the year 2020.

Appendix B. The Excluded 5.8 Million

Many historically marginalized and under-resourced populations are excluded from the traditional sampling frame used by the United States Department of Health and Human Services and federal surveys.¹⁴⁷ The sum total of these populations amounted to 5.8 million people and are disaggregated in the following illustration along with their respective estimated population size:



Appendix C.

Grounding Assumptions and Policy Principles

- Mental and behavioral health equity will lead to benefits in economic and health outcomes with impact that have not been fully explored.
 - Policies must invest sufficiently and sustainably in rebuilding and maintaining equitable mental and behavioral health systems creating infrastructure for the long-term, to ensure access to the right care at the right place and the right time.
- Mental and behavioral health equity across the lifespan is influenced by intergenerational and multigenerational experiences of racism and trauma.
 - Policies must begin with prevention and early intervention and identification to offer a continuum of services also inclusive of treatment and crisis needs.
- Understanding equity requires metrics and measures that matter to unique communities.
 - Policies must establish inclusive standards of health equity and quality measures for accessible health systems, and fund research to study mental/behavioral health equity including evaluation of policies and tracking of these measures to identify progress and ongoing needs.
- Communities are strong and resilient; tailored interventions should build on strengths that match solutions to each community, not employ the same solutions for all.
 - Policies and programs must target interventions, building on community strengths and resiliency in addition to meeting unmet needs. Policymaking for inclusive governance should recognize community members' expertise, involving those who will be impacted by the policy to achieve more equitable outcomes.
- Intersectionality compounds inequity when people suffer discrimination based on race/ethnicity and other identities such as gender, sexuality, or legal status.
 - Policies must ensure that services are offered in a person and community-centered, language-concordant, and culturally-centered manner.
- Race is a social construct and a marker for racism. Structural racism is embedded in policy and impedes accurate data collection.
 - Policies must rebuild data collection systems to dismantle biased reporting structures, improve disaggregation, and examine the impact of racism to more clearly understand mental/behavioral health inequities.
- Stigmatizing language entrenched in laws, policies, and systems perpetuates and codifies inequitable treatment.
 - Federal, state, and local policymakers must systematically examine existing policies and laws for removal of stigmatizing language and ensure that new legislation excludes further stigmatization.
- Policies focusing on social determinants of mental/behavioral health offer upstream solutions and wrap around support.
 - Recognizing the impact of political and systemic power differentials on historically marginalized communities will facilitate policy actions toward equitable culture shifts.



Appendix D.

Policy Recommendations to Improve Behavioral Health Equity.

POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
MENTAL/BEHAVIORAL HEALTH WORKFORCE			
1.1. Develop and disseminate health professional educational programs, best practices, or core competencies addressing mental health disparities and culturally responsive care.	●	●	●
1.2. Improve and expand recruitment through pipeline programs, scholarships, loan repayment, and retention incentives for clinicians who are culturally and linguistically concordant with the populations they serve.	●	●	●
1.3. Participate in interstate licensure compacts to increase access to behavioral health services: the Interstate Licensed Professional Counselors Compact; Psychology Interjurisdictional Compact (PSYPACT); and Interstate Medical Licensure Compact (IMLC).		●	
INSURANCE			
1.4. Expand available billing and reimbursement by unlicensed practitioners, including community health, care coordination, and peer support workers as essential team members under Medicaid State Plan Amendments.	●	●	●
1.5. Expand Medicaid in all states to align with provisions of the Affordable Care Act.		●	
1.6. Expand Medicaid coverage for pregnancy to 1 year postpartum.		●	
1.7. Eliminate copayments for prescription drugs and visits for behavioral health conditions.	●	●	
1.8. Eliminate disparities in Medicaid funding for U.S. Territories by permanently increasing federal allotments and matching rates.	●	●	
1.9. Grant the Division of Labor authority to assess civil monetary penalties for parity violations.	●		



