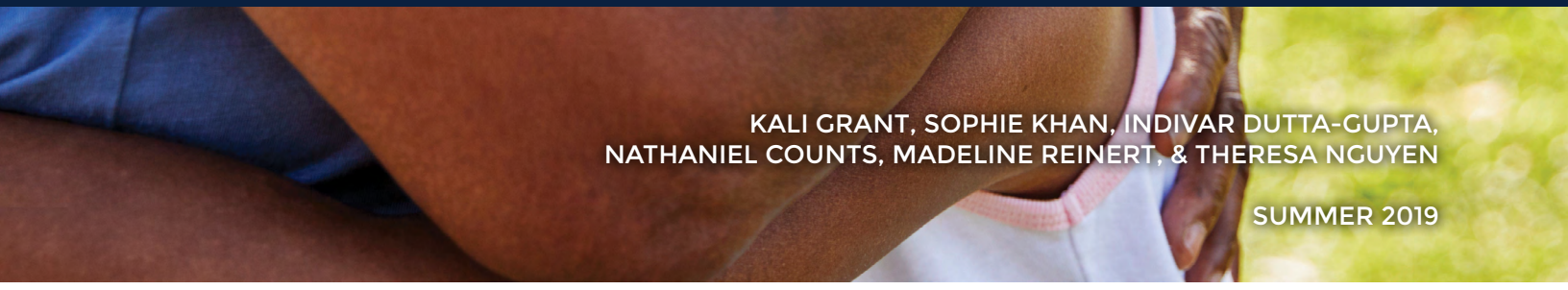
Mental Health America

CENTER ON POVERTY and INEQUALITY
GEORGETOWN LAW

ECONOMIC SECURITY and OPPORTUNITY INITIATIVE

Reimagining Behavioral Health

A New Vision for Whole-Family, Whole-Community Behavioral Health



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SUMMER 2019

Georgetown Center on Poverty and Inequality

The Georgetown Center on Poverty and Inequality (GCPI) works with policymakers, researchers, practitioners, advocates, and people with lived experience to develop effective policies and practices that alleviate poverty and inequality in the United States.

GCPI conducts research and analysis, develops policy and programmatic solutions, hosts convenings and events, and produces reports, briefs, and policy proposals. We develop and advance promising ideas and identify risks and harms of ineffective policies and practices, with a cross-cutting focus on racial and gender equity.

The work of GCPI is conducted by two teams: the Initiative on Gender Justice and Opportunity and the Economic Security and Opportunity Initiative.

Economic Security and Opportunity Initiative at GCPI

The mission of the Georgetown Center on Poverty and Inequality's (GCPI) Economic Security and Opportunity Initiative (ESOI) is to expand economic inclusion in the United States through rigorous research, analysis, and ambitious ideas to improve programs and policies. Further information about GCPI's ESOI is available at www.georgetownpoverty.org.

Mental Health America

Mental Health America (MHA)—founded in 1909—is the nation's leading community-based nonprofit dedicated to addressing the needs of people living with mental illness and to promoting the overall mental health of all Americans. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for people at risk, integrated care, services, and supports for people who need it, with recovery as the goal. Much of our current work is guided by the Before Stage 4 (B4Stage4) philosophy—that mental health conditions should be treated long before they reach the most critical points in the disease process. Learn more about MHA, go to: www.mentalhealthamerica.net.

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Any errors of fact or interpretation remain the authors'. Further information about GCPI's ESOI is available at www.georgetownpoverty.org. Further information about MHA is available at www.mentalhealthamerica.net.

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Contents

Abbreviations, Acronyms, & Initializations

ACA—Affordable Care Act

ACE—Adverse Childhood Experience

ACF—Administration for Children and Families

ACO—Accountable Care Organization

ADA—Americans with Disabilities Act of 1990

ADAP—Adolescent Depression Awareness Program

ADHD—Attention Deficit Hyperactivity Disorder

AHCM—Accountable Health Communities Model

AHRQ—Agency for Healthcare Research and Quality

AIAN—American Indian and Alaska Native

ALPP—Bridges of Iowa Alternative Legal Placement Program

ARTS—Addiction and Recovery Treatment Services

AUD—Alcohol Use Disorder

BJS—Bureau of Justice Statistics

CBT—Cognitive Behavioral Therapy

CCBHC—Certified Community Behavioral Health Center

CCDBG—Child Care and Development Block Grant

CCIO—DOL Center for Consumer Information & Insurance Oversight

CCO—Coordinated Care Organization

CCTP—ACA's Community-based Care Transitions Program

CDA—Child Development Account

CDBG—Community Development Block Grant

CDC—Centers for Disease Control and Prevention

CDCTC—Child and Dependent Care Tax Credit

CHC—Community Health Center

CHIP—Children's Health Insurance Program

CJ/JJ—Criminal Justice/Juvenile Justice

CLAS—Culturally and Linguistically Appropriate Services

CMMI—Center for Medicare and Medicaid Innovation

CMS—Centers for Medicare and Medicaid Services

CPS—Child Protective Services

CSE—Child Support Enforcement

CSFP—Commodity Supplemental Food Program

CTC—Child Tax Credit

CTE—Career and Technical Education

DACA—Deferred Action for Childhood Arrival

DOJ—U.S. Department of Justice

DOL—U.S. Department of Labor

DSM—Diagnostic and Statistical Manual of Mental Disorders

DULCE—Developmental Understanding and Legal Collaboration for Everyone

DV/IPV—Domestic Violence/ Intimate Partner Violence

E&T—Employment and Training Programs

EHB—Essential Health Benefit

EHR—Electronic Health Record

EITC—Earned Income Tax Credit

EMS—Emergency Medical Services

EPSDT—Early and Periodic Screening, Diagnostic, and Treatment

ESSA—Every Student Succeeds Act

FBI—Federal Bureau of Investigation

FCC—Federal Communications Commission

FERPA—Family Educational Rights and Privacy Act of 1974

FFPSA—Family First Prevention Services Act

FPL—Federal Poverty Level

FMAP—Federal Medical Assistance Percentage

FNS—Food and Nutrition Service

FPSW—Family Peer Support Worker

FQHC—Federally Qualified Health Center

GAD—Generalized Anxiety Disorder

HDOSO—Health Determinant of Social Outcomes

HEA—Higher Education Act of 1965

HELP-Link—Montana Health and Economic Livelihood Partnership Link

HHS—U.S. Department of Health and Human Services

HIPAA—Health Insurance Portability and Accountability Act of 1996

HIV—Human Immunodeficiency Virus

HPOG—Health Profession Opportunity Grants

HPSA—Health Professional Shortage Area

HRSA—Health Resources and Services Administration

HUD—U.S. Department of Housing and Urban Development

ICE—U.S. Immigration and Customs Enforcement

ID/DD—Intellectual and Developmental Disability

IDA—Individual Development Account

IDEA—Individuals with Disabilities Education Act

IEP—Individualized Education Program

IHH—Integrated Health Hub

IHS—Indian Health Service

IMD—Institutions for Mental Diseases

IPS—Individual Placement and Support

IRS—Internal Revenue Service

JSA—Jobseeker's Allowance

LEA—Local Education Agency

LGBTQ—Lesbian, Gay, Bisexual, Transgender, Queer

LISC—Local Initiatives Support Corporation

LTSS—Long-Term Services & Supports

MAT—Medication-Assisted Treatment

MCO—Managed Care Organization

MDD—Major Depressive Disorder

MDE—Major Depressive Episode

MFP—Money Follows the Person

MHI Street—Mental Health Improvement through Study, Teaching, Rebranding, Embedded Educations, and Technology

MIECHV—Maternal, Infant, and Early Childhood Home Visiting program

MITA—Medicaid Information Technology Architecture

MOMS—Mental Health Outreach for Mothers

MTO—Moving to Opportunity for Fair Housing

NAS—Neonatal Abstinence Syndrome

NCQA—National Committee for Quality Assurance

NEMT—Non-Emergency Medical Transportation

NIH—National Institutes of Health

NIMH—National Institute of Mental Health

NSLP—National School Lunch Program

OCD—Obsessive-Compulsive Disorder

OECD—Organisation for Economic Co-operation and Development

OMB—Office of Management and Budget

OSFED—Other Specified Feeding or Eating Disorder

OSHA—Occupational Safety and Health Administration

PAIMI—Protection and Advocacy for Individuals with Mental Illness

PAR—Participatory Action Research

PATHS—Promoting Alternative Thinking Strategies program

PBS—Public Broadcasting Service

PEAK—Colorado Program Eligibility and Application Kit

PFML—Paid Family and Medical Leave

PHA—Public Housing Agency

PMDD—Premenstrual Dysphoric Disorder

PTSD—Post-Traumatic Stress Disorder

R&D—Research and Development

RHC—Raising Healthy Children program

SAD—Seasonal Affective Disorder

SAMHSA—Substance Abuse and Mental Health Services Administration

SBHC—School-Based Health Center

SBIR—Small Business Innovation Research

SBIRT—Screening, Brief Intervention, and Referral to Treatment

SDOH—Social Determinant of Health

SE—Subsidized Employment

SEEK—Safe Environment for Every Kid

SNAP—Supplemental Nutrition Assistance Program

SOGI—Sexual Orientation and Gender Identity

SRO—School Resource Officer

SSI—Supplemental Security Income

SUD—Substance Use Disorder

TANF—Temporary Assistance for Needy Families

TBI—Traumatic Brain Injury

TEDS—Treatment Episode Data Set

UI—Unemployment Insurance

USDA—U.S. Department of Agriculture

USPSTF—U.S. Preventive Services Task Force

VA—U.S. Department of Veterans Affairs

VAWA—Violence Against Women Act of 1994

WIC—Special Supplemental Nutrition Program for Women, Infants, and Children

WIOA—Workforce Innovation and Opportunity Act

Methodology

Through this project, the Georgetown Center on Poverty and Inequality (GCPI) and Mental Health America (MHA) explored cross-sector and -systems approaches to addressing the relationship between behavioral health and economic disadvantage for the lowest-income individuals, families, and communities. Using a research-based, holistic approach, the project has aimed to identify innovative ways to engage and coordinate community assets to transform the delivery of whole-person, whole-community behavioral health supports.

This report combines several research methods to offer actionable policy recommendations for producing measurable improvements in the lives of individuals. GCPI and MHA facilitated a series of four, invitation-only convenings with a diverse group of health and health-adjacent content experts, including people with lived experience, over a two-year period to inform the findings and the national, state, and local recommendations in this report. Participants shared key insights about behavioral health needs, challenges, and proven and promising clinical and non-clinical—and medical and non-medical—strategies that can be built upon. These conversations helped to inform the entire report, from the vision and framework, to the recommendations to help achieve the vision, and the conceptualization of opportunity areas. The convenings were then supplemented with extensive secondary research and data analysis, along with dozens of expert interviews. In total, this report draws on insights resulting from engagement with well over 100 experts and stakeholders across the country, and the review and synthesization of hundreds of articles and reports.

The topics of the four convenings were as follows:

1. Next Generation of Whole-Family Behavioral Health Strategies for People With Low Incomes
2. Addressing the Behavioral Health Challenges of Low-Income Mothers
3. Cross-Sector Approaches to Delivering Behavioral Health Services in the Child Welfare System
4. Behavioral Health & Justice Systems: Opportunities and Innovations

Message from the Authors

This report contains discussion of issues related to behavioral health, including depression, eating disorders, substance use, and suicide, along with a discussion of adverse experiences, including domestic violence and intimate partner violence, police violence, and discrimination against the LGBTQ community. Below are some resources if you or someone you know is experiencing a behavioral health condition.

Behavioral Health Resources

Suicide Prevention Hotlines

- National Suicide Prevention Lifeline: 1-800-273-TALK (8255); www.suicidepreventionlifeline.org
- Crisis Text Line: Text HOME to 741741; www.crisistextline.org

Behavioral Health Treatment Services Locator

- Psychology Today: www.psychologytoday.com
- SAMHSA Treatment Locator: www.findtreatment.samhsa.gov

Advocacy Groups

- Mental Health America: www.mentalhealthamerica.net

Domestic Violence/Intimate Partner Violence

- National Domestic Violence Hotline: www.thehotline.org
- National Resource Center on Domestic Violence: www.nrcdv.org

LGBTQ Resources

- Trevor Project: www.thetrevorproject.org

Executive Summary

Health challenges pose one of the greatest barriers to economic equity, and economic challenges pose one of the greatest barriers to health equity. In particular, *behavioral* health is central to our well-being. Both behavioral health and economic challenges harm an individual's ability to work, learn, care for themselves and others, and ultimately lead the life they want to live. And particularly for the 12.3 percent of people in poverty in the U.S.,[i] these challenges cause and compound one another, worsening socioeconomic disparities.

The U.S. falls woefully short in how it approaches and addresses the issue. We do little to actively support the behavioral health of individuals and families throughout their lives and across the communities where they live. We consistently fail to ensure that everyone has access to *any,*[ii] let alone *quality,* mental health and substance use treatment. Worse, our systemic failure to meet behavioral health needs harms people who already face significant adversity the most—particularly people with low incomes, people with disabilities, people of color, and people with other adverse life experiences or facing other structural barriers.

For our nation to reach its potential as a just, inclusive, and thriving society, our systems, structures, services, and communities must prioritize holistic approaches to supporting behavioral health, with attention to reducing socioeconomic disparities for already-struggling people. Achieving this vision requires a paradigm shift that reflects the realities of people's lives and the nature of behavioral health conditions.

We Need Systems Change

The foundations of our behavioral health delivery system were created long before we developed our current understanding of how behavioral health works and how it can be promoted. The behavioral health delivery system was also designed for and by more advantaged members of our society, often neglecting the diverse experiences and needs of people of color and low-income groups. Over time, the path dependency of siloed institutions and structures has created hurdles for aligning prevention and service delivery with people's lived experiences. As a result, today when someone needs behavioral health supports for themselves or a loved one, they must navigate a complex network of uncoordinated and disjointed systems, structures, and services that span multiple sectors and have various requirements for access.

The current health sector is ill-suited to provide straightforward access to high-quality mental health or substance use treatment and care.[iii] Institutions and systems in the health sector lack effective internal coordination—and external coordination with health-adjacent systems.[iv] Institutions in health-adjacent sectors often lack the tools and resources necessary to support the behavioral health needs of children and families. These uncoordinated systems make it difficult for anyone to access care for their behavioral health needs, especially if someone is also struggling with serious or multiple challenges related to economic hardships, adverse life experiences, or disadvantaged identities. For example, an individual or their family struggling with unmet behavioral health or other basic needs may fall through the cracks as they move between and across sectors and interact with various separate stakeholders—including insurance systems, health providers, and pharmaceutical companies in the health sector, and parole

i Fontenot, Kayla, Jessica Semega, and Melissa Kollar. "Income and Poverty in the United States: 2017." U.S. Census Bureau, 12 September 2018. Available at https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-263.pdf.

ii "Access to Care." University of Wisconsin Population Health Institute, and Robert Wood Johnson Foundation, retrieved 24 June 2019. Available at https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/clinical-care/access-to-care.

iii The Future of the Public's Health in the 21st Century. Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century, Washington, D.C.: National Academies Press (US), 2002. Available at https://www.ncbi.nlm.nih.gov/books/NBK221227/.

iv "Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series." Washington, D.C.: National Academies Press, 2006. Available at https://www.ncbi.nlm.nih.gov/books/NBK19833/.

officers, employment and training services, social workers, and case workers in various human service and other health-adjacent systems, such as education, criminal justice, workforce, and child welfare systems.

Even a robust health sector approach to supporting behavioral health would be insufficient in isolation. Other sectors must reconsider and transform their roles in ensuring behavioral health, especially for disadvantaged populations. Yet, few resources in any sectors are devoted to preventing and mitigating behavioral health conditions, promoting healthy development, and shaping a positive social context for families and communities. Despite a voluminous body of research on interventions for diverse populations across diverse settings that prevent or mitigate the development of behavioral health conditions, no sector is currently well-equipped to deliver these strategies.

The Whole-Family, Whole-Community Approach

Any agenda to improve behavioral health outcomes must address the **UNIQUE BEHAVIORAL HEALTH CHALLENGES** people experiencing poverty face

While this report does focus on health coverage and the scarcity of quality, accessible behavioral health services, it goes further to present a proactive vision for a system that takes care of the whole person in their context across the lifecourse: the whole-family, whole-community behavioral health approach. Taking care of the whole person requires considering their socioeconomic well-being, surroundings and communities, and families and social networks. The whole-family, whole-community behavioral health approach offers a unifying framework of approaching sector- and system-level behavioral health challenges by supporting families and individuals holistically.

Using this approach, the report provides traditionally siloed sectors with a shared basis of knowledge on the behavioral health needs of low-income people, women, and key at-risk populations. It identifies common barriers to improving service quality and delivery and then identifies recommendations for policy and systems change. The report takes an expansive view of behavioral health and what influences it, integrating evidence across disciplines and traditions—from clinical research to sociology to the mental health and substance use recovery movement.

Report Structure

This report first reimagines the ways that our current family- and community-serving systems and institutions could support behavioral health and well-being, and then presents a vision for closing system-wide gaps, strengthening transitions, and managing system overlap. Lastly, the report situates these systems-based changes within a broader community-based context, identifying how together and separately, these systems can better function within a broader ecosystem of community-based and community-oriented resources and supports. Thus, this report reimagines the very systems people should be able to access.

Specifically, Chapter I (“Whole-Family, Whole Community Behavioral Health Approach”) introduces a framework for addressing behavioral health through a whole-family, whole-community approach; Chapter II (“Common Behavioral Health Conditions & Compounding Factors”) provides an overview of the most common behavioral health conditions and of the most common social determinants of health (SDOHs); Chapter III (“An Agenda for Whole-Family,

Whole-Community Behavioral Health") presents an overarching agenda for addressing the behavioral health needs of whole families and whole communities, particularly for the lowest income families in the U.S.; and Chapters IV-VI (Opportunity Areas) highlight the behavioral health needs of three populations—mothers and their families, families involved with the child welfare system, and people involved with the criminal justice or juvenile justice (CJ/JJ) systems—and offer holistic, population-specific recommendations.

Summary of Recommendations

The report outlines a set of overarching policy, programmatic, and practice recommendations for addressing the intertwined and interdependent behavioral health and health-adjacent needs of low-income individuals, families, and their communities. Together and separately, the recommendations push us closer to achieving the vision of whole-family, whole-community behavioral health for every individual, family, and community at all stages of life and along the continuum of well-being.

Recommendations are organized according to four main priorities, each of which supports the whole-family, whole-community approach:

1. Health Systems & Sectors Should Account for & Respond to the Realities of Behavioral Health & Compounding Factors
   - 1.1 Ensure Access to Needed Health Services & Supports
   - 1.2 Leverage Opportunities to Improve Holistic Health Services Delivery
   - 1.3 Establish Shared Goals & Hold Health Stakeholders Accountable
   - 1.4 Strengthen & Expand the Health Workforce
   - 1.5 Re-Orient Systems to Prioritize Agency of Individuals & Families in Health Sector

2. Health-Adjacent & Sectors Systems Should Support & Improve Behavioral Health
   - 2.1 Strengthen & Establish Foundational Economic Security & Opportunity Supports
   - 2.2 Nurture the Relationship Between Employment & Behavioral Health
   - 2.3 Help Families Meet Their Intertwined Caregiving & Behavioral Health Needs
   - 2.4 Re-Orient Health-Adjacent Sectors & Systems to be Responsive to Behavioral Health

3. Health & Health-Adjacent Sectors Should Close Gaps & Smooth Transitions Between Them
   - 3.1 Create Seamless User Experiences Across Sectors
   - 3.2 Promote Effective & Efficient Cross-Sector Collaboration
   - 3.3 Ensure Accountability for Effective Service Delivery & Handoffs

4. Communities Should Support Behavioral Health & Well-being at All Times for Everyone
   - 4.1 Leverage Community Assets for Holistic Service Delivery
   - 4.2 Build Safe, Inclusive, & Supportive Environments
   - 4.3 Universalize Access to Behavioral Health Information & Supports

Additional, more specific recommendations also appear at the end of the three chapters on key "opportunity areas" for this issue: maternal behavioral health, behavioral health and child welfare, and behavioral health and the justice system.

Introduction

Health challenges pose one of the greatest barriers to economic equity, and economic challenges pose one of the greatest barriers to health equity. In particular, *behavioral* health is central to our well-being. Both behavioral health and economic challenges harm an individual's ability to work, learn, care for themselves and others, and ultimately lead the life they want to live. And particularly for the 12.3 percent of people in poverty in the U.S.,[1] these challenges cause and compound one another, worsening socioeconomic disparities.

The U.S. falls woefully short in how it approaches and addresses the issue. We do little to actively support the behavioral health of individuals and families throughout their lives and across the communities where they live. We consistently fail to ensure that everyone has access to *any,*[2] let alone *quality,* mental health and substance use treatment. Worse, our systemic failure to meet behavioral health needs harms people who already face significant adversity the most—particularly people with low incomes, people with disabilities, people of color, and people with other adverse life experiences or facing other structural barriers.

For our nation to reach its potential as a just, inclusive, and thriving society, our systems, structures, services, and communities must prioritize holistic approaches to supporting behavioral health, with attention to reducing socioeconomic disparities for already-struggling people. Achieving this vision requires a paradigm shift that reflects the realities of people's lives and the nature of behavioral health conditions.

We Need Systems Change

The foundations of our behavioral health delivery system were created long before we developed our current understanding of how behavioral health works and how it can be promoted. The behavioral health delivery system was also designed for and by more advantaged members of our society, often neglecting the diverse experiences and needs of people of color and low-income groups. Over time, the path dependency of siloed institutions and structures has created hurdles for aligning prevention and service delivery with people's lived experiences. As a result, today when someone needs behavioral health supports for themselves or a loved one, they must navigate a complex network of uncoordinated and disjointed systems, structures, and services that span multiple sectors and have various requirements for access.

The current health sector is ill-suited to provide straightforward access to high-quality mental health or substance use treatment and care.[3] Institutions and systems in the health sector lack effective internal coordination—and external coordination with health-adjacent systems.[4] Institutions in health-adjacent sectors often lack the tools and resources necessary to support the behavioral health needs of children and families. These uncoordinated systems make it difficult for anyone to access care for their behavioral health needs, especially if someone is also struggling with serious or multiple challenges related to economic hardships, adverse life experiences, or disadvantaged identities. For example, an individual or their family struggling with unmet behavioral health or other basic needs may fall through the cracks as they move between and across sectors and interact with various separate stakeholders—including insurance systems, health providers, and pharmaceutical companies in the health sector, and parole officers, employment and training services, social workers, and case workers in various human service and other health-adjacent systems, such as education, criminal justice, workforce, and child welfare systems.

Even a robust health sector approach to supporting behavioral health would be insufficient. Other sectors must reconsider and transform their roles in ensuring behavioral health, especially for disadvantaged populations. Yet, few resources in health-adjacent sectors are devoted to preventing and mitigating behavioral health conditions, promoting healthy development, and

shaping a positive social context for families and communities. Despite a voluminous body of research on interventions for diverse populations across diverse settings that prevent or mitigate the development of behavioral health conditions, no sector is currently well-equipped to deliver these strategies.

The Whole-Family, Whole-Community Approach

While this report does focus on health coverage and the scarcity of quality, accessible behavioral health services, it goes further to present a proactive vision for a system that takes care of the whole person in their context across the lifecourse: the whole-family, whole-community behavioral health approach. Taking care of the whole person requires considering their socioeconomic well-being, surroundings and communities, and families and social networks. The whole-family, whole-community behavioral health approach offers a unifying framework of approaching sector- and system-level behavioral health challenges by supporting families and individuals holistically.

The whole-family, whole-community behavioral health approach offers a **UNIFYING FRAMEWORK** of approaching sector- and system-level behavioral health challenges by **SUPPORTING FAMILIES AND INDIVIDUALS HOLISTICALLY**

Using this approach, the report provides traditionally siloed sectors with a shared basis of knowledge on the behavioral health needs of low-income people, women, and key at-risk populations. It identifies common barriers to improving service quality and delivery and then identifies recommendations for policy and systems change. The report takes an expansive view of behavioral health and what influences it, integrating evidence across disciplines and traditions—from clinical research to sociology to the mental health and substance use recovery movement.

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I. A Whole-Family, Whole-Community Behavioral Health Approach

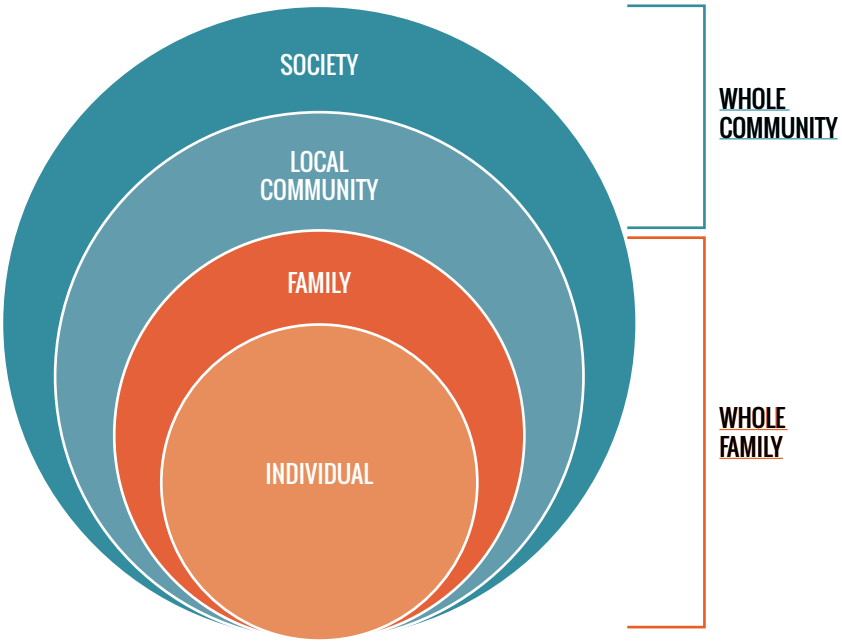
Low income populations are especially likely to face multiple overlapping social, economic, and health challenges, which they often have to address in incomplete and fractured ways using a variety of siloed systems and resources. Interactions of social and economic context also create risk and protective factors for developing behavioral health conditions or inhibit or promote recovery from them. Having a framework that acknowledges and engages this complexity is critical for advancing effective solutions to poverty and behavioral health. The purpose of developing a whole-family, whole-community behavioral health approach is to create a unifying framework that stakeholders and communities can operate from to effectively address the behavioral health needs of low-income populations. A truly whole-family, whole-community approach spans across the various systems, sectors, and stakeholders that they interact with throughout their lives, not only better addressing the behavioral health of low-income individuals and families but utilizing more efficient and cost-effective strategies for the sectors involved.

Historically, both physical and behavioral health conditions were approached with the biomedical model, in which disease is viewed as a disruption in the physiological, biological, or chemical mechanisms of the individual, whether that was caused by internal or external factors.[5] In 1977, George Engel proposed the biopsychosocial model, which went beyond the biomedical model to consider the psychological and social risk factors that influence health and the need to take a more holistic approach to understand the prevention and treatment of disease.[6, 7] Much of behavioral health has been approached within the health sector with the biopsychosocial model to this day; however, there is an increasing need to consider the broader ecosystems that make up the realities of individuals' lives and behavioral health needs, to create a model that unifies stakeholders across health and health-adjacent sectors.

Models to address behavioral health must move beyond the traditional individual-level approach that fails to recognize the socioeconomic context, community and cultural influences, developmental factors, intergenerational experiences, and social networks that interact with the biological and intrapersonal characteristics of the individual. To be truly effective, an individual's behavioral health needs and overall well-being must be proactively supported across these contexts on an ongoing basis, not simply when an individual experiences a behavioral health condition or crisis. This report proposes building upon the biopsychosocial model often used within the health sector by combining it with the socio-ecological model,[8, 9] a theoretical framework often used outside the traditional health sector, for recognizing the reciprocal influences of intrapersonal, interpersonal, community, and structural factors that shape the context for understanding one's environment and their behaviors within that environment.[10] This model recognizes that each individual is in constant interaction with these other levels, and therefore any approach to affect change must holistically address the entire context.

FIGURE 1a. Individuals, families, communities, & society as a whole are all connected

Behavioral health stakeholders & systems



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

The socioecological model starts with a person-centered focus on individuals while acknowledging that what happens at one level has ramifications for other levels and thus, the levels must be viewed as interconnected. The individual level focuses on factors such as individual attitudes, beliefs, and biological and demographic factors. The family, or interpersonal level, focuses on an individual's immediate social supports and the influences of their relationships with others, including family, friends and providers. The third, community level focuses on local communities and cultures, broader social networks, and can include local environmental factors. The fourth level focuses on societal factors, which can include institutions, system-level and structural environments, broader culture, and public policy.

The whole-family, whole-community behavioral health approach used in this report offers a unifying, interdisciplinary framework of approaching sector- and system-level behavioral health challenges by supporting families and individuals holistically. Health and health-adjacent sectors have begun collaborating and coordinating efforts to maximize individual and collective impacts on behavioral health. However, this approach envisions a more proactive behavioral health system that promotes life course and healthy behavioral development, takes care of everyone's direct behavioral health needs, and meets other fundamental needs (e.g. employment, housing, and education) to ensure promotion, prevention, early intervention, treatment, and recovery for mental health and substance use at the individual, family, and population levels in clinical and non-clinical settings.

This approach considers initiatives that coordinate across institutions to develop integrated strategies for economically disadvantaged communities, particularly for women and children. A whole-family approach requires a particular focus on women, motivated by a commitment to racial and gender equity. The approach includes strategies to ensure behavioral health serving

systems and institutions are inclusive, accessible, reflect the communities they serve, and provide resources and support in proportion to the barriers individuals receiving care face. In particular, the whole-family, whole-community approach seeks to advance the following four goals to better align the U.S.' approach to behavioral health with the realities of behavioral health facing low-income individuals, families, and communities:

1. **Establish a shared, cross-systems and -sectors understanding** of the relationship between behavioral health and poverty and common goals and outcomes that include a holistic focus on health, wellness, and economic well-being;

2. **Ensure that services and supports (and their delivery) reflect the realities of behavioral health conditions, particularly as they relate to economic disadvantage,** at each stage of life and at each stage along the continuum of well-being, to *prevent* and *mitigate* the development of behavioral health conditions across family systems, and to support *recovery* and *maintenance* for people experiencing behavioral health conditions;

3. **Identify and encourage crosscutting service delivery and collaboration strategies** and opportunities for ensuring that health and health-adjacent systems, sectors, and the stakeholders within them work seamlessly together to effectively and comprehensively support the behavioral health of individuals, families, and communities; and

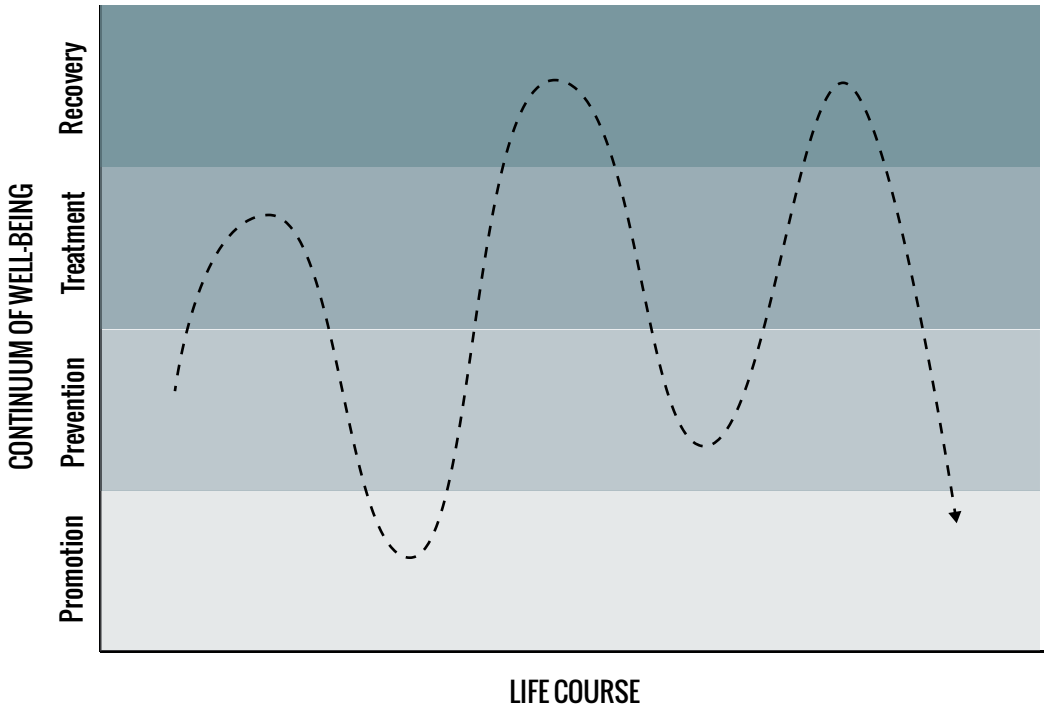
4. **Cultivate supportive ecosystems of polices, services, supports, and conditions,** by advancing community-wide approaches that ensure inclusive and responsive policies and practices, including those that nurture families and communities as leaders and participants with agency.

Supporting Behavioral Health Requires a Holistic Approach

Mental health conditions and SUDs lie at the intersection between objectively measurable biomarkers, subjective experiences of need or distress, and social context and meanings. Simply put, an individual's behavioral health is impacted by many dimensions, including their surroundings and overall well-being. An expansive understanding of the social and economic dimensions of behavioral health implicates the need for a comprehensive, holistic view of behavioral health and well-being—that spans across a continuum of well-being and promotes well-being throughout an individual's life (see Figure 1b). An individual's behavioral health needs and overall well-being should be proactively supported on an ongoing basis, from birth throughout life—not simply when people experience a behavioral health condition or a crisis.[11]

FIGURE 1b. A holistic behavioral health approach recognizes individuals may need a variety of supports throughout their lives

A non-linear continuum of well-being within someon's life cycle



Note: The relationship between the life course & the continuum of well-being or is not always linear. Stages on the continuum may be repeated or skipped depending on the individual.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Based on the "Behavioral Health Continuum of Care Model." Parents Lead, accessed 22 May 2019. Available at https://prevention.nd.gov/files/pdf/parentsleadforprof/ContinuumofCareModel.pdf.

The continuum of well-being model used by the whole-family, whole-community approach builds upon a body of established research on the continuum of care for mental health and substance use conditions.[12, 13, 14] The continuum of care model focuses on the prevention and treatment of behavioral health conditions and long-term care for people diagnosed with a behavioral health condition. Based on the *Mental Health Intervention* spectrum,[15] the model includes four components, though they may overlap:

- **Prevention**: Interventions and supports intended to prevent or reduce the risk of developing a behavioral health condition.
- **Treatment**: Services and supports for people diagnosed with a behavioral health condition.
- **Recovery**: Short-term services and supports intended to help individuals reintegrate back into the community and continue on a recovery trajectory.[16]
- **Maintenance**: Long-term services and supports (LTSS) intended to aid in aftercare and help with reintegration. These strategies include long-term treatment, which could include supports such as therapy and rehabilitation services.

The continuum of well-being model incorporates the continuum of care model, building upon it to create a model that proactively supports individual well-being throughout a lifetime. Ultimately, the model envisions environments and conditions that support thriving families and communities. These conditions would support individual well-being—from individual health and economic security—and promote healthy communities. In this model, the continuum of care is a touchpoint throughout the continuum of well-being. Throughout their lives, individual's may need to touch the continuum of care, preventing adverse experiences or treating a behavioral health condition, but regardless of care support and service needs, the individual will be supported through continuous promotion of well-being.

Everyone Has a Role in Promoting Whole-Family, Whole-Community Behavioral Health

The health and health-adjacent systems are both distinct and overlapping when it comes to population well-being for low-income individuals and families. The health system focuses on both the individual and family as well broader public health as a whole. For health-adjacent systems (including non-health human services), there are various systems that interact with individuals and families, including the environment (meaning physical and social environment), the child welfare system, the CJ/JJ systems, education, employment, housing, economic security, transportation, along with other systems, all of which can impact well-being.

In both the health and health-adjacent systems, there are medical and non-medical supports, which include clinical and non-clinical supports, as illustrated in Figure 1c. In general, this approach understands clinical supports as occurring in traditional institutions and settings that provide direct health services, such as hospitals, urgent care facilities, and in- and out-patient rehabilitation centers, among others; medical supports include services focusing on the direct treatment of a behavioral health condition or other physical or mental health condition.

FIGURE 1c. Strategies for addressing behavioral health span across medical & non-medical supports; clinical & non-clinical supports

Selected behavioral health supports & services

	CLINICAL	NON-CLINICAL
MEDICAL	• Primary Care Physician • Behavioral Health Practitioner • Specialized Medical Care (Optometry, Dentistry, etc.) • Emergency Services	• School Therapist or Nurses • Health Screenings in Schools or Community Centers • First Aid Supports in Workplaces
NON-MEDICAL	• Social Worker in Hospital Setting • Employment Services in Hospital Setting • Spiritual Advisors in Hospital Settings	• Teachers • Community Education on Behavioral Health Conditions • Faith-Based Supports • Employment Supports

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

No single provider can effectively address the behavioral health and related needs of low-income families. As seen in Figure 1d, an array of stakeholders and systems currently already affect the behavioral health of families and communities. Creating an effective behavioral health system will require these various stakeholders working in various stages of collaboration. To facilitate collaboration, each stakeholder involved will need policies, technology, and funding that enable shared learning across sectors. Ideally, coordination would occur in the context of a continuously learning system, in which stakeholders can share data to evaluate their interventions, plan improvements, and ultimately learn how to most effectively meet the needs of their target populations together.

FIGURE 1d. A wide array of stakeholders & systems affect behavioral health

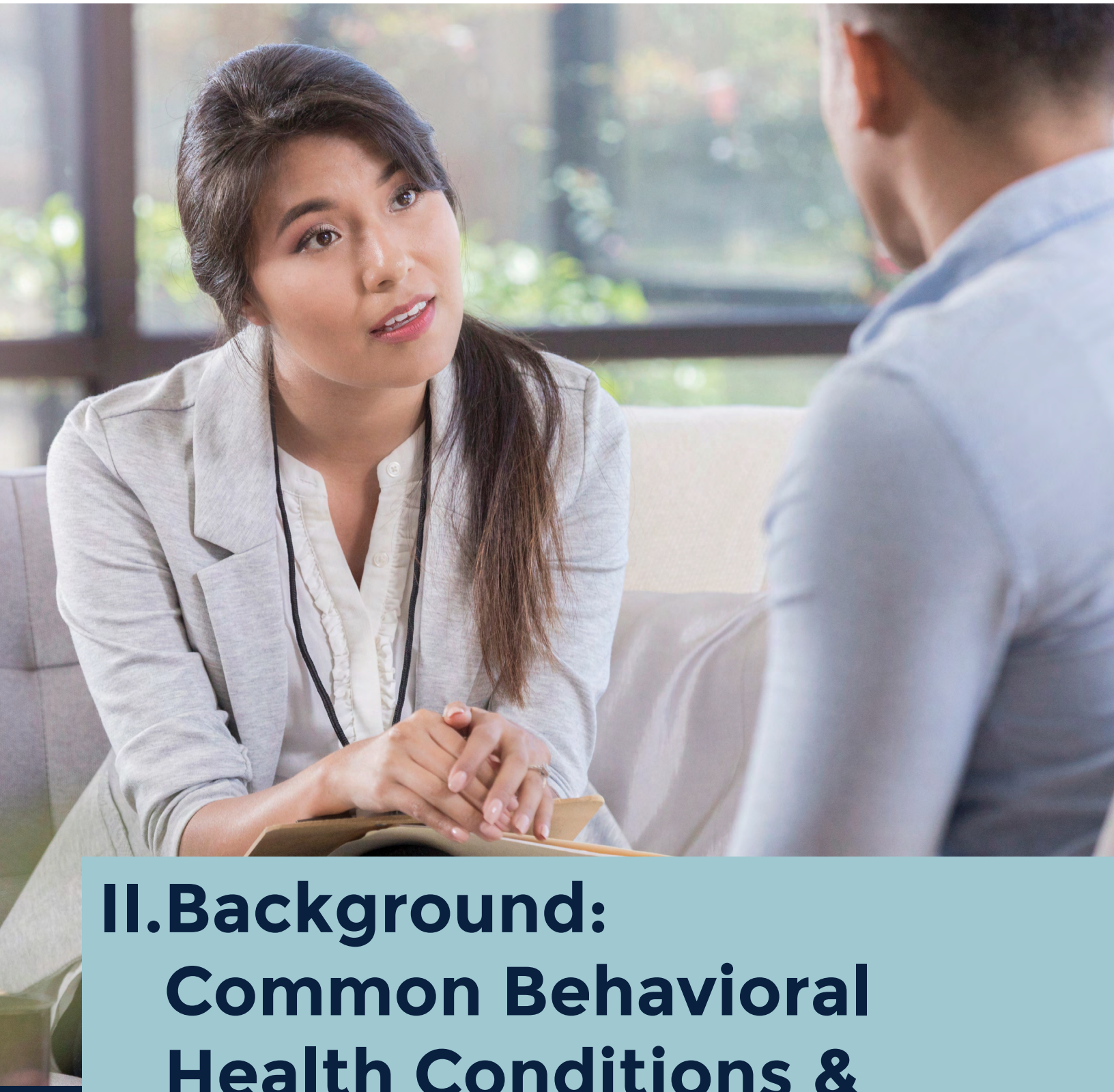
Selected behavioral health stakeholders & systems

	WHOLE-FAMILY		WHOLE-COMMUNITY	
	INDIVIDUAL LEVEL	FAMILY LEVEL	LOCAL COMMUNITY LEVEL	SOCIETY LEVEL
HEALTH SECTOR				
Providers	• Primary/Specialty Health Care Workers (Including Home Visiting) • Navigator/Caseworker • Peer Supports		• CHCs • Hospitals • Emergency Responders	• HRSA
Payers (Including Insurers)				• Medicaid & CHIP • Private Plans
Research Institutions			• Universities	• NIH • Pharmaceutical Companies • AHRQ
HEALTH-ADJACENT SECTORS				
Child Welfare	• Social Workers		• Child Welfare Agency	• Title IV-E Child Welfare Payments
Family Supports	• Program Administrators		• Local Housing Authority • Local Human Service Office	• Tax & Benefit Programs (Including TANF, EITC, & SSI) • Community Development Institutions • FNS
Justice & Law Enforcement	• Police Officers		• Local Law Enforcement	• U.S. Department of Justice (DOJ)
Early Childhood Education	• Early Childhood Educators		• Early Learning & Care Providers	• HHS, ACF • Office of Child Care • Office of Head Start
K-12 Education	• Educators & Administrators		• Youth Support Provider • Schools & Local Education Agencies	• U.S. Department of Education • Title I - Education for Disadvantaged Children

OTHER RELEVANT SECTORS

- Financial Services
- Broadband & Cellular Services
- Charities/Philanthropic Groups
- Environmental Sector
- For-Profit/Private Sector
- Higher Education
- Media
- Private Community & Faith Based/Spiritual Entities & Organizations (e.g. YMCA)
- Third Spaces (e.g. Parks, Libraries, & Resources)
- Transportation
- Utilities
- Workforce Development
- National & Community Service
- Legal Aid

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.



