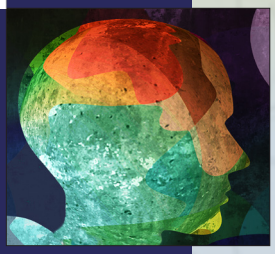


Behavioral Health and Equity

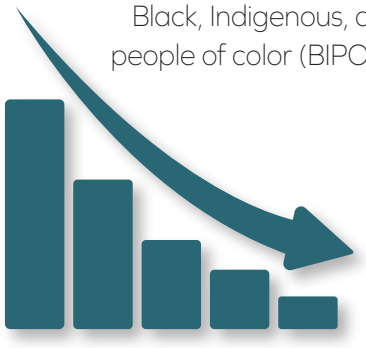
This leadership brief will provide a global overlay for the work around behavioral health equity with a focus on person-centered justice, cultural humility, and the importance of the courts taking an active role in these areas. This focus is not only more humane but will make behavioral health and court systems more effective and efficient.

See also, Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illnesses and Pathways to Care: A Roadmap for Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society, which supports an alternative statutory and legal process for individuals with serious mental illness who find themselves in the criminal justice system.

MILLIONS OF PEOPLE in the United States are living with Any Mental Illness (AMI), Serious Mental Illness (SMI) and Substance Use Disorders (SUD), and many do not receive the treatment they need.

In 2020, among the 52.9 million adults with AMI, 24.3 million (46.2%) received mental health services in the past year, and among the 14.2 million adults with SMI, 9.1 million (64.5%) received mental health treatment in the past year" (Transforming the understanding and treatment of mental illness, 2022). Among people aged 12 or older in 2020 who had a past year SUD, only 6.5%, or 2.6 million people, received any substance use treatment. This left 37.7 million, or 93.5%, without treatment (Substance Abuse and Mental Health Services Administration (SAMHSA, 2022). Further, "(t)he average delay between onset of mental illness symptoms and treatment is 11 years" (Mental Health By The Numbers, 2022).

Demographic statistics also reveal that treatment rates are lowest for Black, Indigenous, and people of color (BIPOC).



The percentage of Non-Hispanic Whites receiving treatment in 2020 was 51.8%. The percentage drops to 43.0% for Non-Hispanic mixed/multiracial; 37.1% for Non-Hispanic black or African-American; and, 35.1% for Hispanic or Latino (Mental Health By The Numbers, 2022). A possible explanation for this disparity is that "61% of U.S. adults overall feel that there are not enough mental health care providers who are trained to address specifics to race, ethnicity, sexual orientation, or socioeconomic status" (National Council for Mental Wellbeing, 2022).

Moreover, people living with SMI or SUD are overrepresented in the criminal legal system and courts have become the default referral system for behavioral health services for those who find themselves justice involved. Arrestees with multiple mental health, SUD diagnoses, or co-occurring conditions in the preceding two years have significantly higher odds of repeat arrest.[1] People living with mental illness are also overrepresented in the courts and in the incarcerated population.[2] The rate of serious mental illness is four to six times higher in jail (14.5% of men and 31% of women in jails) than in the general population.[3] Substance use disorders are even more prevalent than serious mental illnesses in jails and prisons.[4]" More than half (58%) of state prisoners and two-thirds (63%) of sentenced jail inmates met the criteria for drug dependence or abuse, according to data collected through the 2007 and 2008-09 National Inmate Surveys (NIS). In comparison, approximately 5% of the total general population age 18 or older met the criteria for drug dependence or abuse."[5]

WHAT IS PERSON- OR PEOPLE-CENTERED JUSTICE?

"People-centered justice is a rule of law approach that relies on the perspectives, needs, strengths, and expectations of the justice user to improve the quality of justice and reduce barriers to service delivery" (Eriksson, 2022). This approach is designed to fill the gaps in traditional, institution-focused programing and shift towards incorporating an understanding of the cultural and structural factors impacting illness, access to care, and Social Determinants of Mental Health (SDOMH). Just as mediated agreements are more likely to be adhered to than a court order because the parties have ownership of the process and the outcome; individuals should be part of the treatment team to encourage ownership and engagement with treatment. Engagement with treatment is a better predictor of long-term recovery than a court order for involuntary treatment. A fundamental paradigm shift must occur from institution-centered justice to person-centered justice. A focus on the person enables actors in the system to identify individual needs and barriers more effectively. This change not only benefits the justice-involved individual, but the justice and behavioral healthcare systems as well.

