Interim Public Policy and Equity Framework

Disclaimer: This document/rubric is in use by MHA as of March 4, 2021 to help us evaluate through an equity lens the development of and our potential support for public policy initiatives affecting behavioral health. We will make revisions as we gain deeper insights. Future versions will be dated and supersede earlier ones.

At Mental Health America (MHA), the organization's unique contribution to action – and one it has played for more than a century – is to focus on mental health. The country's legacy of racism and other forms of discrimination negatively impacts mental health, but discourse around mental health in our nation often erases the role of inequity and oppression. A legacy of racism and discrimination in mental health care also has contributed to fear and distrust in seeking care, including misdiagnoses, and unequal access to mental health services and supports. Thus, a focus on equity must be core to mental health policy.[1]

This framework and the accompanying rubric are living documents that will be revised as MHA learns more as an organization and as policy initiatives in mental health and equity continue to develop. MHA is also in the process of a comprehensive initiative to guide MHA's equity work that will inform future iterations of this document.

Historical Context for MHA's Public Policy and Equity Work:

The history of racism runs deep within clinical mental health for Black, Indigenous, and People of Color (BIPOC) individuals. For example, people who are African American or Black have historically been subjected to more severe diagnosis than their white counterparts, such as overdiagnosis of schizophrenia. Further, homosexuality was considered a pathology and defined as such in the DSM until 1973.

BIPOC individuals were also pathologized when they objected to racism and indignities that they faced. The most extreme example is the psychiatric diagnosis of Drapetomania, which was used to pathologize the reason that slaves became runaways and avoid acknowledging systemic oppression and abuse. As described in numerous articles, books, and historical compilations, BIPOC individuals with mental health conditions have been subjected to abuse, segregation, experimentation, harmful institutionalization and commitment, criminalization, and other discrimination and acts of oppression.[2,3] This history has laid the foundation for systemic racism that persists today, including a lack of trust and continuing discrimination that limits access to care and has a negative effect on BIPOC mental health and well-being.[4] In 2019, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health (NSDUH) found that 35% fewer adults who identified as Black or African

[1] To read more about what we mean by equity, see: https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html#:~:text=In%20a%20report%20designed%20to,be%20as%20healthy%20as%20possible.
[2] Gordon-Achebe, K., Hairston, D. R., Miller, S., Legha, R., & Starks, S. (2019). Origins of racism in American medicine and psychiatry. Racism and Psychiatry, 3-19.
[3] American Psychiatric Association. (2021, Jan 18) *Historical Addendum to APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry*. American Psychiatric Association. https://www.psychiatry.org/newsroom/historical-addendum-to-apa-apology
[4] Legha, R. K., & Miranda, J. (2020). An anti-racist approach to achieving mental health equity in clinical care. Psychiatric Clinics, 43(3), 451-469.

American with any mental illness received services in the past year than those who identified as White (32.9% vs 50.3%). The 2019 Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey found that almost 50% more youth identifying as Black or African American reported attempting suicide compared to youth that identified as White (11.8% vs 7.9%), while NSDUH data indicates that Black adolescents have less access to depression care than white adolescents – 36% of Black youth with major depressive episodes received access to mental health care compared to 50% of White youth. MHA has committed itself to addressing the root causes of these inequities in mental healthcare access and outcomes and will use its policy and advocacy work to advance mental health equity in the United States.

MHA's Objectives and Goals for Its Policy and Equity Work:

MHA views equity as core to its policy work, and works to advance policy change with two primary objectives:

Advance equity through MHA's policies. In every policy, MHA strives to do what it can through its role in mental health advocacy to: (1) acknowledge the role of systemic inequity and oppression, (2) address the historical discrimination and resulting inequities described above, and (3) ensure that public policies more equitably distribute power and resources toward a more mentally healthy society.

Advance mental health equity in other policy agendas. The equitable treatment of individuals with mental health conditions in health care, education, and community life is a civil rights and public health issue, and one that still requires much work today. MHA strives to ensure that other advocacy organizations consider mental health equity and intersectionalities as part of their policy work.

The first objective of advancing equity through MHA's own policy priorities requires constant interrogation and learning. This document offers a framework for assessing how its policy priorities achieve their goals of improving mental health equity and provides greater context for the organization's Policy and Equity Rubric.

Overall, MHA's goal is to advocate for policies that promote equity and are anti-racist:[5]

1. **Are informed by culture and context, including trauma.** Provide for tools, services, and education to promote mental health and healing that are responsive to the trauma of racism and discrimination, and embrace intersectionality including for individuals and families.[6]
2. **Are community-based and socially integrated**. Provide for prevention, early intervention, and recovery-oriented mental health treatment, services and supports where people are – in their communities in-person or virtually (including through schools, primary care, and other easily accessible places) - and in the ways that are most meaningful and relevant to the individual.
3. **Are representative of the population**. Ensure that individuals have a choice of providers, services, and supports that reflect their race, culture, and ethnicity and who share their sex/gender identity and/or fluidity, speak their language, and are able to deliver care that meets their needs. Center the

[5] To read more about anti-racism, see: https://www.penguin.co.uk/articles/2020/june/ibram-x-kendi-definition-of-antiracist.html

[6] To read more about intersectionality, see: https://time.com/5786710/kimberle-crenshaw-intersectionality/

voice of BIPOC individuals and other communities that have been historically left out of decision-making related to mental health, including all aspects of policy prioritization, design, implementation, and evaluation.