II. Background: Common Behavioral Health Conditions & Compounding Factors

Behavioral health conditions, or mental health conditions and SUDs, are the leading cause of disability in the United States.[17] Economically-disadvantaged adults,[18] in particular, experience higher rates of mental health conditions, including co-occurring SUDs and mental health conditions. People of color, LGBTQ people, immigrants, and survivors of violence often face additional and multiple barriers to meeting their behavioral health needs.[19]

This chapter provides background information on common behavioral health conditions and compounding factors, such as economic insecurity, that may impact an individual's behavioral health and well-being. It also provides framing and context for the report's intersectional, multisystem approach to behavioral health treatment based on a synthesis of existing evidence-based efforts, approaches, and models.

Behavioral Health Conditions

This section provides a brief overview of the following areas of behavioral health: common mental health conditions and SUDs, and the co-occurrence of SUDs and mental health conditions.

MENTAL HEALTH

Mental health conditions are generally characterized by challenges related to mood, thought, or behavior.[20] In 2017, at least 46 million adults (18.9 percent) experienced a mental health condition.[21] Approximately 57 percent of U.S. adults with a mental health condition do not receive treatment.[22] Poverty is associated with mental health conditions: at least 26 percent of individuals with mental health conditions live in households below the poverty line,[23] though the official poverty rate has not exceeded 15.2 percent since 1966.[24] Co-occurring physical and mental health conditions can be physiological, in part because mental health conditions may cause the development of physical conditions.[25] While the report generally uses terms from the Diagnostic and Statistical Manual (DSM)—5th Edition for convenience and consistency, the National Institute for Mental Health (NIMH) no longer uses the DSM. The Director of the NIMH at the time, Thomas Insel, explained the shift:

> "Diagnostic categories based on clinical consensus fail to align with findings emerging from clinical neuroscience and genetics. The boundaries of these categories have not been predictive of treatment response. And, perhaps most important, these categories, based upon presenting signs and symptoms, may not capture fundamental underlying mechanisms of dysfunction."[26]

In 2017, about 17.3 million adults (7.1 percent) had one or more major depressive episodes (MDE) in the past year, & **WOMEN HAD HIGHER RATES OF DEPRESSION THAN MEN** (8.7 percent versus 5.3 percent)

Depression

Depression can be characterized by several different conditions, with major depressive disorder (MDD) being the most prevalent of these conditions.[27, 28] People in the midst of a depressive episode may experience only a worsening of their mood and two or three additional symptoms, while others may experience nearly all of the symptoms.[29] In 2017, about 17.3 million adults (7.1 percent) had one or more major depressive episodes (MDE) in the past year,[30] and women had higher rates of depression than men (8.7 percent versus 5.3 percent).[31] The rate of depression for individuals with incomes below 100 percent of the FPL are substantially higher than that of individuals who live at 200 percent of the FPL or above (10.5 percent versus 6.0 percent).[32]

The percentage of youth ages 12 to 17 who reported having an MDE has grown substantially in the past decade, increasing from 8.8 percent in 2005 to 13.3 percent in 2017.[33] The rise in youth depression has not been matched by a rise in mental health treatment utilization for adolescents and young adults.[34]

Bipolar Disorder

About 4.4 percent of the adult population experiences bipolar disorder during their lifetime.[35] Bipolar disorder and related disorders are characterized by intense mood swings that are accompanied by varying levels of activity and energy.[36] Different types of episodes are associated with bipolar disorder: depressive episodes, manic episodes (an elevated mood along with increased activity), hypomanic episodes (a less serious manic episode), and a mixed state.[37] There are two types of bipolar disorders: bipolar I (manic episodes that are seven days or longer or that require hospitalization; normally with depressive symptoms also occurring for about two weeks) and bipolar II (consistent depressive symptoms and a hypomanic episode).[38] Symptoms of bipolar disorder often occur along with anxiety (71 percent), substance use disorder (SUD) (56 percent), post-traumatic stress disorder (PTSD) (39 percent), and Obsessive-Compulsive Disorder (OCD) (10 percent).[39] As such, symptoms of other behavioral health conditions may appear in individuals before they are diagnosed with bipolar disorder, such as mania and psychosis.[40] Notably, bipolar onset precedes diagnosis by an average of 5.8 years for people of all ages.[41] Approximately three percent of adolescents meet the American Psychiatric Association's requirements for bipolar disorder according to the National Comorbidity Survey Adolescent Supplement carried out from 2001 to 2004.[42, 43]

Psychosis

Three percent of individuals experience psychosis at some time in their lifetime.[44] Most cases of psychosis, defined by losing touch with reality,[45] are likely to manifest after an individual's late teens.[46] Symptoms include 1) delusions, which is when one holds onto an untrue belief even in the face of the facts; 2) thought disorders, which disorganize thinking, resulting in disorganized speech; and 3) hallucinations, which are sensory experiences of something not present.[47] Psychotic episodes may present as the result of physical illness, a response to drugs, or a mental health condition.[48] The lifetime risk for experiencing psychosis increases with exposure to Adverse Childhood Experiences (ACEs), such as childhood abuse, neglect, and household challenges (see the "Social Determinants of Health and Compounding Factors, Adverse Experiences" section for more information). Individuals who experience psychosis are 2.7 times more likely to have had an ACE.[49] People with seven or more ACEs are five times more likely to experience psychosis than people with zero ACEs.[50]

Attention Deficit Hyperactivity Disorder (ADHD)

Symptoms of ADHD include poor organization, poor attention to detail, constant fidgeting, and impulsive behavior.[51] In the U.S., as of 2016, 9.4 percent of children between the ages of 2-17 have ever had an ADHD diagnosis,[52] along with 4.4 percent of adults ages 18 to 44.[53] Most ADHD diagnoses occur in elementary school, as a condition may disrupt classroom-based learning.[54] Historically, boys have been more likely to be diagnosed with ADHD due to gender-based differences in how the condition manifests—hyperactivity-adjacent symptoms are more common in boys, whereas girls are more likely to present inattention-related symptoms.[55] This historical under diagnosis of girls may have had negative multigenerational impacts on families, as parents with untreated ADHD are at higher risk of SUD, along with adverse outcomes related to employment, personal relationships, and education.[56] For a significant proportion of children

with ADHD, symptoms will continue in adulthood.[57] ADHD has a high risk for comorbidity with conditions such as anxiety disorder, MDD, and alcohol misuse; as such, ADHD symptoms are often misidentified as symptoms of the comorbidities.[58] Even with treatment for comorbidities, adult ADHD can lead to poor medical and functional outcomes if unaddressed.[59]

Anxiety

Anxiety disorders are a group of conditions characterized primarily by symptoms of intense worry, restlessness, feeling on edge, intense fear, irritability, sleep problems, and difficulty concentrating. Conditions within the anxiety family include Generalized Anxiety Disorder (GAD), Panic Disorder, Social Anxiety Disorder, and PTSD.[60] Nearly one-fifth (19.1 percent) of the U.S. adult population experiences an anxiety disorder each year.[61] Data from the 2017 National Survey on Child Health indicate that 8.2 percent of children ages 3–17 years have ever experienced anxiety, and 6.9 percent had anxiety at the time of the survey.[62]

People with previous exposure to a traumatic or stressful event are particularly at risk for developing anxiety and other trauma-/stressor-related disorders.[63] PTSD is one of the most common anxiety disorders. More than 7.7 million Americans are estimated to have PTSD in a given year.[64] PTSD results from trauma, and symptoms include sleep problems, flashbacks, nightmares, avoiding anything related to the trauma, startled responses, anxiety, and difficulty regulating emotions.[65] Some people are more likely to experience anxiety, including women, who are more likely to have PTSD than men;[66] and veterans. In the case of veterans, they are more likely to have PTSD because of the stress and life-threatening experiences encountered on military missions.[67] Military sexual trauma is a major cause of PTSD.[68] Among veterans who enroll in U.S. Department of Veterans Affairs (VA) health care, 23 percent of women reported sexual assault while serving in the military, and 55 percent of women and 38 percent of men reported sexual harassment while serving in the military.[69]

Eating Disorders

Eating disorders include bulimia nervosa, anorexia nervosa, binge eating disorder, and other specified feeding or eating disorder (OSFED).[70] People who experience an eating disorder may become preoccupied with body image, food, or their weight, leading to intense, potentially life-threatening, feelings, attitudes, and behaviors.[71] The lifetime prevalence of eating disorders is 2 percent of adults for binge eating disorder, 1 percent for bulimia nervosa, and 0.6 percent for anorexia nervosa.[72] The occurrence of eating disorders is similar across racial and ethnic groups in the U.S. (except for anorexia nervosa, which is more prevalent among the white population).[73, 74] Still, stereotypes around eating disorders can lead to them being seen as a problem for only mostly wealthy, young, white women, which means people who do not fit that description but experience the condition may not be taken seriously by providers and their communities.[75, 76] Treatment can be prohibitively expensive, with residential treatment costing $30,000 monthly (as of 2013), on average; treatment can take three or more months, with years of follow-up care.[77]

BOX 1A.

SUICIDE: PREVALENCE BY GROUP & INTERVENTIONS

Suicide is one of the foremost causes of death in the U.S. It was the second leading cause of death for individuals ages 10-34 and the fourth leading cause for individuals ages 35-54 in 2017.[78] Suicide rates increased 31 percent between 2001 and 2017, from 10.7 per 100,000 to 14.0 per to 100,000.[79] While this increase was across all age groups, youth and young adults (15-24, particularly men from age 15 to 19) in particular have seen increases in "social media use, anxiety, depression, and self-inflicted injuries."[80] The overall suicide rate for ages 10-19 in the U.S. was 4.5 deaths per 100,000 people in 2010.[81] Of reported child suicide victims, 36 percent had a diagnosed mental health condition at the time of death, 26 percent were receiving treatment for a current mental health condition at the time of death, and 21 percent had attempted suicide in the past. Among racial and ethnic groups, the American Indian and Alaska Native (AIAN) community has the highest rates of suicide.[82] Veterans are more likely to die by suicide than the general population.[83] Suicide rates are significantly higher among LGBTQ youth and young adults. A 2019 study found that LGBTQ youth accounted for almost one quarter (24 percent) of suicide deaths among youth ages 12-14.[84] In 2016, almost a third of LGB youth attempted suicide at least once—compared to just three percent of their non-LGB counterparts.[85] There may also be a higher risk of suicide attempts and suicidal thoughts for older gay men and lesbians who have survived verbal or physical attacks compared to LGB older adults who have not.[86, 87] One intervention with success in curbing suicidal ideation is the usage of positive self-appraisals, especially in the face of stressful life events.[88] These self-appraisals can help individuals recognize coping skills, problem-solving skills, and social support they can use in these situations.[89] Another such intervention is called the Good Behavior Game which is a program for elementary school students that can help them develop self-regulation skills and has been associated with reducing the rates of many of the risk factors for suicide, such as aggressive and disruptive behavior. In this game, students are placed into groups where they must follow the rules set by the teacher, avoiding behavioral infractions to win the game.[90]

SUBSTANCE USE

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), SUDs emerge from habitual alcohol or drug use (or both) resulting in, "clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[91] There are more Americans struggling with SUDs than the number of people who have cancer.[92] In 2017, approximately 19.7 million (7.2 percent) individuals ages 12 or older had a SUD.[93] Yet only about four million (1.5 percent) people received substance use treatment in that year.[94] In 2017, 7.5 million Americans had an illicit drug use disorder, and 14.5 million people had an alcohol use disorder (AUD).[95] Over half a million people ages 12 or older had a stimulant use disorder and about 1.4 million Americans had used hallucinogens.[96] Alcohol use causes 88,000 deaths a year.[97] Individuals ages 18-25 are the most likely to use tobacco,[98] and about 480,000 deaths a year are tobacco-related.[99]

There are more Americans **STRUGGLING WITH SUDS** than the number of people who have **CANCER**

BOX 1B.

OPIOID EPIDEMIC: CAUSES & TREATMENTS

Opioid use disorders (OUDs) have recently drawn national attention. There were over 70,000 drug overdose deaths in 2017, with fentanyl among the leading overdose drugs.[100] More than 300,000 Americans have died from opioid overdoses in the past two decades,[101] making it the leading cause of accidental death in the country as of 2017.[102] This crisis has affected both rural and urban areas (see Figure 2a).[103]

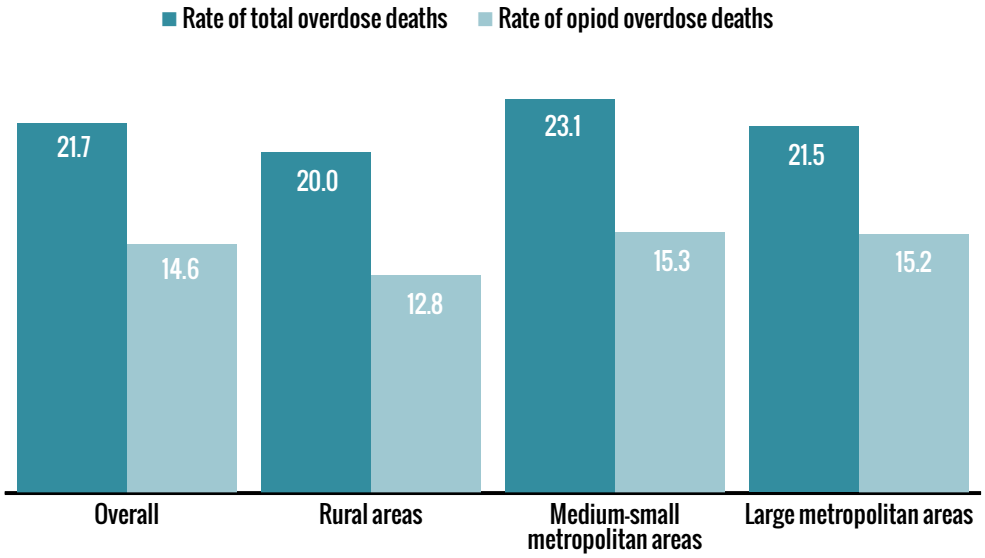
Researchers continue to explore causes of the opioid crisis. Widespread pharmaceutical promotion and increased medical prescription of painkillers, such as Oxycontin, since the late 1990s engendered many Americans' dependency on prescription drugs.[104] The connection to economic disadvantage is complex. Lower educational attainment, which can lead to greater socioeconomic adversity and a higher chance of workplace-related injuries and chronic health conditions, is associated with opioid addiction.[105] One study suggests that for each percentage point increase in a county's unemployment rate, there is a 3.6 percent increase in the opioid death rate per 100,000 and seven percent rise in the rate of opioid overdose emergency room visits.[106] However, another analysis found that the relationship between unemployment and mortality is weak and may be mostly due to confounding factors, such as the county racial and gender makeup and share of foreign-born population.[107]

As with other SUDs, treatment for opioid misuse has not matched need. Medicaid provides health coverage for a disproportionately large share of individuals experiencing opioid addiction and is key to fighting the epidemic.[108] Despite a large increase in Medicaid spending and prescriptions for opioid-dependency/addiction treatment since 2010 in Medicaid expansion states, opioid-related deaths remain high, suggesting that the overall spending may not meet need.[109]

One evidence-based treatment option considered the gold standard for treating opioid dependence is Medication-Assisted Treatment (MAT), which stops the euphoric feelings caused by opioids, stops physiological cravings, and can help normalize body functions.[110] Unfortunately, stigma remains a major barrier to widespread adaptation of this treatment, as some key stakeholders view MAT as replacing one addiction with another.[111] Additionally, federal restrictions on the use of naloxone,[112] methadone, buprenorphine, or naltrexone—key medicines needed to provide MAT, including immediately in a crisis situation—further limit access to addiction treatment.[113]

FIGURE 2a. Young people living in rural and metropolitan areas face similar rates of overall overdose & opioid overdose deaths

Rate of total & opioid drug overdose deaths (per 100,000 population), ages 15-24, by urbanization, 2017



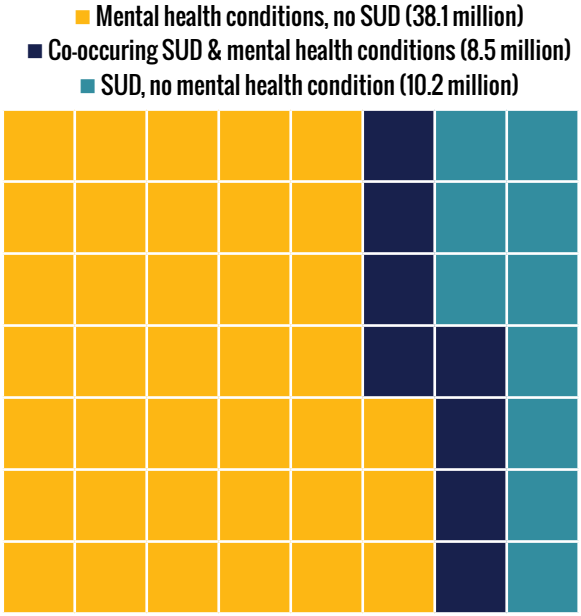
Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from "Overdose Death Rates." National Institute on Drug Abuse, updated January 2019. Available at https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

CO-OCCURRING CONDITIONS

The concurrence of both a mental health challenge and substance use or a SUD is defined as a co-occurring disorder.[114] In 2017, about 8.5 million (3.4 percent) adults had a co-occurring condition (see Figure 2b).[115] Among people with dual diagnoses, about 50 percent received no mental health or substance use treatment in 2017.[116] In 2017, about 345,000 adolescents ages 12 to 17 (1.4 percent) had a SUD and a MDE.[117] Some studies have shown that men are more likely than women to experience a co-occurring condition.[118] This comorbidity can negatively affect treatment outcomes and is associated with an increased risk of hospitalization, suicidal ideation, and homelessness.[119] The association of mental health conditions and substance use can result from inadequate access to mental health care, which can lead to substance use as a coping mechanism, and stigma around receiving mental health treatment.[120] Conversely, mental health conditions can also be developed as a result of substance use.[121]

FIGURE 2b. Tens of millions of adults have a mental health condition, SUD, or both

Number of adults with a mental health condition & SUD, 2017



Note: The share of adults with a mental health condition & no Substance Use Disorder (SUD) is 15.5%. Whereas, those with co-occurring SUD & a mental health condition, & those with SUD & no mental health condition represent 4.1% & 3.4% respectively of all U.S. adults.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Adapted from Bose, Jonaki, et al. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 Natural Survey on Drug Use and Health." SAMHSA, U.S. Department of Health and Human Services, September 2018. Available at https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.htm.

Social Determinants of Health & Compounding Factors

While our understanding of behavioral health, poverty, and their intersections continue to evolve with new research, evidence indicates a mismatch between the science of behavioral health and our current approach. Behavioral health challenges arise out of developmental processes—the sum of daily experiences and exposures over time—which can be modified to mitigate or even prevent the incidence of diagnosable conditions. Because so much of behavioral health is determined in day-to-day life, individualized therapy can be critical, but is not a complete solution. Addressing behavioral health challenges must include supporting an individual's family, community, and socioeconomic context.

This section provides context for the report's intersectional, multisystem approach to behavioral health treatment based on a synthesis of existing evidence-based efforts, approaches, and models. Then, the section introduces the SDOHs and health determinants of social outcomes (HDOSOs) models. This section also discusses common SDOHs that may impact individual behavioral health and family and community well-being. Lastly, this section highlights populations who are more likely to experience behavioral health conditions and barriers to needed care, including women, people of color, and other communities disproportionately impacted by the SDOHs.

SOCIAL DETERMINANTS OF HEALTH (SDOHS) & HEALTH DETERMINANTS OF SOCIAL OUTCOMES

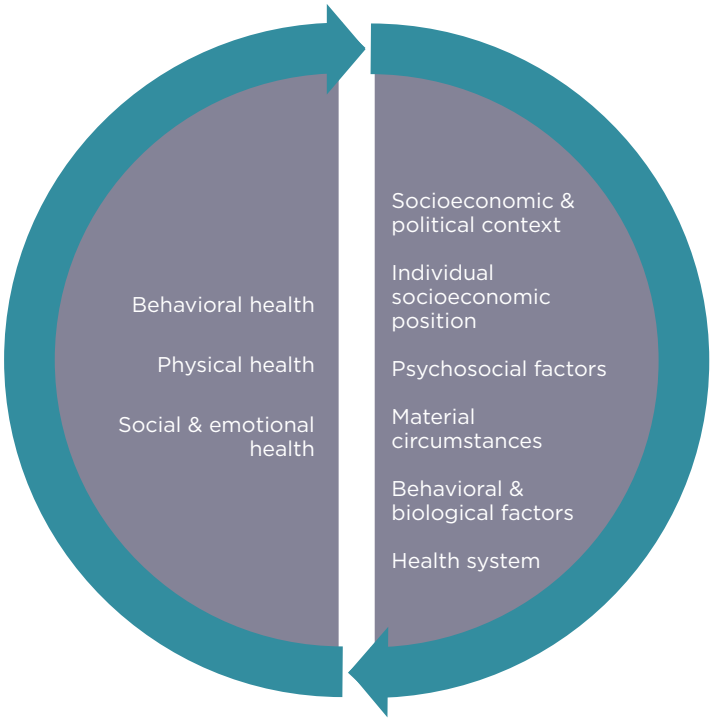
A body of established research has shown that SDOHs affect people in different, intersecting ways and can impact individual behavioral health outcomes, the cost of care, and utilization of behavioral health services.[122] The report's model of SDOHs builds on and adapts the World Health Organization's (WHO) model.[123] The model looks at the structural determinants of health, including the socioeconomic and political context on a societal level and on an individual level, that affect individuals' health, which in turn impact health and well-being and if they are equitable. Intermediary determinants that interact with the structural determinants, and help determine one's outcomes to include psychosocial factors, material circumstances, behavioral and biological factors, and the health system itself.

Social Determinants of Health[124]

- **Structural Determinants:**
  - **Socioeconomic and Political Context:** Governance, macroeconomic policies, social policies (including those relating to the labor market, housing, land, education, health, and social protection), and culture and societal values;
  - **Individual Socioeconomic Position:** Income, occupation, education, race/ethnicity/national origin, sexual orientation and gender identity (SOGI), and social class.
- **Intermediary Determinants:**
  - **Psychosocial Factors:** psychosocial stressors, stressful living conditions and relationships, and the presence of or lack of social support or coping styles;
  - **Material Circumstances:** physical living and working conditions, food availability, and consumption potential, or the ability to buy healthy food and warm clothing, for example;
  - **Behavioral and Biological Factors:** Nutrition, physical activity, substance use, and genetics;
  - **Health System:** Factors within the health system itself such as access to health services, along with collaboration between the health system and other sectors (for example, the provision of transportation to health services), the financing of care, and reintegration programs after someone experiences a chronic and/or serious condition.

FIGURE 2c. Social determinants of health & health determinants of social outcomes are interrelated

Health determinants of social outcomes & social determinants of health



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

Just as social outcomes affect health, health (including behavioral health) can determine social outcomes (see Figure 2c). The HDOSOs demonstrate how an individual's health can affect their quality of life[125, 126] and other social outcomes, such as employment, education, housing, income, and their interpersonal relationships and ties to the broader community.[127, 128, 129]

Health Determinants of Social Outcomes

We first break health into three categories: behavioral, physical, and social and emotional, before outlining how these categories of health can impact an individual's social outcomes:

- **Behavioral health:** to maintain a state of internal well-being through self-actualization, the ability to cope with stress and difficult life events, as well as existing in harmony with and contributing meaningfully to the surrounding community;[130, 131]
- **Physical health:** to maintain a healthy diet and exercise regimen, absence or treatment of injury and disease;[132, 133]
- **Social and emotional health:** to successfully regulate emotions and express them constructively, (pertains to self-esteem, confidence, and resilience),[134, 135] to cultivate meaningful and satisfying relationships, to feel a sense of connectedness with others and have a social support system.[136]

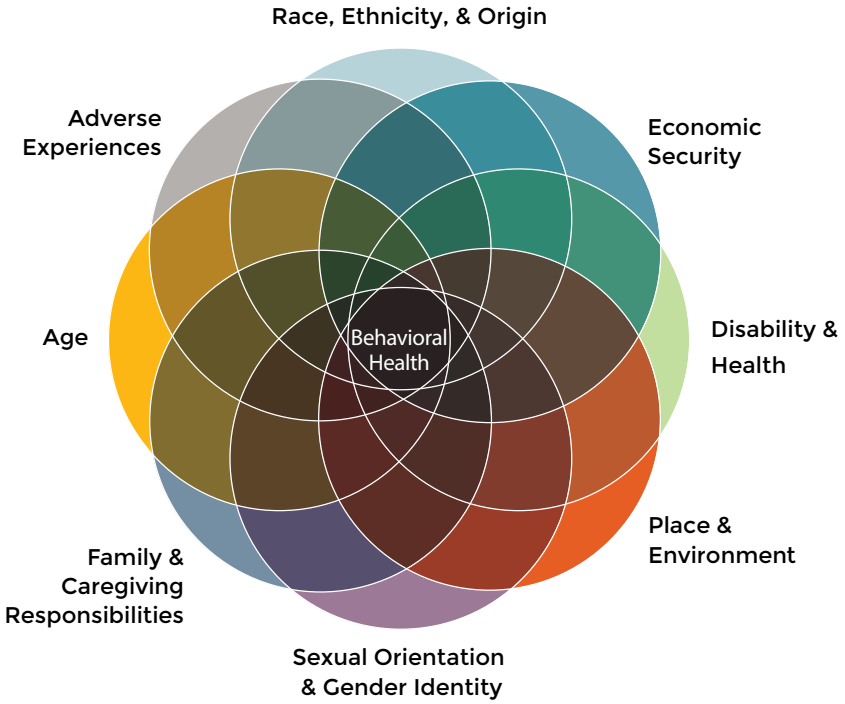
The extent to which health—behavioral, physical, and social and emotional—impacts an individual's ability to perform as desired in social and economic roles related to:

- Physical functioning, e.g. is an individual able to undertake the physical tasks required at a job;
- Cognitive functioning, e.g. can an individual apply the attentional and organizational skills necessary for a job;
- Affective functioning, e.g. do emotional challenges or addiction create motivational barriers for performing job roles;
- Pain interference, e.g. is an individual in chronic or intense pain that impedes success at work; and
- Fatigue/sleep disturbance, e.g. is an individual too tired to function well at work.

Further, economic disadvantage, lived experiences, and identities—including race, ethnicity, and origin; sexual orientation and gender identity; serious health conditions and disability; adverse experiences; geographic location; educational attainment; and age, among others—may impact an individual's behavioral health and well-being and exacerbate existing disparities (see Figure 2d).

FIGURE 2d. Lived experiences & identities affect behavioral health & well-being

Key lived experiences & identities



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

ADVERSE EXPERIENCES

Adverse and traumatic life events can occur at any stage in the lifecourse and can have significant impacts on a person's mental health and overall well-being. Adverse and traumatic experiences can be individual or shared and can arise from a number of situations and factors. Survivors of violence are especially likely to experience behavioral health conditions related to their trauma. In particular, childhood stress and trauma that occur early in life have been shown to have lasting impacts on an individual's health and well-being later on in life.[137] Adverse experiences in childhood and trauma often lead to toxic stress, a "strong, frequent, or prolonged activation of the body's stress response systems" that may disrupt the child's physical, cognitive, and emotional development.[138] When toxic stress occurs repeatedly, it can have a lifelong consequences for an individual's physical and mental health.[139] Some common experiences with trauma and violence are detailed below.

Individual & Intergenerational Trauma

Throughout the life cycle, people experience many different types of adversity and trauma, which can have impacts on them over the course of their lives. Childhood stress and trauma—including physical or emotional abuse, neglect, burdens of family hardship, caregiver substance abuse or mental illness, or exposure to violence—often leads to toxic stress[140] One way adverse experiences and childhood trauma have been measured is through the ACE questionnaire,[141] which scores individuals from zero to ten based on experiences within the first 18 years of life.[142] The questions are broken into the following categories: childhood abuse, neglect, and household challenges.[143] Household difficulties, such as DPV/IPV,[144] and social and environmental factors, such as community violence and structural racism, can cause and compound the effects of ACEs, increasing an individual's likelihood of experiencing toxic stress and other poor health outcomes.[145] The more ACEs a person experiences, the higher the risk of developing a number of behavioral health conditions including depression, anxiety, suicide and PTSD.[146]

Prolonged activation of the body's stress response systems can disrupt the normal growth and development of multiple organs, including the brain, even after individuals enter adulthood.[147] Although changes in development due to toxic stress can be drastic, these changes may not manifest immediately. Research has linked ACEs to increased risk for physical health conditions, mental health conditions, SUDs, and risky behaviors across the lifespan.[148] Twenty-two percent of children in the U.S. have had at least two ACEs, with children in the South and Southwest and Native American and African American children the most likely to have multiple ACEs.[149] A 2018 JAMA study identified that among adults, low-income individuals, individuals with low educational attainment, individuals who are unemployed or who cannot work, and LGB individuals were the most likely to have experienced ACEs (see Figure 2e).[150] Having a lower income and experiencing trauma are also linked to a higher risk of experiencing mental health conditions like depression, anxiety, and psychosis.[151] For example, one study found that almost three-fourths of adults with four or more ACEs in Philadelphia were below 150 percent of the poverty threshold.[152]

Adverse and traumatic experiences can have intergenerational impacts on a family's overall well-being and the mental health of family members. In addition to trauma experienced individually, trauma experienced by previous generations can have significant effects on younger generations, such as with the families of some Holocaust survivors.[153] Adverse experiences may have lasting effects spanning from parent to child. Studies have found that a higher number

of parental adverse experiences predicted poorer child health status[154, 155] and a higher number of adverse experiences for the child.[156, 157] Research suggests that children may be genetically predisposed to have SUDs if their parents engage in substance misuse.[158] Children ages 8-17 are also at increased risk of having a co-occurring disorder if their parents do.[159] Untreated trauma can contribute to the onset of other mental health conditions. The combination of symptoms and stress from trauma result in higher risks for negative outcomes, including school dropout,[160] homelessness,[161] and unemployment.[162]

Adverse experiences can also occur in adulthood. Adverse experiences can include both single instances or experiences that occur over time, such as the death of a family member or community violence and poverty.[163] Other types of common adverse experiences are profiled below.

Domestic Violence/Intimate Partner Violence (DV/IPV) & Sexual Violence

Research supports a connection between DV/IPV and behavioral health conditions, notably depression, anxiety, PTSD, SUD, and suicide.[164] At least one-third of women and one-fourth of men in the U.S. have experienced IPV over their lifetime (including sexual assault, physical violence, or stalking), with even higher numbers for psychological aggression.[165] Women ages 18-24 are the most likely to experience IPV.[166] At least 26 percent of gay men experience IPV, with the rates even higher for transgender people.[167] About 30 million children will be exposed to DV in some form before they turn 17.[168] Young girls face an acute risk of IPV beginning as early as middle school.[169] Native American women on reservations are the most likely to have DV/IPV experiences compared to any other racial/ethnic group.[170] One study found that women of color who are DV/IPV survivors may be more likely to experience mental health conditions.[171] Research also shows that survivors of DV/IPV who experience mental health conditions may also experience lasting, negative effects on their employment due to their psychological distress.[172]

Sexual violence can lead to an increased risk of developing behavioral health conditions, such as eating disorders, depression, PTSD, SUDs, anxiety,[173] and suicide attempts.[174] In the U.S., about 36 percent of women and 17 percent men report being the survivors of attempted or completed sexual violence.[175] Transgender and bisexual people are at particular risk, as about 50 percent may experience sexual violence over the course of their lifetime.[176]

Police Violence

There are many different types of discriminatory and systems-based violence. One type that individuals and communities currently face is violence involving law enforcement. Around 20 percent of American adults have experienced some non-physical form of police violence (which includes psychological violence, such as intimidation or verbal abuse, or neglect).[177] Among the general adult population in the U.S., there is a six percent lifetime prevalence of physical police violence with a weapon, and a four percent lifetime prevalence of sexual violence by police.[178] Exposure to all forms of police violence, both minor and extreme, is associated with a higher likelihood of "psychological distress and depression, suicide attempts, and subclinical psychotic experiences."[179] Communities of color, LGBTQ communities, low-income communities, and other disadvantaged populations have been and are disproportionately affected by exposure to police violence.[180] People with disabilities are also more likely to be killed by law enforcement, as they make up one-third to one-half of all of the deaths attributed to law enforcement.[181] For the African American community, police violence has been found to add at least 1.7 days of

poor mental health per person each year.[182, 183] Research suggests that African American men in particular are likely to face adverse effects on their health due to their high rates of contact with law enforcement,[184] though African American women also face a significant amount of exposure to police brutality.[185]

Collective or Shared Trauma

When a group of people or community experiences a collective or shared trauma, such as a natural or man-made disaster or crisis, this can lead to widespread trauma and the development, triggering, or worsening of behavioral health conditions, such as PTSD, depression, and anxiety.[186] For example, after a man-made event such as a school shooting, 28 percent of survivors experience PTSD, along with depression, anxiety, and substance use.[187] PTSD is also the most common condition for survivors of other mass violence events (ranging from 30 to 40 percent of survivors who were directly impacted), such as 9/11 and the Oklahoma City bombing.[188] As for large-scale natural disasters, they can prompt adverse behavioral health effects like PTSD and depression (see Box 6(a) for more information).[189] For example, following the impact of Hurricane Maria in Puerto Rico, suicide rates climbed by 29 percent due to factors such as anxiety and loss of housing.[190] Collective or shared trauma is also present in neighborhoods with high rates of violence, where all children experience at least some of the behavioral or psychological effects of trauma (see the "Social Determinants of Health & Compounding Factors, Place and Environment" for more information on neighborhood-level factors that can impact behavioral health).[191]

BIDIRECTIONAL RELATIONSHIP BETWEEN ECONOMIC INSECURITY & BEHAVIORAL HEALTH

Behavioral health conditions can stem from or be exacerbated by challenges associated with having a low income, including the stresses of poverty itself.[192, 193, 194] For example, severe depressive symptoms can impact someone's participation in the labor market, including how frequently they change jobs, creating a vicious cycle.[195] Un- or under-addressed behavioral health conditions can also negatively impact individual overall health, well-being, and ability to succeed in formal employment, which can lead to economic insecurity and hardship.[196,197] There are also extra costs associated with behavioral health conditions for individuals and caregivers, such as direct health care costs, productivity losses due to work absence, and income losses due to changes in job responsibilities or employment status.[198, 199] For example, families with children with ADHD incur financial challenges five times greater than families with children who do not have ADHD, and parents in these families were more likely to be fired.[200] Likewise, even short periods of economic insecurity can have a negative effect on mental health[201] (for example, periods of food insecurity negatively impact mental health).[202] Conversely, programs that boost economic security can improve behavioral health and mitigate some of these multiplying effects (see Appendix IV for more information).

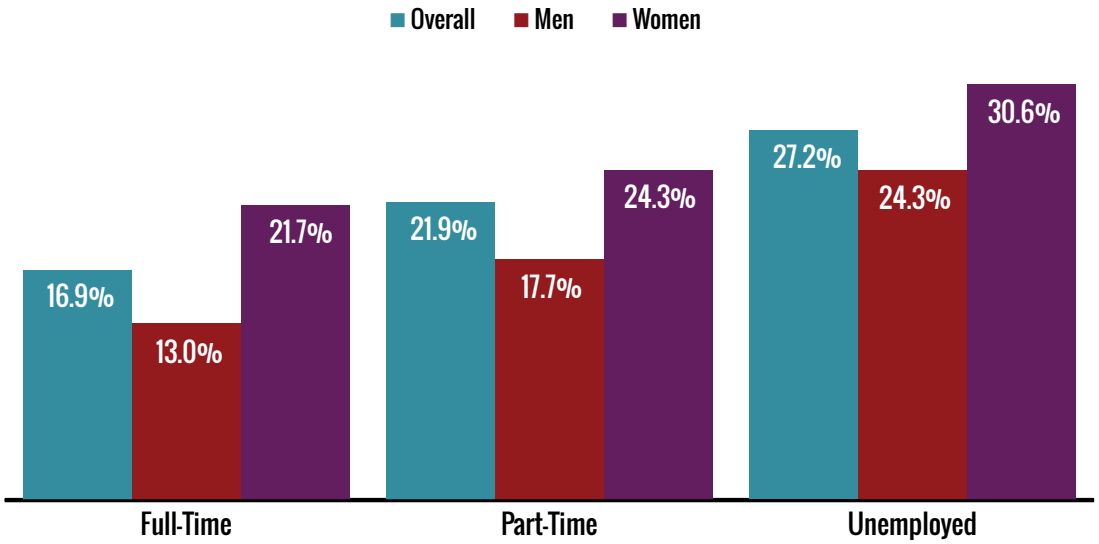
As a result of the compounding relationship between behavioral health and economic insecurity, economically-disadvantaged adults[203, 204] experience higher rates of mental health conditions, including co-occurring SUD and mental health conditions, than individuals with higher incomes.[205] For example, in 2017, individuals below 100 percent of the federal poverty level (FPL) were almost twice as likely to experience co-occurring mental health and substance use conditions and 60 percent more likely to report having insufficient mental health treatment than individuals above 200 percent of the FPL.[206]

People with low incomes have adverse experiences and experience stress, including toxic stress, at higher rates[207] than the general population—all of which may engender or exacerbate mental health and substance use challenges.[208, 209, 210] Many people with behavioral health conditions or individuals who have experienced trauma[211] face barriers to obtaining stable, decent paying jobs, resulting in economic insecurity. For children, concentrated childhood poverty can cause toxic stress, which is linked to behavioral health conditions beginning in their teen years.[212] In adulthood, mental health and substance use can be both a cause and consequence of unemployment.[213] Adults with a mental health condition or SUD are less likely to be employed, which can undermine their economic security and have negative impacts on their health.[214, 215] Poor and unstable working conditions are also associated with negative behavioral health outcomes.[216, 217] A study of hourly workers in the U.S. also found that unstable work schedules and low wages were linked to negative mental health outcomes among workers, such as "psychological distress, poor sleep quality, and unhappiness."[218]

A lack of economic security can also result in housing and food insecurity, among other difficulties. Housing instability—a late rent check, moving multiple times, losing housing, a lack of safety or the presence of trauma in a household, or homelessness—is related to negative behavioral health outcomes.[219, 220, 221] Even individuals who receive adequate mental health or substance abuse treatment may still face a risk of homelessness, which could aggravate their behavioral health conditions.[222] Inadequate access to healthy food and nutrition is linked to poor mental health outcomes, such as depression and anxiety, with an even stronger effect on children's behavioral health.[223, 224, 225] Un- or under-addressed behavioral health challenges[226] increase the likelihood of school dropout and generally limit educational attainment.[227] Research suggests that adults with a college degree have lower rates of attempts and deaths by suicide relative to individuals with a high school diploma.[228, 229, 230]

FIGURE 2e. Women & workers who are unemployed or work part-time have higher rates of mental health conditions

Mental health condition rates among adults, by employment status & sex, 2017



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Authors' calculations using microdata from "National Survey on Drug Use and Health, 2017." SAMHSA, U.S. Department of Health and Human Services, 2018. Available at https://www.datafiles.samhsa.gov/study-dataset/national-survey-drug-use-and-health-2017-nsduh-2017-ds0001-nid17939.

