



**CPEHN**

California Pan-Ethnic Health Network

# Mind, Body, Spirit

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Advancing Mental Health and Substance Use Equity





## Introduction

Health plays a central role in personal and community resilience and mental health is a core component of overall health and quality of life. According to the World Health Organization, mental health is a state of well-being in which a person realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.<sup>1</sup> Mental health and substance use conditions are the leading cause of disease burden in the United States, and mental health-related mortality rates in the U.S. are higher than any other country of similar wealth worldwide.<sup>2</sup> In 2015, the National Institute of Mental Health estimated one in every five adults in the United States experiences a mental illness in a given year.<sup>3</sup> Hence, focusing on mental health and substance use is of profound importance to public, community, family, and personal health.

Improving community health and resilience requires recognition of mental health and substance use as critical public health concerns. It calls for investments that directly address the structural inequalities that influence not only mental health and substance use, but overall health and well-being. These factors, also referred to as social determinants of health, are the leading drivers of the health disparities we see today.<sup>4</sup> Today, policies, programs, and practice interventions for mental health and substance use largely focus on biological and behavioral factors, often neglecting the conditions and circumstances in which we grow, live, work, and age. Socio-economic factors, physical environments, and health care access and quality make up 70% of the factors that drive health outcomes, while health behaviors account for only 30% of our health status.<sup>5</sup>

This brief outlines the structural factors impacting mental health and substance use, and presents policy recommendations to begin improving mental health and substance use outcomes for all Californians.

## Socio-Economic Opportunities

Lack of access to socio-economic opportunities negatively impacts mental health and substance use outcomes, especially for communities of color, immigrants, low income groups, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals. These members of our communities, too often because of their identities, face inequities when seeking access to social, economic, and health care systems and structures that support positive health outcomes. Today, the majority of Californians are communities of color, almost half speak a language other than English, and seniors are expected to comprise nearly one fifth of the population within the next decade.<sup>6</sup> As a tremendously diverse, multicultural population, it is critical to address the disparities we see today that are rooted in unjust historical and current institutional and systemic policies, practices, and programs that cause or exacerbate mental health and substance use conditions.

### Economic Security

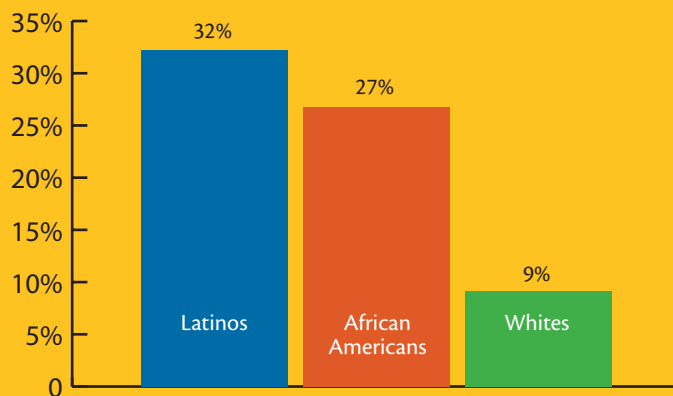
Mental health and substance use issues cross lines of wealth and social status. However, poverty and economic distress can negatively impact mental well-being.<sup>7</sup> Poverty is directly linked to chronic stress that affects the brain and body. Through neuroscience research, we have come to understand the impact of toxic stress on brain and nervous system development, and the lifelong consequences that may ensue, including mental health conditions.<sup>8</sup> Additionally, research has shown that people living in poverty experience mental health conditions that are more severe and have poorer outcomes.<sup>9</sup> Thus, individuals and families experiencing economic instability including unemployment and underemployment, lack of access to affordable housing, food insecurity, and high health care costs are at greater risk for stress-related illnesses impacting one's full participation and quality of life.

This risk especially holds true for communities of color, and other vulnerable communities, who have been denied opportunities to build wealth towards middle class or higher economic standing as a result of long term systemic discriminatory policies. Over 30% of Latinos and African Americans in California have an annual household income of \$20,000 or less compared to one in five White households with an annual income of over \$135,000.<sup>10</sup> This significant wage gap contributes to growing economic inequality. Nationally, the wealth of White households was eight times that of African American households in 2010, and grew to 13 times that of African American households by 2013.<sup>11</sup>

In California in particular, rising rents and unaffordable housing have had the most pronounced impact on families living in poverty and workers who earn less than the average wage.<sup>12</sup> In California, more Latinos (32%) and

African Americans (27%) are living at 100% FPL and below than Whites (9%).<sup>14</sup> In one study of the nine-county Bay Area region, over half of all low-income households are experiencing or at risk of displacement.<sup>13</sup> Due to the lower than average incomes of families of color, they are among the most likely to be displaced by rising housing costs.

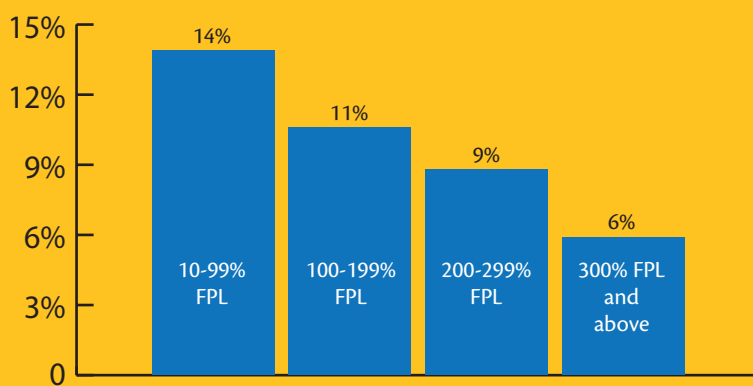
#### Live Below 100% of FPL



Data Source: 2015 California Health Interview Survey

California has taken steps to address income inequality, most significantly by raising the minimum wage to \$15 per hour by 2022. However, economic inequalities remain firmly rooted in our society and contribute to the chronic stress that plagues families who live in poverty.

#### Likely Has Serious Psychological Distress



Data Source: 2015 California Health Interview Survey

Disparities in mental health and substance use conditions will only be improved when opportunities for building greater economic security are part of the solution for improving health outcomes for communities of color.