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
PARITY			
1.9. Grant the Department of Labor authority to assess civil monetary penalties for parity violations.	●		
1.10. Amend the Employee Retirement Income Security Act of 1974 (ERISA) to provide the Department of Labor authority to directly pursue parity violations by entities that provide administrative services to ERISA group health plans.	●		
1.11. Amend ERISA to provide that beneficiaries may recover amounts lost for claims denied in violation of Mental Health Parity and Addiction Equity Act (MHPAEA).	●		
1.12. Amend MHPAEA to ensure that mental health / substance use disorder benefits are defined uniformly based on nationally recognized standards.	●		
1.13. Require insurance carriers to submit annual reports on compliance with parity legislation and empower regulatory agencies to enforce parity laws.		●	
1.14. Define mental health and substance use disorders broadly in statute to include all disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD).	●	●	
1.15. Require parity in coverage for mental health and substance use disorders with physical conditions across insurance benefit management processes, quantitative and non-quantitative treatment limitations, co-pays, and out-of-pocket costs.	●	●	



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
FINANCE AND PAYMENT REFORM			
1.16. Guarantee adequate and stable federal funding for the Indian Health Services, increasing funding over time and shifting from discretionary to mandatory.	●		
1.17. Base funding practices, oversight of programs, and evaluation of programs on tribal self-determination in order to better fulfill the federal trust responsibility to indigenous populations (AI/AN/NH).	●		
1.18. Develop incentives and accountability mechanisms under available value-based payment mechanisms to support behavioral health integration in primary care, such as through Accountable Care Organizations, Health Homes, Medicaid managed care, Medicare Advantage Plans and Delivery System Reform Incentive Payment (DSRIP) programs.	●	●	
1.19. Implement a risk-adjusted population-based payment model for behavioral health integration in primary care to include funding for prevention and health promotion and intervention.	●	●	
1.20. Expand the behavioral health provider types able to bill for services, including care coordination and family/behavioral health navigation.	●	●	
1.21. Allow billing and reimbursement for available codes for behavioral health integration including all Health and Behavior Assessment and Intervention, and Collaborative Care, health and well-being, Current Procedural Terminology (CPT), and crisis/risk assessment codes.	●	●	
1.22. Reimburse behavioral health services without site, provider, or patient restriction, or the need for prior authorization or diagnostic eligibility.	●	●	



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
BEHAVIORAL HEALTH SERVICE CONTINUUM AND SITES OF CARE			
1.23. Additional resources and funding to provide sustainable, school-based psychosocial support and mental health intervention, particularly in schools with a majority of youth of color.	●	●	
1.24. Invest and expand access to online screening, treatment, and referral to in-person treatment to reach underserved students of color with mental health needs on college campuses.	●	●	●
1.25. Permanently allow and expand billing for tele behavioral health services, including in primary care and school settings.	●	●	
1.26. Fund additional research on the effects of social media use on youth and adolescents, and on strategies to encourage health social media use.	●	●	●
1.27. Fund substance abuse prevention centers for individuals who are at greater risk of abusing substances due to intergenerational trauma, racism, and health inequities.	●	●	●
1.28. Establish Employee Assistance Programs and develop procedures to increase employee control and flexibility over schedules and decisions that impact job stress.			●
1.29. Provide funding for forgivable loans for primary care practices and multidisciplinary providers for the up-front costs of practice transformation to integrate behavioral health.	●	●	
1.30. Establish a national system for locally delivered and tailored technical assistance through funding the Primary Care Extension Program authorized in the Affordable Care Act.	●		