Access to Adequate & Affordable Health Care Is Limited for People with Low Incomes

People with low incomes and their families are less likely to access health care, including behavioral health care, and supportive services due to significant structural barriers related to economic disadvantage.[231] Medicaid covers 1 in 5 people with low-incomes in the U.S. and one-fifth of health care costs.[232] In FY2017, about 9.4 million children utilized the Children's Health Insurance Program (CHIP)[233] and 370,000 pregnant women do so each year, including in 15 states where CHIP provides behavioral health services for women. People with Medicaid are almost two times more likely to use behavioral health services and also report less unmet behavioral health needs, though at least 2.5 million still have unmet needs (see Appendix II for more information on Medicaid and CHIP and the barriers to behavioral health care that participants face).[234, 235] Many workers in low-paying jobs lack access to employer-provided health insurance, and even when someone has employer-sponsored health insurance, behavioral health services may be out of reach due to prohibitive costs.[236] Additionally, because there is already a shortage of mental health and substance use services in general, people who are already marginalized and experiencing substantial barriers often face the greatest challenges accessing the care they need.[237] As un- or under-addressed behavioral health conditions can also be a barrier to staying connected to the labor market—for example, compared to other adults, people with mental health conditions are more likely to be unemployed and thus may not be eligible for employer-sponsored health insurance[238]—thus, someone who is not working and is experiencing a behavioral health condition may not have access to health insurance at all. Cultural or social stigma around behavioral health, particularly when combined with internalized biases[239] concerning class[240] and other identities and experiences, may also compound access challenges.

IDENTITIES, EXPERIENCES, & OTHER NON-HEALTH FACTORS CAN ALSO IMPACT BEHAVIORAL HEALTH

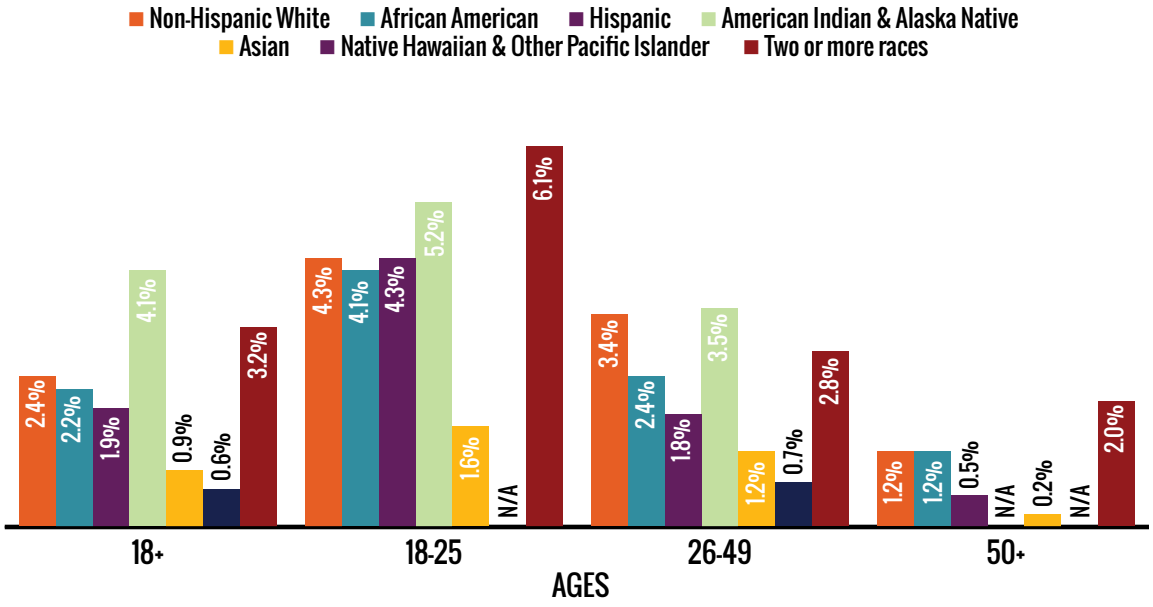
A range of identities, experiences, and other factors may impact an individual's behavioral health and well-being. An effective approach to supporting everyone's behavioral health needs considers the interrelated social identities and lived experiences that exist across communities. Some key identities, experiences, and other factors are listed below.

Race, Ethnicity, & Origin

People of color are at an acute risk of experiencing certain behavioral health conditions but face barriers to accessing care that is culturally representative and responsive. When broken down by race, findings show that AIANs and people who identify with two or more races have among the highest rates of SUD among adults (see Figure 2f).[241] For mental health conditions, people who identified with two or more races have the highest rates among adults.[242] African Americans, Latinos, Asian Americans, Native Hawaiians, and AIANs all experience higher rates of PTSD compared to their white counterparts.[243] Perceived discrimination is associated with behavioral health conditions for African Americans and Asian Americans.[244] For example, people of color are more likely to face a double burden from a disability caused by a behavioral health condition, due in part to the effects of weathering[245] or toxic stress. For many people of color, particularly people with low-incomes, sustained exposure to environmental pollution, crime, systemic racism and concentrated poverty can engender a level of stress that becomes detrimental to health.[246, 247] Structural racism in particular has been linked to negative mental health outcomes and greater likelihood of disability for people of color.[248]

FIGURE 2F. Some racial groups have higher incidence of co-occuring conditions

Percentages of co-occurring SUD & mental health conditions by race, 2017



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from "Results from the 2017 National Survey on Drug Use and Health: Detailed Tables." SAMHSA, U.S. Department of Health and Human Services, 7 September 2018. Available at https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab8-29B.

Populations of color grapple with a lack of culturally competent care. The vast majority of psychologists,[249] psychiatrists,[250] and social workers are white.[251] Research has shown that sharing a similar cultural or ethnic background with a provider can help improve an individual's behavioral health outcomes due to stronger bonds between the providers and patients (also known as therapeutic alliance) and higher retention rates in treatment programs.[252, 253] Individuals whose first language is not English face linguistic barriers; currently, even federal cultural and linguistic care standards[254] have not led to the adequate implementation of translation services and educational materials in languages other than English,[255] let alone led to enough providers who speak diverse languages themselves. Other barriers to treatment include a lack of health insurance—more than half of individuals who are uninsured are people of color—and provider bias about different populations of color.[256, 257] For example, some providers may believe people of color are less likely to experience behavioral health conditions, which can lead to a minimization of the patient's condition.[258]

Immigration status may intersect with numerous factors mentioned in this report, including poverty and race, which may further exacerbate an individual's behavioral health needs and barriers to treatment.[259] A study of undocumented Mexican immigrants living near the US-Mexico border found that individuals who were foreign-born generally reported better behavioral health than people born in the U.S., but their behavioral health tended to deteriorate the longer they stayed in the U.S.[260] Age at the time of migration impacts individual behavioral health; a younger age at time of migration is linked to anxiety and mood disorders.[261] The stresses of and trauma related to the migration itself may lead to PTSD.[262] Undocumented individuals living near the Southern border of the U.S. have a disproportionate risk of experiencing depression, panic disorder, and anxiety compared to the U.S. population overall.[263]

However, one study found that the children of mothers who were eligible for Deferred Action for Childhood Arrival (DACA) saw improved behavioral health outcomes.[264]

Immigrants, particularly first-generation immigrants, are less likely to utilize behavioral health services than people born in the U.S.[265] This trend is more prevalent among immigrant men, people who are uninsured, people who are English learners, and people who are undocumented.[266] Recent immigration policies and proposals, such as the family separation policy and proposed public charge rule, have and may further impact utilization rates among immigrants. Such policies have discouraged immigrant populations from using Medicaid and other economic security programs that help boost behavioral health,[267, 268] while increasing anxiety and worsening behavioral health.[269, 270] In a 2018 study of school administrators in 12 states, 90 percent said that fear of immigration enforcement, irrespective of immigration status, led to more frequent cases of behavioral and emotional problems among students.[271] Children separated from their parents due to deportation are at risk for adverse behavioral health impacts due to the trauma of the separation itself,[272, 273] conditions experienced while children are separated from their parents,[274] and conditions experienced while families are detained after reunification.[275] Evidence shows that behavioral health symptoms persist for some children even after reunification.[276]

Sexual Orientation & Gender Identity

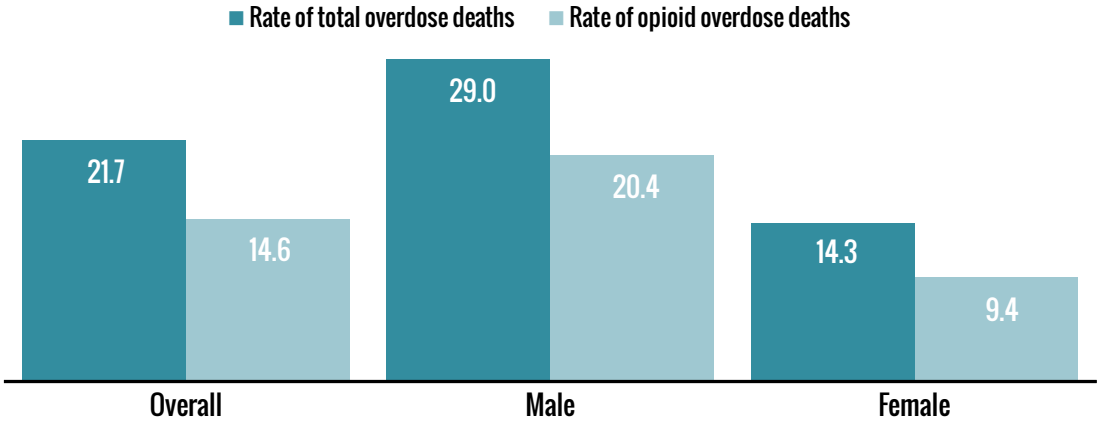
SOGI play a significant role in the prevalence and impact of behavioral health conditions (see Figure 2g). This intersection can be further compounded when someone is also experiencing economic disadvantage (the likelihood of which is also tied to one's gender identity and sexual orientation).

Women are more likely to suffer from depression[277] and anxiety[278] than men; and transgender people are more likely to experience depressive symptoms and anxiety than cisgender people.[279] Women, transgender men, and non-binary individuals experience certain types of depression attributable to hormone changes, such as postpartum depression or premenstrual dysphoric disorder (PMDD).[280] Additionally, 1 in 7 women experience postpartum depression,[281] while between three and nine percent of women experience PMDD.[282, 283] African American women and Latinx women are more likely to experience postpartum depression than white women, primarily related to everyday discrimination.[284, 285]

Many women may be misdiagnosed with depression, and less than half of women who experience depression will seek treatment.[286] Barriers to treatment include stigma and denial,[287] especially with the belief that depressive symptoms during menopause are normal.[288] Young girls in particular are more likely to face behavioral health conditions, such as depression, some of which may be related to early puberty[289] (which may be having a bigger impact as the average age of puberty has been decreasing for girls),[290] and have rising rates of suicide.[291] An estimated 46 percent of transgender men and 42 percent of transgender women report having attempted suicide, compared to 4.6 percent of the general population.[292]

FIGURE 2g. Young men face higher rates of overall overdose, including opioid overdose deaths, than young women

Rate of total & opioid drug overdose deaths (per 100,000 population), ages 15-24, by sex, 2017



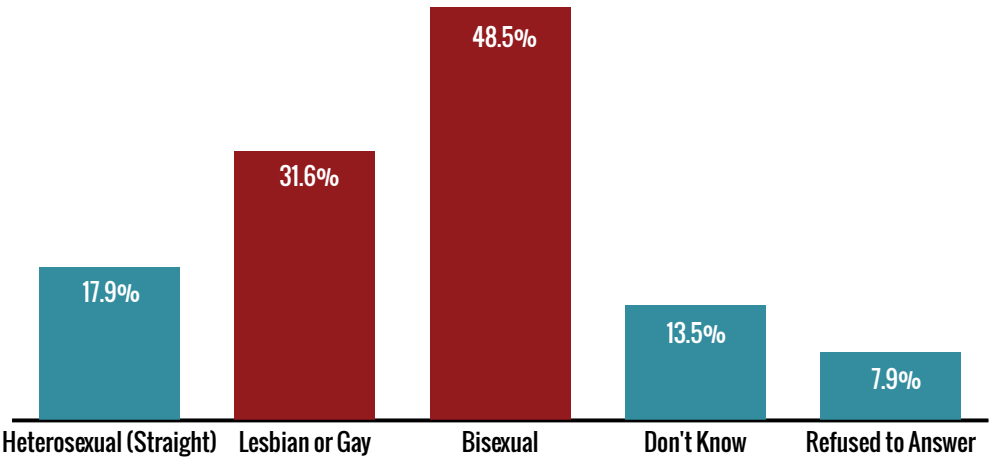
Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from "Overdose Death Rates." National Institute on Drug Abuse, updated January 2019. Available at https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

Women are also more likely to experience poverty and less likely to be financially secure than men.[293] In particular, women have 20 percent less in liquid assets and a higher revolving credit card debt burden, trends that are exacerbated after a major medical payment.[294] For low-income women and girls, gender-specific behavioral health needs are both wide-ranging and often unmet. For example, women in public assistance programs have 12-month MDD prevalence rates between 12 and 36 percent, compared to about 10 percent of women in the general population.[295, 296] In terms of transgender Medicare beneficiaries, 71.4 percent are under age 65.[297] They have at least double the rates of depression, anxiety disorders, bipolar disorders, personality disorders, and PTSD compared to cisgender Medicare beneficiaries under age 65.[298] There are also risk factors that disproportionately impact women, including gender-based violence, low social status relative to men, and having the primary responsibility of caring for others.[299] Not having access to menstrual products is also associated with higher rates of anxiety and depression.[300]

The LGBTQ community is more likely to experience behavioral health conditions, such as depression or alcohol abuse.[301] Although data are limited, it is estimated that LGBTQ individuals experience depression and anxiety at over twice the rate of non-LGBTQ individuals.[302, 303] Bisexual and questioning women ages 14-24 are more likely to be depressed or anxious compared to heterosexual women of the same age.[304] LGB people have also been found to be more likely to report recent substance use.[305, 306] Research suggests that higher rates of stress due to social isolation, discrimination, and stigma may contribute to the higher rates of SUDs among LGB adults (see Figure 2h).[307] An estimated 16.4 percent of LGB people have a SUD, compared to about 7.9 percent of the general population.[308] Rates of depression and substance misuse (specifically alcohol and tobacco) are higher for older LGBTQ individuals than for the overall aging population.[309] Rates of prescription opioid misuse are also higher among LGB adults than heterosexual adults, and highest for bisexual women.[310, 311]

FIGURE 2h. The LGB community face far higher rates of mental health conditions than non-LGB people

Rates of mental health conditions among adults, by sexual orientation, 2017



Note: LGB stands for Lesbian, Gay, or Bisexual.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Authors' calculations using microdata from "National Survey on Drug Use and Health, 2017." SAMHSA, U.S. Department of Health and Human Services, 2018. Available at https://www.datafiles.samhsa.gov/study-dataset/national-survey-drug-use-and-health-2017-nsduh-2017-ds0001-nid17939.

About one-quarter of LGB individuals with mental health conditions receive treatment services, although the LGB population have slightly higher rates of receiving treatment than the general population.[312] Despite these rates of receiving treatment, the LGTBQ community still experiences many factors associated with worse behavioral health outcomes. LGBTQ people are generally more likely to experience poverty, which can be worse for LGBTQ people of color,[313, 314] and homelessness.[315] They are also more likely to be uninsured compared to non-LGBTQ individuals.[316] Stigma and discrimination based on sexual orientation also play a key role in compromising the LGBTQ community's mental health and access to appropriate treatment. For example, peer victimization and harassment in schools amplify the negative outcomes of marginalization among LGBTQ youth.[317, 318] Family rejection also increases the risks of depression, anxiety, and suicide attempts.[319] Barriers to accessing treatment include a lack of cultural competency and outright discrimination among providers when it comes to the LGBTQ community.[320] For example, 8 percent of LGB individuals and 29 percent of transgender individuals report that they were denied access to care due to their SOGI.[321]

Age

Though behavioral health conditions occur across a lifetime, risk factors differ across stages of human development. From an early age, behavioral health conditions can occur in children and affect their development. Over half of mental health conditions start before children reach the age of 14.[322, 323] (Efforts such as the DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood are seeking to help identify developing conditions even earlier in the lifecourse for very young children.)[324] When it comes to adolescence and early adulthood, approximately 1 in 5 U.S. children ages 13 to 18 has a mental health disorder.[325] (See the "Social Determinants of Health and Compounding Factors, Adverse Experiences" section for more information on childhood trauma.)

Behavioral health conditions can also be consequential once one reaches adulthood. Adults ages 18-25 have the highest rate of mental health conditions of any age group at 25.8 percent. Almost one-fourth of adults ages 26-49 experience a mental health condition.[326] Older adults also face unique risk factors for developing a behavioral health condition. About 13.8 percent of people age 50 and above reported having a behavioral health condition in 2017; 11.5 percent of adults over 50 with a mental health condition also suffered from a SUD.[327] Depression and anxiety are two of the most common behavioral health conditions in older adults, impacting about three to seven percent and 11 percent of older individuals, respectively.[328] Faced with high rates of poverty, many elderly adults are at risk of experiencing poor mental health conditions and developing SUDs.[329] Traumatic events such as a natural disaster and other types of disruptions to life routines can also exacerbate behavioral health conditions among older adults.[330]

Disability & Health

At least 40 to 57 million people in the U.S. have a disability as of 2012.[331] (For the purposes of this report, "disability" is defined as any physical, mental, and sensory disability, although within the U.S., disability criteria and definitions vary among systems.) Much as disability is intertwined with economic disadvantage[332] and race,[333] which can create a double burden, the relationship between disability and behavioral health is similarly linked.[334] A mental health condition can be a disability, depending on factors such as duration and impact on daily activities. Having a disability can also impact one's overall well-being and is a risk factor for mental health conditions and compounding effects. For example, a 2014 Centers for Medicare and Medicaid Services (CMS) study found that Medicaid and Medicare participants who were under 65 and had a disability were more likely to have psychological condition.[335] Medicaid participants were also more likely to have another health condition, such as cardiovascular disease, which illustrates the interconnected nature of disability, mental health, and physical health.[336] Ultimately, behavioral health conditions, such as depression, anxiety, SUD, and ADHD, are responsible "for 18.7 percent of all years of life lost to disability and premature mortality."[337] By 2020, depression is projected to become the second leading cause of disability globally.[338]

By 2020, **DEPRESSION** is projected to become the **SECOND LEADING CAUSE OF DISABILITY** globally

Behavioral health also has high rates of co-morbidity with other disabilities. As much as 35 percent of all people with intellectual or other developmental disabilities (ID/DD) have a psychological condition, which may be overlooked or incorrectly seen as a part of an individual's developmental disability through "diagnostic overshadowing."[339] Diagnostic overshadowing is when a provider overlooks or minimizes behavioral health symptoms, instead attributing those symptoms to the individual's developmental disability.[340] Such diagnostic overshadowing is common for children with developmental disabilities, for example, which research suggests can lead to them being at "substantially greater risk of developing mental health problems compared to typically developing children."[341] Unrecognized disabilities in children, including mental health conditions, can have negative effects on their health and social well-being, including on academic performance and longer-term employment opportunities.[342] For example, students with unrecognized disabilities may be more likely than students without unrecognized disabilities to be suspended or expelled from school.[343] This is particularly the case for children of color and lower-income children.[344, 345]

Family & Caregiving Responsibilities

Formal caregiving supports in the U.S. are often out of reach for families, due to prohibitive costs and a lack of work supports such as paid family and medical leave (PFML).[346] As a result, at least 43.5 million people provide unpaid, or informal, care for family members and other people in their communities.[347] These individuals may experience emotional, mental, and physical health problems due to the stress of their caregiving responsibilities.[348] Caregivers are more likely to experience depression than non-caregivers.[349] Unpaid caregivers are also more likely to have co-occurring anxiety disorders, SUD, and other chronic disease.[350] Increased rates of behavioral health conditions are especially pronounced among certain populations of caregivers. Informal caregivers under 45 with a full-time job are the most likely to have worse behavioral health than their non-caregiver peers.[351]

Additionally, many unpaid caregivers are forced to reduce their hours at work or may even have to leave their formal employment,[352, 353] which can also contribute to such health challenges and compound financial hardships associated with informal caregiving.[354] For example, reducing one's hours or leaving the formal labor force may cause someone to lose (employer-provided) health insurance,[355] which can impact their access to behavioral health supports and services.

Place & Environment

Place, or one's spatial context,[356] impacts behavioral health outcomes and access to care. First of all, there are differences among rural and urban areas. SUDs are less likely to occur in rural areas (though the gap between rural and urban areas has closed over time),[357] while other mental health conditions, such as ADHD are identified more in rural areas.[358] Small towns and rural areas also saw a 20 percent increase in suicide rates compared to seven percent in metro areas from 2004 to 2013.[359] On average, rural areas have less access to mental health and substance use treatments than urban areas.[360] About 60 percent of Americans living in rural areas are in health professional shortage areas (HPSA).[361] Common barriers to receiving treatment in rural areas typically fall into one of three categories: accessibility (access to transportation, health insurance, and diagnosis of a mental health condition); availability (of providers); and acceptability (related to stigma and the quality and choice of care).[362] Exposure to toxins is another aspect of spatial context that can have an impact on behavioral health. For example, during the Flint water crisis, people who were exposed to high levels of lead in their water faced negative health effects. Children in utero whose mothers consumed the water faced may face increased behavioral problems, be more prone to criminal activity, and have low educational attainment and poor labor market outcomes in adulthood.[363]

Spatial context can also be more narrow and refer to one's built and social environment, which is based on the neighborhoods people live in and work and go to school in.[364] Neighborhood-level factors include poverty, violence,[365] racism,[366] and limited resources, such as access to affordable housing, schools, and supportive social networks.[367, 368] Many times these factors stem from a history of racist policies, such as redlining (the practice of denying loans to African Americans in areas that were historically whiter, effectively segregating neighborhoods) in urban areas[369] and scarcity of resources in rural areas.[370] Additionally, one's neighborhood can impact their ability to exercise, have a healthy diet, have safe and accessible transportation,[371] and have access to substances.[372] Studies have found a strong link between socioeconomic mobility within a county and neighborhoods and improved cognitive and social-emotional developmental outcomes in children.[373] The Moving to Opportunity for Fair Housing Demonstration (MTO) from 1993 involved a randomized control experiment that provided vouchers to families living in public

housing to move to lower-poverty neighborhoods.[374] Analysis of the MTO program found that it improved mental health outcomes for families who moved to areas with lower poverty rates.[375] In particular, women and their daughters had lower levels of "psychological distress and major depression."[376] The "look, feel, and safety" of an area are also related to mental well-being of all community members, whereas a lack of maintenance or safety in one's community can increase feelings of hopelessness.[377]

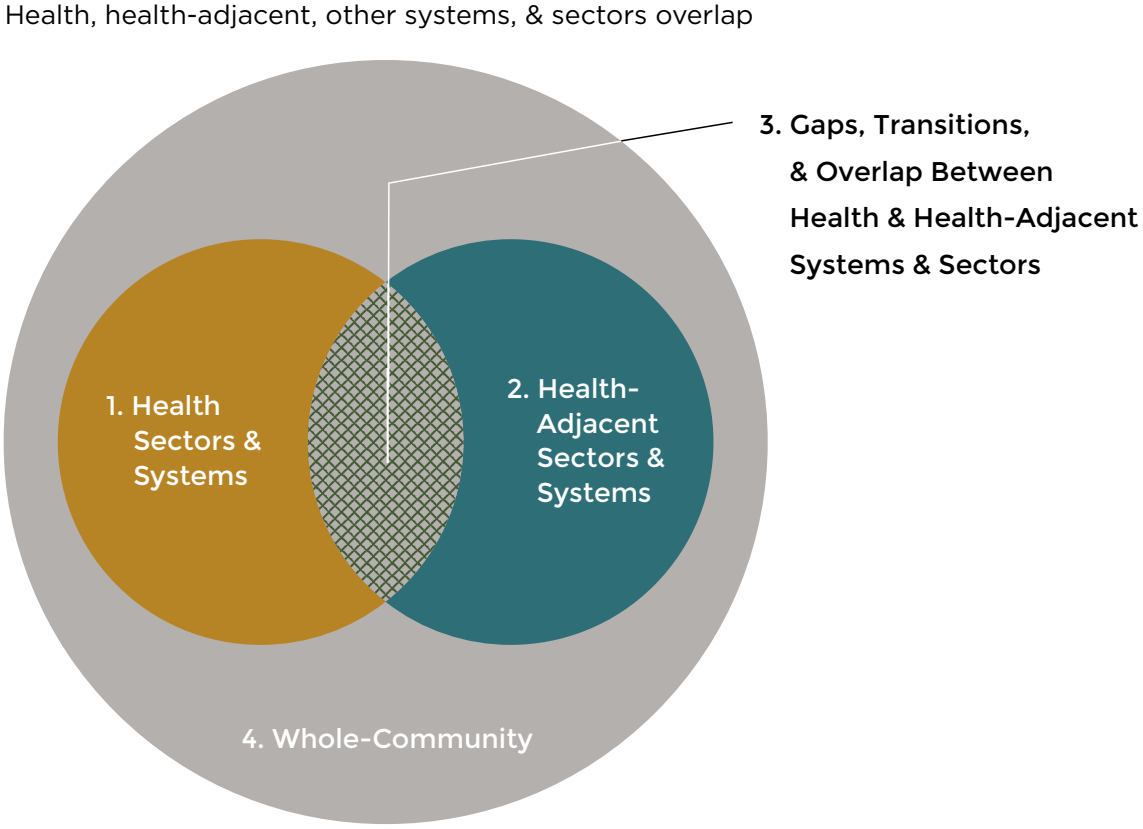
III. An Agenda for Whole-Family, Whole-Community Behavioral Health

This chapter outlines a set of overarching policy, programmatic, and practice recommendations for addressing the intertwined and interdependent behavioral health and health-adjacent needs of low-income individuals, families, and their communities. That said, recommendations have numerous salutary outcomes for systems and sectors beyond their contributions to improving behavioral health and well-being. The recommendations draw upon lessons learned from existing efforts and models, while highlighting new and promising opportunities. Recommendations are organized according to four main priorities, each of which supports the equity-focused whole-family, whole-community approach (see also Figure 3a):

1. Health Sectors & Systems Should Account for the Realities of Behavioral Health & Compounding Factors;
2. Health-Adjacent Sectors & Systems Should Support & Improve Behavioral Health;
3. Health & Health-Adjacent Sectors Should Close Gaps & Smooth Transitions Between Them; and
4. Communities Should Support Behavioral Health Well-Being at All Times for Everyone

The overarching recommendations in this chapter are intended to help lay the foundation for achieving a whole-family, whole-community behavioral health agenda at all levels of government and across sectors, systems, and programs. While not comprehensive, the recommendations cover both broader, longer-term ideas as well as more incremental, intermediate ideas—all of which are intended to contribute to mutually beneficial outcomes for the wide range of involved stakeholders. (Insofar as a recommendation is already being pursued today, it is uneven, failing to address the mental health and substance use challenges of millions of people.) All together and separately, the recommendations work to push us closer to achieving the vision of whole-family, whole-community behavioral health for every individual, family, and community at all stages of life and along the continuum of well-being.

FIGURE 3a. The whole-family, whole-community approach engages various sectors & systems to holistically address behavioral health



Source: Georgetown Center on Poverty and Inequality, 2019.

1. Health Sector & Systems Should Account for & Respond to Realities of Behavioral Health & Compounding Factors

For the health sector and systems within it to truly support the behavioral health of individuals and families, they must be reflective of and responsive to people's holistic needs, lived experiences, and identities. This requires pursuing and integrating strategies that consider the compounding challenges of people with behavioral health conditions who are also socioeconomically disadvantaged. Many of the recommendations in this section focus on advancing medical interventions in clinical and certain non-clinical settings to better address the multifaceted behavioral health and well-being needs of people with low incomes. Other recommendations address structural and socioeconomic barriers to care and strategies for strengthening the quality, impact, and reach of interventions within the health sector. Together, they offer a suite of health sector-specific whole-family, whole-community behavioral health strategies and approaches.

1.1 ENSURE ACCESS TO NEEDED HEALTH SERVICES & SUPPORTS

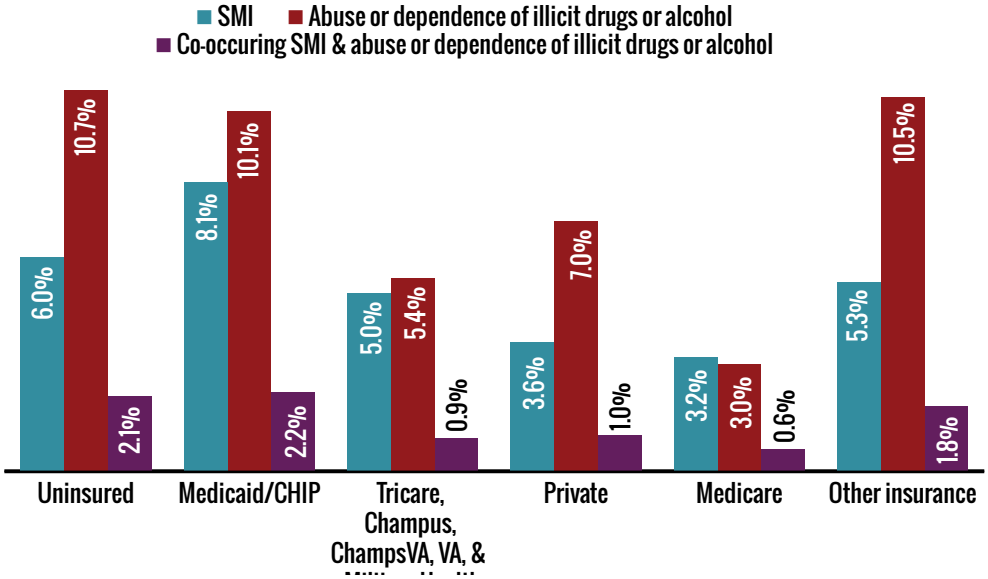
A cornerstone of promoting the behavioral health of all, but particularly people who experience socioeconomic disadvantage and other challenges, is ensuring access to an adequate network of high-quality health services, supports, and providers. Below are some policies that policymakers, administrators, practitioners, and other stakeholders should build upon and strengthen in order to ensure such access.

1.1.1 Ensure Health Coverage for All Low-Income Families

Health coverage serves as the foundation for ensuring equitable and effective access to health services, supports, and providers. Policymakers should expand health coverage to more families and individuals in need—including through levers such as Medicaid expansion, maximizing access to CHIP, expanding Money Follows the Person (MFP) financing, and various mechanisms to make private health coverage more affordable. They should also refrain from instituting harmful changes that would undermine access, such as counterproductive policies like work reporting requirements[378] and eliminating retroactive coverage for Medicaid.[379]

FIGURE 3b. A substantial share of uninsured individuals & Medicaid participants face behavioral health challenges

Share of adults by insurance type & status with mental health conditions, substance use conditions, or co-occurring mental health conditions & substance use conditions, 2017



Note: SMI stands for Serious Mental Illness.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Authors' calculations using microdata from "National Survey on Drug Use and Health, 2017." SAMHSA, U.S. Department of Health and Human Services, 2018. Available at https://www.datafiles.samhsa.gov/study-dataset/national-survey-drug-use-and-health-2017-nsduh-2017-ds0001-nid17939.

1.1.1.1 Expand Medicaid & Increase Medicaid & CHIP Participation

States should work to expand Medicaid and increase participation in Medicaid and CHIP. States yet to expand Medicaid should opt into the heavily federally-subsidized Medicaid expansion, which would increase access to health care among their residents.[380, 381] As of June 2019, 17 states have yet to expand Medicaid, though three more states are set to do so in the next two years according to ballot initiatives they passed.[382] Medicaid expansion ensures that behavioral health services can be utilized as easily as other medical services (see Appendix II for more information).[383] Preventive services now covered by non-grandfathered plans include, among others, screening and counseling for alcohol misuse, depression, and tobacco use.[384]

Among expansion states, increased access to Medicaid coverage has been linked to reductions in depression diagnoses and poor mental health days, as well as an increased likelihood of delivering like MAT and mental health counseling (see Figure 3b).[385, 386] States can also make changes to their Medicaid plans through the state plan amendment process in order to make Medicaid and the services it provides more accessible to more people.[387] For example, states should expand Medicaid coverage to all regardless of immigration status, as California did in June 2019.[388]

Federal and state governments should refrain from pursuing changes to Medicaid that would impede program access or result in counterproductive behavioral health outcomes. For example, in states that have expanded Medicaid, stakeholders should work to ensure

that counterproductive policies such as work requirements do not erode expansion-related improvements in access. As of 2019, nine states have used Section 1115 waivers

to institute work requirements (with seven more awaiting CMS' approval).[389] Work requirements have led to significant drops in Medicaid enrollment in states that have thus far instituted them.[390, 391] A substantial body of research indicates that work requirements are also ineffective at generating long-term employment and may exacerbate existing health inequities.[392] They are especially harmful for people with behavioral health conditions. Work requirements stipulate that adults participating in Medicaid must work or engage in work-related activities for a certain amount of hours each month to maintain health coverage—which can pose a challenge for individuals with behavioral health conditions at certain points in their recovery and create dangerous disruptions in care.[393] Other harmful uses of Medicaid waivers include mandatory premium payments and eliminating retroactive coverage, which can be particularly damaging for people at or near the FPL.[394, 395]

Additionally, in a retreat from health care provisions under the Affordable Care Act (ACA), federal and state governments have recently made efforts to restrict eligibility and reduce funding for Medicaid through rule changes and proposals to transition funding to a block grant or per capita cap structure.[396] Such funding structures are not designed to be responsive to rising behavioral health needs and health care costs,[397] and would leave many people without access to services and supports.[398, 399]

As for CHIP, state governments should work to increase CHIP participation rates in their respective states. CHIP provides mental health services for children in all states. The statistically significant uptick in the number of uninsured children under 19 from 3.6 million in 2008 to 3.9 million in 2017 highlights the need for expanding CHIP access.[400] While various studies emphasize CHIP's positive impacts on children's health overall[401, 402]—for example, a study of children enrolled in CHIP in New York found that coverage improved access to and continuity of care, prescription drug use, and rates of unmet health needs among children with behavioral and other health conditions[403]—more research is needed to fully understand the program's effects on mental health. States can improve CHIP participation rates by expanding eligibility criteria to the extent allowed by federal law (particularly through Medicaid expansion)[404] and bolstering outreach and education efforts to increase awareness of the program.[405]

1.1.1.2 Increase Access & Affordability of Private Health Coverage

Federal and state governments should reduce barriers to accessing private health coverage such as time-limited enrollment periods and out-of-pocket costs. Time-limited enrollment periods under the ACA should be eliminated in exchange for open enrollment year-round for low- and moderate-income individuals and families. Such changes have been made in Massachusetts, which adopted a state policy that enables people with incomes below 300 percent of FPL who are eligible and new to the state's insurance program to enroll in the insurance marketplace at any point during the year.[406] Findings from the impact of Massachusetts' policy indicate that eliminating time-limited enrollment periods contributed to increased enrollment rates, reduced coverage gaps, and lowered uninsured rates, all while avoiding adverse selection.[407] At the federal level, the Senate-proposed "Consumer Health Insurance Protection Act" would similarly help reduce enrollment barriers for millions of low-income people across the country.[408]

Cost-sharing also ensures that people can access private health coverage. The ACA implemented cost-sharing reductions for individuals and families who earned between 100

and 250 percent of the FPL and had silver-level plans from the Marketplace.[409] An estimated 7 million individuals were granted these reductions in 2016, which helped them afford the costs of their deductibles, copayments, and coinsurance.[410] However, in 2017, the Trump Administration repealed the cost-sharing provision, which was estimated to lead to an average of a 10 percent increase in the silver plans' premiums in 2018 and a 16 percent increase in 2019.[411] The cost-sharing provision should be reinstated and protected from further repeal in order to reduce out-of-pocket costs for individuals and families.

Stakeholders should also work to maintain and strengthen the ACA's premium tax credits. These tax credits help reduce individuals' and families' monthly insurance payments for Marketplace plans by setting an income-based cap on the minimum families must pay out-of-pocket for their plan.[412] The tax credit has not been as accessible in states that have not expanded Medicaid, as the 2.2 million individuals in these states who would normally be eligible for Medicaid are locked out of both Medicaid and the premium tax credit since they do not earn between 100 and 400 percent of the FPL.[413] Nevertheless, the tax credit should be maintained and strengthened in order to reach more individuals and families and help limit out-of-pocket costs.

1.1.2 Expand Access to Continuum of Behavioral Health Providers & Services

To make coverage for behavioral health meaningful, families need access to a wider assortment of providers able to deliver a full range of effective services, also known as network adequacy. Numerous federal and state laws and regulations guarantee a consumer's right to an adequate network of providers from their health care coverage, but serious access issues persist. Lax implementation is only part of the problem[414]—even if all available behavioral health providers were covered, it still may not meet access needs nor would it reflect the direction of integrated care and technology-based solutions.[415] Further, network adequacy tends to focus on the availability of providers rather than on the effectiveness of services. Even where behavioral health providers may be available, effective treatments for specific needs, culturally or linguistically responsive care, or developmentally appropriate whole-family prevention and early intervention may not be accessible. Addressing these challenges will involve efforts such as ensuring network adequacy, parity, and minimum coverage; addressing provider supply issues; and expanding both primary care and specialty care access initiatives.

1.1.2.1 Address Behavioral Health Care Provider Shortages & Access Barriers

Medicaid presents opportunities to meaningfully improve behavioral health outcomes, particularly for people in poverty. However, even when people have Medicaid coverage, many participants face obstacles, such as a limited amount of providers (let alone *behavioral* health providers) who will accept Medicaid reimbursement (see recommendation 1.2.1 for more barriers related to Medicaid reimbursement).[416] Strategies to mitigate this barrier include incentivizing providers with higher Medicaid reimbursement rates or requiring payers to provide out-of-network coverage when there is network inadequacy. In order to address provider shortages, barriers to training, licensing, and any other obstacles should be removed so existing providers can more easily provide behavioral health care, and individuals in the workforce pipeline have an easier time becoming behavioral health care providers (see recommendation 1.4 for more information on how to strengthen and expand the behavioral health workforce and recommendation 4.4.2 for more on the barriers that community health workers face, including licensing and training barriers).

Mental health and substance use parity—the requirement that mental health and substance use benefits cannot be more restricted than medical and surgical benefits—can be further advanced through greater enforcement of state and federal laws.[417] Passage of mental health parity laws dating back to 1996 and, most recently, the Mental Health Parity and Addiction Equity Act in 2008, led to rapid improvements in certain aspects of coverage, such as co-pays and visit limits, but additional implementation is required.[418, 419] Many people seeking treatment for behavioral health conditions still face legal barriers and forms of discrimination that inhibit access to health care.[420] The current parity enforcement paradigm tends to focus on either restrictions across a health insurance benefit category or issues in access to acute services, but has not begun to meaningfully explore what parity means for access to the full range of effective behavioral health services, from prevention and recovery, or for other health insurance activities such as ensuring network adequacy. Regulators should work with insurers to achieve more clarity on the parity implications at the level of individual services and across diverse health insurance activities. The Center for Consumer Information & Insurance Oversight (CCIO) should offer grants to states to build capacity to fully oversee and enforce parity, and the U.S. Department of Labor (DOL) should conduct more frequent audits and market conduct examinations.

Minimum coverage requirements, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)[421] or the Essential Health Benefits (EHBs),[422] should be tailored to cover the most effective behavioral health services that promote long-term behavioral health, rather than only those traditionally covered. For example, a body of evidence shows the efficacy of whole-family interventions in childhood for preventing or mitigating later behavioral health conditions for both the caregiver and the child.[423] For example, Familias Unidas is a universal intervention for families of Latino children during early adolescence that has demonstrated effects on substance use, sexual risk behaviors, and externalizing problems.[424] However, access to any of these interventions is minimal and current coverage for them is unclear.[425, 426]

1.1.2.2 Expand Policies & Programs with a Whole-Family or Whole-Community Lens, Such as EPSDT

Expanding Medicaid's EPSDT provision[427] in service of whole families can promote positive future behavioral health outcomes for both children and their parents, and help prevent children from entering the child welfare system (see Chapter V for more information on the factors that influence interaction with the child welfare system).[428] EPSDT currently serves all Medicaid-eligible children ages 21 and under, in addition to about two-thirds of children receiving CHIP.[429] EPSDT needs to be accessible to all children and families, particularly groups at risk for depression and other mental health conditions, such as low-income mothers of color.[430] The federal government should fund a higher share of the program to better incentivize states to increase participation rates. Ensuring health care coverage for at-risk families as soon as possible is critical for prevention. If a family is identified by the child welfare system as at-risk, a process to streamline and expedite enrollment and coverage for adequate health care can prevent entrance into the child welfare system. EPSDT currently serves all Medicaid-eligible children ages 21 and under, in addition to about two-thirds of children receiving CHIP.[431]

EPSDT also has a whole-family frame[432] that could be further utilized to promote family well-being before families come into contact with the child welfare system. For example, through EPSDT, Medicaid could cover screenings for families or other caregivers dealing with depression or other risk factors, and necessary services or referrals. EPSDT could also be used to implement a screening process for children entering the child welfare system and for children who leave the

system through adoption to move the system closer to universal screening. Most states do not have consistent or effective procedures for screening, which can lead to untrained caseworkers doing behavioral health assessments.[433] HHS should set these standards at the federal level to ensure that states are not using different procedures.[434]

1.1.2.3 Promote Integrated Primary & Specialty Care

Barriers to integrated care (where behavioral health specialty care is brought into primary care) should be addressed so integrated care is more accessible for people who are economically disadvantaged and people with a behavioral health condition or who are at risk of experiencing one. Integrated care is especially important for people who do not have access to multiple providers in their area, such as in rural areas.[435] There are currently barriers to integration, including the Stark statute,[436] which prevents providers from referring some of their Medicare patients to any entity where the provider or an immediate member of their family have any financial interest, and anti-kickback statutes, which forbid payments to providers for referrals deemed unnecessary or which prize the providers' financial interests over the patient's best interests.[437] Both provisions limit which providers patients can see and must be addressed by federal policymakers in order to allow further integration of care, as integrated care has been found to be effective, particularly for patients with high needs, in reducing emergency room and inpatient visit costs.[438]

There have been various models that promote integrated care that have shown success. One example of promoting integrated care is the State Innovation Model demonstration, which was authorized in Section 3021 of the ACA.[439] This initiative offers opportunities to improve behavioral health, strengthen connections to human services, and assist people with disabilities. All six states from the first round of the State Innovation Model financing invested in integrating behavioral health and primary care.[440] An evaluation from these states found reduced emergency department use, improved antidepressant medication adherence, and an increase in the use of primary care and specialty services among Accountable Care Organization (ACO) participants (see recommendation 3.2.1 for more information on ACOs).[441] Another example of integrated primary and behavioral health care is the Geisinger Health System in Pennsylvania. Geisinger pediatric community centers piloted an integrated care program in which primary care providers were trained to recognize and screen for several behavioral health conditions, while having a full-time psychologist and multiple psychology residents integrated in the care team to provide therapy and consultations. Preliminary data from this pilot show a reduction in health care and pharmacy costs, a shorter average length of treatment, and increased access to behavioral health care.[442] As these examples show, programs of integrated primary and behavioral health care eliminate many of the barriers to accessing specialty behavioral health care and must be expanded to support prevention and early intervention, as primary care providers are often the first touchpoint for individuals experiencing mental health conditions.