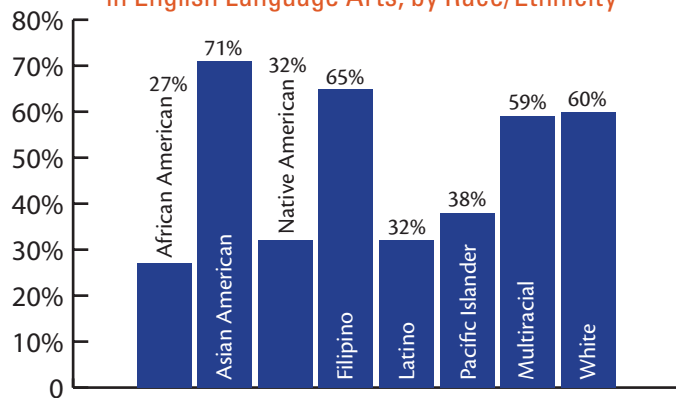
### Access to Education

Ample research shows that children's educational attainment are associated with positive health and economic outcomes.<sup>15</sup> Education provides individuals with greater access to better jobs and helps them become more adept at acquiring resources and social support systems, all of which lead to improved health.<sup>16</sup> Schools recognize the tremendous mental health needs of students, ranking mental health concerns as one of the top needs of students due to the impact on ability to learn, behavior, and attendance.<sup>17</sup> Yet, California's primary and secondary

educational system struggles to meet the academic, social, emotional, and cognitive needs of students.

California's investment in public education lags behind the nation, leaving our children in peril. In 2015-16, California ranked 41st in per student spending, and 37th in K-12 spending as a share of the state's economy.<sup>18</sup> Economic policies, such as Proposition 13 which limits property taxes, have reduced California's investment in our public schools resulting in low achievement and lack of college readiness.

**Students Meeting or Exceeding Grade-Level Standard in English Language Arts, by Race/Ethnicity**



Date Source: California Dept. of Education, 2015 California Assessment of Student Performance and Progress (CAASPP) Results

Nationwide, California ranks 46th in 4th grade reading and 42nd in 8th grade math, meaning that students do not have basic skills necessary for educational or professional advancement.<sup>19</sup> Underfunding also means there are fewer supports and resources to help children succeed in school, learn key skills to prepare them for further education and life, and complete their high school diploma. The start of many mental health issues most often occurs in adolescence with half of individuals experiencing onset by the age of 14.<sup>20</sup> This number jumps to 75% by the age of 24.<sup>21</sup> One in five youth live with a mental health condition, but less than half of these individuals receive needed services.<sup>22</sup> Undiagnosed, untreated or inadequately treated mental health conditions can affect a student's ability to learn, grow and develop. This cycle continues well into adulthood with 87% of adults with low educational attainment having the greatest unmet mental health needs, 63% not receiving any treatment, and 24% receiving some of the treatment they needed.<sup>23</sup>

In addition to limited supports and access to resources, students of color and LGBTQ students often endure harmful discipline policies that push them out of school instead of investing in their emotional well-being.<sup>24</sup> California is beginning to move in the right direction

with new school funding mechanisms that prioritize the students and school districts with the greatest need through the Local Control Funding Formula, and restrict suspensions and expulsions. It's critical that California continue this momentum to ensure not only academic and economic success, but improved health across the lifespan for all children.

## Community Safety and Social Cohesion

Poverty itself is not the only adverse life event that can produce toxic stress and lead to psychological distress. Communities with greater income inequality also can experience a loss of social connections, experience decreases in trust or social support, and experience a weakening of the sense of community.<sup>25</sup> Building connections in communities depends upon people feeling safe in their community. Research indicates that developing relationships, feeling a sense of belonging, and our ability to obtain support from those around us promotes health by reducing stress, improving mental health, and increasing healthy behaviors.<sup>26</sup>

Neighborhoods experiencing high rates of violence tend to have less social cohesion.<sup>27</sup> While violence has many causes, poor police and community relations and lack of community investment are contributing factors. Relations between police and communities of color have historically been strained due to policing practices that target communities of color for stops and cases of brutality or deaths due to police violence.<sup>28</sup> Exposure to such violence can have a tremendous impact on mental health and substance use of surviving members of the community. Homicide rates for African American boys and men ages 10 to 24 are nearly 30 times higher than for White young men. In addition, 31% of African American teenagers report receiving threats of violence or physical harm from peers, compared to 11% of Whites, 9% of Latinos, and 3% of Asians. Young men of color in California experience the physical and psychological trauma of violence at rates much higher than Whites. Individuals who have survived the loss of a loved one to violence are twice as likely to face Post-Traumatic Stress Disorder (PTSD), depression, and/or drug or alcohol dependence.<sup>29</sup> Since African American communities experience homicides at higher rates than most other communities, the impact on family members is also borne disproportionately by these families.<sup>30</sup>

*Half of all individuals living with mental illness experience onset of illness before the age of 14 and three quarters by the age of 24.*

Perception of neighborhood safety is also correlated with psychological distress, making communities that do not feel that their neighborhoods are safe vulnerable to poor mental health.<sup>31</sup> People of color are more likely to live in areas where they feel unsafe, which can



negatively impact their mental health. For example, African Americans, Asian and Pacific Islanders, Latinos, and Native Americans who feel unsafe in their neighborhoods are more likely to report psychological distress than those who feel safe.<sup>32</sup> One in five Latino teens and nearly half of African American teens believe that people in their neighborhood cannot be trusted, compared with one in ten of White teens.<sup>33</sup> If individuals do not trust their neighbors or are afraid to be out in their communities due to violence, real or perceived, the opportunities for engagement and building connections within communities can be hindered. Investments in communities in general as well as specifically in safe places to walk, play, and travel should be a priority to create opportunities for families, neighbors, and communities to create social connection and reduce violence.