Court leaders must ensure the principles of person-centered justice are enforced within the courts and that local structural, attitudinal, and cultural barriers impacting individuals are recognized and considered as individuals move within the justice and behavioral health systems. To effectuate this, attention must be given to implementing policies, procedures, and outcome measures to identify and address any inequities. Regular educational programs to enhance court leaders' ability to recognize individual factors and incorporate them into their decision making should also be developed and regularly updated with evolving research. Court leaders should consider making these programs mandatory.

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[1] Magee, L.A., Fortenberry, J.D., Rosenman, M. et al. (2021). Two-year prevalence rates of mental health and substance use disorder diagnoses among repeat arrestees. Health Justice, 9, 2. .

[2] McNeil, D. E., & Binder (2005). Incarceration associated with homelessness, mental disorder, and violence. Psychiatric Services, 56, 699–704; Osher, F., D'Amora, D., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). Adults with Behavioral Health Needs Under Correctional Supervision. Council of State Governments Justice Center.

[3] Vera Institute of Justice, Incarceration's Front Door: The Misuse of Jails in America (February 2015).

[4] *See 2.*

[5] Bronson, Jennifer, Ph.D, Stroop, Zimmer, Stephanie and Berzofsky, Dr.P.H (June 2107, Revised August 2020) Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009. U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics Health Justice.

WHAT IS BEHAVIORAL HEALTH EQUITY?

Behavioral health equity is the right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

As population demographics continue to shift, behavioral health care systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible.[6]

Courts should support efforts to achieve behavioral health equity including developing a statement *covering the life spectrum* (children, youth, and adults) *as it relates to individuals* with behavioral health conditions. Courts should identify and implement evidence-based practices to ensure diversity, equity, and inclusion across all programs and processes and incorporate them into educational programs for court leaders. *See box on the right for recommended actions to be taken.*

- **Disproportionate Impact** Courts should examine the disproportionate impact of behavioral health conditions and associated demographics such as race, ethnicity, socio-economic status (SES), differential disability, and/or LGBTQIA+ on the overrepresentation of individuals who enter the justice system and ensure that interventions, diversions, specialized dockets, and other programming are equitably applied.
- **Equity Data Analysis** Courts should actively collect and review race and ethnicity data to identify inequitable practices and to monitor progress in achieving equity. This analysis should extend to diversion to treatment, related placements, mental health evaluation referrals and diagnostic outcomes.
- **Explicit and Implicit Bias** Courts should identify, measure, and actively address issues of explicit and implicit bias, disproportionate access to resources and programs, and systemic inequities. Training in implicit bias, microaggression, and other DEIA-appropriate courses to increase their cultural respectfulness awareness is also recommended.

[6] Substance Abuse and Mental Health Services Administration, Behavioral Health and Equity.

SOCIAL DETERMINANTS OF BEHAVIORAL HEALTH

In conjunction with promoting equitable access to high-quality affordable and individually tailored services, Courts must develop a heightened awareness of the nexus between social determinants and behavioral health disparities. Social determinants in under-resourced communities contribute to disparate treatment of and treatment access in poor white communities and BIPOC communities.

Economic Conditions

The myriad issues associated with poverty cannot be overappreciated. Lack of employment and under employment are well known contributors to mental health issues including anxiety and depression. Lack of economic mobility can have a cascading generational impact. Lack of stable housing is both a contributing and exacerbating factor for individuals with mental illness. Extremely low incomes and high needs for services are major contributing factors affecting housing stability. These challenges disproportionately impact BIPOC communities. Insurance coverage is a significant economic factor. An incommensurate number of uninsured and underinsured individuals are BIPOC. An unexpected bill of $100 would throw many individuals into debt, and the associated stress may significantly exacerbate their behavioral health.

Culturally and Linguistically Appropriate Services (CLAS)

"Among the many contributors to health inequities, the lack of culturally and linguistically appropriate services in health settings has been recognized as one of the more modifiable factors. Improving the availability of such services will not only improve the quality of care provided, but it may also reduce disparities experienced by racial and ethnic minorities and other underserved populations who face language, literacy, or other cultural barriers"[7]

Physical Environment

Beyond poverty, the circumstances of where one was born or where one lives matters. Are there parks, hiking trials and/or physical fitness resources available? Is there ready access to a grocery store, medical provider, library, and place of worship? Is there reliable transportation? These elements of a person's physical environment or the lack thereof, are crucial indicators as to the resources available and how an individual may be able to respond to behavioral health challenges. For further details on social determinants, see Social Determinants of Mental Health: Where We Are and Where We Need to Go.