1.1.2.4 Utilize Existing Opportunities to Broaden Behavioral Health Services

There are many underutilized opportunities presented by Medicaid and the ACA that can be further taken advantage of to broaden behavioral health service delivery (many of which are listed throughout this section). For example, the Medicaid Rehab option, which offers states more flexibility to administer services in non-clinical settings and by non-clinicians (including training for the non-clinicians),[443] can also be used to make behavioral health services more available and accessible.[444]

Another example is the MFP Rebalancing Demonstration Grant, which should be fully funded and further expanded. MFP was created in 2016 to help states use Medicaid funding to transition people with chronic conditions and disabilities, including those with behavioral health conditions who made up six percent of total transitions in 2015,[445] from institutions to home and community-based services of their choice to receive long-term care. However, funding for MFP ended in September 2016. Though states can use any leftover program funds until September 2020,[446] it is not sufficient or sustainable and likely will still result in states cutting back services.[447] The MFP program has aided states in creating new transition programs, establishing interagency collaboration between health and housing, and create new programs to improve access to local long-term support services,[448] which can include behavioral health services, peer supports, home visiting, and increased foster care services for adults.[449]

Expansions under the ACA (Section 2403) both strengthened MFP and allowed more states to apply, leading to 44 states and the District of Columbia participating in the program.[450] As of December 2016, over 75,000 people with disabilities and chronic conditions had participated in the voluntary program, transitioning from institutions into home and community-based services.[451] The program has demonstrated success in meeting the needs of those in deep poverty by offering services such as case management and additional transition assistance, including providing affordable and accessible housing, moving expenses, security deposits, home modification, peer support, and other orientation and mobility services.[452] The program must be reauthorized by Congress and the President in the next federal budget. It should also be further expanded to include more individuals with behavioral health conditions who still live in long-term care facilities (many of whom are under age 65)[453] and help address their health care and housing needs.

1.1.2.5 Increase Number of Hospital Beds

The number of hospital beds should be increased, as many times patients are put on waiting lists or stuck going to the emergency room until there are available beds, which can lead to higher rates of mortality and morbidity.[454] The number of hospital beds have been steadily decreasing in the last few decades, and at least 35 states beds face psychiatric bed shortages.[455] There has also been a lot of hospital closures in general in rural areas.[456] Instead, many times the CJ/JJ systems become the last resort for many people experiencing behavioral health conditions when they should be receiving inpatient treatment in the health sector.[457] In these settings, they may receive no treatment and may instead face solitary confinement which can exacerbate their conditions (see Chapter VI for more information on the CJ/JJ systems).[458] States should move to increase the number of general hospital and psychiatric beds that they have in order to make sure people receive the help they need, rather than ending up in other systems or sectors that cannot provide that care.

1.1.2.6 Address Growing LTSS Needs, Including Behavioral Health Needs

There is a growing need for LTSS care in the U.S., including for long-term behavioral health care.[459] One way to address this need is through the creation of a universal catastrophic long-term care insurance program, which is a "risk-based solution that is financed through a combination of public and private funds."[460] Such a fund would help individuals and families afford the care they need, while also helping to reduce states' overall Medicaid costs.[461] Medicaid would still serve as a safety net for those who cannot afford to supplement the universal catastrophic insurance's coverage with private insurance or their own assets.[462] A federal long-

term care insurance system would also make LTSS services and payment levels uniform across the country.[463]

1.1.3 Mitigate Immediate Socioeconomic Barriers to Care

Even within the health system, there are opportunities to address immediate socioeconomic barriers to care. Improved accessibility can in turn help address longstanding disparities in physical and behavioral health access due to historical legacies of exclusion, particularly for people of color and low-income populations.[464] In this vein, access to transportation and telemedicine should be expanded.

1.1.3.1 Provide Adequate Transportation Supports to Improve Care Accessibility, Including Within Medicaid

CMS and states should work together to ensure that each Medicaid state plan maximizes access to behavioral health services, consistent with the goals of the Medicaid program. This includes protecting and expanding access to Non-Emergency Medical Transportation (NEMT) services.[465] NEMT services (in part funded through Medicaid) should be safeguarded and expanded to cover the Medicaid expansion population. Transportation supports are crucial to help people with low incomes access health care. An estimated 3.6 million Medicaid recipients "miss or delay care" each year due to transportation barriers.[466] Data show that the majority of NEMT service use is for behavioral health services.[467] Further, NEMT can be especially helpful for people with mental health concerns such as paranoia, confusion, and hallucinations who face challenges navigating public transit systems.[468] Analysis on the cost-benefit impact of NEMT suggests that the program helps reduce long-term care costs and increase savings for states, largely through reducing emergency room costs.[469] While NEMT is a mandatory benefit of Medicaid, states like Indiana and Iowa have used waivers to limit access to NEMT services, particularly for the expansion population, over concerns of fraud and ineffective administration.[470] Rather than limiting these services, states and CMS should focus on expanding NEMT as a low-cost investment that can reduce health care costs further downstream, while providing much needed access to health care.

Aside from services within Medicaid, more transportation services with a more robust infrastructure are needed especially in rural areas where transportation-related challenges significantly limit access to behavioral health supports.[471] One example is clinics directly offering transportation services such as shuttles to treatment centers.[472] Mobile health care delivery has also proven to be an efficient way of providing health care access in rural and remote communities.[473] One such project is the New Mexico Mobile Screening Program for Miners. A partnership between the Miners Colfax Medical Center and the University of New Mexico, the program offers health care screening services to the miners in the state, a majority of whom are Hispanic and AIAN.[474] It also provides the miners with self-management information and makes follow-up calls. This program has been further expanded to rural Kemmerer, Wyoming.[475]

1.1.3.2 Expand Telemedicine

Telemedicine should continue to be expanded in order to address unmet behavioral health needs in areas where it is hard to access in-person services. Telemedicine enables people in hard-to-reach areas, or places with limited health care infrastructure, to access health services regardless of their location. Through digital platforms, people with behavioral health conditions can find specialists with expertise in their particular mental health issue without geographic limitations. Digital platforms enable people to meet virtually with therapists, psychologists, and psychiatrists

among other specialists, and receive information on diagnosis and treatment, which is especially crucial in places with shortages of psychiatrists and other behavioral health workers.[476] Policymakers should expand the eligible originating sites and practitioners for telemedicine so that it is more readily available. Barriers to telemedicine should also be addressed, such as a lack of access to broadband in the very areas where telemedicine could make a difference in connecting people to behavioral health services (see recommendation 2.1.2.4 for more information). Telemedicine can also be leveraged to help expand Medicaid coverage, particularly for groups at risk of losing continuity of care, such as people in jails or prisons (see Chapter VI for more information). Given the promise telemedicine holds for expanding behavioral health treatment access, states should continue expanding Medicaid reimbursement to include a broader range of telemedicine services.[477] Additionally, more states can tack onto initiatives like the Interstate Medical Licensure Compact, which helps physicians practice outside of their state borders,[478] to expand usage of telemedicine services.

1.1.3.3 Eliminate Co-Pays in Medicaid

Copays in Medicaid should be eliminated because they are a barrier to low-income individuals and families receiving necessary care, even if they are as low as a few dollars.[479] Copays can particularly be a burden for people with serious or chronic conditions, including behavioral health conditions,[480] and may even result in coverage losses, as was the case in Oregon when higher copayments were instituted.[481] They also do not lower health care costs (even resulting in the increased use of more costly services like emergency room visits)[482] or generate significant revenues.[483] They can also lead to reductions in the use of prescription medications, which can be a key treatment for people with behavioral health conditions,[484] which is why they should be eliminated in Medicaid.

1.2 LEVERAGE OPPORTUNITIES TO IMPROVE HOLISTIC HEALTH SERVICES DELIVERY

Various opportunities exist that can be more fully leveraged to provide health services in a more holistic way. These include the use of Medicaid waivers, such as with Coordinated Care Organizations (CCOs), provisions within the ACA, such as the use of health homes, and Certified Community Behavioral Health Clinics (CCBHCs).

1.2.1 Reform Medicaid Reimbursement & Waiver Policies

Barriers related to Medicaid reimbursement prevent people from receiving the behavioral health services that they need and should be addressed. There are a limited number of providers that accept Medicaid reimbursement.[485] Strategies to mitigate this barrier include incentivizing providers with higher Medicaid reimbursement rates (as mentioned in recommendation 1.1.2.1), including for non-traditional services, such as peer supports and telemedicine.[486] Practitioners in integrated and co-located care should also be able to receive the same reimbursement rates as they would in private practice;[487] states can implement this through Medicaid state plan amendments, as some states have done already.[488] Increasing Medicaid reimbursement rates are associated with increased rates of people visiting the doctor when they need care and increased self-reported health.[489]

Medicaid waivers, including Section 1115 waivers and Section 1915 waivers,[490] offer opportunities and flexibility to states looking to improve the delivery of holistic health services and supports. Instead of enacting policies and practices that block access to Medicaid, such as work requirements, policymakers should leverage flexibility in Medicaid waivers to expand access

to health coverage for a variety of needs including behavioral health. To better support states, CMS should provide a suite of tools to help states understand the impact of different waiver options on the behavioral health of their population, using the evaluations of other waivers as well as the published literature. For example, the ReThink Health Dynamics Model offers health systems simulations to understand the impact that a different initiative would have on both costs and health outcomes for their regions.[491] CMS should provide similar tools to states to help them build on existing waivers that have been effective or innovate using the best available information.

CCOs in Oregon are another example of a state leveraging a Medicaid waiver opportunity to expand access to services and supports. In 2012, Oregon utilized the Medicaid Section 1115 waiver to establish CCOs in place of traditional Medicaid managed care organizations.[492, 493] CCOs operate through community-based partnerships of managed care plans and providers, with funding to deliver traditional health care services as well as non-health services not typically covered by Medicaid.[494] These services include care for physical health, behavioral health, and "health-related" needs such as temporary housing for patients recently released from the hospital, or home improvement to alleviate conditions like asthma.[495] Under the state's plan, CCOs are designed to address the SDOHs and provide "community benefit initiatives" such as vaccination campaigns, to improve the overall health and care of communities, in line with a whole-community approach.[496] Since 2012, Oregon's CCO model has delivered a number of positive health outcomes including a 56 percent increase in the amount of children screened for development, behavioral and social delays, improved access to care, and increases in patients' satisfaction with treatment.[497] Additionally, CCOs have helped reduce health care costs by an average of two percentage points annually.[498]

1.2.1.1 Expand & Strengthen Health Home Model

Health homes were authorized as a state Medicaid option by Section 2703 of the ACA and promote care coordination and some integration of human services. Health homes can provide people with chronic conditions, including behavioral health conditions, with comprehensive medical services from a unified and consistent medical team.[499] For a patient with a behavioral health condition, their team can include a primary care provider, a care manager who coordinates care, a peer specialist, a community health worker who can help the patient navigate the health system, a nutritionist, other medical specialists, and a pharmacist.[500] One way to orient health homes to better address behavioral health could be the development of health homes that focus on individuals who have been exposed to violence in order to address the resulting trauma and allowing categorical eligibility based on these experiences.[501] Some health homes, such as some in New York, have also been targeted toward individuals that have previously been involved with the CJ/JJ system and have behavioral health conditions.[502]

1.2.2 Expand Direct Provision of Behavioral Health Through Community-Based Institutions

The provision of behavioral health care directly through community-based institutions such as Federally Qualified Health Centers (FQHCs) and Certified Community Behavioral Health Clinics (CCBHCs) should be broadened. For example, FQHCs should be expanded to provide needed outpatient care primarily to underserved populations, such as farm workers and people experiencing homelessness, regardless of ability to pay.[503] These health centers include community health centers (CHCs) and tribal outpatient programs and facilities and serve about 1 in 6 rural residents and medically underserved areas or populations.[504] Congress should expand

Medicaid and Medicare funding for FQHCs in order to increase the capacity of community-focused outpatient clinics to serve more of their target populations, especially in rural areas which face shortages in psychiatric care and other behavioral health services,[505] while remaining financially solvent.[506] Federal and state agencies can also support the expansion of services offered by FQHCs through investment in telemedicine[507] to serve more underserved and hard-to-reach populations. (Though there are challenges to expanding telemedicine in FQHCs that have to be addressed first, including a lack of sufficient broadband, the cost of such technology, challenges related to billing, a lack of providers who can provide telehealth services, and logistics including credentialing and licensing.[508])

At the federal level, funding should be consistently allocated for CCBHCs, which were created to provide behavioral health services in eight states under the Excellence in Mental Health Act demonstration from 2016 to 2018.[509] Such facilities have an enhanced Medicaid reimbursement rate, as they expand their services to further reach vulnerable communities.[510] These clinics can also meet people where they are through strategies such as mobile crisis teams, outreach workers, and jail diversion programs.[511] While CCBHCs have been a great resource during the opioid epidemic (as they have trained their workforce and provided MAT), they need long-term funding authorized by Congress.[512] Without this funding, CCBHCs face closures, major layoffs, longer wait times, and less access to treatment,[513] so they should be adequately funded through at least 2022 as proposed to continue to address short-term and long-term behavioral health needs.[514]

1.3 ESTABLISH SHARED GOALS & HOLD HEALTH STAKEHOLDERS ACCOUNTABLE

Key stakeholders within the health system must align goals and measures of effectiveness that promote and realize whole-family and whole community behavioral health principles. Such alignment will require among other things changes to payment incentives, greater collaboration to encourage shared learning, and quality measures that are consistent with the whole-family, whole-community framework. Performance and quality measures/outcomes should be strengthened to better reflect the types of services and supports that people with behavioral health needs and other related socioeconomic needs require.

1.3.1 Change Payer & Provider Incentives to Reward Holistic Approaches

Providers and payers should be incentivized through payment policies to help empower individuals to direct their course of care and to promote models that specifically address behavioral health in conjunction with other health needs. One such example for providers is the $50,000 tax penalty levied on nonprofit hospitals if they fail to meet their community benefit requirements[515] (for more information on this policy, see recommendations 1.5.1 and 3.3.2). Requirements and penalties such as this should be expanded as a way to incentivize investment in short-term and long-term behavioral health.

1.3.1.1 Allow Providers Time to Engage With Individuals & Families

CMS should review its current payment policies to ensure that it supports providers in engaging individuals and families as directors of their own behavioral health care after screening positive for a mental health or substance use condition. Current payment policies do not incentivize providers to dedicate time and resources to educate and engage with individuals with

behavioral health conditions so that they are empowered to make informed decisions and direct the course of their care.[516]

1.3.1.2 Promote Coordinated & Advanced Primary & Specialty Care Through Innovative Service Delivery Models

Coordinated care between one's behavioral health providers and other medical providers through increased communication and information sharing should be incentivized. Such coordination can help improve outcomes for patients, who can then have a seamless experience in the health system especially while transitioning among providers, while also helping providers and payers.[517] One example of coordinated care comes from advanced primary care models, which widen the scope of what primary care contains, should also be expanded. In advanced primary care models specifically, the Center for Medicare and Medicaid Innovation (CMMI) is working with private health insurers to ensure consistent incentives for providers so that both public and private insurance companies offer similar value-based payment amounts across the same set of quality measures—an approach that would be especially effective in collective impact. One way to prepare providers for value-based payments comes from New York. In New York, groups of providers (called Behavioral Health Care Collaboratives) were given grants in order to prepare for the shift to value-based payment in the state's Medicaid system.[518] Health homes are one of the most common ways that advanced primary care models have been utilized thus far and should be further expanded (see above for information on health homes).[519]

1.3.2 Incentivize Investment in Short- & Long-Term Behavioral Health

Incentives should be created for payers and providers to invest in short-term and long-term behavioral health. The long-term returns from investing in behavioral health increase dramatically the earlier in the lifecourse that one invests. Given the rapid pace of brain development in childhood, and even physiological development that impacts later brain development during the perinatal period, interventions can alter developmental trajectories and improve adult outcomes.[520] Investments in low-income families early in the life of a child have been demonstrated to prevent behavioral health conditions entirely,[521] reduce the incidence and severity of potential physical health comorbidities,[522] and decrease the likelihood of being low-income as an adult.[523] In one oft-cited cited study, a preschool program enhanced with social and emotional learning and home visiting produced a return on investment (ROI) of over 7:1 over forty years.[524] Specifically, for payers, companies tend to just cover care in times of crisis, rather than focus on preventive services.[525]

Currently, the payment formula for Medicare Advantage and Medicaid Managed Care Organizations (MCOs) offer more payment when the population prevalence of behavioral health conditions is high, but no payments if the health insurer is able to invest to reduce the prevalence. Instead, the federal government should change the payments to reward prevention based on reductions of population-level prevalence of behavioral health conditions and risk factors relative to benchmarks. Commercial insurers can be engaged through all-payer models or forms of regulation that help to allocate incentives for effective prevention. Effective prevention should also be included in quality measurement programs, such as STAR Ratings. For example, quality measures could predict the benchmark prevalence of a health condition, such as depression, or of a developmental event, such as kindergarten readiness, across a population and then assess the actual prevalence to determine the rate at which providers prevented conditions from occurring or improved developmental trajectories.

The U.S. Preventive Services Task Force (USPSTF), which dictates which services health insurance companies need to cover under the Preventive Care EHBs in the ACA,[526] can also be refocused on whole-family behavioral health promotion, rather than solely identifying early onset of conditions in individuals. Often, the most effective prevention for behavioral health conditions in children is supporting the whole family, and the USPSTF should structure its reviews and recommendations to better reflect this. For example, the USPSTF currently recommends screening and treating adolescents for depression prevention,[527] but the evidence demonstrates that engaging families earlier can prevent depression from ever developing.[528]

1.3.3 Embed Continuous & Shared Learning into Existing Interventions

Processes are created to test and evaluate current structures and practices and promptly implement new interventions based on what is learned, particularly from the lived experiences of families and communities. Training for evidence-based practice is important, but the capacity to generate and integrate practice-based evidence can be just as critical—especially for underserved populations. Many evidence-based practices were not tested across cultures and community contexts and may need to be adapted or entirely reinvented for some populations. Further, the complex array of challenges facing low-income communities will require frontline innovation to identify effective approaches that can most effectively promote behavioral health. Continuous improvement and shared learning offer the opportunity to evaluate interventions and rapidly scale what works so providers know which interventions work best for these communities.

1.3.3.1 Conduct More Research Focused on Underrepresented Groups

More data on underrepresented groups should be collected in order to accurately assess these groups' needs and to see if the interventions that are currently in place are effective for them. Currently, the proportion of socioeconomic groups represented in clinical research is unclear, as many clinical studies do not reliably collect information on income level.[529] Incentives should be created for the inclusion of underrepresented groups both in terms of race/ethnicity and socioeconomic status in scientific studies. The National Institutes of Health (NIH) can provide priority scoring to studies that have demonstrated a focus on populations with lower SES and other underrepresented groups. The NIH can revisit their standard operating procedure for Review Criteria to emphasize the importance of including underrepresented groups as participants in assigning a significance score to a study.

Additionally, more funding for the Agency for Healthcare Research and Quality (AHRQ) should be allocated so the agency can annually update the evidence on best practices for effectively promoting behavioral health across different contexts and populations and disseminate the findings for integration into training programs, which it currently does.[530] These effective behavioral health promotion strategies should be freely accessible by authorizing AHRQ to generate online training modules, and the AHRQ should offer grants for federal grantees to create online modules out of promising practices identified in the practice-based evidence evaluations. Building on the Foundations for Evidence-Based Policymaking Act of 2017 will also increase funding for AHRQ to lead an effort to create systems for more real-time evaluation and practice-based evidence across federal programs, so that federal investments contribute to the evidence about what works in behavioral health in addition to what can be found in the published literature. Additionally, special designations should be expanded and incentivized for practices that use continuous learning and evaluation to better integrate behavioral health. For example, the National Committee for Quality Assurance (NCQA) provides a Distinction in

Behavioral Health Integration for health homes that undergo analyses and implement changes to fulfill standards for behavioral health care integration.[531] Additional funding should be allocated to AHRQ to develop standards for behavioral health integration in practices beyond health homes for a special designation with a focus on continuous evaluation and improvement.

1.4 STRENGTHEN & EXPAND THE HEALTH WORKFORCE

When health care is provided in ways that are responsive to behavioral health realities (including how they intersect with experiences, identities and other socio-cultural and -economic factors), people and families are more likely to receive the quality and holistic support they need. In recent years, the health sector has made important strides in embedding more culturally- and trauma-responsive approaches into the training and selection of its workforce. However, the current health care system has not historically been set up—nor adequately incentivized—to prioritize these shifts in approaches to care. To more easily and effectively provide responsive, equitable, and accessible care to the diverse populations described in this report, certain structural and cultural shifts must be made to the health care system, particularly its workforce. To ensure that the health care workforce is equipped to provide such responsive and inclusive care, stakeholders must focus on the training and education of the current workforce, as well as tackling underlying issues with the workforce pipeline itself. There is currently a workforce shortage of behavioral health providers, and demand for behavioral health services continue to outpace the supply of providers.[532] There should be a focus on identifying and expanding strategies and practices for addressing recruitment, retention, and overall workforce supply challenges.

BOX 3A.

BEHAVIORAL HEALTH WORKFORCE

According to SAMHSA, the behavioral health workforce includes a wide range of professions including "psychiatrists and other physicians, psychologists, social workers, advanced practice psychiatric nurses, marriage and family therapists, certified prevention specialists, addiction counselors, mental health/professional counselors, psychiatric rehabilitation specialists, psychiatric aides and technicians, paraprofessionals in psychiatric rehabilitation and addiction recovery fields (such as case managers) and peer support specialists and recovery coaches."[533] Overall, there are 24 different occupational categories that provide behavioral health services, each with unique requirements for education, training, and certification.[534]

Behavioral health work is a growing profession in the U.S., but there are also workforce shortages and various other problems, such as high turnover rates (up to 50 percent for some in addiction services) and inadequate training.[535, 536] Specialists themselves are aging.[537] Currently, the mean age in the behavioral health workforce is over 50,[538] and 70 percent of psychiatrists are age 50 or older.[539] There is also a lack of behavioral health care in many localities in the U.S. As of 2014, over half of U.S. counties had no practicing behavioral health worker, and 77 percent of U.S. counties had unmet needs related to behavioral health.[540] This trend was particularly pronounced in rural areas.[541] A 2017 report found that 60 percent of counties had no psychiatrist.[542] Additionally, areas that have the lowest-income per capita are more likely to be mental health professional shortage areas.[543] A 2017 study found that 25 percent of communities in the top income quartile had access to psychiatric service providers and 35 percent had access to therapy practices.[544] In contrast, only eight percent and 13 percent of communities at the lowest income quartile had access to psychiatric and therapy practices, respectively.

These shortages are likely to continue if they are not addressed, as by 2030, it is predicted that there were be only one geriatric psychologist for every 6,000 older adults who need them, along with a shortage of more than 4,000 children and adolescent psychiatrists by 2020.[545] There is also a shortfall in government funding for behavioral health professionals.[546] Salaries for the behavioral health workforce are well below other comparable health and business professions.[547] Other problems that the behavioral health workforce, particularly psychiatrists, report include burnout, "insufficient time with patients to do proper assessments, regulatory restrictions on information sharing, and increased time spent on entering required data into patients' electronic medical records."[548] Many also do not take on Medicaid patients or individuals with certain mental health conditions.[549] Note that this description of the problem focuses on behavioral health specialty care providers—health care professionals and paraprofessionals dedicated to addressing behavioral health needs. The other issue with the behavioral health workforce is that non-specialty care and even non-health care professionals and paraprofessionals need to be part of the workforce. Primary care providers, early care and education providers, and even lawyers—among countless other stakeholders—must be equipped and engaged to meet behavioral health needs, in order to effectively improve the behavioral health of the population.

1.4.1 Build a Trauma-Informed, Culturally Responsive, & Representative Workforce

Developing a culturally responsive and trauma-informed health workforce can reduce barriers and disparities in health outcomes, particularly for communities of color. It also can allow providers to reflect and understand the identities and experiences of the people they serve.[550] The health care workforce needs to be trained to be culturally and linguistically competent (on an ongoing basis with evaluation in order to institute continuous improvement) with an emphasis on "sensitivity to variations within populations as well as among populations, including individual variations in beliefs, expectations, and preferred modes of communication."[551] Providing services in a culturally and linguistically relevant manner has been proven to improve quality of health care and services.[552] Health care organizations can leverage the HHS National Standards for Culturally and Linguistically Appropriate Services (CLAS)[553] to develop strategies for instituting culturally responsive practices, such as language supports for non-English speakers, into their service delivery. Health agencies should also develop implicit bias training and education for behavioral health workers with a focus on racial equity, gender equity, and LGBTQ cultural competency. Such training should help practitioners recognize and combat bias in screening and treatment of mental illness and SUDs to ward against both dismissal and pathologizing or misdiagnosing behavioral health conditions due to cultural misunderstandings or insensitivities.[554]

1.4.1.1 Train Existing Workforce to Better Understand & Meet People's Holistic Behavioral Health Needs

Within the health care pipeline, education programs should be incentivized to train workers on addressing behavioral health and the SDOHs. Programs like the Public Health Service Commissioned Corps focus on a specific provider type—such as incentives for primary care practitioners in underserved areas,[555] but do not highlight the competencies expected—e.g. whether these practitioners are expected to be able to offer any effective interventions for family behavioral health. Funding incentives can be created for education and training programs, such as through graduate medical or nursing education or the Public Health Service Corps, for integrating effective behavioral health promotion and awareness of the interplay between behavioral health and the SDOHs into these programs.

The behavioral health care workforce can play a crucial role in advancing whole family well-being. Mental health and substance use treatment and care providers should train practitioners who are already in the health system on evidence-based models of behavioral health integration. Aside from behavioral health integration, primary care physicians and other practitioners should be trained on addressing the SDOHs. For example, pediatricians should be trained to ask about a child or family's food security needs and be able to point them to resources in non-health sectors and systems.[556]

1.4.2 Remove Barriers to Workforce Participation

In service of responsiveness and equity, there should also be a focus on building a pipeline of health workers who reflect the populations and communities they serve (see Box 3a for information on the current state of the behavioral health workforce). Such a pipeline would advance more responsive care as providers would possess lived experience, likely generating greater empathy and mitigating bias between care providers and beneficiaries, and ultimately helping to transform the health system.

To promote retention of a more diverse and culturally responsive workforce, health agencies and provider organizations should incorporate and institutionalize bias prevention, diversity, and inclusion principles in hiring practices and conduct outreach to groups who are underrepresented in the health workforce. Successful outreach efforts include health care apprenticeships for Opportunity Youth or adults ages 16-24 who are neither enrolled in school nor in the labor force.[557] Apprenticeship programs in cities such as Philadelphia and New Orleans have also demonstrated promise in connecting young adults with past involvement in foster care and the CJ/JJ systems to stable employment in the health sector.[558] Telemedicine can also be an important tool for recruitment and retention (see recommendation 1.1.4.2 for more information on telemedicine), particularly in rural or remote areas.[559] Additionally, existing health care workforce programs, such as the Public Health Service Commissioned Corps, should continue to be used to build out the workforce, but should specifically focus on recruiting a diverse selection of participants (see above for more information on this program and how else it can be utilized).

1.4.2.1 Use Health Profession Opportunity Grants (HPOG) or Similar Programs to Expand Behavioral Health Workforce

Expanding existing and/or exploring opportunities for new programs that specifically target and mitigate structural causes of occupational segregation in the health sector can help ensure the health workforce pipeline is more reflective of the populations it serves. For example, HHS Administration for Children and Families' (ACF) HPOG program grants funds to organizations (such as higher education institutions, nonprofits, and governmental organizations at the state and tribal levels)[560] for five-year periods to educate, train, and support Temporary Assistance for Needy Families (TANF) participants and other low-income individuals to work in health care.[561] As of June 2019, there have been two rounds of HPOG grants in 2010 and 2015[562] that have enrolled at least 36,000 participants.[563] For most participants, training has averaged about 3.5 months and relevant supports they have received included child care, transportation, temporary housing, legal assistance, and medical care, such as addiction and substance use counseling.[564] While the majority of HPOG enrollees have trained to become home health aides, nurses (some of whom are psychiatric aides) and nurse practitioners, medical assistants, and pharmacy technicians thus far,[565] there are also major gaps in the behavioral health workforce that could be filled with people with lived experience. Thus far, HPOG has seen higher rates of employment and earnings for program participants, and participants have overwhelmingly been women of color.[566] Such an intervention includes individuals with lived experience as part of the behavioral health workforce, which they otherwise face barriers to joining, while also filling gaps in the workforce. After the 2015-2020 round has been completed, ACF should continue awarding further grants with a specific focus on strengthening the behavioral health workforce.

1.4.2.2 Promote Peer-to-Peer Support

Individuals can also play a critical role in helping one another, and policy should facilitate and support these opportunities. One such opportunity is to invest in training, credentialing, and integrating peer support specialists throughout health care as well as in transitions with other settings, such as jails and prisons. Peer supports provide the opportunity for individuals with lived experience to offer their insights and services to other individuals with behavioral health conditions. Such community-based interventions are more accessible and may help reduce stigma around receiving help. For example, research around peer support has shown that such interventions help reduce the symptoms of behavioral health conditions and hospitalizations, and related costs, while also helping recoveries last longer and improving individuals' well-being, social functioning skills, and self-esteem.[567] Programs like the Health Resources &

Services Administration's (HRSA's) Behavioral Health Workforce and Training program can collaborate with CMS to ensure that peers are integrated into a sustainable business model that fully captures the value they produce within a health care system.[568] For example, HRSA and CMS could work together to integrate peers into ACOs or other alternative payment models, which offer peers the flexibility to effectively practice and recognize the savings from reduced hospitalization and emergency department utilization.

1.5 RE-ORIENT SYSTEMS TO PRIORITIZE AGENCY OF INDIVIDUALS & FAMILIES IN HEALTH SECTOR

Individuals and families are often disempowered when they are navigating the health sector and systems. Cost and coverage barriers, socioeconomic challenges, inadequate access to representative care, and other obstacles undermine individuals' and families' agency. Individuals with behavioral health conditions should be able to help direct their course of care by being a part of decision-making at all levels and by being equipped with tools to help address their own behavioral health conditions; the course of care is still primarily left up to the provider in many instances.[569] Health organizations should be held accountable by payers for ensuring patient empowerment. Additionally, trauma-informed and culturally-rooted practices should be implemented throughout the health system in order to make care more effective and accessible than it is now for all populations.

1.5.1 Ensure Providers Utilize Patients' Input

Health providers should establish structures affirming the rights and agency of key stakeholders by creating structures that embed the concerns and goals of the target individuals, families and communities, while also involving them in the decision-making and design of health interventions. These practices could include improving or bolstering the use of focus groups and listening sessions, engaging in patient experience mapping, and recruiting health care recipients to serve on leadership boards and advisory councils.[570] Such practices can foster deeper partnership between health care providers and the people they serve,[571] and empower families and community to exercise agency over their health and well-being. FQHCs already ensure that more than half of the board of directors be made up of individuals from the population being served—an approach that could be expanded to other health care entities and other aspects of decision-making.[572] The FQHC model focuses on testing ways of establishing community-wide collective ownership and governance of pooled funding from place-based investment strategies.[573] By instituting community leadership in health interventions through patient board membership, FQHCs can develop shared goals of well-being centered on the people they serve.

The federal government can further utilize community needs assessments to ensure that the patients served by hospitals are directly involved in their care. In 2014, the Internal Revenue Service (IRS) issued final rules in Section §501(r)-3 for charitable hospitals to conduct community health needs assessments. These requirements stipulate that hospitals must receive input from "members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of these populations."[574] Hospitals should be required to not only receive input in identifying needs but integrate underserved and underrepresented members of the community into the team conducting the needs assessment.

1.5.2 Prioritize Trauma-Informed & Culturally-Rooted & -Responsive Services

Communities that have experienced systemic oppression have unique mental, emotional, and other health needs that must be met through trauma-informed, culturally-rooted and -responsive approaches. Navigating systems that were not designed to account for or respond to someone's cultural and individual experiences, barriers, and identities adds an additional layer of difficulty and increases the likelihood of someone having a negative experience from an interaction with health systems.[575] Trauma-informed, culturally-rooted and -responsive services (including bilingual and bicultural services)[576] can be more effective,[577] as they are informed by the patient's experiences.[578] For example, acknowledging historical trauma has proven to be helpful for Native American youth along with storytelling, both of which are cultural practices.[579] Strategies for Latinx youth include acknowledging specific trauma experienced by them, including stress related to integration into society for immigrant children; specific types of therapy that could be useful include play therapy, music therapy, and gardening therapy, which can help address cultural gaps and language barriers.[580] Supporting and incorporating historical and cultural trauma-informed practices into service delivery can make those services more accessible for marginalized groups.[581]

Achieving this goal requires addressing service supply issues: as with health services overall and behavioral health services in particular, there is currently a dearth of culturally-responsive services available for individuals and families.[582, 583] Equitable and participatory processes for developing, disseminating, and facilitating access to culturally-responsive and trauma-informed services can help health institutions and other decisionmakers design the services and/or facilitate the use of services based on direct input from the communities they serve. Supporting and incorporating historical and cultural trauma-informed practices into service delivery can make those services more accessible for marginalized groups.[584]

Health insurance providers can support indigenous or culturally-derived healing practices by providing reimbursement for these services. One Community Health in Oregon is one example of a culturally-responsive clinic that has historically relied on Medicaid, Medicaid, and private insurance reimbursements to provide specialized services.[585] Over the years, with the help of reimbursements and government support, the clinic expanded from just providing case management and lay health education for hypertension, diabetes, and heart patients[586] to a multi-center organization with services ranging from pediatrics to behavioral health care for migrant workers, their families, and the broader community.[587] Clinic staff are trained on different norms across cultures and program materials are designed so they are accessible to patients at all levels of literacy.[588]

Evidence from horse therapy, a practice of the Lakota Nation in South Dakota, in addressing behavioral health conditions underscores the potential for culturally-rooted inteventions.[589,590] For many Lakota people, horses have spiritual significance and are able to connect with humans on an emotional and psychological level.[591] For this reason, the Lakota Nation (and other tribes that have adapted their practices) have used equine-assisted therapy to help Native youth and adults with behavioral and other health conditions to improve their symptoms while also connecting with their cultural heritage.[592] In equine-assisted therapy, participants engage in horse-rearing activities, such as grooming and feeding a horse, and then reflect on their experiences with the horses, typically with guidance from a mental health professional.[593] Equine-assisted therapy has been shown to help address PTSD in children, soldiers, and people

in prisons, in general.[594] Additionally, horse therapy has been utilized in substance use and psychiatric treatment programs,[595] and has been shown to be effective in addressing dissociative disorders, as well as improving ADHD, depression, and anxiety symptoms, among others.[596, 597, 598]

1.5.3 Use Medicaid to Invest in Workforce Development

States should also invest in workforce development programs that address some of the major needs people have for attaining employment, such as building new skills or accessing transportation. State programs like Montana's Health and Economic Livelihood Partnership Link (HELP-Link) have generated positive gains in employment without undermining health coverage for Medicaid expansion enrollees.[599] The HELP-Link program provides job supports, such as job training and career counseling, to unemployed Medicaid enrollees without disabilities who face major barriers to finding and keeping work.[600] HELP-Link has effectively contributed to increased employment and income among this group of Medicaid enrollees, with as much as 70 percent of program participants securing jobs one year after the completion and over half of participants seeing an increase in their wages after finishing the program.[601] Such programs should also be expanded to Medicaid enrollees with disabilities specifically.

2. Health-Adjacent Sectors & Systems Should Support & Improve Behavioral Health

Health-adjacent sectors, and the systems and programs within them that provide foundational economic and social supports, have the potential to indirectly and directly promote the behavioral health of the populations they serve. By meeting individuals' and families' key non-health needs, these systems and programs can positively affect both the SDOHs and the HDOSOs (see Chapter 1 for more information on the SDOHs and the HDOSOs). Recommendations in this section include strengthening and establishing foundational supports, including cash assistance and savings vehicles, transportation and broadband, affordable housing, food assistance, and legal aid; supporting behavioral health through removing barriers to employment for people with behavioral health conditions and ensuring people can meet their caregiving needs; and reorienting health-adjacent sectors and systems to be more responsive to behavioral health. Recommendations also focus on removing and mitigating behavioral health-related systemic barriers to accessing these supports and shifting economic security services and supports to address more holistic needs, including behavioral health. (While this section primarily focuses on systems that work to meet people's foundational needs through economic security and basic assistance programs, the framework can be applied to other types of family-serving, "health-adjacent" sectors, systems, and services—such as the child welfare system and CJ/JJ, which are discussed in Chapters V and VI.)

2.1 STRENGTHEN & ESTABLISH FOUNDATIONAL ECONOMIC SECURITY & OPPORTUNITY SUPPORTS

Economic security and opportunity programs should be strengthened and expanded (and, in some cases, established) to help individuals and families meet their foundational health and non-health needs. Even with health coverage through Medicaid or other health insurance, families facing economic insecurity may not have adequate resources to cover additional health-related expenses, such as medicine, or non-health-related needs, such as food or rent payments. Programs that provide cash assistance or access to savings vehicles, such as TANF and General

Assistance, or GA, Supplemental Security Income (SSI), the Child Tax Credit (CTC), and the Earned Income Tax Credit (EITC), among others. Programs that provide vital housing and food assistance, such as SNAP, provide assistance to families in need and are critical for the economic security of millions of low-income families.[602] These programs have also been shown to support positive behavioral health and other health outcomes.[603] To bolster their effectiveness, these programs must be adequately funded and eligibility expanded. They must also be complemented by additional supports for other non-health needs that can be consequential for someone's ability to access behavioral health services and supports—such as transportation, broadband access, and access to affordable legal assistance; employment status and related supports and opportunities; and caregiving needs. Below, we profile a selection of the programs that have specifically been tied to improvements in behavioral health, as well as other supports and services that appear promising for promoting behavioral health.

2.1.1 Expand Cash Assistance & Access to Savings Vehicles

The additional financial costs associated with having a behavioral health condition (or having a family member with a behavioral health condition)[604] can be especially burdensome for families already struggling with economic insecurity. Having access to adequate cash assistance programs (such as TANF and General Assistance, or GA), key tax credits (such as the EITC and CTC), and non-predatory savings vehicles (such as Child Development Accounts [CDAs] and Individual Development Accounts [IDAs])—and the opportunity to build assets and wealth without losing vital economic assistance—can help ensure that families are better equipped to navigate the double burden of behavioral health and economic disadvantage.

2.1.1.1 Modernize & Strengthen TANF & GA

TANF provides basic assistance to families with children with incomes below the FPL.[605] State GA programs provide basic assistance to low-income adults not raising children, including individuals with a disability.[606] When adequately funded and targeted, cash assistance keeps low-income families from making impossible choices between essentials like food, health care, and housing costs. Cash assistance also allows people to afford transportation to reach behavioral health services, out-of-pocket medical expenses, and other health-related costs. Unfortunately, since the late 1980s, cash assistance through transfer programs like TANF and GA has been shrinking dramatically in terms of value and access,[607, 608, 609] with harmful results to families and children.[610,611] Policymakers should restructure funding for federal and state cash assistance programs like TANF and GA to more effectively serve their target populations, which include people with behavioral health conditions. Currently, the programs are largely inaccessible to most eligible families[612] (and GA is virtually nonexistent, as many states have cut or severely limited their programs).[613]

In practice, both TANF and GA fall short of reaching an adequate share of people in need or providing sufficient assistance—especially for people with a disability or serious health condition (such as a behavioral health condition) who are unable to meet SSI's stringent qualifications and also cannot fulfill TANF's strict work requirement.[614, 615] To ensure that TANF can respond adequately to changing levels of need, is sufficiently generous, and is accessible to people with behavioral health conditions, structural reform is needed to convert the program's nominally fixed and capped block grant structure[616] to an entitlement funding structure similar to that of SNAP.[617] As for GA, states that have eliminated their programs should restore them, and all states should expand eligibility, end time limits, and ensure adequate benefit levels. (See

recommendation 2.4 to see how TANF administrators and caseworkers can better address participants' behavioral health conditions.)