*The family and community members of incarcerated individuals experience mental health impacts, including anxiety, nightmares, and depression.*

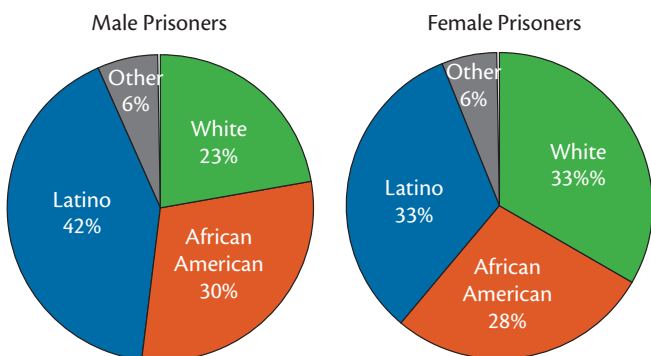
It is critical to address incarceration – both as an inappropriate substitute for mental health and substance use treatment, and as a cause of trauma that results in significant mental health needs in communities of color. While constitutionally mandated to provide health and mental health and substance abuse care, prisons and jails have continuously failed to provide adequate services, resulting in inmates experiencing rates of chronic disease that are higher than the general population.<sup>37</sup>

The connection between substance use and the increase in the prison population also presents particularly challenging inequities for communities of color. Communities of color have been the most impacted by policing and incarceration related to criminalization of substance use. As a result, many are often unable to seek substance use treatment. Thus, it is no surprise that, while alcohol consumption and substance use conditions have declined among Whites, the rates have remained stable or increased among African Americans and Latinos.<sup>38</sup> At least half of the prison and jail population experience mental health and substance use conditions. Individuals leaving the criminal justice system often do not have access to the services and treatment they need. While the Patient Protection and Affordable Care Act (ACA) includes some opportunities for formerly incarcerated individuals to access health coverage, and links community re-entry programs with mental health care and treatment for substance use, these programs are sparse.

## Access to Justice

Incarceration has significant health, economic, and community impacts. California's criminal justice system disproportionately incarcerates communities of color and people with mental health and substance use conditions. Over the past 15 years, the number of people with mental health conditions in California state prisons has doubled, now representing nearly half of the state prison population.<sup>34</sup> Three quarters of male prisoners are people of color.<sup>35</sup> Decades of harsh and biased policing and sentencing practices have led to the incarceration of communities of color reaching such a level that the U.S. Supreme Court declared it unconstitutional in 2009.<sup>36</sup> These disproportionate incarceration rates are due to policing practices, sentencing laws, bail policies, and a lack of successful re-entry programs and life opportunities to prevent recidivism.

### Incarceration by Gender



Source: Prison Census 2013, California Department of Corrections and Rehabilitation



Communities are also socially and economically devastated by mass incarceration. The family and community members of incarcerated individuals experience mental health impacts, including anxiety, nightmares, and depression.<sup>39</sup> Researchers have shown that the impacts of high incarceration rates in a community extend beyond those immediately impacted. Due to factors such as increased police presence, lost economic revenue, and parenting instability, even community members who are not directly impacted by incarceration experience the associated stress and psychological distress.<sup>40</sup> Significant criminal justice reforms remain necessary as the impact of decades old policies targeting communities of color and people with mental illness has yet to be undone.

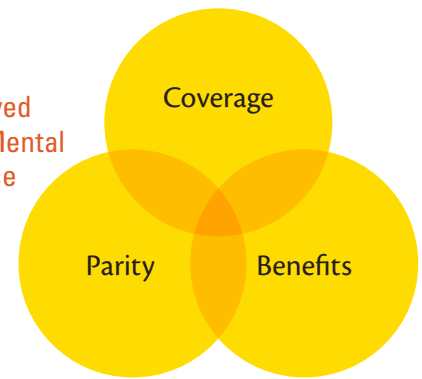
## Equitable Health Systems

The structure and appropriateness of California's mental health and substance use delivery system determines whether or not communities receive the care they need, when they need it. Despite significant progress in reducing the rate of uninsurance, numerous barriers continue to impede care, including the lack of culturally and linguistically appropriate care, quality measurement, and system capacity.

### Health Insurance Coverage

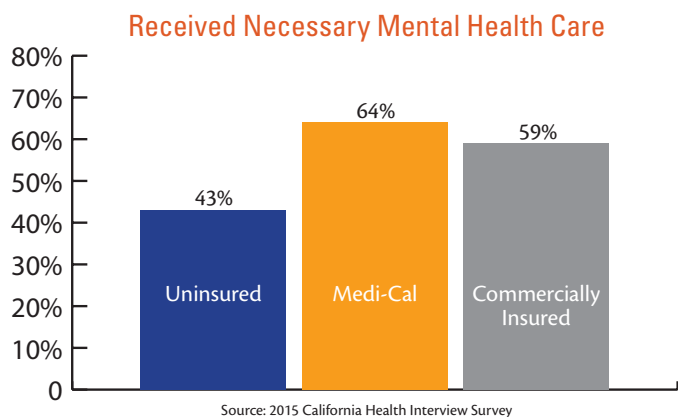
Health care is important for the prevention and treatment of illness. Prior to the passage of the ACA in 2010, many Californians were uninsured because coverage was unaffordable or unattainable. Coverage for mental health and substance use benefits were often very limited, perpetuating the lack of access to these services even for those with insurance. For example, California's mental health parity law, passed in 1999, required equal coverage for mental and physical health conditions, but only for mental health conditions considered severe.<sup>41</sup> Similarly, in 2008, the Federal Mental Health Parity and Addiction Equity Act required plans to provide equal coverage but only if mental health or substance use benefits were covered by the plan. The ACA set out to address these gaps by expanding federal protections and coverage of mental health and substance use treatment benefits in three distinct ways: (1) including mental health and substance use treatment benefits in the Essential Health Benefits; (2) applying federal parity protections to mental health and substance use treatment benefits in the individual and small group markets; and (3) reducing the number of uninsured individuals living with mental health and substance use conditions. The ACA included one of the largest expansions of mental health and substance use treatment coverage in over a generation.<sup>42</sup>