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
BEHAVIORAL HEALTH SERVICE CONTINUUM AND SITES OF CARE (CONTINUED)			
1.31. Expand funding for safety-net service providers and establish a grant program for Federally Qualified Health Centers and Rural Health Clinics to establish interprofessional behavioral health care teams in primary care settings.	●	●	
1.32. Embed equity in implementation of the national 988 system to enhance behavioral health crisis response and suicide prevention services.	●	●	
1.33. Fund crisis walk-in centers and mobile crisis units staffed by peer support and community health workers.	●	●	
1.34. Expand crisis stabilization services, short-term respite facilities, peer respite centers, behavioral health urgent care walk-in centers and the crisis hotline center.	●	●	●
COMMUNITY-LED SOLUTIONS			
2.1. Establish an agenda of priorities for the White House Office of Faith-Based and Neighborhood Partnerships and federal agency Centers for Faith-Based and Neighborhood Partnerships to address mental health equity.	●		
2.2. Establish sustainable funding mechanisms to scale peer and community-driven programs that provide culturally specific and culturally responsive behavioral health services to people of color, tribal communities, and people with lived mental health experience.	●	●	
2.3. Co-develop safe and inclusive public spaces for all ages that values the cultural history of a community.	●	●	●
2.4. Certify both community health workers and peer support specialists with best practices and core competencies in mental health and substance use, as well as accessing resources and coordinating care.	●	●	●



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
CULTURALLY-CENTERED CARE			
2.5. Implement anti-racist training for clinicians to decrease personal and systemic biases in health care institutions.			●
2.6. Require training with culturally informed and anti-racist principles to decrease the discipline gap in schools experienced by students of color.	●	●	●
2.7. Mandate socio-emotional curricula and school professional development in suicide prevention in schools.	●	●	●
2.8. Develop and launch anti-stigma campaigns with collaboration from community leaders or community-based organizations to change public attitudes toward mental illness.	●	●	●
2.9. Integrate traditional and cultural practices in prevention and intervention services.			●
2.10. Promote programs aimed at creation of a coalition of native mental health professionals, including native community mental health workers.	●	●	●
MATERNAL MENTAL HEALTH			
2.11. Invest in community-based programs for maternal behavioral health and initiatives to raise awareness of maternal behavioral health conditions.	●	●	●
2.12. Expand funding sources to support family-based intervention programs including parenting programs.	●	●	●
PEOPLE LIVING WITH DISABILITIES			
2.13. Implement initiatives aimed at educating police departments on responding effectively to crises and to people with serious mental illnesses (SMI) and intellectual/developmental disabilities (I/DD).	●	●	



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
GERIATRIC POPULATION AND CAREGIVERS			
2.14. Conduct a comprehensive, systematic effort to identify and disseminate information about family caregiver strategies tested by states.	●		
2.15. Measure the number, demographics, contributions, and needs of the family caregivers who assist Medicaid enrollees.	●	●	
2.16. Provide assistance for both caregivers and patients in navigating the mental health system, with active outreach to caregivers to offer information and care coordination.	●	●	●
2.17. Appropriate funds to incentivize new providers to seek specialization in geriatric mental health and improve training for health care workers, including registered nurses.	●	●	
2.18. Establish a national hub in partnership with a coordinating organization to support communities with the planning and implementation of Aging Friendly Communities with culturally distinctive programming.	●	●	●
LGBTQIA+ POPULATIONS			
2.19. Protect the rights to, and/or oppose or veto any legislation that criminalizes, gender-affirming care.	●	●	
2.20. Enact laws and organizational policies to include gender identity and expression as protected classes under non-discrimination clauses.	●	●	
2.21. Allow changing pronouns and legal names on government-issued documents consistent with an individual's gender identity.	●	●	
VETERANS			
2.22. Expand access to mental health services outside of the Veterans Administration through the Veterans Choice program and increase recruitment for mental health providers in this program.	●		
2.23. Examine weaponization of military discharges that prevent veterans from accessing vital behavioral health services.	●	●	
2.24. Increase resources to help with homelessness, trauma, and behavioral health concerns.	●	●	●