2.1.1.2 Expand EITC & CTC for Workers & Their Families

Federal tax credits like the EITC and the CTC, which provide an annual lump sum payment after families and individuals file their federal income tax returns,[618] boost the economic security of individuals and families and, in the case of the EITC, have been tied to positive behavioral health effects. For example, a study found that mothers who used the EITC were less likely to have mental stress or smoke during pregnancy.[619] Another study found that higher EITC payments were associated with a reduction in self-reported poor mental health days among mothers.[620] New research has even linked EITC payments to a reduction in "deaths of despair" among adults, specifically a 5.5 percent drop in suicide, drug-, and alcohol-related deaths due to a 10 percent increase in EITC.[621] These tax credits should be broadened and strengthened at the federal level, and implemented or expanded at the state level to promote behavioral health and well-being.[622]

Currently, the EITC (and, of course, CTC) overwhelmingly benefit families raising children.[623] Making the EITC a universal tax credit would broaden the reach of this important anti-poverty support to even more people who otherwise would not be eligible for either support.[624] One such way to implement such a proposal would be to have "a wage tax credit of 100 percent of earnings up to a maximum credit of $10,000."[625] This type of change would also ensure the EITC reaches unpaid caregivers (by automatically assuming they make a set amount of income), students, young adults, and older adults (through removing the age limit).[626]

The EITC has been expanded on numerous occasions since it was created in the 1970s.[627] Policymakers should look to lessons learned from these demonstrations for behavioral health-specific takeaways. One such pilot, "Paycheck Plus," provided low-wage workers in New York City and Atlanta[628] without dependent children a bonus of up to $2,000 at tax time and extended eligibility to up to $30,000 in earnings (an increase over how much a childless worker could normally receive and when they would lose eligibility).[629] An evaluation by MDRC found increased earnings and a reduction in poverty among participants, along with improved employment rates, specifically for women and participants with lower incomes.[630] Additionally, findings from the New York City pilot indicate that the program reduced anxiety and depression among participants.[631]

2.1.1.3 Facilitate Asset-Building Through Equitable Policies & Savings Vehicles

Families should be able to grow and protect their assets and savings so they can be prepared for both expected expenses, such as the additional costs associated with having a chronic or acute behavioral health condition,[632] as well as unexpected ones, such as developing a behavioral health condition in the future. Six percent of adults in the U.S. are unbanked and an additional 16 percent are underbanked, meaning they used an alternative financial service product in addition to their bank account, such as a payday loan.[633] People of color and low-income individuals are more likely to be unbanked or underbanked[634] and the most likely to be harmed by predatory alternative financial service products.[635, 636] In addition to their poverty-reducing effects, non-predatory savings vehicles have been linked to positive effects on a parent's mental health and well-being. For example, the use of CDAs (which are universal savings or investment accounts with the purpose of long-term development, such as for college) has seen improvements in asset building, parental attitudes, and child development.[637] One example is the SEED for Oklahoma Kids CDA, which saw improvements in maternal mental health.[638]

IDAs are one tool that have been used to build assets, which have been proven to be essential to reduce poverty. In an IDA program, participants receive financial education, such as education and training related to assets. A bank or credit union holds IDA participants' saving accounts, providing participants with monthly savings and interest. Increasing funding and outreach for such programs would further help people with behavioral health conditions, as IDA programs have done so far (see Appendix IV for more examples).[639] Asset limits on economic security programs, such as SNAP and TANF, should also be lifted nationally, as they can discourage people from saving or strip them of their benefits when they still need them.[640] Disability trusts are another option, as such trusts can hold public assistance through a third party so that these assets do not count against beneficiaries in economic security programs.[641]

2.1.2 Ensure Stability, Security, & Mobility Through Housing, Food, Transportation, & Broadband Assistance

Cash assistance and access to saving vehicles should be complemented by additional supports for other non-health needs that are also consequential for someone's ability to address their behavioral health needs and to ensure their economic stability, security, and mobility. Such foundational supports include access to affordable housing, food and nutrition assistance, transportation, and broadband.

2.1.2.1 Expand Access to Affordable Housing

When someone has stable and secure housing, they are better able to access the behavioral health supports and services they need. Housing assistance is also associated with improving behavioral health.[642] On the other hand, inability to pay housing costs has been tied to people not having access to a usual source of health care (such as a "health home") and an increased likelihood that they would postpone treatment unless it was an emergency.[643] Children whose families struggled with affording housing costs were also more likely to have health and behavioral problems.[644] Currently, housing need is largely unmet due to inadequate HUD funding levels, with nearly 40 percent of low-income people lacking access to Section 8 Housing Choice Vouchers.[645] Instead of implementing policies that would further narrow the reach of housing assistance programs, such as work requirements, access to Section 8 Housing Choice Vouchers through HUD should be expanded through increased funding levels.[646] Another HUD voucher that can be further utilized is mainstream housing vouchers, many of which will be awarded to Public Housing Agencies (PHAs) that use their funds to house non-elderly individuals with disabilities who are transferring out of institutional living, are experiencing homelessness, or are at risk of experiencing either.[647] Medicaid can also support housing needs in some cases and for particular populations, like through proven solutions such as supportive housing[648] and housing-related services. These options should also be utilized more widely and expanded on a national level—for example, some states do not provide access to supportive housing through Medicaid.[649]

2.1.2.2 Bolster Food Security

Food assistance programs—including SNAP, the National School Lunch Program (NSLP), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—should be bolstered and expanded. Food insecurity is associated with negative behavioral health outcomes, particularly increased depression for seniors,[650] increased anxiety, depression, and behavioral problems in children, and worse maternal behavioral health.[651] Instead, increasing SNAP benefits is associated with better nutrition and improved long-term health outcomes.[652]

Access to SNAP should be expanded to promote individuals' and families' food security, instead of instituting policies like work requirements in SNAP that will restrict the number of people who can participate.[653] Access to school nutrition programs, such as the NSLP, should also be expanded, as they are also associated with improved behavioral health outcomes for children, including reductions in anxiety, hyperactivity, and depression.[654] Ways to improve NSLP include simplifying the application process, including through using community eligibility and data matching, making specific efforts to reach foster youth, along with migrant and runway children and children experiencing homelessness, and ensuring that children are enrolled the entire year.[655] Access to WIC, which is also associated with better health outcomes for children as they are exposed to less stress, should be expanded.[656] Ways to improve WIC include streamlining eligibility and enrollment,[657] increasing outreach and promotion, particularly in languages other than English, promoting partnerships between WIC and other state and local public assistance programs, such as SNAP and Head Start, and addressing barriers to receiving assistance, such as transportation.[658]

2.1.2.3 Increase Transportation Supports

Without affordable, reliable, and safe transportation, many people with behavioral health conditions may be unable to receive needed supports, which can raise the risk of experiencing a health crisis or emergency (see Chapter II for more information). Transportation supports are also vital for connecting people to decent and stable job opportunities, which can in turn bolster economic security and improve behavioral health outcomes.[659] Increasing assistance for transportation, such as through a transportation subsidy, will help people better meet their behavioral health needs . In addition to establishing a transportation subsidy, federal and state agencies can increase cash benefits in programs such as TANF and EITC to provide eligible families with more resources to cover transportation costs. Policymakers should also fully fund NEMT (as described in recommendation 1.1.3.1). (Currently, there are no other real sources of federal government funding for transportation to behavioral health services.) Also to help with accessibility issues, local and federal agencies can co-locate health and non-health services and supports or locate basic assistance and work support services near treatment centers, health care providers, or by accessible locations, such as near public transportation stops, affordable housing complexes, and near community hubs (schools, community centers, and places of worship) to reduce travel distance, which could particularly help residents in rural areas."[660]

2.1.2.4 Make Broadband More Accessible

Expanding and improving access to telehealth services will require a robust broadband infrastructure that reaches currently underserved populations, particularly rural residents. Despite growing demand, the use of telehealth services in behavioral health has not reached full potential due in part to disparities in broadband access. Thirty percent of U.S. households lack access to broadband, with people of color and people with low incomes disproportionately impacted.[661] African Americans, Hispanics, Native Hawaiians and Pacific Islanders, AIAN on tribal lands, people with disabilities, the elderly, and people who make under $30,000 per year are all the least likely to have broadband access.[662, 663]

Federal investment in broadband infrastructure is needed to ensure robust coverage and connectivity to telehealth services. Currently, the Federal Communications Commission (FCC) and U.S. Department of Agriculture (USDA) administer a number of federal programs that provide funding to support broadband infrastructure.[664] Yet, these funding sources have been underutilized in part due to delays in implementation and narrow eligibility requirements.[665,666]

These agencies can bolster utilization of these funds by expanding eligibility to include more health care providers and committing to fund a higher share of costs in partnership with grantees.[667] The FCC can also partner with state and local agencies to expand the reach and connectivity of existing telehealth and health-enabled programs that target underserved communities, such as areas hit hardest by the opioid epidemic.[668] The FCC can also work across federal health agencies such as CMS to map out areas current broadband capacities and identify areas for future broadband expansion.[669] Government agencies can also work to align strategies and stakeholders including practitioners, administrators, and researchers to coordinate and bolster efforts to expand broadband access, particularly in rural areas.[670] As part of these efforts, the FCC and other agencies engaging in broadband infrastructure development should prioritize the privacy and security of user data and health information, particularly in areas where people are most likely to use public devices to access telehealth and other services.[671]

2.1.2.5 Improve Access to Legal Supports & Services

Legal aid should be expanded for people with behavioral health conditions who interact with health-adjacent systems, such as the CJ/JJ systems (see Chapter VI for more on the intersection of behavioral health and the justice systems), often because they cannot access adequate medical assistance.[672] Additionally, medical and legal partnerships, which embed lawyers and free legal services in clinical settings, should be expanded. This allows clinics to provide targeted services steeped in knowledge of poverty law and administrative law that many low-income families have need for. One example is the partnership between Georgetown Law School and Georgetown University Medical Center.[673]

Another example of legal services being integrated into a behavioral health program is the Bridges of Iowa Alternative Legal Placement Program (ALPP) project, which is a yearlong substance use treatment program that provides rehabilitation services to people who are formerly incarcerated and recovering from SUDs.[674] Through the ALPP project, individuals undergo cognitive behavioral therapy (CBT) which has proven to be an effective treatment for addiction.[675] To support reentry efforts, the ALPP project provides legal services along with transitional housing, job training, and other supports to help enrollees find and retain adequate-paying jobs.[676] The project also provides jail diversion services, designed to help keep at-risk individuals out of the justice system.[677] A promising strategy in SUD recovery, the ALPP project has helped 100 percent of its enrollees find employment upon program completion, with a recidivism rate of six percent, and sobriety rate of 85 percent five years after treatment.[678]

2.2 NURTURE THE RELATIONSHIP BETWEEN EMPLOYMENT & BEHAVIORAL HEALTH

Being employed can be beneficial for someone's behavioral health,[679] and, at the same time, behavioral health can also be a barrier to employment.[680] Supports, services, and policies are needed to nurture the relationship between behavioral health and employment and to ensure that everyone with a behavioral health condition who wants to work, can.[681] Supports that either promote behavioral health within an employment services and/or training context, or promote employment within a behavioral health care context, are both critical for ensuring that regardless of their current employment or mental health status, workers can more easily navigate and stay attached to the labor market with the supports they need. Currently, neither type are easily accessible to workers and jobseekers.[682, 683] (For example, most mental health facilities do not offer employment services or training to patients; in 2014, just 19.6 percent of mental health facilities provided supported employment services and 15.9 percent provided

vocational rehabilitation opportunities.[684]) Behavioral health-strengthening supports include stable employment, training, unemployment insurance (UI), and a Jobseeker's Allowance (JSA) for when one is looking for a job. In order to nurture the relationship between employment and behavioral health, barriers to employment should be addressed by expanding access to behavioral health-strengthening supports and through establishing employment and workplace policies that promote behavioral health.

2.2.1 Reduce Barriers to Employment

Research finds that most adults experiencing any mental health conditions want to work, and the majority can do so with the right supports.[685] However, workers and jobseekers with behavioral health conditions may face barriers to work that are structural or individual (such as employer discrimination and stigma, which can affect hiring decisions; a lack of appropriate workplace accommodations and work supports; or challenges related to symptoms of their conditions, such as attention deficits or anxiety).[686] For these and other reasons, these workers are also more likely to cycle between jobs.[687] Investing in programs that help jobseekers through the provision of benefits, jobs, and training can help workers with behavioral health conditions more easily navigate and stay attached to the labor market with the supports they need.

2.2.1.1 Strengthen Economic Security of Unemployed Jobseekers

Policymakers should strengthen and expand the reach of UI, which currently has significant gaps in coverage including for people with behavioral health conditions. Most recently in 2016, only 27 percent of adults who qualified for UI received benefits.[688] UI can support people with behavioral health conditions who face barriers to stable employment with adequate pay. For example, while stress related to unemployment can lead to strained familial relationships and negatively impact children, access to UI and other financial resources can help reduce stress and improve behavioral health for these families.[689]

To increase UI participation and access, federal policymakers should modernize the program,[690] and state policymakers should link benefits with career pathways and job training or apprenticeships programs.[691] Additionally, policymakers should refrain from instituting counterproductive and costly changes to the program that would categorically exclude or dissuade people with behavioral health conditions, such as mandatory drug testing to qualify for benefits.[692] To reach the workers who, even with a more robust and inclusive UI program would still be unable to access benefits,[693] a parallel, complementary program to UI should also be established. This program, also known as a JSA, would particularly benefit workers such as contractors, young adults entering the job market, people exiting from prison, and full-time caregivers who are reentering the labor force, many of whom may be more susceptible to experiencing behavioral health conditions.[694, 695]

2.2.1.2 Invest in Subsidized & Public Employment

Subsidized employment (SE) programs should be further expanded nationally, along with a public option, where people are directly hired by the government to serve in public service positions.[696] Such programs specifically target individuals facing significant barriers to employment, including people with behavioral health conditions, and provide participants with wage-paying jobs, training, and wraparound services.[697] These programs offset employers' costs to encourage the hiring of workers who otherwise would not be considered for employment.[698] SE programs are a proven but underutilized strategy for improving behavioral health and increasing employment, with positive impacts on earnings and employment that are sustained

even after the programs end.[699] SE programs can also provide wraparound supports, like mental health services and SUDs counseling, to better support people with behavioral health conditions. A national SE program with robust wraparound supports, in tandem with a public employment option, would promote the well-being and workforce participation of workers with behavioral health conditions, and would lead to positive impacts for families, employers, and communities.[700]

An example is New Hope for Families and Children-Milwaukee; the program's wraparound services included an earnings supplement, along with subsidized health insurance and child care.[701, 702] Another program that saw positive results was the Next STEP program in Texas that was specifically for formerly incarcerated individuals.[703] The program, which provided behavioral health services such as counseling and peer supports, was associated with lower rates of arrests and reductions in recidivism due to behavioral changes and changes in thought processes based on the counseling.[704]

Another strategy to help boost individuals with behavioral health conditions find and maintain employment is through adequately funding SNAP Employment and Training (E&T) programs and making them easier to administer, which would help more SNAP participants find and keep jobs.[705] The E&T programs that had the most success in helping individuals with significant barriers to work were voluntary and combined directly addressing barriers to employment, conducting individualized assessments, and helping participants build skills and experience.[706] States can use new funding to specifically focus on groups facing barriers to employment, such as people with behavioral health conditions and expand the successful features of past programs in additional employment and training programs. For example, individualized placement and support (IPS) strategies that provide services specifically for individuals with behavioral health conditions and partner with behavioral health providers in order to provide employment support on an ongoing basis should also be expanded. IPS programs also conduct outreach to employers in order to find jobs that are the right fit for program participants and their goals.[707] One example is from Ramsey County in Minnesota which targeted TANF participants with disabilities, and is a promising model where the program group saw increased earnings in their first year compared to the control group.[708]

2.2.1.3 Invest in Workforce Development & Training Programs

Federal workforce development and training programs, such as the Workforce Innovation and Opportunity Act (WIOA) and career and technical education (CTE) can be important connectors to behavioral health supports while helping address workers' barriers to employment. WIOA funds employment, education, and training programs that include wraparound supports (such as behavioral health services) for adults, dislocated workers, and youth.[709] For WIOA, which states use to encourage workforce development,[710] funding should be increased in order to fully meet the needs of workers with behavioral health conditions. (Historically, due to inadequate funding, WIOA has fallen short of serving the workers who most need the services, programs, and supports it provides, including people with behavioral health conditions.[711])

A substantial expansion of career and technical education (CTE) is another way to reach workers with serious or multiple barriers to employment, including behavioral health conditions. CTE has been linked with increased educational attainment rates and has helped provide workers with the necessary skills for evolving industries.[712] Successful CTE programs involve sector partnerships, where workers receive training needed to break into local industries (such as health care) and meet the labor supply needs of employers.[713]

2.2.2 Establish Behavioral Health-Supportive Employment Policies

Policies that ensure job quality and worker protections can help workers with behavioral health conditions succeed at work. There are potential positive effects of employment on someone's mental health (as noted in Chapter II), though these effects may be moderated by the quality and related stress of one's job—including the hours, pay, and general predictability and stability of the job.[714, 715, 716] As a result, whether the work environment or job itself is set up with behavioral health-supporting policies and practices can be critical to a worker's ability to maintain, let alone thrive in, employment.

2.2.2.1 Promote Job Quality

When workers are paid liveable wages, consistently know when and how often they are working, and have adequate protections against employer discrimination, they are better equipped to manage the additional challenges associated with having a behavioral health condition. Policymakers and other stakeholders should support policies and practices that promote job quality to achieve this end.

First, the minimum wage should be raised—and the tipped minimum wage eliminated—so that workers can better handle the extra costs that come with having a behavioral health condition, especially a serious or chronic one.[717] (Working in tipped jobs has been tied to increased sexual harassment,[718] which can cause and exacerbate behavioral health conditions.[719]) Second, predictable scheduling practices should be instituted, as many low-paid workers are not assigned regular hours of employment. This makes it hard for workers to plan ahead and/or meet personal and family responsibilities, such as providing care for a family member with a behavioral health condition, or making ends meet amidst volatile earnings from month to month.[720] Unpredictable hours are also associated with behavioral health conditions and increased stress, which can impact the behavioral health of the rest of the worker's family and have long-term effects on their children.[721] Providing advance notice of schedule changes, on the other hand, is associated with lower levels of stress.[722] A 2019 study found that requiring employers to provide a minimum of 72 hours' notice for shift changes would lessen psychological distress among affected workers by 4.5 percentage points.[723]

Lastly, unsafe or unsupportive workplace conditions can increase risk for suicide, addiction and overdose, and other behavioral health crises, in the same way that workplace conditions can create risks for physical injuries.[724] Worker protections against employer discrimination based on one's behavioral health condition should be strengthened,[725] and federal and state workplace policies can also better integrate the growing science of workplace mental health. For example, the Occupational Safety and Health Administration (OSHA) could include behavioral health as a workplace safety issue. If OSHA promulgated guidance on workplace mental health safety and expanded its oversight and enforcement into this area, workplaces could better include individuals with mental health conditions and improve the behavioral health of the labor force as a whole. Increasing worker bargaining power can also help protect against employer discrimination.[726]

2.2.2.2 Consider & Include Behavioral Health in Workplace Policies

Many employers recognize the importance of employee behavioral health and well-being for workplace productivity and other outcomes.[727, 728] To ensure that workers are well-supported, employers should institute practices and policies that are responsive to the behavioral health needs of their employees and help promote wellness in the workplace. While evidence on

effectiveness builds, employers can focus on holistic approaches, such as creating a culture of well-being at all levels within their organizations, which crosscut corporate policies and expectations for managers, benefit packages and design, and intentional efforts to promote behavioral health and psychological safety in the workplace.[729, 730] Other strategies include providing telehealth services as part of employee benefits and implementing trainings for human resources teams and supervisors on how to recognize and respond to employees with behavioral health conditions.

2.3 HELP FAMILIES MEET THEIR INTERTWINED CAREGIVING & BEHAVIORAL HEALTH NEEDS

Families have caregiving needs across the lifecourse, which depending on the degree to which they are met (and the mental and economic strain it takes to meet them), can positively or negatively affect family members' mental health and well-being. As caregiving needs vary over time and circumstance (as do behavioral health needs), a universal, comprehensive suite of accessible supports, including child care, paid family and medical leave (PFML), and LTSS (see recommendation 1 for more information) is needed. That way, individuals can address their own or their loved ones' short and more long-term caregiving and health needs, including chronic behavioral health conditions.

2.3.1 Provide Comprehensive & Inclusive Paid Family & Medical Leave (PFML) for All Workers

Comprehensive, inclusive, and affordable PFML is essential for all workers, and yet it is least available to the people who need it most, including workers in low-wage jobs.[731] For many reasons, workers must have access to PFML to be able to take time off to care for their own or a family member's behavioral health condition, including those that are serious or chronic.[732, 733] To ensure that workers can maintain employment while also being able to access the behavioral health-related supports they or a loved one needs, job-protected, comprehensive PFML should be available for all workers.

There is a body of evidence that PFML can lead to improved mental health outcomes for both parents and their children.[734, 735] To expand access to PFML, a national paid leave law is needed at the federal level that includes provisions that a) expand access to all workers, such as covering workers at employers of various sizes and extending eligibility to part-time workers, and b) support behavioral health, such as enabling intermittent use of leave and ensuring job protections for workers who take leave.[736] As over 80 percent of households do not fall into the nuclear family model (traditionally a household made up of a married couple and their children),[737] any modern and inclusive PFML policies should also include chosen family definitions (meaning anything "equivalent to a family relationship").[738] Universal access to an adequate number of job-protected paid sick days is also important so workers can attend doctor's appointments and meet other incremental health-related needs while working.[739]

2.3.2. Make Child Care More Affordable & Accessible

Affordable and accessible child care should also be expanded to better support parents and children with behavioral health conditions. Parents of children with behavioral or developmental conditions often struggle to find adequate and affordable child care, which can limit or jeopardize their employment and economic security.[740] Currently, affordable, quality child care is out of reach for most families.[741] As a result, low-income families, who are more likely to have children with disabilities, are particularly at risk of experiencing compounding challenges related

to inaccessible and/or unaffordable quality child care.[742] Funding for child care through the Child Care and Development Block Grant (CCDBG) should be expanded along with vouchers for families that may need care during nontraditional work hours.[743] There is also a lack of specialized care for children with disabilities, including mental health conditions.[744] To address this supply issue, states should create incentives for more child care providers to provide care to children with disabilities, including through grants and contracts.[745] Providers should also be trained so they can more effectively serve children with disabilities.[746] Additionally, when parents are accessing services and supports for their own behavioral health conditions, they should be bundled with temporary or dedicated child care supports. One option is to expand therapeutic child care, which is used in states like Washington specifically for children whose parents are in SUD treatment. Services during therapeutic child care include assessments, play therapy, counseling, and self-esteem building.[747]

2.4 RE-ORIENT HEALTH-ADJACENT SECTORS & SYSTEMS TO BE RESPONSIVE TO BEHAVIORAL HEALTH

Re-orienting health-adjacent sectors and systems to be more responsive to behavioral health could have a multiplying effect for the efficacy of their non-health-related activities, services, and efforts, since the socioeconomic challenges that many of these sectors and systems aim to address are interrelated with behavioral health challenges. Just like in the health sector, these health-adjacent sectors and systems should be behavioral health and trauma-informed (and culturally-rooted) in both design and administration. Below, several administrative strategies for basic assistance programs are outlined (which have applicability for other family-serving health-adjacent sectors and systems).

2.4.1 Address Administrative & Eligibility Barriers in Basic Assistance Programs

The current administrative requirements for basic assistance programs must be streamlined, simplified, and made more navigable so they do not act as barriers to program participation for people already struggling with the challenges of having un- or under-addressed behavioral health conditions. The requirements for documentation, verification, and tracking make applying to, becoming eligible for, and maintaining access to basic assistance programs difficult. The current systems design also places a disproportionate burden on potential and current participants.[748] This can be particularly difficult for people with behavioral health conditions, as each program may have distinct requirements involving paperwork and in-person appointments, and may have different sets of rules across different programs, all of which can be hard to navigate depending on one's condition.

Applying for such programs also comes along with obstacles such as red tape, long wait times, and difficulties related to technology. Behavioral science research has found that the best ways to reduce poverty through basic assistance programs is to reduce the mental burden of participation as much as possible, provide resources, time and attention to participants as they go through the process of applying and staying eligible for benefits, and change the narratives around basic assistance programs to be more empowering to individuals instead of stigmatizing.[749]

Eligibility requirements should be altered to reduce the burden on participants, and participants should be offered help throughout the process in order to meet what requirements do exist, so they are not discouraged from applying. For example, rather than requiring passage of a drug

test for program eligibility (which hurts people with SUDs), program administrators should focus on connecting participants to robust complementary supports (such as substance use treatment services) along with traditional benefits to more holistically support their well-being and recovery.[750]

Lastly, immigrant families face specific restrictions in accessing basic assistance programs; for legal permanent residents, they must wait five years before being eligible for Medicaid, SSI, SNAP (they can also be under 18 for SNAP), and TANF.[751] Undocumented immigrants do not qualify for Medicaid and CHIP as a whole, except for emergency medical assistance.[752] As mentioned in Chapter II, immigrants face specific behavioral health needs that improving access to basic assistance could help address. Families with mixed statuses also experience challenges related to accessing these foundational supports, including chilling effects that may further distance people from accessing the non-health and health supports they need.[753] There has also been a move to further restrict immigrant access to basic assistance programs through the proposed public charge rule as mentioned in Chapter II. Rather than compound difficulties for this population, policymakers should work to ensure all people have access to these foundational supports, regardless of immigration status.

2.4.2 Ensure Programs & Policies Account for Interrelated Socioeconomic & Behavioral Health Challenges

The administration of programs and policies in health-adjacent sectors should account for the specific, intertwined socioeconomic and behavioral health challenges that potential and current program participants (and their families) may be facing. Without making these programs and services more navigable for people with behavioral health conditions, health-adjacent systems may be setting participants up for failure from the start.

In principle, these programs and policies should ensure that they are well-suited for people struggling with these challenges. For example, caseworkers and other administrators could focus on reducing the burdensome costs of participating in such programs (i.e., financial resources, time, and cognitive effort) through providing clear and reliable communication (including in the primary language of the participant) and eliminating unnecessary and challenging restrictions and barriers such as excessive paperwork and documentation requirements.[754] This would also lessen the additional work associated with enforcement that these burdensome practices create for administrators. Instituting such practices may be a way to ensure trauma-informed and culturally-rooted and -responsive services are instituted in health-adjacent sectors and systems.

In addition to ensuring that programs and policies are better designed to account for behavioral health and related challenges, administrators should utilize promising and proven behavioral science-informed practices. Conversely, administrators should avoid counterproductive program design elements like work requirements (see recommendation 1.1.1.1 for more information about the harmful effects of work requirements).

2.4.3 Train Workforce Across Sectors & Systems to Promote Behavioral Health

Human services program administrators should be equipped with tools to best understand and meet the holistic needs of the populations they are serving, including through pre-employment education and on-the-job training. (Current workforce preparation and training often do not include behavioral health-specific guidance or information.)[755, 756] State agencies should invest in training TANF caseworkers and administrators on trauma-informed care practices to strengthen

their efficacy in delivering services and supports for TANF enrollees who have experienced challenges such as toxic stress and behavioral health conditions.[757] This training could cover: 1) the relevance of behavioral health to their primary focus areas; 2) approaches and interventions for indirectly or directly promoting behavioral health; 3) methods of continuous improvement that allow for better outcomes beyond the existing evidence; and 4) strategies for cross-sector collaboration and integration, including collective impact, that offer opportunities for systemic change. Within the training, there should also be an emphasis on optimizing family well-being and understanding the socioeconomic context for all families, along with any other relevant factors. (And more broadly, individuals preparing to enter any family-serving sector, system, or institution should leave their preparation programs understanding how they, in their future roles, can most effectively promote behavioral health within and across sectors. They should also receive training on how they can provide their sector's or system's services through a behavioral health and trauma-informed lens [see recommendation 1.5.2 for more information on trauma-informed care.])

Aside from training, federal policymakers should establish a human-services-focused program similar to HPOG in order to ensure that the human services workforce is culturally representative of the populations it serves (see recommendation 1.3.1.1 for more information on HPOG). Additionally, state agencies should develop and implement partnership agreements with vendors and providers that require similar workforce education/training efforts to ensure these principles are incorporated and implemented consistently across systems and sectors. The New Jersey Department of Human Services' Blueprint for Action is a promising example of how a state agency can operate with trauma-informed care as a core systemwide principle and practice.[758]

3. Health & Health-Adjacent Sectors Should Close Gaps & Smooth Transitions Between Them

Meeting the often-intertwined behavioral health and economic security needs of individuals and families requires a variety of working relationships between and across the health and health-adjacent sectors and the systems, programs, and services they encompass. As individuals and families often must navigate multiple sectors to access holistic supports and services, effective and efficient cross-sector collaboration is needed to either eliminate gaps where systems do not overlap or ensure adequate transitions and handoffs. The ultimate goal should be a seamless experience for users as they navigate different sectors and systems.

To make this coordination possible, health and health-adjacent sectors and the systems within them need policies, technology, and funding in place that incentivize holistic and shared approaches. Coordination should occur in the context of a continuously learning system that bridges programs, systems, and sectors, in which stakeholders share data to evaluate their interventions, plan improvements, and ultimately learn how to collectively most effectively meet the needs of their populations together.[759] Areas to focus on include eligibility regulations, program financing, data collection and integration, and accountability measures, as well as providing behavioral services in non-clinical settings.

3.1 CREATE SEAMLESS USER EXPERIENCES ACROSS SECTORS

Across the health and health-adjacent systems and sectors, people often experience challenges navigating within and between them to access the programs and services they encompass.[760] When someone faces multiple barriers to well-being (e.g., both economic disadvantage and behavioral health challenges), they typically must navigate multiple systems, thus multiplying difficulties. In the process, they often must meet duplicative and burdensome eligibility requirements.[761] Strategies include streamlining and harmonizing eligibility requirements across programs, the use of cross-sector navigators, and integrating information across sectors and systems.

3.1.1 Streamline & Harmonize Eligibility Across Programs

Programs should aim to reduce eligibility-related participant burdens and increase access to essential health and health-promoting supports (see recommendation 2.2.2 for more examples of application barriers to basic assistance programs). (For any program, enrollment can be either automatic—meaning that participants of one program can be enrolled into another program through data sharing and without a separate application—or streamlined—which involves eliminating at least one step in the application process by using a participant's enrollment in another program to fulfill at least one eligibility requirement in another program.)[762]

Along with automatic enrollment, state SNAP and Medicaid/CHIP programs have implemented streamlined enrollment through screening processes, colocation of program offices, and using data from one program to qualify for another.[763] Another way to institute streamlined enrollment is through categorical eligibility, which allows participants of one public assistance program to be automatically eligible for assistance in another program.[764] One example of expanded categorical eligibility is from SNAP, where states such as Illinois allow TANF recipients to automatically be eligible for SNAP without additional paperwork through the Work Support Strategies initiative.[765] Categorical eligibility can be facilitated further through existing waiver options[766] or federal mandates.[767] Additionally, federal policymakers can convert national existing policies currently practiced at the state and local levels—such as self-attestation or presumptive eligibility—into public programs to simplify eligibility determinations. (For example, under WIOA, self-attestation policies enable youth and other individuals to verify their own eligibility through signing and dating one form without additional documentation.[768]) Presumptive eligibility rules allow *providers* to make an assumption that their patients are Medicaid-eligible without being provided any documentation.[769]

3.1.2 Fund Cross-Sector Navigators to Connect People with Needed Resources

The ACA established and funded navigators to help enroll people in health insurance, but funding was subsequently slashed.[770] Policymakers should restore funding for this program. More ambitiously, cross-sector navigators should be funded to provide access to a single navigator who can help connect people to the full range of benefits and services for which they are eligible. Navigators would be trained to connect people with program-specific resources, including people and local organizations and agencies able to facilitate the application of needed benefits and services. Like ACA-funded navigators, publicly-funded navigators should serve as guides and resources for individuals and families, as they often have to simultaneously navigate several complex systems with differing processes to access needed health and health-

adjacent supports. These navigators should be able to address—in a culturally competent manner—individual issues involving program eligibility, insurance, geographic area, and accessible transportation.[771, 772] A smaller-scale example of this concept is the Community Behavioral Health Clinicians model.[773] These clinicians help youth who have had involvement with the JJ system and/or the child welfare system with consultations, assessments, coordination of services, and are their advocates within and outside of the system.[774] This model is currently used in the state of New Mexico and localities in Arkansas and Colorado, and should be expanded to other states and localities.[775]

3.1.2.1 Family Peer Support Worker Model (FPSW)

Whereas navigators use their knowledge of systems and programs to help families and individuals, peer supports provide important social support that draws from the peer's own similar or shared lived experiences. Existing peer support models, like those the health sector (see recommendation 1.4.2.2), can be leveraged and/or expanded to support families navigating across multiple sectors and systems. One example of this approach is the Family Peer Support Worker model (FPSW) model, which leverages lived experience and peer networks to support families and children with behavioral health needs in accessing care on their own terms.[776] FPSWs are caregivers who draw upon their personal experiences with having a child with behavioral health conditions and navigating child-serving systems (including the child welfare system). FPSWs provide advice, training, and other supports to families raising children in similar circumstances.[777] FPSWs typically receive training on important topics such as SDOHs and adverse experiences so that they can provide holistic, trauma-informed guidance and support to families.[778] Models like FPSW and similar programs such as the Youth Peer Support Worker[779] could be scaled up to reach more families in need of support.

3.1.3 Ensure Information Integration Across Sectors & Systems

User information should be integrated across sectors and systems, while protecting privacy. While there have been efforts to integrate information across the health system and also efforts to integrate data across human services, individuals and families need more integrated information across the health and health-adjacent systems. People should be able to apply for multiple programs at one time and in one place. Data repositories can make a client's information accessible no matter what system they are in or where in a system they are to limit the burden on clients. One example comes from Colorado with its Program Eligibility and Application Kit (PEAK).[780] The portal allows program applicants to apply to SNAP, Medicaid, and subsidized private health care from home, in program offices, and in community partners' offices.[781] Application decisions are delivered in real time so applicants do not have to wait to access these critical supports.[782]

BOX 3B.

ADDRESS GAPS & OBSTACLES FOR AIAN POPULATION

AIAN populations face specific gaps and obstacles related to accessing needed behavioral health supports and services. AIAN populations experience some of the highest rates of behavioral health conditions across racial/ethnic groups.[783] They are also disproportionately represented in the CJ/JJ and child welfare system.

Federal funding also should be expanded to address disparities for Native populations. For example, SAMHSA's grants related to suicide prevention have allowed some tribes to implement a Native Connections Program, which provides behavioral health first aid training from trained clinicians in particularly at-risk areas intended to raise awareness and increase peer support.[784, 785] In addition, 16 federal grants exist to address the behavioral health needs of tribal youth. For example, the HHS grant "Planning and Developing Infrastructure to Improve the Mental Health and Wellness of Children, Youth and Families in American Indian/Alaska Natives Communities" has been used by various local organizations such as CHCs to implement trauma-informed care and peer counseling services.[786] In determining the implementation policies for programs, federal agencies should respect the nation-to-nation trust responsibility with tribes and ensure that they are complying with their appropriate tribal consultation policies.[787]

Tribal governments and organizations sometimes are unaware that they are eligible to apply for federal grants, particularly grants that are not specifically for tribal communities; some organizations have also said that they thought they were less likely to succeed when applying for those grants, so they did not apply in the first place.[788] GAO suggests that increasing awareness for all relevant grants and providing more assistance and time for tribal organizations during the application process would help tribal communities.[789]

Nearly 67 percent of the AIAN population lives in or near cities and not on tribal lands.[790] The 33 Urban Indian Health Programs across the country, funded through the Indian Health Service (IHS), are severely underfunded each year[791] and should be funded adequately. Additionally, avoiding cuts to Medicaid will further help address disparities.[792]

3.2 PROMOTE EFFECTIVE & EFFICIENT CROSS-SECTOR COLLABORATION

Where possible and effective, health and health-adjacent systems must build partnerships in care and service delivery that optimize the well-being of whole families and whole communities. Funding should incentivize further cross-sector partnership, collaboration, and coordination in part to eliminate gaps between and within systems and services.

3.2.1 Provide Flexible & Accountable Funding for Cross-Sector Partnerships

There should be support included for cross-sector collaboration, partnerships, and collective impact in the funding for all relevant stakeholders. This includes authorizing statutes for CHCs,[793] schools, and child welfare stakeholders, or in requirements for community health needs assessments and similar community-level activities. Efforts should also prioritize protecting time so that cross-sector collaboration can be a priority; allowing flexibility in metrics, reporting, or

other policies to facilitate cross-sector alignment; and including financing for data systems that enable coordination.

In the health sector, this would require scaling cross-sector approaches like the CMMI's ACOs or Accountable Health Communities Model (AHCM), where health care providers partner with community organizations to identify needs, implement interventions, and provide wraparound services to individuals and families,[794] or InCK, which provides integrated health services along with other community-based services in schools and homes,[795] but with a focus on engaging private health insurers in the same way that CMMI is pursuing with advanced primary care models.[796] ACOs are commonly used as a method of organizing and providing coordinated care through voluntary networks of doctors and hospitals.[797] ACOs are intended to improve care and reduce costs through collective accountability. Providers have an incentive in joining or forming ACOs because they can share in any cost-savings. Because of the risks they bear, ACOs have an incentive to utilize human services as a tool to improve patient outcomes, especially for those with chronic conditions, including behavioral health conditions. Services may include nutrition assistance, transportation, housing, job counseling, peer support, or financial and legal services.[798] In fact, ACOs in several states incorporated assistance to meet patients' fundamental needs as part of their strategies.[799]

3.2.2 Leverage Data & Technology to Support Multi-Stakeholder Coordination & Collaboration

To best assist individuals with behavioral health conditions, data collection, measurement, and technology standards should be aligned so they can be used across sectors and systems. Currently, the health and health-adjacent systems have different practices, which can lead to problems serving individuals across systems. Community participation in data collection and analysis and technology development ensure that programs work for racially and economically diverse populations. Navigating privacy requirements, such as those in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act of 1974 (FERPA), and standardizing data collection and management guidelines can help individuals maintain control over their information and protect their privacy while facilitating the cross-sector coordination they want. As discussed elsewhere, the behavioral health workforce reports challenges related to information sharing, and significant time spent entering required data into patients' EHRs.[800]

The ACA provides models for addressing these challenges. Section 6402 of the ACA requires that the CMS integrated data repository include information from Medicaid and other CMS programs, helping with intrasystem collaboration;[801] such a mechanism could also be implemented across sectors and systems. It also extends these data requirements to other federal agencies' health programs and the Social Security Administration. Section 4302 of the ACA promotes improved data collection and analysis regarding health disparities by requiring federal health programs to collect data by indicators of disparity (e.g., race, primary language, disability, etc.).[802] Section 1561 of the ACA promotes health information technology standards that would allow for the interoperability of health and human services programs' information systems.[803] Based on this, CMS can offer an increased Medicaid Information Technology (MITA) 3.0 federal match to test scalable models of continuously learning systems across sectors and systems that focus on improving behavioral health outcomes for low-income families. This can be coupled with support for the development of quality improvement organizations that help other communities most effectively use their information technology to improve population

health. These continuously learning systems can also be used as a mechanism of integrating care, to build in contact with behavioral health specialists and train other medical professionals how to identify, screen, and refer patients for their behavioral health and social needs."