### How the ACA Improved Access to Care for Mental Health and Substance Use Conditions



The successful implementation of the ACA in California resulted in nearly 3.8 million previously uninsured people with health coverage and access to mental health and substance use services through Medi-Cal<sup>43</sup> and 1.4 million Californians gaining coverage through the state-based exchange, Covered California.<sup>44</sup> Communities of color, who are disproportionately uninsured, experienced significant gains, with the majority of Medi-Cal (70%) and Covered California (66%) members today from communities of color.<sup>45</sup> Close to three-quarters (70%) of Covered California's members are low-income (earning less than 250% FPL).<sup>46</sup> One in three of Medi-Cal beneficiaries speak a language other than English as their primary language. The ACA and expansion of Medi-Cal eligibility also expanded coverage for LGBTQ communities, who experience disproportionately high levels of poverty and faced discrimination in eligibility for health care coverage prior to the ACA.<sup>47</sup>

Nonetheless, affordability and eligibility for coverage continue to be significant barriers for the remaining 2.9 million uninsured in California, nearly three quarters of whom are communities of color.<sup>48</sup> In 2015, one in four uninsured Californians were age 25 to 34, one in three were noncitizens, and more than half were Latino.<sup>49</sup> Of those uninsured, 58% worked full-time.<sup>50</sup> Insurance status is strongly associated with accessing mental health treatment, yet individuals with serious mental illness and substance abuse are more likely to be uninsured and have lower incomes. Seven percent of adults with incomes under 100 percent of the federal poverty level have a serious mental illness, compared with three percent of those with incomes above that threshold.<sup>51</sup> Uninsured adults with mental health needs are significantly less likely to receive necessary mental health treatment (43%) compared to adults with mental health needs who had Medi-Cal (64%) or private insurance (59%) coverage all year.<sup>52</sup> Vulnerable populations who are more likely to be uninsured also face barriers to accessing mental health and substance use treatment. For example, nearly half of all young adults ages 18-24 who sought help for mental health or substance use issues did not receive treatment, the



largest share of any adult age group. Young adults are also more likely to be uninsured than other age groups.<sup>53</sup>

Without health care coverage many Californians, particularly undocumented immigrants and Latino communities, LGBTQ, and young adults do not receive needed mental health and substance use treatment services. The consequences are far reaching, impacting the ability of individuals to function in communities, and can lead to job loss, school dropout and pushout, incarceration, and homelessness. Providing health care to all Californians that includes access to mental health and substance use treatment is of paramount importance.

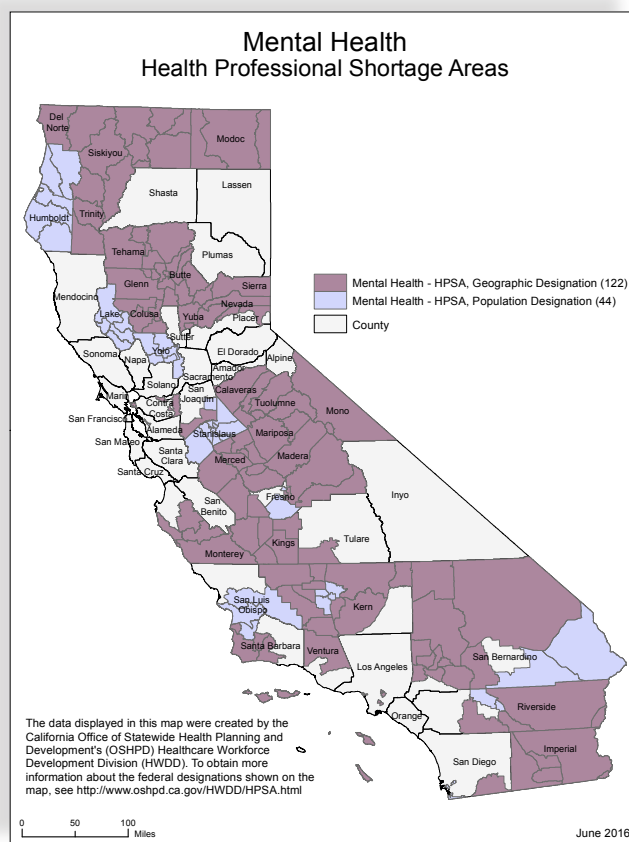
### Mental Health and Substance Use Treatment

The expansion of health care coverage and parity for mental health and substance use services are historic moves towards removing systemic barriers to care. However, challenges within our mental health system, including lack of access to appropriate providers, stigmatization, and discrimination continue, leaving many with undiagnosed, misdiagnosed or untreated needs.

#### Access to Providers

California's public mental health system is challenged with many provider shortages, including a lack of diverse and bilingual providers, and the maldistribution of providers. There are 166 areas of California that have been designated a Mental Health Professional Shortage Area (MHPSA), which means that either there are not enough providers to serve the population or there are access barriers specific to the geographic area such as expansive distances. Well over four million Californians live in these designated shortage areas.

In addition, many Californians face difficulties accessing primary care physicians, who play an important role in screening, intervention, and referral to treatment. The United States Preventive Services Task Force (USPSTF) recommends that all 12- to 18-year-olds and adults be screened for depression in primary care, yet 70% of youth with mental health needs do not have



access to services.<sup>54</sup> In California, 20% of Latinos and 15% of Asians report having no usual source of care, or no primary care provider.<sup>55</sup> Communities of color are more likely to rely on primary care providers for mental health services.<sup>56</sup> This presents a significant obstacle to accessing specialized mental health and substance use treatment. While referrals are not always required, most consumers do rely on primary care providers as a gateway to specialty care.

#### Cost of Care

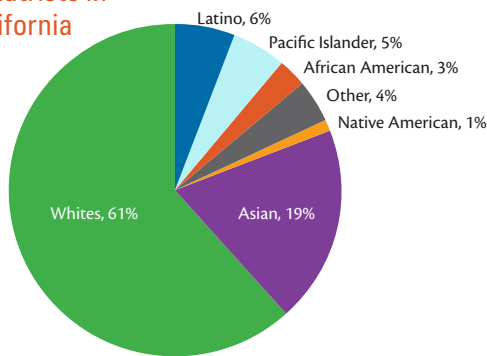
Although recent changes in health care programs provide access to mental health and substance use treatment, the cost of health care remains a significant barrier. In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported unaffordable cost of treatment as the top barrier for the 4.9 million adults with an unmet need for mental health and substance use treatment.<sup>57</sup> States often play a more significant role in financing mental health and substance use services because the federal government traditionally provided very little funding prior to the Affordable Care Act. During fiscal downturns, California often reduces resources to the public mental health system, raising the cost of mental health care for individuals. Therefore, continued implementation of the Affordable Care Act, the Medicaid Expansion, and the Mental Health Parity and Addiction Equity Act is critical to ensure that cost is not an insurmountable barrier for individuals seeking care.