4. **Are transformative in how they address crises**. Transform emergency responses to individuals with mental illness and addiction from a law enforcement response to a public health response.
5. **Are providing accessible, affordable health coverage and equitable financing**. Individuals will have access to health insurance coverage that is affordable and accessible. In addition, there should be equitable compensation of a wide range of providers who serve communities of color, people with a mental illness, and other marginalized populations. This also includes access to necessary transportation and technologies.
6. **Are focused on long-term equity.** Promote healthy mental development from early in life as a key strategy for promoting life-course health equity, acknowledging that systematic racism places additional layers of intergenerational stress on families of color.
7. **Are encompassing of social and economic needs.** Address social needs and social determinants of health in communities,[7] appreciating the intersection of economic equity and mental health, as well as the way systemic racism has harmed the mental health of BIPOC individuals by denying equitable access to economic, educational, and social opportunities and resources.
8. **Are power-shifting.** Shift power and resources away from systems that have perpetuated inequities related to mental health toward those individuals and communities that work to advance equity.
9. **Are empowering individuals.** Evaluate and ensure that any system of care for people with mental illness and addiction is humane, as least restrictive as possible, person- and recovery-focused, allows for self-determination, and is designed to reduce inequity. This includes a commitment to reduce the use of institutional settings, such as hospitals and jails.

While systemic racism motivated this work, MHA focuses on equity for a range of populations that experience structural disadvantage in the U.S.:[8]

- BIPOC Individuals
- Women
- LGBTQIA2S+
- Gender diverse populations
- Unhoused or insecurely-housed people
- People with limited financial resources
- People with a disability, including intellectual and developmental disabilities
- Immigrants, including those without documentation and refugees
- Veterans and active-duty military
- New or expecting mothers
- Individuals with limited English proficiency
- Older adults

[7] Read more about social determinants of health here: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[8] We use "structural disadvantage" to refer to those impacted by structural determinants related to public policy, read more here: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0879-9

- Children, adolescents, and young adults
- People with experiences of trauma
- Caregivers
- People with justice system involvement, including children
- People whose identities encompass the intersections of these, and the unique experiences that arise from these intersections

While those with a range of mental health experiences are always centered in MHA's work, it encourages other organizations to also consider mental health needs in their equity frameworks, as well as the many intersections across identities.

For each of these populations, MHA asks itself:

1. **PRIORITIZATION:** Where are the greatest disparities and the greatest opportunities for equity? What can MHA add value to? What conversations are happening currently and how can the organization participate in those conversations/make sure those conversations involve the principles discussed here? Does it address some of the key issues identified above such as:
   a) addressing mistrust in the mental health system,
   b) improving disparities in access to mental healthcare,
   c) diversifying the mental health workforce, including peers and clinicians, or
   d) ending the criminalization of people of color with mental illness?

2. **VOICES AND PERSPECTIVES:** How can MHA better center the voices and perspectives of those with lived experience? Reciprocally, how can MHA be an ally to others to advance equity in related policy areas? MHA is creating a network of policy advisors of all different backgrounds and experiences to help answer the questions posed here and will ask itself at the start of each policy generation process how to better include other voices and perspectives. MHA will seek input from its affiliate network and from other organizations that reflect diverse lived experiences.

3. **POLICY OBJECTIVES, DESIGN AND EQUITY:** How would the proposed policy impact populations that experience structural disadvantage, both positively and negatively? Does the policy serve the needs of different populations and protect them from harm? How could the policy be improved to better serve the needs of each population or ensure that it achieves its intended effect for each population? Are there provisions MHA could add to the policy that might better meet the needs or otherwise advance equity for some populations? Could the policy have negative consequences – intended or unintended – for some populations, including harms from stereotyping, segregating, or unequal applications and impacts of provisions of the policy based on race? If so, can the policy be improved, or should the organization work to stop it?

4. **ADDRESSING LEGACIES OF DISCRIMATION/REDISTRIBUTING POWER:** Are populations that experience structural and intersectional disadvantage being included in all aspects of the policy development, communication, and implementation? Are those implementing the policies (such as those providing services) reflective of the communities served and how can MHA promote greater representation through the policy? How could a policy better address systemic oppression and inequality? Has MHA considered the histories of discrimination that shape the systems involved in

the policy, and can the organization's policies heal these toxic legacies? How are existing incentives leading to the poor outcomes the mental health community is now seeing? Are there ways that the policy could more effectively shift power toward individuals and communities in each population?

Could interventions and outcomes be better centered around agency and empowerment? Could the policy be leveraged to also create more economic, social, and civic opportunities for these populations – especially during the workforce implementation of the policy or relevant interventions?

5. **POLICY OVERSIGHT, EVALUATION AND DATA:** Are data being collected to ensure that equity goals are realized and to document any changes in outcomes, access, and workforce? How could a policy include an oversight and evaluation strategy that ensures that the policy both benefits each population and protects them from unintended harms? Does the policy include enough resources for data collection to capture the experiences of each population and data disaggregated by race/ethnicity/sexuality? Are the measurement tools and data collection tools, and data collection mechanisms, that MHA is using discriminatory in and of themselves? Do the outcomes incentivized reflect the needs and desires of each population? Are there protections and safeguards in place to avoid harms that are identified in the evaluation, including private rights of action and meaningful administrative enforcement mechanisms to protect civil rights?

6. **COMMUNICATIONS AND EQUITY:** Does the proposal communicate the impact on populations that experience structural disadvantage with data and description of barriers, including relevant historical context? Does MHA's communications note the legacy of racism and discrimination that the systems involved were built on – and how the policy helps to heal it? Do the communications reinforce the centrality of advancing equity in all policies? Are there other voices that can be elevated in the communications?

7. **REMINDER TO REEVALUATE AND CONTINUALLY LEARN:** Finally, what voices, perspectives, or needs might have been left out, even after answering these questions? What additional steps can MHA take to include left out voices, perspectives, or needs? How can MHA make sure that the policy will adapt to our changing society, or as its impacts are determined?