[7] Davis, Martin, Freemont, Weech-Maldonado, Willams and Kim (2018) Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. U.S. Department of Health and Human Services Office of Minority Health.

BARRIERS TO BEHAVIORAL HEALTH EQUITY

Knowledge of the social determinants is critical, but there must also be understanding of the various barriers that exist to achieving behavioral health equity. Courts must take steps to effectively reduce these barriers.

Criminal Justice Associated Barriers

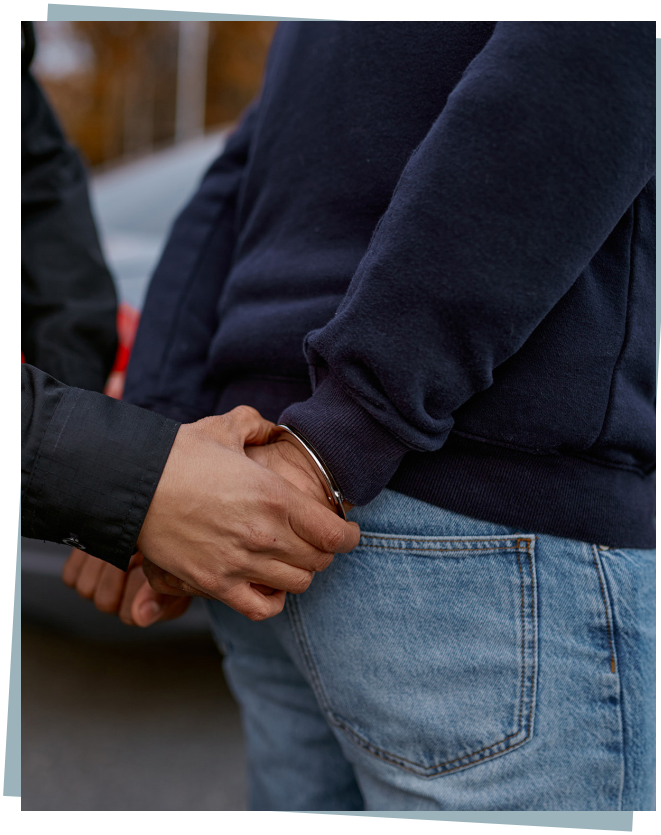
A variety of criminal justice associated barriers impede achieving behavioral health equity including systemic racism, exposure to the criminal justice system, lack of diverse and culturally responsive providers, and inadequate criminal justice programing.

SYSTEMIC RACISM

The pervasive impact of racism and unconscious bias contributes to the overrepresentation of Black and Brown people in the justice system. "African Americans are more likely than white Americans to be arrested; once arrested, they are more likely to be convicted; and once convicted, they are more likely to experience lengthy prison sentences. African-American adults are 5.9 times as likely to be incarcerated than whites and Hispanics are 3.1 times as likely. As of 2001, one of every three black boys born in that year could expect to go to prison in his lifetime, as could one of every six Latinos—compared to one of every seventeen white boys" (Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System, 2018).

EXPOSURE TO THE CRIMINAL JUSTICE SYSTEM

According to a study published in the American Journal of Public Health, "[e]xposure to police stops, arrests, and incarceration were each associated with lower well-being in every domain compared with those not exposed. Longer durations of incarceration and multiple incarcerations were associated with progressively lower well-being. Those who were stopped and frisked by the police had low well-being similar to that of those who had been incarcerated multiple times. Any exposure to police contact or incarceration is associated with lower well-being in every domain. More involved exposure is associated with even



lower well-being" (Ram Sundaresh, 2020). Even further concerning, these encounters with law enforcement are more likely to lead to violent outcomes if the individuals are Black."[8] Based on data compiled by the FBI's Uniform Crime Reporting (UCR) program, it found that while Black people make up 13% of the U.S. population, they were 33% of persons arrested for non-fatal violent crime (NVC), which includes rape, robbery, aggravated assault, and other assaults. Black people were 36% of those arrested for serious non-fatal violent crimes (SNVC), including rape, robbery, and aggravated assault.

Similarly, Hispanics make up 18% of the US population and were 21% of those arrested for serious non-fatal violent crimes. Whites, who are 60% of the population, were 46% of persons arrested for non-fatal violent crimes, and 39% of those arrested for serious non-fatal violent crimes" (Clarke, 2021).

LACK OF DIVERSE AND CULTURALLY RESPONSE PROVIDERS

Another contributing factor impacting access is the dearth of BIPOC mental health providers and of culturally responsive providers which contributes to the lack of access or reluctance of BIPOC individuals to access treatment even when it is available.[9] Greater efforts should be made to encourage BIPOC treatment providers and diversion programs that are actually managed by BIPOC individuals.