## Workforce Diversity

With a state as diverse as California, cultural and linguistic needs must always be a top priority in the delivery of quality care. Having a diverse health workforce that speaks the same language as patients and shares similar historical and cultural experiences increases the likelihood that individuals receive better care and improves compliance. California's mental health workforce does not accurately reflect the state's demographics and diversity. Based on a 2014 report from the Office of Statewide Health Planning and Development (OSHPD), 6% of psychiatrists in the state are Latino, 19% are Asian, and 61% are White. A total of 768 psychiatrists in the state speak Spanish.<sup>58</sup> This is compared to a Medi-Cal population that is 47% Latino, 13% Asian, 8% African American, and 20% White.<sup>59</sup>

Psychiatrists in California



Source: Office of Statewide Health Planning & Development, 2014

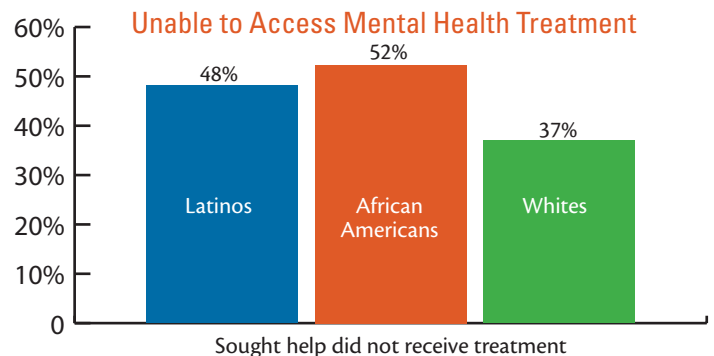
To help expand diversity, California's mental health workforce includes community health workers, peer providers, cultural brokers, and other non-traditional providers in a variety of roles. Peer providers and community health workers have demonstrated improved effectiveness at reaching communities of color and other historically underserved communities.<sup>60</sup> However, these providers are not fully integrated into the mental health and substance use delivery system. Therefore, Medi-Cal enrollees are not able to benefit from peer provider services to the full extent possible. While California has strong protections for Limited English Proficient (LEP) enrollees - including the right to translated documents and interpreter services - communities of color often lack access to linguistically appropriate services, creating a barrier for those with mental health and substance use treatment needs.<sup>61</sup>

## Stigma and Discrimination

Stigmatization of mental illness and substance abuse is also a significant barrier to accessing treatment services. Most adults in the United States hold stigmatizing beliefs about individuals with mental illness. Predominantly, these include the belief that individuals living with mental health conditions are violent, incompetent, or irresponsible.<sup>62</sup> These attitudes and beliefs, held by individuals, the public, and systems, lead to stigmatization and discrimination that results

in individuals living with mental health conditions being less likely to seek treatment, and treatment being non-existent, or coercive and segregated. These biases are elevated when interlinked with other forms of discrimination based on one's race, ethnicity, culture, or social identity which makes one more vulnerable and shapes an individual's experiences when accessing services.

Despite similar mental health and substance use treatment needs, people of color who need care are far less likely to access services compared to Whites. For instance, 16% of Latinos and 17% of African Americans needed help for emotional/mental health problems or use of alcohol/drugs, compared to a similar number of Whites (18%). Yet, 48% of Latinos and 52% of African Americans who sought help did not receive treatment, compared to 37% of Whites.<sup>63</sup> African Americans are 2.5 times more likely to fear mental health treatment than Whites. Asian Americans and Pacific Islanders have the lowest rates of mental health treatment, and tend to seek services only when the acuity of illness is high, signaling potential fear, stigma, and access barriers.<sup>64</sup> LGBTQ communities are also more likely to have unsuccessfully sought mental health or substance use treatment than their heterosexual peers.<sup>65</sup>



Source: 2009 California Health Interview Survey

California has made tremendous progress in providing coverage for mental health and substance use treatment for all residents. However barriers to access remain, including coverage gaps, workforce adequacy, affordability, and discriminatory practices.

## Quality of Care

Coverage and access alone do not guarantee the reduction of disparities or successful health outcomes. Quality of care is critical to ensure that individuals receive the right care at the right time. Culturally and linguistically appropriate services are particularly important in California, where the majority are from communities of color, and over 200 different languages are spoken.



### *Culturally and linguistically appropriate services*

Communities of color are more likely than Whites to report experiencing poor quality patient-provider interactions - a disparity particularly pronounced among the millions, nationwide, with limited English proficiency (LEP), meaning they speak English less than very well.<sup>66</sup> Language barriers can deter individuals from seeking treatment either because they are not aware of available services, due to limited linguistically appropriate outreach, or because they do not feel they can adequately communicate with their providers. Nearly half of Californians speak a language other than English at home.<sup>67</sup> For some populations, such as those who speak Vietnamese, Korean, Thai, Cambodian, and Laotian, over half are LEP. Additionally, over 4.5 million Spanish speakers are LEP.<sup>68</sup> In California nearly 92% of Limited English Proficient adults reported unmet needs for mental health services, with about 70% receiving no treatment at all.<sup>69</sup> For youth with parents who have Limited English Proficiency, 80% with mental health needs do not have access to services, even if they have health insurance.<sup>70</sup> Therefore, access to a workforce that can meet communities of color needs, including having greater access to qualified medical interpreters, is an important component to the quality of mental health services.