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
CLINICAL CARE AND SCREENING			
3.1. Incentivize universal screening for social determinants of health, including experiences of perceived and experienced racism.	●	●	●
3.2. Provide funding for community health navigators across settings of care to coordinate connections to social services.	●	●	●
3.3. Expand alternative payment models to include social services including transportation, connection to public benefits.	●	●	
ADDRESSING LEGAL NEEDS: MEDICAL-LEGAL PARTNERSHIPS (MLP)			
3.4. Add new Medicare quality metrics in medical homes, ACO and ACH payment models to incentivize providers to incorporate MLP services in private managed care contracts.	●	●	
3.5. Finance MLPs as an “enabling” or “wrap-around” service under section 330 of the Public Health Services Act.	●		
HOUSING			
3.6. Review Department of Housing and Urban and Department of Health & Human Services programs and policies for funding permanent supportive housing with the goal of maximizing flexibility and the coordinated use of funding streams for supportive services, health-related care, housing-related services, the capital costs of housing, and operating funds such as Housing Choice Vouchers.	●	●	
3.7. Clarify Centers for Medicare & Medicaid Services (CMS) policies and procedures for states to use to request reimbursement for allowable housing-related services, and states should pursue opportunities to expand the use of Medicaid reimbursement for housing-related services to beneficiaries whose medical care cannot be well provided without safe, secure, and stable housing.	●	●	
3.8. Develop multi-sector partnerships to increase the supply of permanent supportive housing utilizing a Housing First approach.	●	●	
3.9. Expand tax incentives that encourage low-income housing in affluent areas and enact low-income community revitalization policies that encourage residential and commercial development in low income and primarily communities of color.	●	●	



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
IMMIGRATION			
3.10. Expand access to health insurance coverage to undocumented persons through expansion of Medicaid and ability to purchase insurance on the marketplace.	●	●	
3.11. Make marketplace subsidies available to people with incomes under 100 percent of the poverty level or otherwise fill the Medicaid coverage gap.	●	●	
SUPPORTED EMPLOYMENT			
3.12. Expand funding, interagency collaboration, and early intervention efforts to increase access to supported employment programs and the use of International Placement and Support (IPS) model.	●	●	
3.13. Streamline Medicaid funding of SE programs in order allow states to fund SE more conveniently.	●	●	
3.14. Expand Medicaid income eligibility criteria to ensure that individuals with SE and mental health concerns will continue to have access to care .	●	●	
3.15. Train diverse SE program personnel able to implement SE initiatives in linguistically and culturally centered ways to ensure various communities can utilize and benefit from SE programs.	●	●	●
STRENGTHEN SOCIOECONOMIC SUPPORT			
3.16. Expand EITC programs to adults without children and people who are undocumented.	●	●	
3.17. Enact paid family and medical leave.	●	●	
3.18. Mandate paid sick leave.	●	●	
3.19. Extend Supplemental Security Income (SSI) to American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands.	●		



POLICY RECOMMENDATIONS	FEDERAL ACTION	STATE OR LOCAL ACTION	NON-GOVERNMENTAL ACTION
REENTRY SERVICES AND SUPPORTS			
3.20. Fund programs to provide reentry services and support for persons scheduled for release from county jail.	●	●	
3.21. Expand inclusion criteria for diversion programs to include individuals with felony charges, as this excludes many individuals with serious mental illness (SMI) from diversion programs.	●	●	
3.22. Enroll individuals in prison with behavioral health conditions into SSI or Medicaid benefits pre-release so they have access to the medical and behavioral benefits they need to remain stabilized as well as supports and connections to housing, food, and other essentials.	●	●	
FIREARM SAFETY			
3.23. Increase and expand firearms suicide prevention research.	●	●	●
3.24. Amplify education on lethal means and suicide prevention.	●	●	●
3.25. Authorize Extreme Risk Protection Orders (ERPOs), also referred to as “Red Flag” laws.	●	●	
3.26. Pass legislation enabling persons to voluntarily place themselves on “do not sell” lists for firearms.	●	●	
3.27. Clarify and refine existing mental health firearm disqualification criteria relating to involuntary hospitalization.	●	●	
REPRODUCTIVE HEALTH			
3.28. Regulations that may reduce the number of willing abortion providers or that pose implications for the availability and accessibility of abortion require significant justification on the part of the state.		●	
3.29. As in the Supreme Court case <i>Hellerstedt v. Whole Woman’s Health</i> , the health benefits of abortion restrictions must conclusively outweigh the burdens they impose on women and should be considered in the context of all available scientific evidence and other existing restrictions.	●	●	