Electronic Health Records (EHRs) are another promising mechanism to enable data sharing across stakeholders in the health system.[804] Sharing capabilities can provide patients with a portable repository of their health information which can be more easily presented when seeking medical consultation such as a second opinion.[805] Enabling EHR sharing in the health system can also create a rich source of data for clinical and public health research.[806] EHR data can enable deeper research into factors that affect behavioral health, as well as which treatments are most effective for treating specific behavioral health conditions.[807] The portability of EHRs can also foster collaboration across health and health-adjacent systems. EHRs could improve delivery of wraparound services by enabling health-adjacent workers to better tailor these services based on unique individualized health circumstances. There are still challenges related to the design, customization, and usability of EHRs, which can lead to inefficiency or even patient harm; these challenges should be addressed before EHRs are further expanded across sectors.[808]

Hotspotting—the digital mapping of a community's health indicators—[809] represents a cross-sector approach that should be further expanded. It was originally used to map residents' hospital costs block-by-block to identify the individuals with the highest hospital bills and re-admittance rates,[810] which can be especially useful for individuals who have behavioral health conditions and have high service utilization rates. The hotspotting technique is now applied nationwide as a way to encourage public health authorities, hospitals, health systems, and local economic development organizations to work together to make targeted and coordinated investments at the community level.[811] The federal government's partnership with community-based organizations through the ACA's Community-based Care Transitions Program (CCTP) represents a promising utilization of hotspotting. CCTP focuses on reducing hospital readmissions through strategic planning, follow-up, and coordination for high-risk patients. Some state-level groups who received funding under the program have made addressing behavioral health a priority by integrating mental health assessments, and by incorporating behavioral health coaches after patients were released from the hospital, with referrals to further support services based on the patient's risk level.[812] Services could include language service and nutrition services, and partnering with local behavioral health boards.[813] Data collection and coordination through hotspotting could also be utilized for outreach and education efforts for low-income populations and programs, for which funding is available per Section 3306 of the ACA. Such approaches can specifically be used to help stem the opioid crisis.[814]

3.2.2.1 Modernize Emergency Responders' Systems & Procedures

Emergency responders' systems and procedures should be modernized to be more effective. Emergency responders include Emergency Medical Services (EMS), police officers, 911 dispatchers, firefighters, and rescue workers. These workers are many times are the first person people with behavioral health conditions interact with.[815] Right now, there is a lack of funding for some emergency responders, such as EMS workers and 911 dispatchers, particularly in rural areas.[816, 817] In addition to more general funding and training (see recommendations 1 and 2 for more information on workforce training), there should also be improved data sharing across national and local EMS systems in order to best deliver care and further train responders (including real-time data and feedback on providers' performance for continuous evaluation).[818] Such modernization will require new federal funding and investment in emergency services,

along with an expansion of broadband (see recommendation 2.1.3 for more on how to expand broadband).[819] EMS data should also become more integrated with those of other providers in order to bridge the gap between a person's entry into a specific system and the other systems they interact with, all while still prioritizing patient privacy.[820]

3.2.3 Build a Culture of Continuous Improvement & Shared Learning Across Sectors & Systems

One strategy to ensure continuous improvement and shared learning across sectors and systems is adapting CMMI's and the Center for Medicaid and CHIP Services model for cross-agency, cross-departmental collaboration called the Medicaid Innovation Accelerator Program.[821] The program supports states' continuous payment and delivery system reforms by providing targeted technical, including support for reducing SUDs and for integrated care.[822] Multi-agency flexibilities in waiving rules (with accountability), evaluating results, and scaling effective models for initiatives could better improve the behavioral health of low-income families than current authorities allow for each individual sector (Performance Partnership Pilots offers a good example of these kinds of flexibilities across sectors[823]). To enable more effective prevention and early intervention, models initiated under this program should be allowed to demonstrate cost neutrality or cost savings across the entire federal budget over 20 years, and encourage states to co-invest based on their projected long-term savings (the Social Impact Partnerships to Pay for Results Act offers a template of how this could work[824]).

3.2.4 Hold States Who Contract to Private Service Providers Accountable

The federal government should ensure that states that contract to private service providers hold those providers to the same standards as public providers. For example, prisons have privatized health care, which can be especially harmful to the high population of people in prison who have behavioral health conditions; at least 20 states have contracted to private health care operators in prisons as a way to cut costs.[825] Another example of private service providers providing behavioral health care is through Medicaid managed care programs. MCOs are public-private partnerships that over two-thirds of Medicaid recipients receive care through. They sometimes have lower-quality services, particularly for specialized services, such as behavioral health services,[826] or claims that are denied improperly.[827, 828] Studies have found that there has been a lack of necessary care provided and not enough doctors in network.[829] In MCOs particularly, states must properly monitor the level of care and spending by insurers in managed care arrangements, as a national Medicaid database is still unfinished. Additionally, in the child welfare system, many states and the agencies they contract to are not meeting standards for behavioral health assessment and treatment, particularly for children who may need therapeutic foster care.[830] States and tribes need to more frequently assess private service providers to make sure they are providing high-quality care and track outcomes related to child well-being among individual providers, particularly for children with high behavioral health needs.[831]

3.3 ENSURE ACCOUNTABILITY FOR EFFECTIVE SERVICE DELIVERY & HANDOFFS

To assure the most effective service delivery, all stakeholders should be held accountable when transferring individuals from one system or sector to another. Practices that can help accomplish these warm handoffs include sharing data; using blended and braided funding streams; learning how to serve individuals that have multiple, overlapping needs;[832] and government monitoring and tracking of participant outcomes. With any approach, participants' privacy should continue

to be protected and prioritized. Below, some examples of how to implement such practices are profiled, including holding states that contract to private service providers accountable and aligning funding incentives across systems and sectors.

3.3.1 Hold States That Contract to Private Service Providers Accountable

Federal, state, and tribal governments should ensure that states that contract to private service providers hold those providers to the same standards as public providers. In recent years, public-private partnerships have increasingly become a fixture of health care service delivery, particularly within the health sector, the child welfare system, and the CJ/JJ systems.[833, 834, 835] For example, at least 20 states have contracted to private health care operators in prisons as a way to cut costs.[836] This trend of privatization of health care in prisons has particularly harmful consequences for the high population of people in prison who have behavioral health conditions.[837] Another example of private service providers delivering behavioral health care is through Medicaid managed care programs. MCOs are public-private partnerships that deliver care to over two-thirds of Medicaid recipients.[838]

Areas ripe for increased accountability include quality (MCOs have been shown to sometimes provide lower-quality services, particularly for specialized services like behavioral health services[839]) and claims processing (such as claims that are denied improperly[840, 841]). Studies of MCOS have identified failures in network adequacy, including inadequacies in care delivery and accessibility, a lack of in-network doctors.[842] In MCOs particularly, states must properly monitor the level of care and spending by insurers in managed care arrangements, as a national Medicaid database is still unfinished.[843] Additionally, in the child welfare system, many states and the agencies MCOs contract to are not meeting standards for behavioral health assessment and treatment, particularly for children who may need therapeutic foster care.[844] States and tribes need to more frequently assess private service providers to make sure they are providing high-quality care and track outcomes related to child well-being among individual providers, particularly for children with high behavioral health needs.[845]

3.3.2 Align Funding Incentives Across Systems & Sectors

To ensure the most efficient and effective outcomes for all sectors and systems involved directly or indirectly in serving populations with behavioral health conditions and related needs, funding incentives should be aligned across health and health-adjacent sectors, systems, and programs. Any level of cross-sector and cross-system partnership, collaboration, coordination, or even overlap ideally would include shared accountability measures tied to incentives and accountability where appropriate. A potential "stick" approach could be to institute a recurring penalty if various sectors do not adequately address behavioral health as a part of their work. In the health sector, an example of such a penalty is nonprofit hospitals' community benefit requirements, which include community needs assessments, financial assistance policies, and hospital charge limits (see recommendation 1.5.1 for more information on this provision), for which hospitals face a $50,000 tax penalty for non-compliance.[846] A potential "carrot" approach could involve tax credits or bonus funding for systems and institutions that prioritize behavioral health or that meet certain behavioral health benchmarks, or a version of the HUD demonstration mentioned in recommendation 2.1.2.1 (wherein PHAs that prioritized helping people with disabilities were more likely to receive funding) for other systems and institutions. The health sector has instituted performance pay and bundled outcomes (see recommendations 1.1-1.5 for more information on these policies), which hold health systems and institutions

accountable for outcomes and impacts. To promote warm handoffs, these sorts of policies should also be instituted across systems and sectors, such as between the CJ/JJ systems, education system, and the health system.

4. Communities Should Support Behavioral Health Well-Being at All Times for Everyone

Communities have a meaningful role to play in promoting behavioral health at the individual, family, and community levels. Embedding the whole-family, whole-community behavioral health approach throughout community institutions will ensure that everyone, regardless of their circumstances or stage of life, can have their behavioral health needs and overall well-being supported. Community based efforts dovetail with those in the health and health-adjacent sectors discussed above to promote behavioral health. Services and information about them should also be accurate, easy to find and understand, and use in order to promote health literacy.[847]

4.1 LEVERAGE COMMUNITY ASSETS FOR HOLISTIC SERVICE DELIVERY

Holistic behavioral health interventions should meet people where they are, be it at home, school, work, or other community institutions. Approaches and interventions that are relatable and accessible, such as peer supports, can help promote the well-being of all community members regardless of where they are on the continuum of well-being or which stage of life they are in.

4.1.1 Ensure No Wrong Door for Behavioral Health Support

There should be no wrong door for reaching services and supports that directly or indirectly support behavioral health. Programs and policies must meet people where they are—whether at home, a community institution, the workplace, or school—to provide services or connections to services. For example, even in places with limited social infrastructure, such as some rural communities, the most likely first-responders (such as law enforcement officials) should be properly equipped to manage interactions and provide the most appropriate and least harmful response to behavioral health crises.

Initiatives focused on supporting health should utilize existing community institutions to embed mental health services throughout a community. Such efforts would overcome barriers to access by providing mental health service at locations such as barbershops (profiled below). Behavioral health interventions such as mental health screenings or trainings could also be conducted at laundromats, places of worship, and other community hubs.[848] A no-wrong-door approach has been used to address the opioid crisis in Michigan, California, and Massachusetts.[849] In such an approach, behavioral health services are provided to people wherever they need it, whether that is a jail, emergency room, or Social Security office, for example.[850] Michigan is also using the approach to specifically prioritize people experiencing homelessness.[851]

Participatory research and local partnership initiatives demonstrate the potential for behavioral health gains of community based approaches. As part of the Mental Health Outreach for Mothers (MOMS) Partnership, the Yale School of Medicine collaborates with local nonprofits and government agencies to reach out to low-income pregnant women[852] and mothers, connecting

them with stress management classes (which include skill-building therapy, life coaching, and a parenting program to strengthen their relationship with their child), health care, job training, diapers, and other basic services.[853] Community mental health ambassadors staff hubs around New Haven, Connecticut. Ambassadors are mothers and members of the community who are trained by mental health professionals and they are well-versed in the circumstances other mothers in their communities face.[854] The MOMS program[855] also has an app to help mothers called MoMba, which allows new mothers to locally support healthy mother-infant interaction, community engagement, and social connectedness, along with a specific feature to help mothers stop smoking.[856] Evaluations of the MOMS program would shed light on the relative effectiveness of the program and its various components, helping similar but less established initiatives across the country.

Building on a prior initiative based in Chicago,[857] NYU professor Joseph Ravenell has worked to connect over 7,000 black men with health information and resources through partnerships with local barbershops.[858] To address high rates of hypertension and colon cancer among African American men, Dr. Ravenell worked with local barbershops, which are cultural and social hubs for many African American men.[859, 860] The initiative involved training barbers Dallas and New York City to take blood pressure measurements, and inviting community health workers to provide health advice and education on colorectal screenings, while customers got their hair cut.[861] Dr. Ravenell then utilized the blood pressure data to create infographics on the general health status of customers for each shop. These infographics were distributed to the participating barbershops, encouraging health literacy among barbers and their clients.[862] The initiative ultimately yielded positive outcomes: the number of men who met their target blood pressure levels increased by 20 percent as result of the barbers' blood pressure training, and men were two times more likely to go for colorectal screenings after speaking with a community health worker.[863] Similar initiatives can be launched to address behavioral health needs for at-risk populations.

In fact, another organization, called Mental Health Improvement through Study, Teaching, Rebranding, Embedded Education, and Technology (MHI STREET), based in the District of Columbia connects local barbershops with mental health care.[864] The program encourages African American men to tell their stories and helps community members, like barbers, recognize the symptoms of common mental health conditions.[865] The program intends to help destigmatize mental health care and about mental health and. The program will be expanded to places like liquor stores, movie theaters, train stations, and basketball courts as well.[866]

Named after a community in Chicago, the Little Village model involves locally-based organizations that have formed collectives or working groups around a community issue such as safety, education and mental health.[867] Community-wide networks across service providers, public policy institutions, and organizing groups, stakeholders successfully launched the Youth Violence Initiative, to raise awareness in the Little Village community and partner with local schools to reach and provide services to at-risk youth and their families.[868] Following the Little Village model, community organizations can work to form comprehensive networks across sectors and systems to address community-wide behavioral health concerns and conditions.

Health systems can leverage the role of faith organizations as community touchpoints to provide an array of support services and connect health providers to their target populations. Health organizations can partner with religious centers and places of worship to provide services such as support groups and counseling; provide behavioral health trainings and toolkits; and

launch awareness and outreach campaigns for at-risk or target communities.[869, 870] Additionally, religious centers can host and facilitate online and in-person training courses on behavioral health issues, and tele-therapy practices for local congregations.[871] One example of partnership between health and religious organizations is the Faith-based and Community Initiatives under SAMHSA, which provides funding, training, and technical assistance to religious organizations to implement substance abuse prevention and mental health initiatives.[872]

4.1.2 Encourage Integrated Health Hub Models

To increase multi-sector, community-based collaboration for service delivery, stakeholders should utilize integrated health hub (IHH) models. IHH models provide comprehensive community-based health services, including integrated primary and behavioral health care services, along with human services, such as housing, through working with community partners.[873] This model builds on the hub-and-spoke model, where the "hub" is the specialized medical team and the spokes are the community supports and services provided to the individual.[874] The IHH model has been used in Canada and New York[875] and should be further expanded in the U.S.

One example of a health hub is the AHCM, where health care providers partner with community organizations to identify needs, implement interventions, and provide wraparound services to individuals and families.[876] Models include communities in Iowa, which focus on issues such as tobacco use, medication safety, and the SDOH; and in Washington, which focus on access to care, integrated behavioral and primary health care, housing, SUD, ACEs, and health equity.[877] These can serve as models for engaging private insurers as well. Because of the risks they bear, the AHCM gives providers an incentive to utilize human services as a tool to improve patient outcomes, especially for those with chronic behavioral health conditions. The AHCM could also be used to specifically target whole families through an Accountable Health Community for children and families, which would specifically focus on children up to age 26 along with their primary caregivers in a certain community.[878]

4.1.2.1 Expand Community-Based SUD Treatment & Services

As the opioid epidemic has worsened, the need for community-based treatments combined with clinical interventions like MAT has increased. One model under Medicaid that states could look to is Virginia's Addiction Recovery and Treatment Services (ARTS) program, which aims to integrate addiction treatment into the larger health care system. Launched in 2017, the ARTS program enables health clinics in Virginia to administer buprenorphine as a form of MAT to people with opioid addictions.[879] MAT services are provided in conjunction with physical health care, and wraparound services such as employment and housing assistance.[880] Additionally, to address the shortage of opioid and other substance addiction treatment services, the program increased Medicaid reimbursement rates for providers and funding for case management and coordination of wraparound services.[881] Since taking effect in 2017, ARTS has appeared to be a promising model for making opioid treatment more affordable and accessible in community-based settings.[882, 883]

To facilitate the expansion of this and similar models, states should take several steps. First, states that have not expanded Medicaid should do so, so that people with incomes up to 138 percent of FPL can access MAT services under Medicaid.[884, 885] Second, MAT should be expanded to increase accessibility within communities for everyone who needs it[886] (such as in CHCs, which use federal funds,[887] but are impacted by whether states expanded Medicaid or

not).[888] One way to enforce parity is to make sure that similar to other medications, MAT does not require prior authorization, as states like Illinois have done.[889] States can implement laws that require insurers to cover medications on those terms, also following Illinois' lead. This will particularly help low-income families, as people are more likely to pay for MAT out-of-pocket or through private insurance rather than through Medicaid or Medicare. This would also help people of color with SUDs, who have disproportionately had less access to MAT.[890] Other strategies include expanding CCBHCs, as discussed in recommendation 1.2.2; extending improving access to opioid treatment to people who are incarcerated;[891] and providing in-home MAT to individuals, such as through a partnership with pharmacies to provide remote support during the treatment process, like Boulder Care in Colorado.[892]

4.1.3 Improve Behavioral Health Efforts Throughout Child Care & Education Systems

Child-serving systems, such as the early care and education systems (elementary, middle, and high schools, and post-secondary education) should be geared toward promoting behavioral health and providing behavioral health services in accessible, localized, community-based settings.

4.1.3.1 Promote Behavioral Health Interventions in Early Care & Education

Policymakers and practitioners should expand behavioral health services in early childhood education centers. State governments can increase funding for mental health consultation services to support teachers and educators at public preschools and child care centers. Mental health consultation programs have been implemented in a number of states and cities with promising results, including improved overall quality of care and staff competence in working with children with behavioral challenges, as well as lower staff turnover and behavioral problems from students.[893, 894] At the federal level, funds for programs under Head Start and in the child welfare system can also be allocated to expand mental health consultation services[895] and mental health workforce development (see Box 3a. Behavioral Health Workforce). Further, targeted investment in Head Start can help address early childhood behavioral health needs. One specific Head Start model targets adverse childhood experiences stemming from family SUDs significantly improved children, and 88 percent of the mothers who became pregnant while their young children were in the program gave birth to full-term, drug-free children.[896]

4.1.3.2 Shift School Practices from Undermining to Advancing Behavioral Health

Schools must eliminate the use of punitive disciplinary practices, which disproportionally punish children of color. Such practices hamper academic achievement and heighten the risk of involvement with the justice system.[897, 898] They also risk worsening behavioral health outcomes, as students who face disciplinary actions are more likely to experience trauma and other behavioral health conditions.[899] In place of punitive, zero-tolerance policies, school administrators should introduce restorative policies that emphasize counseling and conflict resolution practices in response to student behaviors.[900] Additionally, more behavioral health services are needed in schools, particularly those that serve predominantly low-income students and students of color. State agencies should dedicate funding to increase and expand behavioral health services among the 37 percent of public schools that lack counselors, the 78 percent without a full-time psychologist, and the 82 percent without a resident social worker, according to a 2016 estimate.[901]

Another strategy to promote behavioral health involves integrating trauma-responsive practices into the education system. As mentioned in Chapter II, community environmental factors, such as violence, can exacerbate behavioral health conditions, and up to 70 percent of youth nationally may be exposed to such violence.[902] Factors that help build resiliency include familial, friend, and neighborhood support, much of which can be addressed at school.[903] School-focused interventions include the Adolescent Depression Awareness Program (ADAP) and Mental Health First Aid trainings for teachers, administrators, and other educators to more effectively support students with behavioral health needs,[904] and universal depression screenings for students to combat mental health stigma. Programs like the Teacher Quality Partnership[905] in the Higher Education Act (HEA) focus on enhancing specific competencies related to student educational success and do not—but could—include behavioral health considerations.

Schools can provide preventive services and out-of-home interventions for all students, which is especially important for those facing particular barrier to school success, such as involvement with the child welfare system. Policymakers and administrators should implement a whole-school approach integrated in a broader whole-community strategy to optimize child behavioral health outcomes by providing wraparound behavioral health services at schools. For example, Local Education Agencies (LEAs) could adopt a community school strategy, which involves turning schools into a hub for multiple health and human services, including behavioral health services. At least one person in the school should be trained in mental health and how to identify at-risk children instead of focusing on disparate disciplinary practices and mistakenly diagnosing learning disabilities and behavioral health conditions. The design and implementation of community school interventions should be done in collaboration with health sector organizations such as FQHCs and should leverage the reach and specialties of existing programs like EPSDT.

A few models that could be expanded to specifically promote behavioral health in schools include the Community Schools approach,[906] Communities That Care,[907] and PROSPER.[908] These three models are build capacity, assess needs, and evaluate outcomes, while partnering with community organizations. These models could be used in partnership with Medicaid, MCOs, FQHCs, and other health care payers and providers. Medicaid and other health payers can support schools should through EPSDT, free care,[909] and Individualized Education Programs (IEP)[910] provisions. The Every Student Succeeds Act (ESSA) should reinforce these models so that all adults in schools are equipped with the knowledge and adequate behavioral health tools they need in order to best help students, as ESSA has specific funding streams that can be used for comprehensive mental health services.[911]

Expand Behavioral Health Interventions in School-Based Health Centers (SBHCs)

The nearly 2,000 school-based health centers (SBHCs) in the U.S. provide a wide range of primary, behavioral health, and oral health care, as well as health and nutrition education. HRSA funds 20 percent of SBHCs,[912] but a December 2014 decision by CMS liberalized a longstanding Medicaid rule that had significantly limited Medicaid funding for SBHCs.[913] This change should boost these health centers' ability to help low-income students in particular.[914] Expanding this model will help youth of color, in particular, who are less likely to receive mental health services, especially of a high quality.[915, 916] Three-fourths of SBHCs have a behavioral health provider, and studies have found that behavioral health counseling is the top reason that students visit the centers, which they are more likely to visit than other community-based health centers.

An evaluation of one SBHC suggests that it may be associated with fewer school discipline problems, improved grades, and lower absences.[917]

Some SBHCs have also implemented specific models or interventions to help students who are the most at-risk. For example, implementing the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model in some SBHCs has helped decrease out-of-school suspensions,[918] while other SBHCs, particularly in California, have implemented trauma-informed approaches by having school-wide screens to spot students with experiences of chronic stress. For those students, specific interventions include support groups, consultations, and healing circles. Some SBHCs also train teachers on how adverse experiences can impact these students' classroom-based learning.[919] SBHCs can also successfully reach students in rural areas where it may be harder for families to reach other providers. Options such as telehealth are also provided more often in rural SBHCs.[920] Rural SBHCs also serve more non-student populations compared to their suburban and urban counterparts.[921] Further integrating such approaches into SBHCs on a wider scale can help address student and community behavioral health needs.

Promote Positive Social & Emotional Development in School-Aged Children

Health-adjacent systems and sectors should focus on building children's positive social and emotional development to help improve well-being across the lifespan and reduce the need for more intensive services down the line.[922] Trauma-informed resiliency should be promoted through schools, special education, health care, child welfare-preventive services, child and family support programs such as Head Start, and programs under the CCDBG. For youth in the child welfare system, child care providers, teachers, and other adults can nurture their own relationship with children and create an environment and routine where they are less likely to experience stressors.[923] This can be implemented through home visits focusing on the child and the caregiver.[924] Studies have found that caregivers in these situations can respond better to their children's needs through improved parenting skills and attitude changes. With older children, interventions may occur in school, where teachers help build self-regulation skills.[925] For example, the Raising Healthy Children (RHC) program focuses on training elementary school teachers, parents, and students to mitigate disruptive or aggressive behavior and increase protective factors at home and in the classroom, especially for children referred for academic or behavior problems.[926] The program has been found to have long-term benefits, including higher academic performance, commitment to academics, and social skills for involved students.[927] Additionally, The Promoting Alternative Thinking Strategies (PATHS) program was created to reduce aggressive and problematic behaviors universally among elementary school-aged children, while promoting resilience and positive behaviors such as exercising self-control, reducing stress, expressing and identifying feelings, and using steps for interpersonal problem-solving.[928] Evaluations have found that the preschool version of the program, which has been implemented as a part of Head Start, helped teachers with their social-emotional management and with the children's social skills, emotional identification, and ability to respond to challenges.[929]

Address Specific Behavioral Health Needs in Post-Secondary Education

Policymakers and higher education administrators should focus on addressing the behavioral health needs of all students, including student parents who are often overlooked but make up 1 in 5 college students.[930] To address the mental health needs of student parents, policymakers should improve accessibility of quality child care, and expanding eligibility for health care and economic security programs to cover more student parents.[931] For example, non-expansion

states can opt in to expand Medicaid to include more low-income parents without imposing work requirements which would be difficult for student parents to fulfill.[932] Additionally, colleges administrators can promote peer support groups to combat isolation among student parents; engage in outreach, education and other efforts to help students access economic support programs like SNAP and TANF; employ behavioral health professionals equipped to respond to the unique needs and challenges of student parents; and work to destigmatize mental health conditions on campus.[933]

4.1.4 Expand Home Visiting Programs

Congress should expand home visiting funding. Since 2010, HHS has administered the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program that helps parents, and especially at-risk pregnant women, promote their children's development. MIECHV funds various initiatives at federal, state, and local levels that connect families with trained professionals who enable parents to support the healthy development of their children.[934] The program builds upon decades of rigorous research demonstrating that home visits during pregnancy and early childhood by social workers, early childhood educators, nurses, and such other professionals enhance the lives of children and their families.[935] Home visiting interventions are associated with improved child and maternal health, better development and school readiness of children, prevention of child neglect and abuse, and adoption of positive parenting practices.[936] These practices can be cost-effective, as they increase children's future earnings and decrease future government spending (due to lessening families' need for supports such as TANF, SNAP, and Medicaid).[937]

Despite its demonstrated impact, MIECHV does not reach a significant portion of eligible families.[938] A 2017 analysis of home visiting programs indicates that less than 50 percent of all U.S. counties have home visiting programs, leaving many qualifying families un- or underserved.[939] States and regions vary widely in their home visiting rates, with eligible families in states like Mississippi and in rural areas being less likely to receive home visiting services.[940] Increased, stable federal funding for MIECHV and reauthorization in a timely manner would do much to expand the reach of home visiting and its ability to support early child development as well as family well-being.[941]

4.2 BUILD SAFE, INCLUSIVE, & SUPPORTIVE ENVIRONMENTS

A community's built and social environment can significantly affect individuals' behavioral health outcomes. Targeted efforts are needed to ensure that built and social environments are safe and accessible for all members of a community. Communities should also be designed or redesigned to include culturally-rooted, trauma-informed social[942] and structural supports that promote behavioral health and well-being (see recommendation 1.5.2 for more information on interventions related to community trauma). Additionally, individuals should have agency and dignity when navigating different systems, which is more possible if all sectors, systems, and institutions learn how to support behavioral health. Intentional efforts should involve including, reaching, engaging, and supporting certain populations for whom existing interventions and delivery strategies may fall particularly short. Community members can also help reduce disparities and improve equitable access to health by implementing interventions in trusted community settings. Needs assessment and evaluation should encourage mixed-methods approaches, integrating both data that considers subpopulation disparities as well as community preferences, goals, and narratives.

4.2.1 Mitigate System-Level Discrimination & Improve Social Inclusion

A legacy of place-based racist regulations, coupled with systemic discrimination in many family-serving systems[943, 944, 945] and spaces, has led to many individuals with behavioral health conditions being unable to fully access their communities' assets and supports. Certain populations, due to their identities and experiences, may face additional discriminatory barriers.[946] To mitigate the compounding effects of multi-system discrimination and bias, policymakers should enact and enforce robust mental health anti-discrimination policies to ensure access to necessary care without additional structural barriers or stigma.[947] For example, the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act[948] should receive additional funding from Congress to ensure non-discrimination in all sectors—including health care, housing, and employment—for all individuals with behavioral health conditions. Since its implementation, PAIMI has already led to nearly 400,000 cases of discrimination filed, many service referrals, and the dissemination of information and trainings about behavioral health conditions.[949]

Exploring gaps in enforcement of anti-discrimination laws could reveal demographic disparities. For example SAMHSA has standards for grantees to submit disparity impact statements. These standards could be further strengthened and enforced to drive systematic changes across programs and systems, such as addressing biases within programs and ensuring that program funds are spent equitably. (Typically, SAMHSA's standards are implemented in behavioral health programs within health-adjacent systems—such as for jail diversion programs—which can help to address discrimination and bias across systems.[950])

Also to address the links between social inclusion and mental health,[951] communities could look to the Americans with Disabilities Act of 1990 (ADA) for opportunities to promote the accessibility of community spaces for individuals with mental health conditions. ADA implementation came with federal, state, and local guidance and enforcement for accessibility of businesses, public facilities, and other spaces for individuals with physical disabilities,[952] but all accommodation of mental health conditions has been individualized and specific to an individual requesting accommodations.[953] Given the high population prevalence of mental health conditions, communities should change policies and give guidance for community spaces to maximize their accessibility for individuals with mental health conditions, rather than relying on individualized and setting-specific accommodations alone.

4.2.2 Include Behavioral Health Focus in Regional & Community Economic Development

Community and economic development efforts regarding capacity building and planning should include a focus on supporting community behavioral health. These efforts could involve responsive, collaborative partnerships with community institutions and prioritize investments in inclusive, culturally-rooted infrastructure.

Building upon the Obama Administration's efforts to advance economic growth through a place-based framework,[954] the federal Office of Management and Budget (OMB) could request that agencies consider the intersection of behavioral health and economic development through a place-based framework, allowing the federal government to determine how best to coordinate policies and programs. State and local policymakers and other stakeholders also should ensure that regional and community economic development efforts and strategies at each stage consider socioenvironmental impacts,[955] including behavioral health impacts, on community

members and assets. Because of the profound impact of social and economic context on individual, family, and community behavioral health, regional and community economic development efforts should make behavioral health a core consideration.

4.2.2.1 Use Wellness Trusts to Address Unmet Behavioral Health Needs

An increasing number of communities are exploring the use of common, co-governed funds—often referred to as wellness trusts—to invest in new behavioral health and development services for youth and community efforts to alleviate child poverty.[956] Many collective impact efforts identify community needs, but lack capacity to address the needs once identified. Wellness trusts are different. They can be formed from special taxation efforts, public funding, private philanthropy, or even health care financing set-asides[957] and are typically governed by community stakeholders that represent different sectors but are united in a goal of investing in improvements to community health and well-being.[958] Policies that support local collective impact initiatives, such as the AHCM (see recommendation 3 of this chapter for more information), should also provide support for establishing a wellness trust (such as raising capital and building governance infrastructure, and even providing some seed funding) to ensure that the initiatives are successful in addressing community needs.

For communities that are new to collective impact, HHS should make available a pool of planning grants for building collective efficacy and trust. Collective impact requires trust among community members and institutions to be successful, and for communities that have been systemically excluded, this may present a challenge. Initial grants should focus on building collective efficacy and preparedness for cross-sector collaboration, which can then transition into eligibility for programs that build on these new relationships. The Trauma-Informed Community Building model pioneering by San Francisco State University offers one example of how this work could be conducted.[959]

4.2.2.2 Invest in Inclusive, Culturally-Rooted Infrastructure in Communities

Communities should support and invest in inclusive "third places" (places between work and home where people spend their leisure time)[960] that integrate evidence on effective community behavioral health promotion. Prioritizing these should be built into infrastructure policies and community development efforts at the national, state, and local levels. Additionally, policies that direct public funding for building social infrastructure should also prioritize improving community-wide behavioral health and tracking social inclusion outcomes. Stakeholders can learn from existing efforts in communities in places like Chicago and Denver. For example, in Chicago, a community violence prevention initiative called READI focuses on harm reduction and collective care in an effort to address collective trauma among young men in Chicago.[961] Project Self-Discovery in Denver, Colorado, diverted teens from substance use to socialization through dance, music, art, martial arts, and life-skills training.[962] There are also international models to draw from, like the more broad-based policy effort in Iceland that provides low-income families with funding for their children's recreational activities.[963] Evidence from the Iceland initiative showed that tobacco, alcohol, and marijuana use decreased among the target population.[964] Also when investing in community social infrastructure, there should be a focus on places, initiatives, and supports and resources that promote healing-centered care. Healing-centered care is holistic, strengths-based, and focuses on collective healing while considering culture, spirituality, and civic action, rather than just focusing on purely clinical services.[965]

4.2.3 Pursue Narrative & Norm Change Through Social & Traditional Media Inputs

Media can play a profound role in shaping social norms and context within families and communities—for better or worse.[966, 967] Media consumption can promote or reinforce both harmful and helpful health-related attitudes and behaviors, such as negative body image and eating challenges or positive activities that support children's social and emotional development. Media can also promote social isolation or social inclusion depending on the content and use. For example, social media use can both take away from supportive in-person interactions while also facilitating new opportunities for connection that transcend physical place.

While policymakers cannot directly shape media consumption, they can help guide and moderate its impact on individuals, families, and communities. For example, they can support investing in NIH-led rapid-cycle evaluation research on the impact of different media and related technologies on family behavioral health. Actionable insights from this research could be incorporated into various family-serving grant programs, such as including social media best practices and child development in the MIECHV program. The CDC should also be funded to create evidence-based media materials for promoting whole-family behavioral health, guides and technical assistance for adaptation to diverse populations and contexts, and evaluation tools. The CDC currently offers evidence-based parenting resources for promoting behavioral health, and additional funding could ensure that these messages effectively reach families and communities in ways that produce measurable norm change.[968] For example, tax incentives can be provided for social media and other companies to help target messages effectively, to include content that promotes behavioral health in their programming, and then to evaluate the impacts, in much the same way that hospitals receive a tax preference when they invest in community benefit. The Public Broadcasting Service (PBS) already receives federal funding to make programming designed to promote family well-being, including behavioral health;[969] similar incentives could be offered to other private entities. An example of this is in Nashville, where PsychHub will provide short videos on different behavioral health conditions that also offer treatment and medication options.

4.2.3.1 Develop & Expand Interventions That Cut Across Systems to Reduce Stigma

Public initiatives designed to reduce the stigma of mental health conditions and treatment have been associated with reduced discrimination and changes in attitudes around behavioral health in California and in countries such as England, New Zealand, and Germany, allowing individuals to be more open about their behavioral health conditions and leading to more acceptance from their peers.[970] Strategies include reframing the definition of mental health to be positive and emphasizing that it is a population-level problem.[971] Additionally, local health and health-adjacent providers can work with communities to reframe paradigms of health and healing that value the trauma-informed lived experiences of the people they serve. Such reframing can be exercised by "teaching accurate accounts of history, telling authentic stories of survival, and allowing communities to have their own trauma narrative in their words." An example is the "In the Number" campaign in New Orleans, LA which aims to reduce stigma around behavioral health conditions and care through interviewing youth and providing resources about trauma-informed care.

4.3 UNIVERSALIZE ACCESS TO BEHAVIORAL HEALTH INFORMATION & SUPPORTS

Optimizing behavioral health outcomes at the family and community levels requires the engagement of community members and institutions, as shown in the examples below. Accordingly, health and health-adjacent sectors must invest in creating opportunities for community leadership and engagement.

4.3.1 Create New Opportunities for Shared Governance That Engage Community Members

Community members should be empowered to collectively determine existing community needs, desired outcomes, and raise capital to meet them through outcomes-based financing. Community members can be engaged through identifying needs, collecting data and participating in community health assessments. Community health needs assessments must use qualitative narrative data and quantitative data to adequately capture various viewpoints of community members. This combination unveils differential outcomes across communities; policymakers and practitioners can change regulations and practices with this greater understanding of who is being served well and whose needs are going unmet. Such assessments will need to include both the governance structures and the infrastructure (e.g. technology systems or the availability of accessible community spaces) to make this possible, as well as methods of building community capacity to be able to efficiently perform these functions. Any and all models will need to pilot effective ways of sharing data, incentives, and learning among and between communities.

To improve community co-production, stakeholders should build on models like Community Partners in Care[972] or Hennepin Health,[973] which focus on testing ways of systematically identifying trusted community partners and appropriate sites for community hubs, and then integrating community member perspectives into the design of no-wrong-door screenings, referrals, and coordination capacities for individuals and families. This also would involve piloting models of paying trusted community partners to build hub infrastructure with continuous community engagement in the design, delivery, and improvement of services provided, as well as paying for non-credentialed community members to aid in meeting identified community needs—while avoiding undesirable intracommunity competition.

4.3.1.1 Use Participatory Research Practices

To support the behavioral health of all families and individuals, policies and systems must reflect and respond to their holistic needs. To ensure this, policymakers and researchers should include and collaborate with community members as they work to innovate and evaluate new health and human service delivery systems. Participatory Action Research (PAR) can be used as a means to decentralize power and democratize knowledge production in the research process.[974] PAR is an approach to research that is participant-driven and involves the people most impacted by an issue in the research and knowledge production process.[975] PAR involves collaboration at each stage of the research process and changes the conventional researcher-to-subject relationship into a partnership in co-production and inquiry.[976, 977] Through such an approach, individuals and communities can be empowered in owning and utilizing their data to inform grassroots solutions.[978, 979]

In the health sector, PAR can empower and include individuals with behavioral health conditions in the research process. Examples include community mapping of assets, allowing behavioral

health clinics to partner with academics on finding the most effective interventions for providing medication to patients with behavioral health conditions,[980] and designating youth with behavioral health conditions as research assistants so they are directly involved in figuring out how to best improve behavioral health services for them and spread awareness.[981] Such research can be particularly helpful in understanding behavioral health disparities experienced by different groups based on race/ethnicity, SOGI, and socioeconomic status by getting individuals in this communities directly involved in increasing the responsiveness and accessibility of care.[982]

4.3.2 Train & Equitably Pay Community Members for Contributing to Community Behavioral Health

As policymakers strive towards greater community representation in behavioral health and adjacent systems, they should increase access to adequate training and pay practitioners equitably. Currently, many people face significant structural barriers to employment in health sectors, such as inequitable pay for community health workers[983] and stringent and narrow provider licensing and scope of practice laws.[984] These barriers limit the health sector's ability to meet social and economic needs. In other countries, community health workers are able to implement a range of behavioral health interventions with high evidence of effectiveness for some models, but laws in the United States limit opportunities for community health workers.[985] The federal government should support states in collaborating with the provider community to examine possibilities to amend policy to maximize the capacity and diversity of the behavioral health workforce, while avoiding role conflicts.

Another approach is to expand Small Business Innovation Research (SBIR) grants to scale effective approaches in promoting behavioral health by low-income communities for low-income communities. Under a directive from the Small Business Administration, federal agencies with extramural Research and Development (R&D) budgets exceeding $100 million must allocate a percentage of these programs to SBIR grants.[986] These grants are awarded to small businesses to conduct research and develop innovative technologies for future commercialization. SBIR grants could be expanded and offered to prioritize partnerships with low-income communities in the creation of innovative new digitally-mediated interventions to meet the behavioral health needs of socioeconomically and culturally diverse users. To date, digital behavioral health innovations created by and implemented for low-income families have been limited, and additional SBIR investments in this area could potentially catalyze key breakthroughs.

4.3.3 Equip Community Members With Tools to Promote Behavioral Health

Positive behavioral health promotion should begin in the spaces where people spend their daily lives—e.g., at home, in school, and at work—well before the need for individual or family-specific interventions arise. Not every support needs to be offered by a health provider in a clinical setting; rather, individuals can also help themselves and others when equipped with effective tools and a supportive context. To facilitate this, communities should increase the availability and accessibility of information about behavioral health services and supports in public spaces and through community institutions. For example, schools and workplaces could put behavioral health care providers' information up in common spaces or disseminate widely through other means in order to destigmatize these services and make the information available to everyone.[987]

Additionally, knowledge and skill-building for self-regulation and pro-sociality (i.e. the ability to interact with peers in ways that promote the well-being of one another), as well as management

strategies that reinforce these goals, should be integrated into educational and workplace settings. FQHCs, advanced primary care models, and other critical access points could also disseminate evidence-based tools, including digital health interventions. These tools could focus on individual and family behavioral health promotion. For educational settings, incentives can be built into the Elementary and Secondary Education Act, the Individuals with Disabilities Education Act (IDEA), or the HEA through measurement activities, use of school improvement and enrichment funds, and professional development activities, among others.[988] As for private workplaces, tax incentives could reward management and programming that improves behavioral health, or grants could be issued to help employers integrate these practices.

IV. OPPORTUNITY AREA: Maternal Behavioral Health

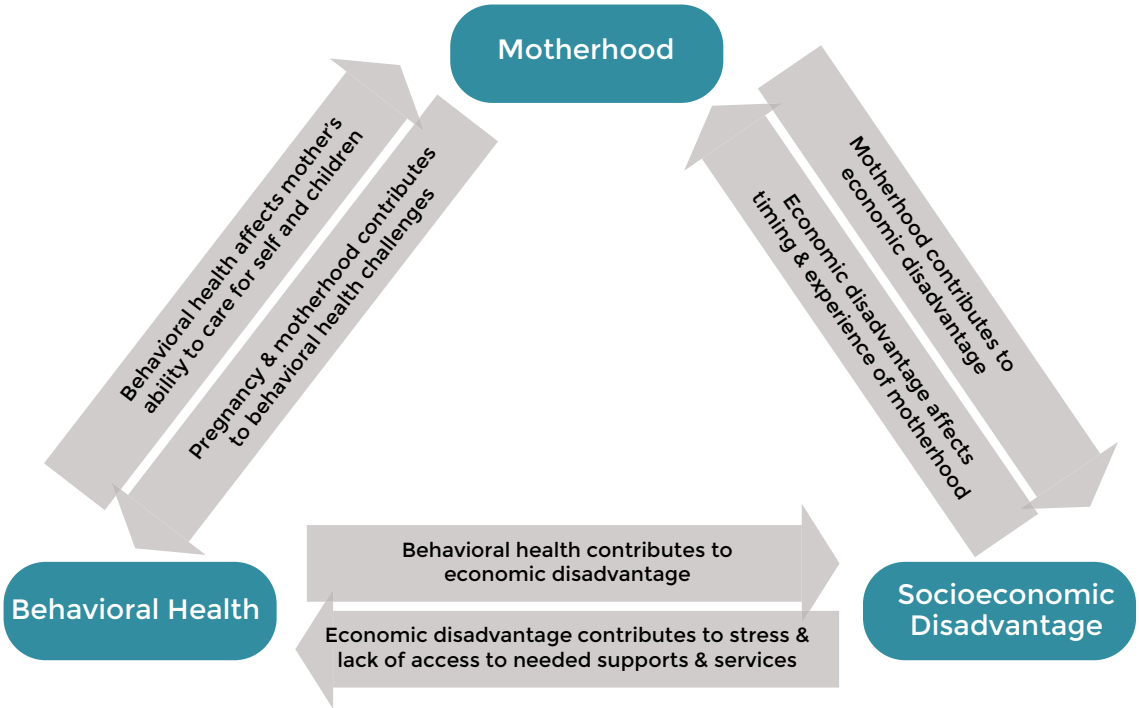
As part of a broader agenda to meet families' behavioral health needs, maternal behavioral health is one area that is ripe for transformation. This chapter first explores pertinent social, economic, and health-related factors and challenges that can impact the behavioral health of mothers and their children—including economic disadvantage; reproductive health, including physical health conditions such as pregnancy; identities and experiences, such as age, race and ethnicity, and gender and sexual orientation; urbanization factors; and DV/IPV. It also profiles some of the most common mental health and substance use conditions mothers experience. Lastly, it outlines several key recommendations to improve the behavioral health of mothers and their families by strengthening access to and the quality of comprehensive maternal mental health and substance use care and services.