Cultural appropriateness or competency is also an important aspect of quality of care. Cultural competence means meeting the social, cultural, and linguistic needs of consumers. This is particularly important in mental health and substance use treatment, where the presentation of symptoms and conditions vary widely between racial and ethnic groups, and it is important

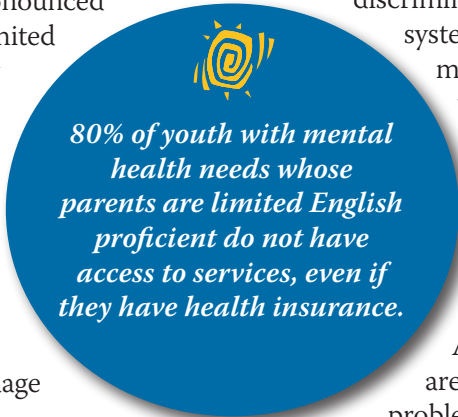
for bipolar disorder and depression, and Asian Americans are generally under-diagnosed for all mental health conditions.<sup>71</sup> These trends reflect both diagnostic error and bias, including historic racial bias and discrimination rooted in the mental health system. Once in treatment, individuals may have a hard time talking about their mental health needs and substance use, particularly with clinicians who do not share their race or ethnicity. In fact, African Americans disclose less to White therapists than African American therapists. Latinos, Asian Americans, and African Americans are significantly more likely to report problems communicating with a doctor than Whites.<sup>72</sup>

Cultural competence has a particular relevance for immigrant and refugee communities, who face additional stigma and discrimination about mental health and substance use, as well as greater and unique mental health care needs. For example, refugees may have been exposed to trauma related to their migration, including violence, poverty, and discrimination. Many refugees are living with depression, post-traumatic stress disorder, and related mental health conditions.<sup>73</sup> Cultural and linguistic differences may create additional stress for immigrants. For some, this compounds stigma around mental health that individuals may face in their own communities.<sup>74</sup> Finally, access to appropriate mental health services is limited as California's 3 million undocumented immigrants are largely uninsured.<sup>75</sup>

### *Quality Measurement*

The importance of quality measurement has been increasingly recognized in healthcare as a tool to reduce disparities and advance equity. Quality measurement is equally important in mental health care, where early intervention is known to be effective, but inappropriate treatment is prevalent. Historically, quality measures for mental health and substance use have been limited, and measuring performance and outcomes on addressing stigmatization, discrimination, and integration of care has been challenging. For example, California's mental health quality measures are still lacking. The Department of Health Care Services (DHCS) collects and reports on the performance of Medi-Cal managed care plans each quarter, however, information is not readily available on mental health outcomes, disparities, or access for Medi-Cal enrollees.<sup>76</sup>

At the federal level, the ACA took steps to improve the efficacy of health care. For example, the U.S.



*80% of youth with mental health needs whose parents are limited English proficient do not have access to services, even if they have health insurance.*



for providers to recognize this in order to make accurate diagnoses. Research demonstrates that these factors, as well as clinician bias, contribute to misdiagnosis and under-diagnosis. For example, African Americans are over-diagnosed for schizophrenia and under-diagnosed

Department of Health and Human Services (HHS) was required to develop a National Quality Strategy to improve quality, a model that SAMHSA then used to develop the National Behavioral Health Quality Framework (NBHQF). Over several years, the NBHQF recommended a set of measurements to include in quality frameworks: 1) evidence-based practices; 2) person-centered care; 3) coordinated care; 4) healthy living for communities; 5) reduction in adverse events; and 6) affordable and accessible care.<sup>77</sup>

One pitfall of quality measurement in mental health and substance use treatment is a focus on adherence to evidence-based practice, despite the fact that communities of color are not well-represented in the research protocols for most research. Evidence-based practice does not necessarily equate with quality care for diverse populations, given that therapies are often tested without representation of communities of color.<sup>78</sup> The confines of a traditional mental health provider in a medical facility providing therapy and/or medication may not be relevant and appropriate for all communities. Given the structural and systemic factors impacting mental health and substance use, as well as the history of stigmatization, discrimination, and trauma encountered by communities of color and LGBTQ populations, culturally relevant treatment may require a broad and sustained approach to improve quality of care.

Despite these limitations, quality measurement is an important component of disparities reduction in mental health and substance use health care. Communities of color continue to receive inadequate and inappropriate treatment, and tend to be misdiagnosed more frequently than Whites. In addition, communities of color have less access to appropriate and preferred therapies. For example, communities of color report preferring psychotherapy to medication treatment, but have less access to it.<sup>79</sup> In addition, little psychopharmacologic research has been conducted with communities of color and there are disparities in prescribing practices.<sup>80</sup> Thus, quality measurement is a key aspect of equity, but relies on accurate and consistent data collection to expose the full picture of access and disparities.

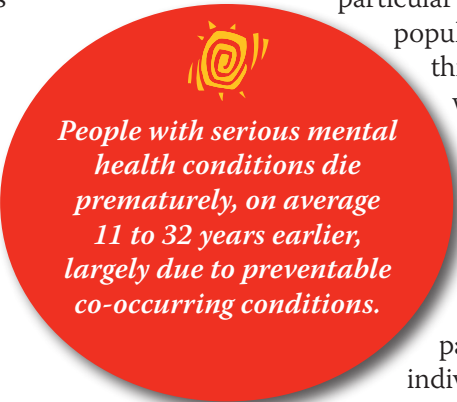
### Integrated Care

There is increasing awareness that we must treat the whole person in order to make meaningful improvements in health outcomes. With greater coverage gains and enhanced federal funding, the ACA allowed California's health care delivery system

to orient toward integration with a more intensive focus on the needs of the whole person. It is timely and critical that mental health and substance use care be integrated into physical health care to address the holistic needs of individuals. California has paid particular attention to ensuring that the re-entry population is enrolling in Medi-Cal. With this opportunity, the state and counties were also able to expand behavioral health programs for formerly incarcerated individuals who now have health insurance.<sup>81</sup> In addition, California received federal approval in 2015 for a major expansion of substance use treatment services, paving the way to more effectively treat individuals living with co-occurring mental health and substance use conditions.<sup>82</sup>

These advances in integration are particularly important for communities of color and Limited English Proficient communities, who are most likely to lack a usual source of care or to rely on primary care providers for mental health and substance use services.<sup>83</sup> Communities of color are also more likely to report symptoms of mental health conditions to primary care providers.<sup>84</sup> Therefore, primary care providers must be trained and equipped to recognize mental health conditions and provide appropriate referrals to culturally competent mental health providers. Optimally, mental health care providers practice alongside their primary care colleagues to complete a care team that focuses on the whole person. These steps towards integration are vital for prevention, early intervention, and normalizing mental health and substance use care.