Appendix E. Reports with Additional Detailed Recommendations

For additional detailed recommendations for **behavioral health workforce**:

- Strategies for Advancing Diversity, Inclusion, and Equity, Pacific Southwest Mental Health Technology Transfer Center, Center for Applied Research Solutions, 2020 <https://cars-rp.org/MHTTC/docs/Diversity-Inclusion-Equity-Guide.pdf>

For additional detailed recommendations for **mental health parity**:

- Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage, 2022 <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>

For additional detailed recommendations for **988 implementation**:

- Embedding Equity into 988: Imagining a New Normal for Crisis Response: https://kennedysatcher.org/wp-content/uploads/2022/06/988-Policy-Brief_Final.pdf
- Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System, The Well Being Trust, 2021 <https://wellbeingtrust.org/wp-content/uploads/2021/11/988-Crisis-Response-Report-November-FINAL.pdf>

For additional detailed recommendation for **culturally and linguistically appropriate services**:

- Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, U.S. Department of Health and Human Services Office of Minority Health, 2020 https://www.minorityhealth.hhs.gov/Assets/PDF/clas%20standards%20doc_v06.28.21.pdf

For additional detailed recommendations for **youth suicide prevention**:

- Advocacy and Policy Strategies for Suicide Prevention, American Academy of Pediatrics and the American Foundation for Suicide Prevention, 2022 <https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/advocacy-and-policy-strategies-for-suicide-prevention/>
- Ring the Alarm: The Crisis of Black Youth Suicide in America, The Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, 2019 https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

For additional detailed recommendations for **primary care integration**:

- Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration, Bipartisan Policy Center, 2021 https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf

For additional detailed recommendations for **school-based mental health**:

- Addressing the Youth Mental Health Crisis: The Urgent Need for More Education, Services, and Supports, Mental Health America, 2020 <https://mhanational.org/sites/default/files/FINAL%20MHA%20Report%20-%20Addressing%20Youth%20Mental%20Health%20Crisis%20-%20July%202021.pdf>

For additional detailed recommendations for **crisis response**:

- Youth Mobile Response Services: An Investment to Decriminalize Mental Health, The Center for Law and Social Policy, 2021 https://www.clasp.org/wp-content/uploads/2022/04/Youth20-Mobile20Response20Services_0.pdf

For additional detailed recommendations for **community-based solutions**:

- Social Connectedness Guidance Document Considerations and Examples from States and Communities, Building Resilient Inclusive Communities, 2021 <https://chronicdisease.org/wp-content/uploads/2021/07/BRIC-Social-Connectedness-Strategies-7152021-FINAL.pdf>

For additional detailed recommendations for **caregivers**:

- From Momentum to Movement: Developing a Unified Strategy to Support Family Caregivers Across the Nation, National Alliance for Caregiving, 2021 https://www.caregiving.org/wp-content/uploads/2021/02/NAC_50state-Strategy_Report_NAC-FINAL_02_2021.pdf

For additional detailed recommendations for **military and veterans**:

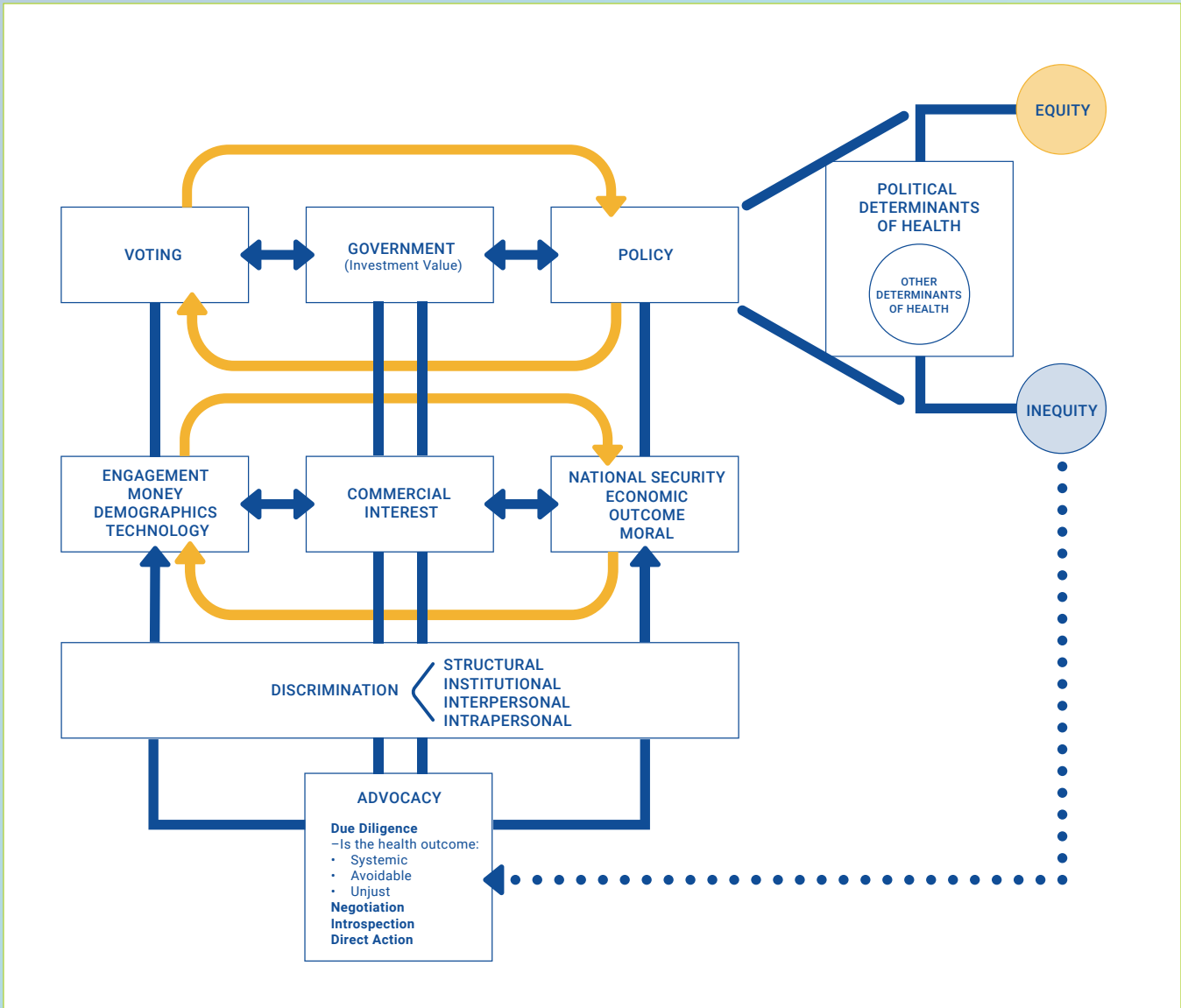
- Interagency Task Force on Military and Veterans Mental Health 2017 Annual Report, Department of Defense, Department of Veterans Affairs, Department of Health and Human Services, 2017 https://www.mentalhealth.va.gov/docs/2017_ITF_Annual_Report.pdf

For additional detailed recommendation for **geriatric populations**:

- Older Adults Living With Serious Mental Illness: the State of the Behavioral Health Workforce, Substance Abuse and Mental Health Services Administration, 2019 <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf>



Appendix F.
The Political Determinants of Health Model⁴



Satcher Health Leadership Institute



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