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[8] "Two additional and intersecting factors lead to overrepresentation of Black people with SMI in the criminal justice system: the barriers to healthcare faced by Black people and the higher likelihood of violent outcomes from police encounters for Black people suspected of crimes. First, barriers to Black people accessing mental healthcare include distrust of medical institutions, lack of "culturally competent providers," and a disproportionately high number of uninsured and underinsured individuals. Second, inability to access mental healthcare when SMI symptoms first present exacerbates those symptoms and leads to a higher likelihood of criminal activity. Once a person's symptoms bring them into contact with law enforcement, they face a higher likelihood of violent police encounters if they are Black. The inability to form mens rea puts people with SMI at risk of criminal justice involvement regardless of race. Black people are at a higher risk of harmful criminal justice experiences regardless of SMI status. The intersection of the two spaces—being Black and living with SMI— compounds the risk of unjust outcomes and intensifies the need for alternate approaches to adjudicating violent offenses committed by people occupying that intersection." See Sabah Muhammad and Michael Gray, Race, Mental Illness, and Restorative Justice: An Intersectional Approach to More Inclusive Practices, Seattle Journal for Social Justice, Volume 20, Issue 1, Article 18 (12-31-2021).

See generally Bernice Roberts Kennedy et al., African Americans and their Distrust of the Health Care System: Healthcare for Diverse Populations, J. Cultural Diversity 56 (2007) (explaining Black distrust in healthcare research and researchers); Lindsay Wells

See generally Division of Diversity and Health Equity, Mental Health Disparities: African Americans, Am. Psychiatric Ass'n 3 (2017).

See generally Off. of Rsch. & Pub. Affs., Anosognosia, Non-Treatment, and Violent Behavior, Treatment Advoc. Ctr. (Sept. 2016).

See Edwards et al., Risk of Being Killed by Police Use of Force in the United States by Age, Race-ethnicity, and Sex, 116 Proc. of the Nat'l Acad. of Sci. of the U.S. of Am. 16793, 16794 (Aug. 2018); Mark Hoekstra & Carly Will Sloan, Does Race Matter for Police Use of Force? Evidence From 911 Calls 31 (Nat'l Bureau of Econ. Rsch. Working Paper No. 26774), (discussing the propensity of white police officers to use violence more often when responding to calls in minority neighborhoods).

[9] See Sabah Muhammad and Michael Gray, Race, Mental Illness, and Restorative Justice: An Intersectional Approach to More Inclusive Practices, Seattle Journal for Social Justice, Volume 20, Issue 1, Article 18 (12-31-2021).

INADEQUATE CRIMINAL JUSTICE PROGRAMS

Once an individual enters a behavioral health or criminal justice diversion program (e.g., Restorative Justice), they are often met with a structure that does not meet their specific needs.[10] Programs serving individuals with behavioral health issues are often designed primarily by white people to meet the needs of individuals who are white. The result is that the program structure does not meet the needs of BIPOC individuals and further exacerbates disparate treatment and inhibits program participation.

Historical and contemporary distrust by BIPOC individuals involved in the criminal justice system has led to disengagement with diversion programs.[11] Many young BIPOC men feel that systems are not built to support them, and they cannot share their full experiences and emotions without negative repercussions. For example, young people fear involvement with the child protective system and fear being institutionalized by the mental health system.[12] Also, "[r]esearch has also shown that Latino and Black men may avoid treatment due to fears around immigration status and arrest, respectively. Pregnant women and mothers may also avoid treatment due to fears of legal consequences or losing custody of their children (NAMD , 2022).

Other Barriers

EQUITY VS. EQUALITY

There is a significant difference between equity and equality. Simply put, equality means giving everyone shoes. Equity means giving everyone shoes that fit. This statement can be a lightning rod for some persons who believe favoring some racial and ethnic groups over others will inflame rather than heal racial division. Yet, advancing equity is a crucial part of establishing fairness, reinforcing justice, and creating an equal playing field for all. Related political debates often muddle work currently under way relative to "equity initiatives" in the courts and in other institutions. "To improve equity, we must increase justice and fairness within the procedures and processes of institutions or systems, as well as their distribution of resources. Tackling equity issues requires an understanding of the root causes of outcome disparities within our society" (Monisha Kapila & ProInspire, 2016).