The integration of primary and mental health and substance use care is also important to individuals with co-occurring chronic conditions. People who suffer from a chronic disease are more likely to also suffer from depression.<sup>85</sup> Depression is found to co-occur in 17% of cardiovascular cases, 23% of cerebrovascular cases, 27% of diabetes patients, and over 40% of cancer patients.<sup>86, 87</sup> Co-occurring conditions has the biggest impact on communities of color. For example, Latinos and African Americans are most likely to be diagnosed with diabetes.<sup>88</sup> The risk of diabetes is 77% higher for African Americans and 66% higher for Latinos when compared to Whites.<sup>89</sup> Strikingly, people with serious mental health conditions die prematurely, on average 11 to 32 years earlier, largely due to preventable co-occurring conditions.<sup>90</sup> These individuals tend to have the most complex medical needs and often require more costly care. Data from the Medi-Cal program shows that about half of the most costly diabetes patients are also diagnosed with a serious mental health condition and



*People with serious mental health conditions die prematurely, on average 11 to 32 years earlier, largely due to preventable co-occurring conditions.*



11% are diagnosed with alcohol or drug dependency. The integration of primary care with mental health and substance use care helps providers and people better manage their conditions through medical adherence and other aspects of their treatment plans and reduces episodes requiring higher cost of care.

Mental health and substance use conditions may also occur simultaneously or sequentially for an individual.

Compared to the general population, adults in the

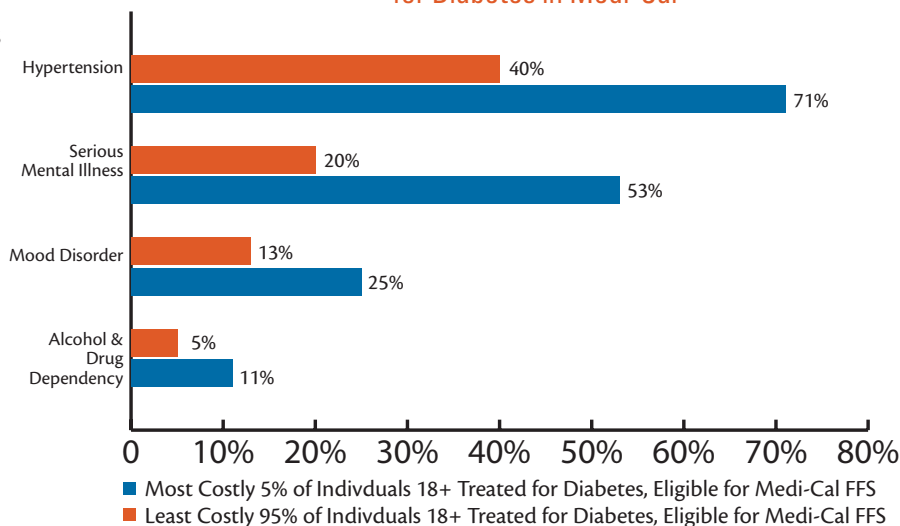
United States living with a mental health condition are more than twice as likely to also live with a substance use condition.<sup>91</sup> Research has not concluded that there is a causal relationship between mental health and substance use conditions. However, the three commonly discussed theories of co-occurring mental health and substance use conditions include: that misuse of drugs and alcohol can lead to symptoms of mental health conditions; that individuals use

drugs and alcohol to “self-medicate” for mental health conditions; and that social determinants, such as trauma and violence, and genetic factors may contribute to mental health and substance use

conditions. The availability of services, or lack thereof, may be influenced by these theories. For example, many mental health treatment programs and social support systems require individuals to be clean and sober, which may be difficult for individuals who have not received adequate treatment or referrals, and

may perpetuate their co-occurring condition. The improved integration and treatment of mental health and substance use conditions are key to increased access and equity, and require thinking differently about service locations, provider types and training, and funding mechanisms. By pursuing these strategies to reform our delivery systems we can better tackle the stark disparities that exist currently.

**Dual Diagnosis Among Individuals Treated for Diabetes in Medi-Cal**



Source: DHCS, Research and Analytic Studies Division, July 2015



## Policy Recommendations

While there has been progress on expanding access to health care coverage, we have not seen the necessary improvements towards integrating our communities' socio-economic needs and the importance of mental health and substance use care as strong components of our health equity strategies. The following are beginning steps towards addressing the stark and continued mental health and substance use disparities outlined in this brief.

### Socio-Economic Opportunities

**Strengthen investments in education:** California must continue to invest in public K-12 education by extending Proposition 30 and continue to ensure children have quality teachers, healthy facilities and other educational and health resources. The state and local governments should ensure that the Local Control Funding Formula and other funding streams provide equitable resources to meet the needs of students of color, students with limited English proficiency, students with disabilities, and foster youth. This includes teachers who reflect the diversity of the student population and who are well-prepared to teach. It also includes providing underserved students with access to afterschool activities and nutritional supports including breakfast, lunch, and dinner at the school site.



**Cultivate affirming school environments:** Young people may arrive at schools after having experienced trauma, and the school setting may be the first opportunity to intervene with services. This should be prioritized as a health promotion and academic achievement strategy, as well as a violence prevention

priority. Schools should be equipped to provide a continuum of mental health and substance use services on-site, including through school-based health centers, and should partner with local agencies to provide services to families in the community. By actively and visibly providing mental health and substance use services, schools can work to reduce stigma and create a positive school climate. It is important that schools have strong policies and programs to prevent bullying and harassment.<sup>92</sup> And to support students to use mental health and substance use resources when needed.

**Transform policing and sentencing practices with supportive alternatives:** Law enforcement should effectively partner with culturally responsive mental health and social service providers to meet the needs of community members with acute needs, for example individuals who lack stable housing, live with mental health conditions, or are victims of trafficking.<sup>93</sup> The court system should also acknowledge these realities and be required to consider both trauma and poverty when determining bail amounts and sentences. Successful alternative court models, such as drug courts, should be expanded.<sup>94</sup> We should transform our state to provide culturally appropriate mental health and substance use services and advance equity, while reducing incarceration.