At-Risk Populations & Factors

This section will discuss populations with higher risks of facing maternal behavioral health conditions. These populations often face adverse and compounded barriers at intersections of mental health, substance use, economic insecurity, and gender- and identity-based structural inequalities.

FIGURE 4a. Gender inequities result in systematic disadvantage for mothers

Relationship between motherhood, socioeconomic disadvantage, & behavioral health challenges



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

Behavioral health and economic insecurity can interact in ways that particularly harm women and mothers (see Figure 4a). As it is, women are more likely to experience poverty than men. More than 1 in 8 women lived in poverty in 2016, versus 1 in 11 men.[989] Thirty-four percent of households headed by single mothers were in poverty in 2017, compared to 16 percent of

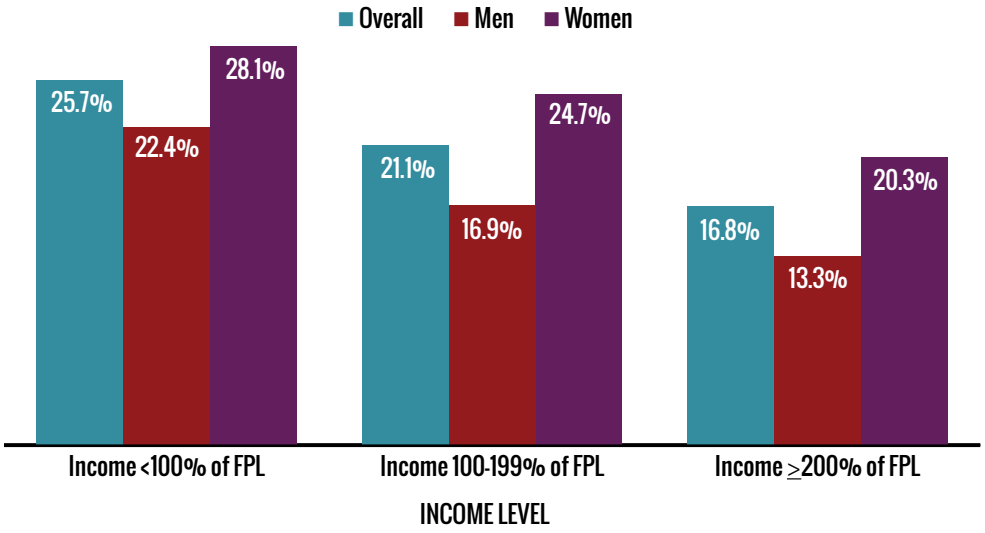
households headed by single fathers.[990] Poverty can be even more common for women just before and during pregnancy.[991]

MOTHERHOOD, ECONOMIC DISADVANTAGE, & BEHAVIORAL HEALTH ARE INTERWINED

Access to mental health and substance use care and supports is especially important for low-income women of childbearing age.[992] Low-income women are more likely to experience behavioral health conditions and less likely to have access to treatment (see Figure 4b).[993] Along with being more likely to experience poverty than men,[994] women have less financial security than men, with 20 percent less in liquid assets and a higher revolving credit card debt burden, trends that are exacerbated after a major medical payment.[995]

FIGURE 4b. Incidence of mental health conditions is higher among adults living in poverty & women

Share of adults with behavioral health conditions, by income level & sex, 2017



Note: Poverty level is determined using the Official Poverty Measure. FPL stands for Federal Poverty Line.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Authors' calculations using microdata from "National Survey on Drug Use and Health, 2017." SAMHSA, U.S. Department of Health and Human Services, 2018. Available at https://www.datafiles.samhsa.gov/study-dataset/national-survey-drug-use-and-health-2017-nsduh-2017-ds0001-nid17939.

Low-income mothers, particularly mothers of color, have greater risks of behavioral health conditions and may experience substantial barriers—such as discrimination, cost, competing responsibilities, and geographic inaccessibility—to accessing treatment than the general population.[996, 997] According to one study, over half of infants in low-income households live with a mother experiencing some form of depression.[998, 999] Mothers with low incomes are more likely to experience anxiety than higher-income mothers. For example, studies have found that food-insecure mothers are more likely to experience depression or GAD than mothers who are fully food secure.[1000, 1001]

Over **HALF OF INFANTS IN LOW-INCOME HOUSEHOLDS** live with a mother experiencing some form of depression

Women with young children are far more likely to experience homelessness or unstable housing situations.[1002] Mothers in these situations are more likely to face higher DV/IPV rates and behavioral health conditions compared to the rest of the population.[1003] One study from a shelter for people experiencing

homelessness found that women, particularly single mothers, were more likely to experience poverty and be at risk for homelessness.[1004] If these women also had a behavioral health condition, were survivors of DV/IPV, or had experienced housing instability, they were at an even greater risk of experiencing homelessness and may experience homelessness for a longer period of time due to the compounding risk factors.[1005] Among mothers experiencing homelessness, rates of behavioral health conditions are elevated, particularly rates of psychological distress, PTSD, and rates of substance abuse.[1006] The lifetime rates of MDD among mothers experiencing homelessness is 52.4 percent, and 15 percent of mothers experiencing homelessness have had at least one hospitalization for a behavioral health condition, though rates of behavioral health conditions among mothers experiencing homelessness may be underreported due to the mothers' fear of losing custody of their children.[1007]

REPRODUCTIVE HEALTH & BEHAVIORAL HEALTH ARE INTERCONNECTED

Behavioral health and reproductive health are interconnected. Just as behavioral health conditions can develop or worsen due to reproductive health-related conditions, outcomes, and barriers to care, reproductive health can also be impacted or complicated by someone's behavioral health and related challenges. Reproductive health-related experiences and factors that can contribute to someone's behavioral health and well-being include a lack of choice and agency in reproductive decisions, traumatic personal and medical experiences related to reproductive health, unintended pregnancy, unsafe abortion and the stigma around abortion, sexually transmissible infections, and fertility and pregnancy-related complications.[1008]

When behavioral health and reproductive health overlap with motherhood, the social, economic, and health consequences for economically insecure mothers can be severe. One study found that 56 percent of low-income mothers who were patients at the University of Rochester's Children's Hospital experienced depression between 2 and 14 weeks after giving birth.[1009] Another study found that nine percent of low-income mothers who had children under six experienced at least one MDE in the past year, meaning that some mothers experience depression much longer after childbirth.[1010] Behavioral health conditions and gaps in coverage can also lead to increased maternal mortality rates.[1011, 1012] In the U.S., seven percent of deaths related to pregnancy were due to underlying mental health conditions.[1013] Among those deaths, around 42 percent had contributing factors such as a lack of social support and not adhering to treatment plans.[1014] Another 27 percent were due to factors related to providers, such as the use of treatments that were ineffective or a lack of screening.[1015] In general, African American women face much higher maternal mortality rates than white women, regardless of educational attainment or median income, for physical and non-physical reasons, such as a legacy of segregation, continued systemic gender and racial discrimination in hospitals, and unconscious biases that are perpetuated within the health system.[1016] Due to a lifetime of socioeconomic disadvantage, African American women's health may worsen in early adulthood, adversely impacting maternal health.[1017]

YOUNG MOTHERS EXPERIENCE UNIQUE BEHAVIORAL HEALTH CHALLENGES

Young mothers face a confluence of behavioral health-related challenges, including limited economic and social resources, increased exposure to violence and traumatic experiences, and other systemic barriers to physical and economic stability. Teenage mothers, in particular, face high risks of behavioral health conditions.[1018] Teenage mothers experience twice the rates of

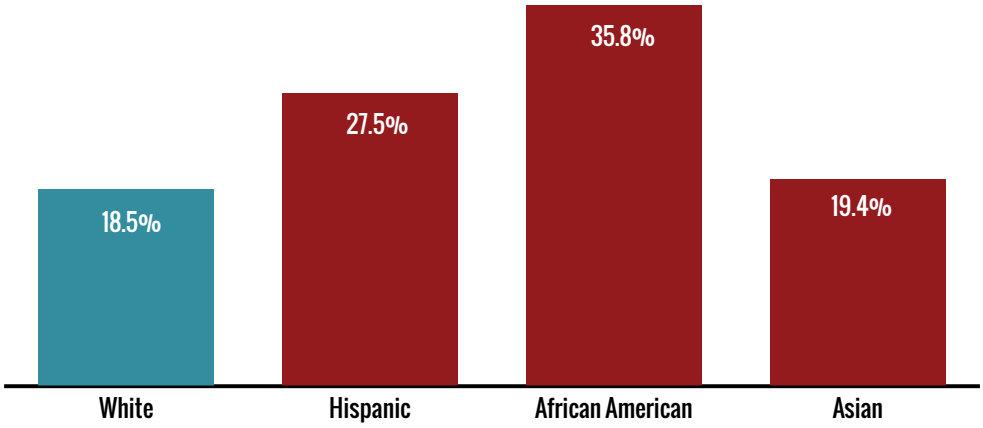
prenatal and postpartum depression as non-pregnant teens and women and may experience higher rates of suicide ideation.[1019] One study found that 50 percent of teen mothers met all of the qualifications for PTSD; teen mothers were two times more likely than mothers older than 21 to be victimized by a partner, their child's father, or a family member.[1020] Mothers ages 12-21 are more likely to be low-income and have limited social support networks, increasing their barriers to accessing behavioral health supports.[1021] These barriers include lower rates of health care coverage and caregiving and transportation challenges.[1022] Teenage mothers are disproportionately African American and Latina,[1023] and face additional barriers to care, including discrimination[1024] and a lack of culturally and linguistically accessible care.[1025]

MOTHERS OF COLOR FACE LARGE BARRIERS TO MEETING BEHAVIORAL HEALTH NEEDS

Mothers of color face higher rates of behavioral health conditions. Single African American mothers, in particular, face depressive symptoms at six times the rate of the general population and double the reported rate for African American women overall.[1026] One in three Latina mothers, and one in two African American mothers who have ever experienced a MDE are low-income.[1027] As seen in Figure 4c, women of color in general are more likely to experience postpartum depression. These behavioral health conditions do not exist in isolation—pervasive discrimination, structural inequality, and lack of culturally accessible care may affect these rates of behavioral health conditions. African American and Latinx single mothers experience significantly higher poverty rates than the general population.[1028] Studies demonstrate that African American patients receive fewer diagnostic and therapeutic interventions than white patients with the same symptoms.[1029, 1030] Native American women also faced significant barriers in their prenatal health experiences, such as communication barriers, a lack of continuity of care, and sociodemographic barriers including poverty and sexual or physical abuse.[1031]

FIGURE 4c. Women of color generally are more likely to experience postpartum depression

Rate of depressed mood during pregnancy in Los Angeles County, CA, by race, 2016



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from "Health Indicators for Mothers and Babies in Los Angeles County, 2016." County of Los Angeles Public Health, July 2018. Available at http://publichealth.lacounty.gov/mch/LAMB/Results/2016%20Results/2016LAMBSurveillanceRpt_07052018.pdf.

LGBTQ PARENTS FACE UNIQUE OBSTACLES TO CARE

The LGBTQ community faces unique barriers, such as a lack of access to care, greater stigma and discrimination, and having to navigate a binary and heteronormative health care system.[1032, 1033, 1034] These difficulties are magnified by the challenges of parenthood, particularly when someone also has limited economic resources and security. As a result, LGBTQ parents often experience compounded challenges that can impact their overall behavioral health and well-being. Individuals who identify as LGBTQ have higher depression rates in their first year postpartum.[1035] One study showed that bisexual women have higher rates of mental health conditions and substance use.[1036] Another study found that LGB women trying to conceive and LGB women who were less open about their sexuality were more likely to utilize mental health services.[1037]

Individuals who identify as LGBTQ have **HIGHER DEPRESSION RATES** in their first year postpartum

Transgender parents also face unique barriers to care and a risk of behavioral health conditions, both during and after pregnancy.[1038] Transgender men may face a specific risk of experiencing postpartum depression, which could be worsened by a lack of culturally competent behavioral health services for them.[1039]

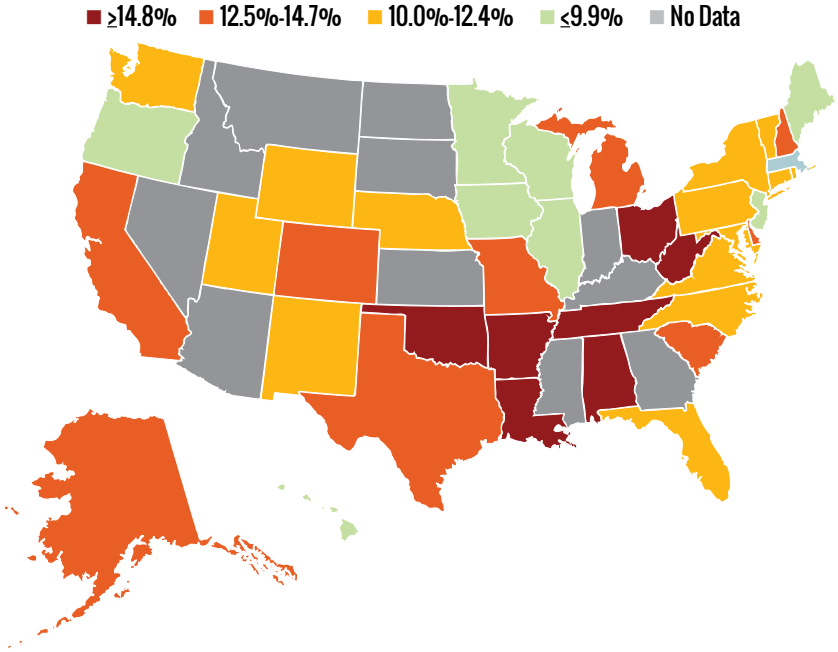
URBANIZATION INFLUENCES MATERNAL BEHAVIORAL HEALTH INCIDENCE & ACCESS TO CARE

Geographic location can impact rates of pregnancy and related health conditions, including behavioral health conditions (see Figure 4d). Rural areas of the U.S. have a higher prevalence of teen pregnancies.[1040] Additionally, rural residents get married and have their first child at an earlier average ages.[1041, 1042] These factors may lead to a higher risk of behavioral health conditions for rural mothers.[1043] Poverty in rural areas can also impact rates of behavioral health conditions, as one study of rural, low-income families in 14 states found that mothers with one or more jobs were more likely to have substance use challenges.[1044] The maternal mortality rate in rural areas is almost two times as high as in central metro areas.[1045] Notably, disparities between black women and white women exist irrespective of geography due to historical and structural inequities.[1046]

Women in rural areas in general face many obstacles in terms of receiving specialty health care. Overall in the U.S., less than half of women in rural areas live within 30 minutes of the nearest hospital offering any perinatal services.[1047] When it comes to behavioral health care, rural women, particularly low-income women, report facing transportation access issues, shortages of trained behavioral health specialists in their community, stigmatization in their communities, and a lack of awareness of behavioral health supports and services.[1048, 1049]

FIGURE 4d. Postpartum depression rates vary substantially by state

Share of women with a recent live birth who reported experiencing postpartum depression, by state, 2018



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Adapted from "National Postpartum Depression." United Health Foundation, 2018. Available at https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/postpartum_depression/state/ALL?edition-year=2018.

DV/IPV & SEXUAL VIOLENCE CAN LEAD TO WORSE HEALTH OUTCOMES FOR BOTH MOTHER & CHILD

Research supports a connection between DV/IPV and behavioral health conditions, notably depression, anxiety, PTSD, SUD, and suicide.[1050] At least one-third of women in the U.S. have experienced IPV over their lifetime (including sexual assault, physical violence, or stalking), with even higher numbers for psychological aggression.[1051] Approximately three to nine percent of women experience IPV during pregnancy.[1052] Experiencing IPV during pregnancy makes women twice as likely to miss or delay prenatal care.[1053] This in turn contributes to worse health outcomes for the mother and child, including low birth weight and preterm birth.[1054] Further, women experiencing DV/IPV during pregnancy have higher rates of smoking, alcohol use, substance use, and depressive symptoms than women who were not experiencing DV/IPV.[1055] For mothers, DV and sexual abuse experiences are associated with maternal depression.[1056, 1057] IPV-related suicide and homicide remains a leading cause of maternal death during pregnancy.[1058]

Behavioral Health Conditions & Challenges

Mothers, and low-income mothers in particular, can experience a range of behavioral health conditions, some of which are briefly profiled below. Low-income women are more prone to face one or more mental health or substance use challenges and have less access to needed supports and services. Additionally, women who have pre-existing, untreated behavioral health conditions may be more susceptible to developing or worsening behavioral health conditions during and post-pregnancy.[1059] If a mother's partner or another family member has an untreated behavioral health condition, she may also face a higher risk of developing one herself.[1060] Unaddressed maternal behavioral health conditions are associated with a range of adverse outcomes for mothers, their children and families, and society as a whole. For example, prenatal behavioral health conditions have been linked to premature birth,[1061] later behavioral health symptoms for the child,[1062] and impairments on a child's cognitive functioning.[1063]

MENTAL HEALTH

Low-income women who are mothers are at risk for experiencing a variety of mental health conditions, including anxiety, depression, and other mood disorders. The most common mental health conditions experienced by mothers are discussed briefly below.

Depression & Other Mood Disorders

Approximately 10 percent of new mothers experience postpartum depression,[1064] and up to 23 percent experience depressive symptoms.[1065] Postpartum depression is a form of depression specific to the transition to parenthood. Symptoms of postpartum depression include traditional symptoms of depression, such as changes in energy levels, increased sadness, and withdrawing from social situations, as well as symptoms specific to new parenthood, such as feelings of shame or guilt about not bonding with the new child and increased anger toward family members.[1066] Several factors influence the likelihood of developing postpartum depression, notably unemployment, smoking, psychosocial stress, and pre-pregnancy illnesses, such as diabetes.[1067] Aside from depression related to pregnancy, a 2016 study found that for mothers with young children under age six, 15 percent experienced a MDE over the course of their lives and eight percent did so in the past year.[1068]

FORTY PERCENT of mothers with depression **DO NOT RECEIVE TREATMENT**

Aside from the obvious impact on the mother experiencing the condition, maternal depression also increases a child's risk for a number of conditions later in life, such as behavioral health symptoms[1069] and cognitive challenges.[1070] For example, 1 in 11 babies are affected by their mother's perinatal depression, which can result in delayed emotional, cognitive, and social development in childhood, as well as increased risk of having mental health conditions later in life.[1071] Maternal depression can create more stress for their children, increasing the child's future risk of experiencing poverty.[1072]

Forty percent of mothers with depression do not receive treatment,[1073] with low-income mothers even less likely to receive treatment.[1074] Of the mothers who do receive treatment, only 35 percent say they received adequate treatment.[1075] Untreated maternal depression affects a mother's overall health, well-being, and ability to function in various social and economic roles, and has significant negative effects on the cognitive and behavioral development of her children, particularly young children.[1076] Barriers to treatment include a lack of health insurance

(a 2014 study of mothers with the greatest behavioral health needs found that 23 percent were uninsured) due to its high cost.[1077]

Mothers may face other mood disorders, including less common, highly consequential conditions such as postpartum psychosis. Over 23 percent of women experience anxiety.[1078] Between 8 and 10 percent of women develop anxiety during pregnancy, and between 4 and 10 percent of women develop it postpartum.[1079] Some studies have found that women are less likely to seek out treatment for anxiety compared to depression.[1080] Mothers may also experience PTSD during delivery or postpartum. About nine percent to twenty-seven percent of mothers experience clinically significant symptoms of PTSD after giving birth.[1081] While 1.8 percent of women overall experience OCD,[1082] one study found that 11 percent of new mothers experience postpartum OCD.[1083] Mothers may also face postpartum psychosis, which may include mania, mood swings, delusions, paranoia, and hallucinations, within the first few weeks of giving birth; it is experienced after 0.1-0.2 percent of births.[1084]

SUBSTANCE USE

Substance use conditions among mothers or expectant mothers typically involve alcohol, tobacco, or illicit substances—the use of which can vary among women in terms of prevalence, effects on the person and their children, and other factors. In some parts of the country, doctors frequently prescribe opioids to mothers-to-be to treat back pain or abdominal pain. For example, a 2017 study found that nearly 42 percent of pregnant women participating in the Medicaid program in Utah were prescribed opioids, and roughly 36 percent in Idaho.[1085] Maternal opioid use was nearly 70 percent higher in rural counties than urban ones.[1086] From 2004 to 2013, the proportion of newborns with Neonatal Abstinence Syndrome (NAS) increased more than sixfold in hospitals in rural counties, while the uptick among urban infants was more than threefold.[1087] Depending on circumstances, anywhere from 55 to 94 percent of babies exposed to opioids in utero develop NAS.[1088] Pregnant people struggling with SUDs often have previous experiences with trauma and mental health conditions,[1089] including greater stress levels and increased depressive symptoms.[1090] Their higher levels of mental health conditions may be caused and exacerbated by high levels of food and housing insecurity and lack of overall resources.[1091]

While access to SUD treatment is limited[1092] regardless of socioeconomic status,[1093] mothers struggling with SUDs face additional, compounded barriers to receiving behavioral health services and supports. Pregnant people and mothers struggling with SUDs also face higher levels of stigma and discrimination when seeking treatment and services. Punitive policies discourage women from accessing prenatal care and encourage women to withhold information about their substance use if they did attend appointments.[1094] For example, in some states, taking methadone during pregnancy is a criminal offense and grounds for removal of children, despite the fact that methadone treatment is the clinical standard for pregnant women with OUDs.[1095] If a pregnant person or mother does seek treatment or services for a SUD, higher levels of unemployment, lower levels of health coverage, and a lack of transportation, child care, and overall resources may impede take up of treatment.[1096, 1097] When parents do not receive the necessary behavioral health services and supports, there are considerable effects on their child's well-being. Of the women receiving treatment for a SUD, about 73 percent are mothers with children under age 18 who also have high rates of mental health conditions.[1098]

Recommendations

To help prevent and address maternal behavioral health challenges, especially among low-income women who face the greatest risks, these recommendations span from health screenings and services to reproductive health and material needs.

1. PROVIDE BEHAVIORAL HEALTH SCREENINGS FOR MOTHERS & EXPECTANT MOTHERS

Mothers and expectant mothers may be more likely to receive necessary behavioral health if preventive screenings are integrated into primary care and other settings. Screenings can help identify mothers experiencing or at risk of experiencing behavioral health challenges. However, the impact of screenings ultimately depends on the provider response to screening results (see recommendation 2).

According to the AHRQ and CMS, five of the most salient behavioral health conditions and risk factors in pregnant and postpartum (one year after birth) women are:

- Depression (approximately 10 percent of pregnant and postpartum women);[1099]
- Alcohol use (approximately 10 percent of pregnant women);[1100]
- Tobacco use (approximately eight percent of pregnant women);[1101]
- Other substance use (approximately six percent of pregnant women use illicit drugs);[1102] and
- IPV (approximately 2.5 percent of pregnant women).[1103]

Four of these risk factors (all except illicit substance use) have been the subject of a USPSTF recommendation, meaning they: have a significant impact on the public health of our nation, and can be effectively addressed through clinical intervention. With these USPSTF recommendations, all health insurers must cover the screens.[1104, 1105]

Screens for mental health and substance use should be provided to all mothers and expectant mothers. Potential screenings include AHRQ's Behavioral Health Risk Assessment for Pregnant Women, which screens for antenatal depression, substance use, and intimate partner violence.[1106] Screening periodicity should consider that people who breastfeed may experience postpartum depression after weaning.[1107, 1108] Screening and support for maternal mental health should also include an exploration of all mental health conditions including perinatal anxiety and psychosis.

Model(s)

The Edinburgh Postnatal Depression Scale offers an effective postnatal screen for maternal depression[1109] and the Safe Environment for Every Kid (SEEK) Parent Screening Questionnaire offers a postnatal screen for maternal depression, parenting needs, and relevant SDOHs.[1110]

Financing

All state Medicaid plans should reimburse for comprehensive antenatal and postpartum screenings focusing on mental health and related risk factors, as allowed under federal guidelines. These screenings could occur during Medicaid-covered well-child visits.[1111] New York State provides two options for postpartum depression screenings.[1112] The first option includes up to three reimbursable screenings during the first year of the baby's life, either at a maternal

health care provider or an infant's primary care doctor.[1113] The second option includes two separate services the provider can bill for using each person's Medicaid identification number.[1114] Other states, such as Texas, provide the second option only.[1115] CMS should encourage screening for the full range of maternal behavioral health needs that impact the behavioral health of the child.

2. INCREASE USE OF INTEGRATED & COLLABORATIVE CARE FOR MOTHERS

Mothers and their children need effective services and supports to meet needs identified in their screenings. Federal and state Medicaid agencies should: (1) ensure that current coverage enables the provision of effective follow-up care, (2) test models of value-based advanced maternity and primary care, and (3) collaborate with other child-serving agencies to equip providers with tools to offer needed care directly or refer patients to trusted partners. Integrated or collaborative care models provide a combination of maternity, pediatric, and adult primary care, behavioral health, human services, and employment services concurrently to improve coordination and outcomes. Below we profile promising models and a financing mechanism that could be scaled up.

Model(s)

Family Foundations is a psychosocial intervention that provides group sessions for new parents—starting during pregnancy and continuing into the early months of their child's life, often co-located with maternity care—to learn co-parenting strategies that promote healthy social and emotional development.[1116] Family Foundations reduced maternal depression and anxiety,[1117] improve birth outcomes for at-risk pregnancies,[1118] and advanced child social and emotional outcomes years later.[1119] Future research can focus on ensuring that this and other perinatal psychosocial and parenting support interventions are effective for single parents, LGBTQ couples, and other family and caregiver arrangements.

Project DULCE (Developmental Understanding and Legal Collaboration for Everyone) is a trial collaborative care model in Boston that provided universal supports and aimed to improve parenting skills in a primary care setting from 2011 to 2013.[1120] The program screened low-income mothers for mental health conditions and provided economic resources such as food, housing, and utilities.[1121] Infants from families who participated in Project DULCE had lower emergency department utilization at six months old, and families had significantly increased access to resources, including local food programs, discounted telephone service, and utility discounts and shut-off protection.[1122]

Whole-family behavioral health programs, such as the MOMs Partnership, can be also expanded using an AHCM. An AHCM can involve health care providers partnering with community organizations to identify needs, implement interventions, and provide wraparound services to pregnant women, mothers, and their families as a part of a population-based payment model.

Financing

In contrast to fee-for-service payment systems, value-based payment models could allow providers to focus on outcomes rather than maximizing the number of services provided. Unfortunately, many maternity care bundled payment models emphasize cost containment rather than promoting innovations that would best serve the behavioral health of low-income women. State Medicaid directors and health insurers should collaborate to test new models for

maternity care value-based payment that create incentives for optimizing the behavioral health and social and emotional health of mothers and infants. Value-based payment models can build new incentives for providers to meet women's behavioral health needs and drive additional resources to implement effective interventions, based on the savings from healthier births.[1123]

Because of the high prevalence of mood and anxiety disorders in women who are of reproductive age, along with additional risks of new or worsening mental health conditions during pregnancy, payers should also focus on pre-conception care.[1124] Many women may not interact with maternity care until later in their pregnancy. Routine well-woman visits should be used to address behavioral health and give women the best start in their pregnancies.

3. EXPAND HOME VISITING SERVICES

Federal policymakers and state Medicaid agencies should increase social supports for low-income mothers through increased support for programs like MIECHV,[1125] which provides home visiting services to first-time mothers (see recommendation 4.1.4 for more information on MIECHV and why it should increase). Home visiting can be conducted by community nurses or paraprofessionals,[1126] who can help address behavioral health needs holistically,[1127] and in culturally-appropriate ways.[1128] By establishing career pathways and professional development opportunities, the government can also help build the home visiting workforce.

Model(s)

Durham Connects is a model that goes beyond first-time mothers to address the needs of at-risk of families. The program is funded through a mix of federal and local dollars, including Medicaid and private funds.[1129] It has been shown to reduce emergency room visits by 59 percent in the first year of babies' lives and has been associated with lower levels of anxiety in participants.[1130]

Financing

State agencies could allow Medicaid to cover home visiting costs.[1131] State and federal agencies can use value-based health care financing reforms—which focus on quality of care instead of quantity, such as in a fee-for-service model—to encourage new funding for effective home visiting services.[1132]

4. PROMOTE ACCESS TO REPRODUCTIVE HEALTH CARE

Women who lack access to reproductive health care can develop behavioral health conditions or see them worsen due to reproductive health-related conditions, outcomes, and barriers to care.[1133] Health insurance benefit protections, such as the EHBs, should consider and promote both reproductive justice and behavioral health in coverage, and non-discrimination protections should include these considerations in its definition of discrimination based on gender identity and sexual orientation, health status, and socioeconomic status.

5. INCREASE ACCESS TO DIAPERS & MENSTRUAL PRODUCTS

Being able to access basic material goods like diapers and menstrual products can positively impact a mother's mental health and well-being. Research has shown that if a mother does not have access to diapers for her child, she is more likely to experience depression.[1134] As some child care services will turn mothers away if the mothers cannot provide a supply of diapers for them to use, diaper need can also act as a barrier to the mother's ability to secure (or return to) and maintain employment.[1135] As for menstrual products, currently, there is no dedicated federal

assistance program for menstrual products,[1136] and cash assistance is meager to unavailable in much of the country.[1137]

Model(s)

Expanding federal programs such as the National Diaper Bank Network, which supports 200 community-based diaper banks across the U.S., can help provide resources to low-income women and help prevent the development of behavioral health conditions.[1138] Other solutions could include providing a diaper stipend to low-income families or having Medicaid cover cloth diapers as a durable medical good.[1139] Further funding could be allocated to Departments of Education and county health departments, as is the case in Georgia[1140] and New York State,[1141] to provide free menstrual products in schools and other public spaces throughout communities.

V. OPPORTUNITY AREA: Behavioral Health & Child Welfare

The intersection of behavioral health and the child welfare system also presents a key opportunity to holistically address families' behavioral health and related needs. The child welfare system (in collaboration with the health and health-adjacent sectors) has the opportunity to acknowledge, account for, and help address structural barriers standing between families, needed supports, and the prevention or mitigation of interactions with the child welfare system. This chapter first provides a brief overview of the child welfare system, including its legacy of systemic racism, and its intersection with the CJ/JJ systems. It then outlines key at-risk populations—such as families disadvantaged by their economic status, the children of parents with behavioral health conditions, and children with their own adverse experiences—as well as demographic characteristics—e.g., race and ethnicity, gender, sexual orientation, and age—geographic factors, and common behavioral health challenges experienced by families who have or are at risk of interacting with the child welfare system. Lastly, the chapter offers targeted recommendations for at-risk and system-involved populations.

Overview of Child Welfare System & How It Intersects With Other Systems

Broadly, the child welfare system refers to the system of agencies and services charged with protecting child well-being.[1142] Child welfare systems are state-run, with federal support—though nine states have county-administered systems, and three states have hybrid systems.[1143] State systems receive substantial federal funding and are governed by federal law, overseen by the Children's Bureau within HHS.[1144] The child welfare system saw its population grow by 10 percent from FY2012 to FY2016 due to a rise in parental substance use (including opioid use).[1145] According to HHS, at the end of FY2017, there were 443,000 children in foster care, and during FY2017, there were 123,000 children waiting to be adopted and 59,400 children adopted through the foster care system.[1146] The child welfare system also provides preventive services to families, such as parent education and support groups, and early childhood health and development assessments.[1147, 1148] Generally, a family's experience with the child welfare system starts after a child maltreatment claim is reported to Child Protective Services (CPS); depending on if the claim is verified, the family may be referred to specific services, or the child may receive an out-of-home placement.[1149] Appendix VII provides more in-depth information about how the child welfare system works in theory and practice for families and communities.

Once children interact with the child welfare system, rates of family reunification range from 76 percent to 30 percent depending on the state one lives in, with children under age one only reunified with their families at a rate of 35 percent.[1150] The rate of reunification also varies by race/ethnicity. Asian American children have the highest rates of reunification at 68 percent, as compared to 48 percent of African American children.

As for the behavioral health conditions faced by children in the child welfare system, at least 50 percent of youth in the child welfare system experience mental health conditions,[1151] with up to 80 percent of children and adolescents in the foster care system having a significant mental health need, and 60 percent of children under age five in foster care having developmental concerns.[1152] While youth in the child welfare system are nearly 10 times more likely to utilize mental health services, few receive specialty mental health services.[1153]

BOX 5A.

DEFINITION OF CHILD WELFARE

Childwelfare.gov defines child welfare as "a continuum of services designed to ensure that children are safe and that families have the necessary support to care for their children successfully. Child welfare agencies typically:

- Support or coordinate services to prevent child abuse and neglect;
- Provide services to families that need help protecting and caring for their children;
- Receive and investigate reports of possible child abuse and neglect and assess child and family needs, strengths, and resources;
- Arrange for children to live with kin (i.e., relatives) or with foster families when safety cannot be ensured at home;
- Support the well-being of children living with relatives or foster families, including ensuring that their educational needs are addressed;
- Work with the children, youth, and families to achieve family reunification, adoption, or other permanent family connections for children and youth leaving foster care."[1154]

SYSTEMIC RACISM HAS AFFECTED THE CHILD WELFARE SYSTEM SINCE ITS CREATION

The child welfare system's legacy of systemic racism remains a challenge today in policy and in practice. Specifically, certain communities are overrepresented in the system, despite roughly equal risk of system involvement[1155] due to historic and present-day discrimination and bias based on their identity and other socioeconomic factors (particularly race, ethnicity, and origin, but also class and disability, among others, as demonstrated later in the chapter). Structural racism and classism in the child welfare system are inextricably linked and compound the behavioral health-related challenges people face, putting them more at risk of interacting with the child welfare system and experiencing more punitive responses once in the system.

"Suitable home" provisions were found to disproportionately affect African American mothers, causing them to face **HIGHER RATES OF POVERTY** & have a higher chance of **LOSING CUSTODY OF THEIR CHILDREN**

"Suitable home" requirements, which are behavioral requirements that low-income families participating in public assistance programs must meet in order to receive assistance and, in essence, keep their children, have been instituted in some public benefit programs since the New Deal and most recently through the 1996 welfare law.[1156] These requirements linked receipt of child support and decisions on placing a child in foster care to the mental, moral and physical "fitness" of the parent.[1157] Historical analyses of "suitable home" requirements found that criteria for meeting these requirements were vague and often dependent on case worker discretion.[1158] "Suitable home"

provisions were found to disproportionately affect African American mothers, causing them to face higher rates of poverty and have a higher chance of losing custody of their children.[1159]

Some communities of color, particularly African American and Native American communities, have been and remain overrepresented in the child welfare system compared to the general population.[1160] African American children are 1.6 times more likely to be represented than the general population, while Native Americans are 1.7 times more likely to be identified by CPS as having been abused.[1161] Latinx children face higher rates of cases that are substantiated (where it has been proven that abuse or neglect occurred) and have these cases substantiated at faster rates than white children, though Latinx representation in the foster care system more closely matches their overall population share.[1162] Compared to reports of maltreatment for children of other races and ethnicities, African American child maltreatment is overreported, due in large part to society-wide structural racism.[1163] The effects of this disproportionate representation are compounded once children enter the child welfare system. For example, research shows that even after coming into contact with the child welfare system, African American children still may not receive the services they need compared to white children.[1164]

Stakeholders within the child welfare system have started acknowledging that racial disproportionality exists within the system and have started trying to pinpoint how and why this phenomenon occurs in order to address it.[1165, 1166] In this vein, HHS has determined four explanations for racial disproportionality. The first explanation is the "disproportionate and disparate needs of families of color," meaning higher rates of poverty among families of color may increase the likelihood of involvement with the child welfare system. The second explanation is racial bias before a child comes into contact with the child welfare system on the part of individuals like caseworkers and mandatory reporters. Two studies from Texas show how race, risk, and income are supposed to be considered holistically by caseworkers, but, in reality, are not. Even though African American families tended to have lower risk scores than white families in these studies, they were more likely to lose custody of their children, have substantiated abuse or neglect cases against them, or receive safety services.[1167] The third explanation is factors within the child welfare system itself, such as "such as a lack of resources for families of color and caseworker demographics." Racial bias and discrimination against communities of color may be a result of the underrepresentation of people of color in the child welfare and behavioral health care workforces, as the majority of child welfare workers and mental health professionals are white,[1168, 1169] which has helped contribute to large-scale cultural competency deficiencies within these systems.[1170] Lastly, the fourth explanation is a failure to account for geographic location, which obscures race/ethnicity differences in child welfare involvement across state and federal levels.[1171]

INTERSECTION OF CJ/JJ SYSTEMS & CHILD WELFARE SYSTEM

The CJ system intersects directly with the child welfare system. In 2013, HHS reported that approximately eight percent of children in foster care were there because of parental incarceration, though this figure does not count children involved with the child welfare system in any other way.[1172] Another study found that 13 percent of the incarcerated population spent time in foster care, which shows how the two systems currently interact throughout the lifecourse.[1173]

Parental interaction with the CJ system raises their children's risk of contact with the child welfare system. Parental incarceration is associated with a host of factors mentioned in this chapter, including poverty, parental SUD, DV/IPV, and other parental behavioral health conditions. Parental incarceration can lead to negative mental health outcomes for children, such as depression, anxiety, and ADHD.[1174] Parental CJ involvement impacts children's housing stability as well, as one study found that the gap in homelessness between African American and white children widened by approximately 65 percent due to the increasing number of African Americans being incarcerated.[1175] The children of incarcerated parents are more likely to come in contact with the CJ system,[1176] where people have much higher rates of behavioral health conditions than the general population.[1177]

Immigration Enforcement

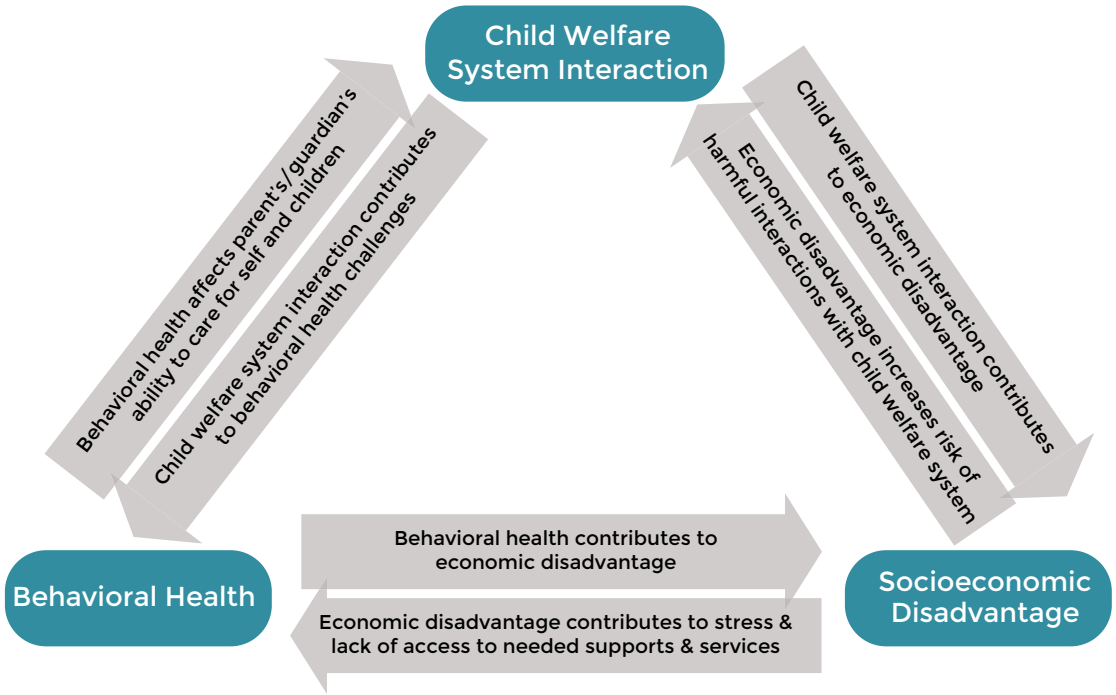
For immigrant families, U.S. Immigration and Customs Enforcement (ICE) plays a role in child welfare system involvement. ICE's policy is to inform local child welfare agencies of upcoming raids so agencies prepare to care for children separated from their parents.[1178] ICE prioritizes placing children within the child welfare system instead of with other relatives.[1179] Children separated from their parents due to deportation may face even higher rates of behavioral health conditions due to the trauma of the separation itself.[1180] Additionally, the living conditions experienced while children are separated from their parents[1181] and the living conditions experienced while families are detained after reunification[1182] may also cause the development or exacerbation of behavioral health conditions. Behavioral health symptoms persist for some children even after family reunification.[1183] Undocumented people may also fear of reporting abuse because of the threat of deportation.[1184] A UC Berkeley study found that, once in the child welfare system, young Latinx people with immigrant parents (regardless of their own immigration status) may have higher rates of mental health conditions than children with native-born parents, due to the increased stress of being part of an immigrant family, which may include financial difficulties, isolation, and the loss of support networks.[1185]

At-Risk Populations & Factors

This section discusses populations at particular risk of adverse outcomes due to the intertwined nature of behavioral health, socioeconomic disadvantage, and the child welfare system (see Figure 5a). Specifically, the section considers factors that a) increase the risk of involvement with the child welfare system in the first place, and b) contribute to harmful health and other outcomes once individuals and families become system-involved. These populations are more likely to face challenges ranging from economic insecurity to unmet behavioral health needs to discrimination based on identity and lived experiences—all of which increase the likelihood of interacting with the child welfare system.