[10] Restorative justice will never achieve its potential and provide more fair and effective results than the existing criminal justice system unless it actively engages the people who are harmed the most by the current system." See Sabah Muhammad and Michael Gray, Race, Mental Illness, and Restorative Justice: An Intersectional Approach to More Inclusive Practices, Seattle Journal for Social Justice Volume 20 Issue 1 Article 18 (12-31-2021).

[11] Furthermore, the very location of many restorative justice programs—within existing criminal justice infrastructure—risks both creating hesitancy in Black victims and individuals accused of crimes to take part as well as overreliance on components of the criminal justice system that have failed throughout the nation's history to bring just sentencing for Black justice-involved people." See Sabah Muhammad and Michael Gray, Race, Mental Illness, and Restorative Justice: An Intersectional Approach to More Inclusive Practices, Seattle Journal for Social Justice, Volume 20, Issue 1, Article 18 (12-31-2021).

[12] See Ujima Youth Researchers, D'angelo Moore et al., Changing the Beat of Mental Health: Amplifying Our Voice, Communities United (2022).

CULTURAL HUMILITY vs. CULTURAL COMPETENCE

"Cultural competencies are loosely defined as the ability to engage knowledgeably with people across cultures."[13] (healthcity.bmc.org/policy and industry). The concept of cultural competency was developed in the 1960s and 1970s at the height of the civil rights movement. The assumption is the more knowledge we have about a culture and the group of people within that culture, the greater competence we will have when dealing with individuals we meet in the justice system who are part of this group. However, this assumption along with having categorical knowledge about a person who is a member of a particular culture or ethnicity can lead to stereotyping and bias. It also inherently implies that there is an end point to becoming fully culturally competent. These limitations have led to a shift away from the cultural competence framework toward the importance of cultural humility and sensitivity.

The concept of "cultural humility" arose from the medical field in the late nineties and involves a dynamic and ongoing process of self-reflection and personal critique where an individual not only learns about another's culture but starts with an examination of their own cultural identity and biases. Cultural humility incudes an openness to consider your own privileges and blind spots. This reflection includes recognizing that culture includes the multidimensional intersection of race, ethnicity, gender identity, gender expression, sexual orientation, physical or mental ability, language, age, religion, professional status, and other perspectives. Cultural humility involves developing and nurturing an attitude and orientation of openness and respect of all persons and their views. This requires personal introspection in order to develop an understanding of how our culture has an impact on those we serve. Humility is a state of being and an interpersonal and intrapersonal way of relating that cultivates and supports person-centered justice.

Developing cultural humility is a lifelong process with no discrete end. It requires us to step back and examine our own biases and values. Cultural humility cannot be condensed into a classroom or educational offering but rather, requires ongoing reflection. Our own culture comes from a variety of cultures including work, family, social, school, or religious. The overall purpose of the reflection is to be aware that our values and beliefs come from a combination of cultures with the goal of increasing our understanding of others.

[13] Khan, Shamalia, PhD. (2021). Cultural Humility vs. Cultural Competence — and Why Providers Need Both. Health City.

Culturally responsive care is not a one-size-fits-all approach. What is considered effective and respectful care might vary greatly from one community and person to another even within the same racial and ethnic groups.[14] One must appreciate how socio-cultural background affects people's worldviews, behavior, and expectations for treatment. Achieving a justice system where all persons receive behavioral health equity and where court employees practice cultural humility must include the voices of those who have been marginalized and oppressed. These voices have often been silenced or ignored because of systemic racism and systemic barriers. We must honor the experiences and insight of those whose lives are most affected by mental health disparities, inequities, and injustices if we hope to achieve equity. These voices can help us with our lifelong journey to practice cultural humility.

RECOMMENDATIONS FOR COURT LEADERS

Courts are the default referral system for services for those persons with behavioral health conditions and who are justice involved. The criminal justice system should pivot toward person-centered justice in order to support and achieve behavioral health equity. Developing cultural humility is an essential pathway toward achieving person-centered justice. Court leaders should develop and adopt a statement in support of behavioral health equity, develop training programs in cultural humility and the social determinants of behavioral health, and develop criminal justice programs that are tailored to the needs of individuals who will be served by them. All of these endeavors must include the voices of those who have been marginalized and oppressed to inform our efforts to achieve equity.

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[14] Counselors and administrators should understand that each client embraces his or her culture(s) in a unique way and that there is considerable diversity within and across races, ethnicities, and culture heritages. Other cultures and subcultures often exist within larger cultures." See TIP 59: Improving Cultural Competence, U.S. Department of Health And Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, HHS Publication No. (SMA) 14-4849, (First Printed 2014).

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