**Prioritize economic and social investment in low-income communities:** It is important to identify and strengthen community assets, including neighborhood organizations, schools, cultural groups, health care providers, libraries, food sources, and places of worship. State and local policy must ensure that economic development advances equity by reinvesting in community and strengthening local assets. This includes increasing rates of home and small business ownership in communities of color, and building and diversifying the local workforce so career pathways are available.<sup>95, 96</sup>

### Equitable Health Systems

**Expand coverage to all Californians:** Mental health and substance use coverage is an essential part of access to care. Additionally, it is imperative that we provide coverage for the remaining uninsured, including California undocumented adults, and that we strengthen enrollment efforts for historically underserved populations, including formerly incarcerated individuals.

**Improve data collection and research regarding the mental health and substance use treatment needs of culturally diverse communities:** There is insufficient data and research to support sound policy making or program design in mental health





and substance use care specifically for communities of color and the LGBTQ community. Historically, these communities have been subjected to harmful mental health practices. There is a need for investment in community-based research regarding mental health and substance use treatment needs, best practices for services, as well as standard data collection processes in mental health and substance use care systems to track utilization, retention, and other factors.

**Measure performance and quality of mental health and substance use health care services:** In order to address disparities and inappropriate treatment, it is time to implement robust quality and performance measurement systems for plans and providers. Quality measurement should engage individuals utilizing mental health and substance use services in determining metrics and evaluating performance, and ensure that equity and disparities reduction is central to quality improvement efforts.

**Adopt community-defined practices that promote prevention and early intervention:** Prevention and early intervention are critical components of population health and addressing the mental health needs of California's communities of color. Mental health and substance use conditions can be successfully treated if diagnosed early. We should work to develop, disseminate and fund community-defined best practices for prevention and early intervention, including education, stigma reduction, and screening.

**Adapt diagnostic and screening tools to be culturally responsive:** Mental health and substance use conditions impacts all communities, but our diagnostic tools are not sufficiently responsive to communities of color. We must adapt our screening

and diagnostic tools and processes to be culturally responsive, to accurately diagnose individuals, and to provide appropriate treatment.

**Ensure culturally and linguistically diverse provider networks:** Network adequacy determinations should consider the cultural and linguistic needs of regional communities, ensuring access to bilingual and culturally competent providers. Non-traditional providers such as cultural brokers, peers, and community health workers should also be incorporated into the mental health and substance use workforce, shifting to focus on a team-based approach of care. Both peers and community health workers add culture competency but should be incorporated into mental health and substance use teams so that other practitioners can also benefit from their expertise. Additionally, all mental health providers should receive cultural competency training specific to mental health and substance use.

**Ensure timely access to trained mental health care interpreters:** Ensure that trained mental health care interpreters are available to all Limited English Proficient individuals at the time of service. Individuals should not have to rely on family members or other medical professionals for interpretation, nor should appointments be delayed due to lack of availability of interpreters.

**Ensure that health and healthcare organizations comply with enhanced National CLAS Standards:** The US Department of Health and Human Services (HHS) has developed enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS).<sup>97</sup> These standards serve as guidelines for health and healthcare organizations to provide culturally and linguistically competent services.



They include guidelines that encompass governance, leadership, and workforce, communication and language assistance, and engagement, continuous improvement, and accountability. All health and healthcare organizations should be in compliance with the 15 outlined standards.

**Develop health career pathways:** In order to expand provider networks and develop a culturally and linguistically competent workforce there must be investment in the ability of our communities to join the mental health and substance use workforce. This includes health career pathway programs in communities of color from middle school through professional training, as well as financial assistance programs.

**Integrate mental health and substance use care with primary care:** Mental health is but one component of our overall health, and must be viewed holistically and as part of a continuum of care to best meet the needs of underserved populations. Since many people with chronic conditions are also dealing with mental health and substance use conditions, it is vital to integrate mental health and substance use

care and primary health services in the same setting to ensure that needs are being met comprehensively and efficiently. One way to achieve better integration is through the co-location of services, in settings that are familiar to individuals, including community centers, faith settings, and schools that are key to meeting community members where they are. Mental health and substance use services can also be co-located with legal services, language support services, educational, and vocational services.

**Move beyond the medical model:** In order to provide appropriate services and continue to improve quality, it is important to move beyond the traditional medical model of care delivery and address the determinants that places individuals, families, and communities of color at greater risk for mental and substance abuse conditions. For many, care should be viewed in the context of family and community, not only of a diagnosis. This means both addressing the social needs – housing, employment, transportation – and including the family and community in a care plan.

## Conclusion

We have important opportunities to transform our mental health care delivery system to better meet the needs of California's majority. We must consider how intersecting identities and needs operate to determine well-being and how our health care system either improves outcomes or makes conditions worse. With greater data, analysis, integration, and flexibility in resources, we have the tools available to make change. We look forward to working with fellow advocates, researchers, policymakers, and community members to bridge the gaps in physical health and mental health care to improve the quality of life for all.

### Terms

Behavioral Health:	Mental and emotional well-being, including mental health and substance use.
Mental Health:	A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. <sup>98</sup>
Mental Illness or Disorder:	A range of conditions that impact mood, thinking, and behavior.
Substance Use, Abuse, Addiction, or Disorder:	A condition in which use of one or more substances leads to significant distress or interferes with daily functioning.
Intersectionality:	Intersectionality is a concept that enables us to recognize the fact that perceived group membership can make people vulnerable to various forms of bias, yet because we are simultaneously members of many groups, our complex identities can shape the specific way we each experience that bias. <sup>99</sup>
Health Disparities:	Health and health care disparities refer to differences in health and health care between population groups. <sup>100</sup> Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation. <sup>101</sup> Policy can influence disparities in physical, mental, and oral health.
Health Equity:	The absence of structural inequalities that drive disparities in health between groups with different levels of social advantage/disadvantage. <sup>102</sup>



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