FIGURE 5a. Socioeconomic disadvantage contributes to behavioral health challenges & child welfare system interaction

Relationship between child welfare system interaction, socioeconomic disadvantage, & behavioral health



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

FACTORS THAT INCREASE RISK OF INVOLVEMENT WITH CHILD WELFARE SYSTEM

There are various factors that can influence whether children and families face a greater risk of contact with the child welfare system. These factors include the criminalization of poverty and other risk factors, such as disability and housing instability, un- and under-addressed parental behavioral health conditions, and adverse experiences.

Criminalization of Poverty Puts Some Families at Greater Risk of Child Welfare System Interaction

The child welfare system has deep intersections with poverty and interacts with many other systems that children, parents, and other family members come into contact with, such as the criminal justice, health care, other human services, and education systems. As a result, it is particularly important to consider how the criminalization of poverty—in combination with stigma against behavioral health conditions (particularly when they are un- or under-addressed) and other challenges—puts some families particularly at risk of harmful interactions with the child welfare system.

The criminalization of poverty, in particular (among other factors below), has led to challenges for low-income parents.[1186] In the 1990s, a set of laws, such as chronic nuisance ordinances (which give landlords the ability to evict tenants if a certain number of police calls are attributed to their residence[1187]) and laws criminalizing homelessness, were put into place that penalized

people because they faced poverty.[1188] Individuals who are unable to pay the penalties they face for violating these laws can lose their employment and their access to economic security programs and can even face claims of abuse or neglect for their failure to pay. Accordingly, in the NSCAW Wave 1 (1999-2000) results, 47 percent of cases of child home removal in the U.S. involved families who had trouble paying for basic necessities.[1189] While living in poverty can be correlated with child harm, the condition of living in poverty is not the same as child maltreatment. Low-income parents make significant sacrifices to provide for their children, and the condition of being in poverty does not mean that a child is not being cared for.[1190] While a body of evidence suggests poverty as the strongest predictor for child maltreatment, there are significant differences in risk of abuse based on employment and household arrangements.[1191, 1192] For example, one study found that the rate of child maltreatment increases as the share of children living in extreme poverty increases, but children with absent fathers and non-working mothers showed no higher risk of maltreatment than children in two-parent or working father and non-working mother households.[1193] As of 2016, just twelve states, along with the District of Columbia, had exemptions for "financial inability to provide for a child" in their definitions of neglect.[1194]

Disability

Having a parent with a disability increases the likelihood of a child being taken away from their parents, as most states have statutes that refer to parental disability in their grounds for termination of parental rights.[1195] Many workers within the child welfare system are also not culturally competent or trained to work with parents who have disabilities, and have overcriminalized these parents many times just because they have a disability, not because their child has faced abuse or neglect.[1196] Overall, 1 in 10 children have a parent with a physical disability[1197] and nearly 1 in 5 of children in foster care have at least one parent with a disability, including a "physical or emotional illness."[1198] In addition, children with disabilities are more likely to come into contact with the child welfare system, as they are more likely to face abuse (3.4 times more) and are more likely to have substantiated claims of abuse (1.7 times more) than children without disabilities.[1199] Additionally, the criminalization of poverty may also affect the parents of children with disabilities. For example, if they have limited economic resources to meet the disability-specific needs of their children, they may face the prospect of losing custody of their children.[1200]

Housing Instability

Housing instability can worsen[1201] or contribute to the development of behavioral health conditions,[1202] and housing insecurity and homelessness are also associated with a higher chance of being in the child welfare system. For example, one study estimated that 25 percent of children experiencing homelessness in the U.S. have either been in the foster care system or will be.[1203] The U.S. Department of Housing and Urban Development (HUD) estimates that if families had "adequate housing", this would prevent almost 30 percent of all child welfare cases.[1204]

Barriers to Parents Accessing Needed Behavioral Health Supports Lead to Negative Consequences for the Whole Family

Children with parents with behavioral health conditions are overrepresented in the child welfare system.[1205] Over a third of children enter foster care in part due to circumstances surrounding a parent's substance use condition.[1206] These parents may also face other exacerbating factors including DV/IPV, being a single parent, stress, poverty, or interaction with the CJ system that can further increase their risk of interacting with the child welfare system.[1207] Other

circumstances include poverty, which can prolong parental SUDs, namely through barriers to accessing treatment, such as limited transportation and a lack of child care.[1208] These parents are also more likely to not have an adequate family or social support network that can step in if the parent is facing a behavioral health crisis, leading the child welfare system to step in instead.[1209]

Over a third of children enter foster care in part due to circumstances surrounding a **PARENT'S SUBSTANCE USE CONDITION**

When it comes to receiving treatment for their behavioral health conditions, some parents may be reluctant to do so considering the criminalization of poverty, the stigmatization of behavioral health conditions, and the identity-based discrimination many parents with low incomes already face when seeking help or support. Parents are often met with what can feel like impossible choice, between improving their own well-being and health or preserving their family's stability, so they may be less likely to seek out mental health or substance use treatment than their counterparts without children because of well-founded fears that seeking help may lead to their children being taken away. For example, a study in New Jersey found that African American parents faced a specific risk of having their children taken away due to any parental drug use—even if there were no other abuse, neglect, or abandonment factors—especially if they used public hospitals.[1210] Even if a parent does seek out support, the services provided need to be multigenerational and address the effects of the parent's behavioral health condition on the rest of their family in order to be most effective; however, that is unlikely to be the case.[1211] When families cannot access needed, holistic behavioral health services and supports, this creates ripple effects like their children facing a greater risk of experiencing negative externalities such as toxic stress.[1212]

Grandparents Step in as Caregivers, But Lack the Same Legal Rights

The child welfare system is not set up to work with non-normative family structures and lacks the capacity to utilize opportunities for alternative arrangements to outright family separation, even when they may exist. For example, with the deepening of the opioid crisis, many grandparents have stepped in as caregivers for children of parents with behavioral health conditions. As of 2016, about 2.5 million grandparents were responsible for meeting their grandchildren's fundamental needs; these grandparents were more likely to experience poverty.[1213] These numbers are higher in states with higher rates of opioid prescribing, with the greatest concentration in Southern states.[1214] However, many grandparents do not have the same custodial or guardianship rights as licensed foster care providers, which means they cannot make decisions about their grandchildren's behavioral health treatment.[1215] It is estimated that for every child staying in foster care with relatives, there are 20 more children living with relatives who are not licensed providers.[1216]

Adverse Experiences Increase Likelihood of Child Welfare System Involvement

In comparison to the general population, children in the child welfare system are more likely to have experienced at least four ACEs.[1217] Adverse experiences, including ACEs, increase the likelihood of child welfare system involvement and child welfare system involvement may increase the likelihood of having ACEs (see the "Social Determinants of Health and Compounding Factors, Adverse Experiences" section for more information). Children entering the child welfare system are more likely to have higher ACE scores.[1218] In fact, some ACEs—such as experiencing abuse or neglect, neighborhood violence, domestic violence in the household, the passing of a parent, divorce or separation of one's parents, and the SUD, mental health condition, or incarceration of a household member—may be the cause of a child entering the

child welfare system.[1219] DV may also put children at risk of increased contact with the child welfare system and of experiencing behavioral health conditions, including further DV/IPV in other relationships and teen pregnancy.[1220] Further, experiences within the child welfare system may be traumatic. For example, removing children from their primary caregivers—even for a short period of time—can be traumatic in itself.[1221]

CHILD WELFARE SYSTEM-RELATED FACTORS THAT CONTRIBUTE TO HARMFUL HEALTH & OTHER OUTCOMES

Interacting with the child welfare system can exacerbate or lead to behavioral health and related challenges for children and families. Because of the structural challenges discussed previously, certain populations may experience adverse consequences. Below, some of these groups are profiled.

Children of Color Involved with Child Welfare System May be Less Likely to Receive Behavioral Health Treatment

The incidence of behavioral health conditions for children in the U.S. varies somewhat across racial and ethnic groups (about 11-12 percent for African American and white children, and seven percent for Latinx children).[1222] However, children of color face unique challenges associated with a higher risk of developing or worsening behavioral health conditions. These include living in a lower-income household, factors related to family structure (which can include parental age of child-bearing, marital status, and paternal involvement, among others), a higher chance of facing ACEs, and neighborhood and social stress.[1223] They are also less likely to be diagnosed with behavioral health conditions, such as ADHD, than white children.[1224] Accordingly, the rates of treatment vary by race, as white children were more than twice as likely to visit a mental health specialist compared to African American or Latinx children (5.7 percent versus 2.3 percent).[1225, 1226] This could be related to the general societal stigma around African American and Latinx people's behavioral health, along with stigma within their own racial/ethnic communities.[1227] Children of color also face cultural barriers to health care, such as language barriers.[1228, 1229] Young African American males, in particular, face "cultural mistrust" and may feel that behavioral health professionals do not listen to them and thus are less likely to trust the professionals.[1230, 1231] Studies suggest that treatment by doctors of the same race can mitigate cultural mistrust.[1232, 1233]

Similar patterns of disparity exist within the child welfare system. Evidence suggests that up to 50 percent of children of color in foster care for at least a one and a half years were reported to be in poor health, including mental health and developmental conditions.[1234] Yet, children in foster care are less likely to have their health care needs met.[1235] A 2006 study found that children in foster care were the most medically underserved population in the US.[1236] Latinx and African American children in the child welfare system are less likely to receive mental health services, such as counseling and psychotherapy, than white children, even if they have similar rates of behavioral health conditions.[1237, 1238] This inequitable access to treatment and services increases as a child's time in the child welfare system increases.[1239]

Gender Influences Experiences with the Child Welfare System

Girls are more likely to experience abuse and neglect and be in the child welfare system than boys.[1240] One study found that 41 percent of girls with some contact with the foster care system faced behavioral health problems, such as depression, impulse control, or hyperactivity; 55 percent experienced trauma.[1241] These conditions can have broader effects, as one study found that girls in the child welfare system exhibited an average of 1.7 school functioning-related

problems, such as skipping school, physical fights with other students, and failing a class, in the past year.[1242]

Teen mothers and their children also face unique risks of contact with the child welfare system and developing behavioral health conditions. Girls in foster care are almost twice as likely to face pregnancy and may experience multiple pregnancies before age 19, further elevating their risk of facing behavioral health conditions throughout and after pregnancy.[1243] According to the Children's Hospital of Philadelphia, teen mothers with a history in the child welfare system experience high rates of mental health conditions prior to the birth of their baby and are more likely to stop postpartum mental health care.[1244] Abuse and other adverse conditions faced during teen pregnancies can make it more likely for teen mothers' children to be placed in foster care.[1245] Another layer of care may be needed to meet the behavioral health needs of the teen mother and the needs of the child.[1246]

Though trafficking victims are of varied genders, the vast majority of trafficking victims in the U.S. are women and girls.[1247] Research has shown that at least 50 percent of girls involved in the commercial sex trafficking industry were previously involved with the child welfare system;[1248] in 2013, 60 percent of child sex trafficking survivors found through Federal Bureau of Investigations (FBI) raids had been in foster care or group homes.[1249] Many of these girls may have already experienced trafficking before they entered the system and may require specialized services.[1250] The behavioral health conditions trafficking victims may face include "PTSD, panic attacks, OCD, GAD, MDD, dissociative disorders, and SUD."[1251]

LGBTQ Youth Face Unique Barriers to Care in the Child Welfare System

At least 23 percent of youth in foster care identify as LGBTQ.[1252] LGBTQ youth are as much as two times more likely to be in the foster care system, as many face familial rejection, neglect, and abuse.[1253] LGB youth who experience family rejection are nearly eight times more likely to attempt suicide, six times more likely to have depression, and three times more likely to abuse illegal drugs, with Latinx boys at a particular risk.[1254] Many LGBTQ youth face discrimination within the child welfare system or within the health care system.[1255] A Human Rights Campaign report found that only 13 states and the District of Columbia have enacted regulations that prohibit discrimination against foster youth based on gender identity and sexual orientation; seven other states only do so for sexual orientation.[1256] LGBTQ youth experience higher rates of placement changes and lower rates of permanency, which are both correlated with negative behavioral health outcomes and long-term prospects due to chronic stress.[1257] LGBTQ children in foster care are more likely to be hospitalized due to their behavioral conditions as well.[1258]

LGBTQ girls of color, in particular African American girls, have been diagnosed with behavioral health conditions for reasons such as fighting in school.[1259] After their diagnosis, they have been prescribed high levels of psychotropic drugs—potentially an outsize response rooted in bias;[1260] such trends are likely to be replicated in the child welfare system, where psychotropic drugs are also overprescribed.[1261] LGBTQ experiences within the child welfare system may have more long-term effects such as homelessness: in a 2006 sample of 400 LGBTQ homeless youth in San Diego, California, 65 percent reported that they had been in a child welfare placement in the past.[1262]

Geography Affects Incidence of Behavioral Health Conditions & Access to Care Within Child Welfare System

Geographic disparities in behavioral health persist within the child welfare system. Studies have found disparities in regional mental health care for children in foster care; some of the barriers these children face include mental health stigma,[1263] a lack of culturally and linguistically competent providers, and a lack of transportation.[1264] Children in the child welfare system in rural areas were more likely to be given psychotropic drugs, especially if they came from low-income families.[1265] Children diagnosed with maltreatment in rural areas were more likely to be diagnosed with ADHD than children with the same diagnosis in urban areas.[1266] One study of children in the child welfare system found that those with prenatal substance exposure from rural areas were more likely to have co-occurring mental health disorders, especially anxiety and mood disorders, than children from urban areas.[1267]

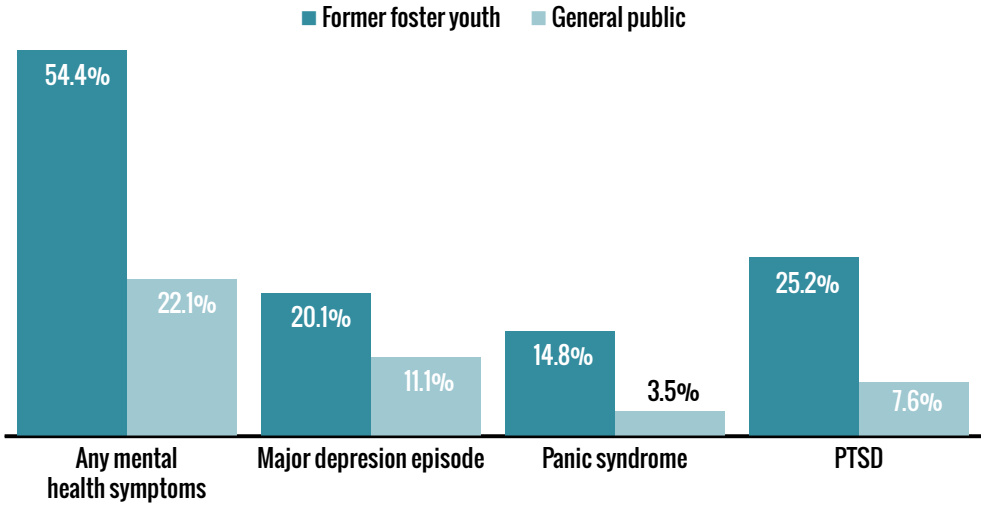
Aging Out of the Child Welfare System Can Exacerbate Behavioral Health Conditions

Aging out of the child welfare system—often reaching age 18 with no permanent placement—places youth at risk of developing or exacerbating behavioral health conditions.[1268] Twenty-five states and the District of Columbia provide foster care services past age 18 under the Fostering Connections to Success and Increasing Adoptions Act of 2008.[1269] Other states provide independent living services until age 21 and the option to provide state-funded extended foster care.[1270] The aged-out population still face unique challenges, as these individuals are less likely to graduate from high school and attend or graduate college.[1271] Twenty percent of these children will experience homelessness as soon as they age out, and 70 percent of girls who age out will become pregnant before they are 21, putting them and their children at risk of exacerbating or developing behavioral health conditions.[1272]

People who age out of the child welfare system face significant barriers to behavioral health care. About 15 percent of foster youth ages 17-25 experience PTSD, nearly double the percentage of youth who faced PTSD when they were aging out.[1273] An average of 17 percent of youth close to aging out may experience depression, and an average of 17 percent of youth who aged out experience an AUD or another SUD within a year of turning 21.[1274] Aging out can also mean a discontinuation of the behavioral health services received while in foster care because of barriers such as a lack of health insurance, transportation, and difficulty finding a provider or scheduling appointments.[1275] Because of their behavioral health conditions, securing a job and acquiring adequate housing may be a challenge.[1276]

FIGURE 5b. Youth who have aged out of foster care face higher rates of behavioral health conditions than the general public

Behavioral health condition rates among former foster youth in Washington & Oregon in past 12 months



Note: PTSD stands for Post-Traumatic Stress Disorder.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Adapted from Pecora, P. J., et al. "Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges." *Child Welfare,* 88(1): 5, 2009. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3061347/.

Behavioral Health Conditions & Challenges

Many children in the child welfare system experience behavioral health conditions, and only a subset receive related services and supports. The Center for Health Care Strategies found that one-third of foster care children enrolled in Medicaid receive behavioral health services, compared to 1 in 15 Medicaid-enrolled children in general.[1277] The number of children in the system who need behavioral health care but do not receive it is likely even higher because of a lack of access to behavioral health services.[1278] Even when services are provided, an HHS survey of the child welfare agencies in all 50 states, Washington, D.C., and Puerto Rico found that 91 percent of agencies still needed to improve the quality of their mental health services.[1279]

This section discusses the environmental impacts that contribute to the development of behavioral health conditions in children who come into contact with the child welfare system and descriptions of the behavioral health conditions themselves. Unfortunately, no reliable data exist on the prevalence of mental health conditions and SUDs prior to interactions with the child welfare system. The child welfare system is designed in such a way that localities, states, and the federal government all have varying systems for collecting data on people as they enter into the system. Most systems do not collect data on whether their populations have had a prior diagnosis or past mental health care.[1280]

TOXIC STRESS & TRAUMA

Toxic stress is common for children within the child welfare system because placement in the child welfare system is often a result of exposure to situations that result childhood stress and

trauma.[1281] Toxic stress is particularly harmful for youth with a family history of mental health conditions.[1282]

Untreated trauma can contribute to the onset of other mental health conditions. The combination of symptoms and stress from trauma result in higher risks for negative outcomes, including school dropout,[1283] homelessness,[1284] and unemployment.[1285] Many negative outcomes can be attributed to poor social supports, placement disruption, negative placements, and age of placement.

While risk factors like exposure to toxic stress result in negative outcomes, increasing protective factors for children can help build resiliency.[1286] Children who are taught healthy ways to adapt to their environment experience increased cognitive capacity, healthy attachment within relationships, and better behavioral control.[1287] Children between ages 6-17 with multiple ACEs who "learned to stay calm and in control when faced with challenges are over three times more likely to be engaged in school compared to peers with multiple ACEs who have not learned these skills."[1288]

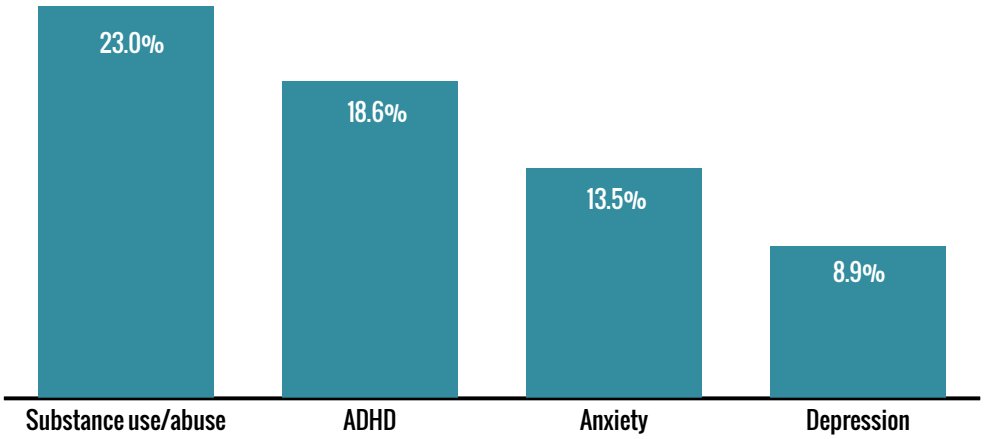
MENTAL HEALTH

Rates of mental health conditions are higher among children within the child welfare system. For example, one study found that, regardless of placement, 43 percent of children in the child welfare system reported one mental health condition.[1289] Children in the child welfare system also had high rates of concurrent conditions.[1290] Nearly one-third had two concurrent mental health conditions and 20 percent had three or more concurrent conditions.[1291, 1292] These numbers may be even higher for children in foster care specifically.[1293] These trends persist into adulthood (see Figure 5c). A study of adults ages 20-33 who aged out of foster care found that within the past year, they were more than two times more likely to have mental health symptoms than the general public (54 percent versus 22 percent).[1294]

A 2011 study found that 34 percent of foster youth used behavioral health services that year.[1295] Foster youth were also three times more likely to use behavioral health services than children not in foster care.[1296] However, youth in the foster care system are prescribed psychotropic drugs at higher rates than for the general population of children and at dosages higher than are deemed safe.[1297] Infants within the system have also been prescribed psychotropic drugs, which has no medical basis.[1298] Foster youth may be over-hospitalized. One study in Illinois found that hundreds of children were still in psychiatric hospitals even though they had been cleared to leave the child welfare system because the Department of Children and Family Services was unable to find a placement for them.[1299]

FIGURE 5c. Children in contact with the child welfare system experience high mental health & substance use disorder rates

Behavioral health condition rates among children in contact with the child welfare system, 2008-2009



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from Heneghan, et al. "Mental Health Problems in Teens Investigated by U.S. Child Welfare Agencies." *Journal of Adolescent Health,* 52(5): 634-640, 2013. Available at https://www.sciencedirect.com/science/article/pii/S1054139X12007033.

Common Mood Disorders

Some of the most common mood disorders among children in contact with the child welfare system are profiled below.

Anxiety & PTSD

Children are often placed in the foster care system because of exposure to situations that result in trauma. About 14 percent of children in the child welfare system experience anxiety.[1300] Anxiety, (specifically panic disorders) was more than four times as common for foster care alumni (21 percent versus five percent) and PTSD was almost four times higher among this population (30 percent versus eight percent).[1301] Among foster care alumni, 83 percent had at least one mental health diagnosis,[1302] and 22 percent met the diagnostic requirements for PTSD.[1303] When screening processes are implemented, researchers find that the rates are even higher. For example, up to 40 percent of youth entering Connecticut's child welfare system who were screened met the criteria for PTSD.[1304] While little data exist on youth within the child welfare system and their experiences with bipolar disorder, many of the hallmark symptoms of mania can appear with other conditions commonly experienced by children in the child welfare system. For example, people with a history of sexual abuse may act hypersexually, and PTSD may lead to extreme risk-taking or aggression.[1305]

Among foster care alumni, **83 PERCENT** had at least **ONE MENTAL HEALTH DIAGNOSIS**

Depression

An study on adolescents in the child welfare system found that 42.7 percent of teens reported having one mental health problem and nine percent reported having depression.[1306] Studies of foster youth ages 11 to 17 found that 15 percent had an MDD, while foster youth ages 17 and up had a lifetime prevalence of MDD of 10.5 percent.[1307] Another study found that foster care alumni had a lifetime rate of 41 percent versus 21 percent for the general public (see Figure 5b).[1308] Risk factors for depression include abuse

of any type,[1309] witnessing or being the target of violence,[1310] sudden death of a close relation,[1311] separation from parents,[1312] poor social networks/social isolation,[1313] and genetic predisposition, many of which are experienced by children in contact with the child welfare system. Exposure to or possession of three of the aforementioned psychosocial risk factors in the prior year puts an adolescent at high risk for depression.[1314]

Other Common Mental Health Conditions & Related Outcomes

In this section, some other common mental health conditions experienced by children in contact with the child welfare system are profiled. Little data exist on youth within the child welfare system and their experiences with psychosis specifically. However, either the death of a parent or long-term separation from one before age 17 is associated with a two to three times higher risk of experiencing psychosis.[1315] Studies have found a close relationship between childhood abuse and psychotic symptoms.[1316] According to the Centers for Disease Control and Prevention (CDC), nationally, 9.4 percent of children between the ages of 2 and 17 had ever had an ADHD diagnosis,[1317] while for children in the child welfare system that number is around 19 percent,[1318] depending on the survey.

Additionally, suicide is one of the leading causes of death for adolescents,[1319] and increased suicidal ideation risk is correlated with interaction with the child welfare system. A meta-analysis of studies investigating suicides in individuals ages 14 years and younger found that between 20 to 25 percent had contact with child welfare institutions.[1320] Out-of-home placements further increased the risk of suicidal ideation.[1321] For youth in foster care, suicidal ideation ranges from 7 percent to 27 percent while rates of suicide attempts range from 8 percent to 15 percent, which is three to nine times higher than the rates of the general population.[1322]

SUBSTANCE USE

Demographic (including gender and age), psychosocial (including mental health conditions), and contextual factors (including a history of abuse), put youth in the child welfare system at specific risk of substance use.[1323] Other strong risk factors include peer or sibling substance use and older age when they come into contact with the system.[1324]

Research suggests substance use and diagnosable SUDs are higher among youth in the child welfare system than in the general youth population. For example, a 2012 study found high rates (17 percent) of illicit substance use within people ages 11 and over in the child welfare system as compared to eight percent in the general population.[1325] Data from 2009 also indicate that 10 percent of youth ages 11-17 in the child welfare system had used cigarettes and 19 percent had consumed alcohol in the previous 30 days,[1326, 1327] higher than youth in that age group generally; 23 percent had either used or abused alcohol in a three-year period.[1328] Beyond the immediate harm caused by underage alcohol use, children who consume alcohol regularly are at risk for issues in brain growth and development.[1329] Additionally, consumption of alcohol before the age of 15 leads to a six-times-greater lifetime risk of alcohol dependence than adults who start drinking at age 21.[1330] About 17 percent of youth who age out of the foster care system experience an AUD or other SUD after turning 21.[1331]

SUDs concerning opioid use have recently drawn national attention. Though they are not the primary drug causing children's interaction with the child welfare system,[1332] they have put disproportionate pressure on the child welfare system's resources and will likely continue to put pressure on the system in the coming years. In communities hardest hit by the opioid epidemic, the effects have been multigenerational. In some cases, agencies, hard-pressed to find substitute

caregivers for children, have had to deem children wards of the state at higher rates.[1333] States that have seen an increase in the number of children in foster care due to the epidemic include Ohio, Oregon, North Dakota, and California.[1334]

Recommendations

This section describes ongoing, innovative efforts that combine clinical and non-clinical strategies for families at risk of contact with the child welfare system and families who are already within it. The section also examines federal, state, and local strategies for effectively addressing the risk factors that can put families in contact with the child welfare system and addressing the behavioral health needs of children within the system and the children who have aged out. These interventions described here show positive impacts on the behavioral health of parents, guardians, and children.

1. CHANGE THE SYSTEM FROM CHILD WELFARE TO FAMILY WELL-BEING

The child welfare system must undergo a systems change to improve outcomes for families within the system.[1335] Child welfare interventions should not penalize families for un- or under-addressed behavioral health conditions or economic disadvantage. The shift will include a strengths-based orientation and trauma-informed approach, affirming that the whole family deserves support. Relevant stakeholders who can change their orientation towards family well-being include public agencies, nonprofit community-based organizations, birth and foster parents, advocates, such as kinship navigators, individual assessors, the child welfare and mental health workforces, faith communities, the court system,[1336] regional administrators, judges, and national organizations. This approach will involve service providers working closely with family members in decision-making throughout their involvement with the child welfare system, helping families identify and achieve their goals through permanency services.

Model(s)

One example of moving from child welfare to family well-being is Shared Family Care, a whole-family foster home program in Contra Costa County, California. Families at greatest risk of family separation, or who are currently separated and in need of a safe place for reunification are placed with parents and children together in the home of a foster family trained to mentor, support, and teach parents the skills needed to care for their children independently, including job coaching, meal preparation, and routine-setting.[1337] Shared Family Care increases employment and income levels and reduces recidivism of families into the child welfare system.[1338]

Financing

The Family First Prevention Services Act (FFPSA)[1339] has shown one path that can be used to provide more continuity of care for families and to keep families together. Elements from the FFPSA that are geared toward family well-being include increasing foster family care, using preventive dollars to prevent re-entry into the system, using early intervention services such as behavioral health treatment and in-home parent skill building and family counseling, and having family engagement in residential-based treatment, such as for SUD, for 12 months of services. Additionally, funding for courts should require contracts with health care providers to provide effective family supports to address behavioral health.

2. PROVIDE COORDINATED PREVENTIVE SUPPORT SYSTEMS FOR FAMILIES

Preventive coordinated support systems for at-risk families could help prevent and manage behavioral health crises that contribute to child welfare system involvement. For example, hotlines for at-risk families, foster families, and foster youth can provide advice, services, conflict resolution, and support in order to specifically reach families before they are in the child welfare system. Also, digital portals could be developed as a one-stop shop for families to find information about services, including parenting skills, behavioral health interventions, and other resources that are trauma-informed and culturally competent.

Model(s)

One model is the Family Urgent Response System, a 24-hour hotline accompanied by mobile response units available specifically for foster families and former foster youth up to 21 years old.[1340] California proposed such a hotline, but has not yet passed it into state law, while New Jersey has implemented it.[1341]

3. PROVIDE CULTURALLY COMPETENT SUPPORT FOR FAMILIES

Culturally competent services are frequently unavailable to families within the child welfare system. For example, in Illinois, there have been many cases of children with Spanish-speaking birth parents being placed in out-of-home placements where Spanish is not spoken, which can break a bond shared between the child and their parent.[1342] The lack of culturally competent staff can lead to further child harm, as staff were unable to properly identify some cases of child maltreatment.

Model(s)

There are promising, community-based models for providing culturally competent care to families. Two organizations that provide culturally competent parental support are Asian Health Services,[1343] an FQHC and Asian Perinatal Advocates, both in California. To prevent child abuse and neglect, Asian Health Services has behavioral health specialists on staff and provides peer support and education around parenting for young mothers during well-baby appointments.[1344] There were also behavioral health specialists on staff. Asian Perinatal Advocates' services include in-home visits,[1345] a crisis hotline,[1346] therapy,[1347] and activities that help parents bond with their child.[1348] For families already within the system, the program helps provide monitored visits in a safe environment for foster children and their biological parents, along with case management, which can help connect families to economic security programs and parenting resources.[1349] A case study on the Asian Health Services program model found the parental support program contributed to increased face time between parents and pediatricians, as well as stronger parental peer networks.[1350]

More can be done within FFPSA to specifically promote programs and services adapted to culture and context of tribal communities. For example, decision-makers should consult tribes in AIAN communities as reforms to FFPSA are implemented and set aside specific funds for training tribal relations staff in cultural competency.[1351]

Financing

Medicaid and other payers should cover effective family-centered and culturally-responsive interventions to promote family well-being and prevent child welfare contact, and these services should be coordinated through both maternity care and primary care for children and adults. Courts should also be culturally competent and connect families to responsive preventive services that are proven to be effective for particular communities, or across diverse cultural groups.

4. INTEGRATE PRACTICES PROMOTING CONTINUOUS IMPROVEMENT IN THE CHILD WELFARE SYSTEM

Practices that promote continuous improvement by evaluating interventions so providers know which interventions work best and rapidly scaling what works should be widely used in the child welfare system. One example is a quality service review, which has been used by a few states and localities. A randomized, voluntary quality service review for youth can assess many factors, including their risk of behavioral problems and their emotional well-being.[1352] The review includes the case file and interviews from all relevant people from the child's journey through the system, including their behavioral health service providers.[1353] The review team then rates and offers feedback to the local staff on how to implement changes to better help their clients.[1354] This allows staff and providers an outside, real-time look at how the system is working or not, allowing for local knowledge sharing and system-wide improvement.[1355] Such reviews have been done in New Jersey, the District of Columbia, and Montgomery County, Maryland,[1356] and should be expanded further into other states and localities.

5. IMPROVE HOUSING FOR PEOPLE INVOLVED WITH THE CHILD WELFARE SYSTEM

Housing assistance should also be provided for individuals and families throughout their interaction with the child welfare system. When families first become involved with the child welfare system, there should be opportunities for them to receive supportive housing. A 2012-2017 demonstration by HHS called "Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System" provided housing subsidies and various types of assistance such as education, parenting services, employment services, DV services, and transportation services to a treatment group.[1357] Both the treatment and control group received behavioral health services at around the same level. Treatment group families saw higher rates of housing stability and quality a year after the program started and faster and higher rates of family reunification and parent-child bonding, suggesting that supportive housing programs such as this should be further expanded in partnership with child welfare agencies.

Financing

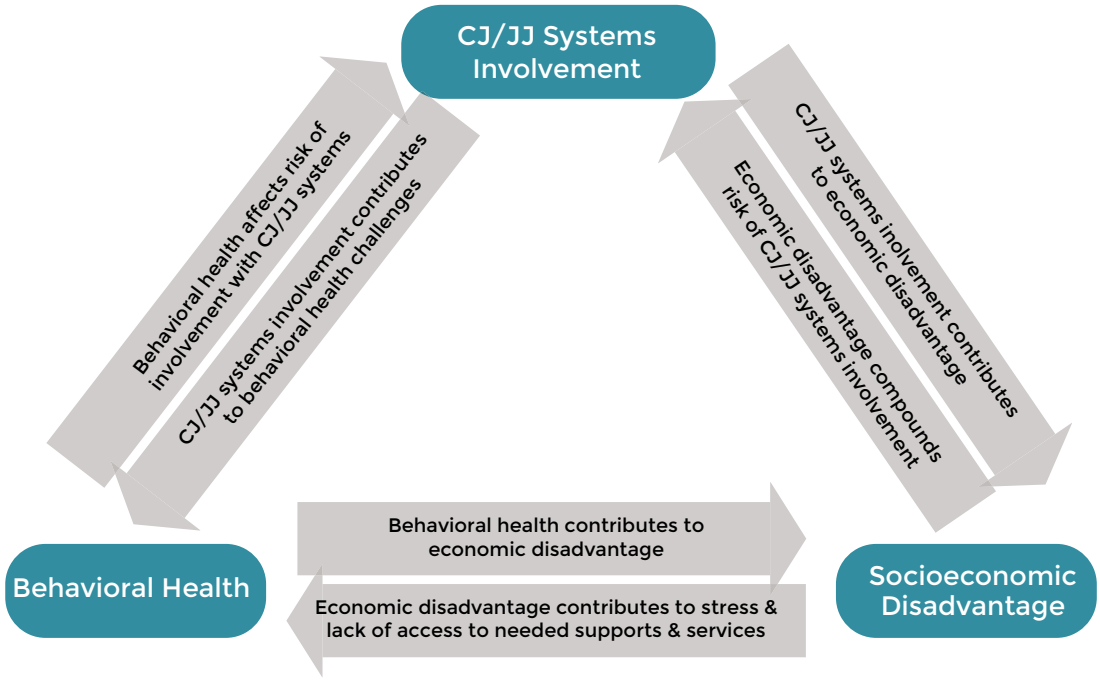
Flexible funds should be made available for local jurisdictions to provide the first or last month rent to ensure consistent housing, and develop housing plans for people previously involved with the child welfare system so that they do not experience housing instability once they are out of the system, which would exacerbate any behavioral health conditions. Such a strategy has been implemented in localities such as Philadelphia.[1358]

VI. OPPORTUNITY AREA: Behavioral Health & Criminal Justice/ Juvenile Justice (CJ/JJ)

Addressing our nation's behavioral health needs requires special attention to the CJ/JJ systems, both of which are undergoing significant reform as it is. This chapter provides a brief overview of both the CJ and JJ systems, before exploring demographic, economic, and other factors that risk placing people at the intersection of justice system involvement and behavioral health challenges. The chapter then provides background on mental health and substance use conditions that are common among people involved with the justice system. Lastly, it outlines several key recommendations to improve the behavioral health of people involved with the two systems.

FIGURE 6a. Socioeconomic disadvantage contributes to behavioral health challenges & CJ/JJ systems interaction

Relationship between CJ/JJ systems involvement, socioeconomic disadvantage, & behavioral health



Note: CJ stands for Criminal Justice; JJ stands for Juvenile Justice.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

Overview of Criminal Justice & Juvenile Justice Systems

The CJ system is a patchwork, with federal, state, or local government jurisdiction depending on the crime committed (see Figure 6b).[1359] The JJ system functions similarly, holding youth up to age 17 in 45 states, and up to age 16 in the other five states currently (unless the youth is prosecuted for a more serious crime, such as murder or a violent felony, and they are tried as an adult, which is applicable in all states and the District of Columbia).[1360, 1361]

For many, the first point of contact with the CJ system is law enforcement. The breadth of what law enforcement encompasses is expansive: police, immigration enforcement, school resource officers (SROs) and the like—all professionals who often lack the necessary training to interact

constructively with people facing behavioral health conditions[1362] (for more discussion on the connection between the child welfare system and the CJ/JJ systems, see Chapter V). After interacting with law enforcement, youth or adults may then go through the judicial system (where they may face risk assessments, which could be racially biased[1363]) and find themselves in the corrections system (see Figure 6a).[1364] The U.S. CJ system and law enforcement has systematically and disproportionately targeted people of color, particularly African Americans, dating as far back as the end of slavery in 1865.[1365] One of the earliest examples was the "Black Codes," which criminalized poor African Americans for offenses such as vagrancy.[1366] Because the CJ system is based on this legacy of discrimination and economic disadvantage, African Americans, as well as Latinx people and Native Americans,[1367] continue to be incarcerated at higher rates than the general population.[1368]

TREND OVERVIEW

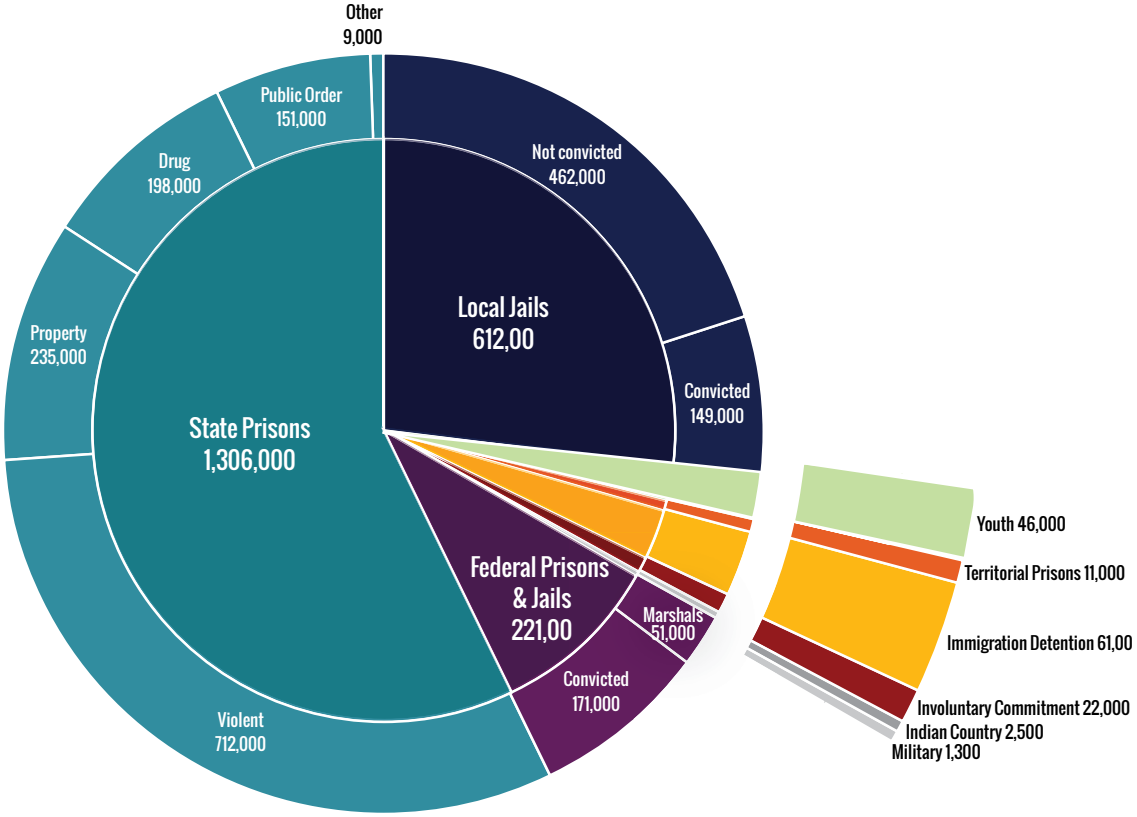
Even though crime rates have declined, arrest rates for certain crimes have actually increased. Between 1980 and 2014, the U.S. incarceration rate increased by over 220 percent.[1369] The growth in incarceration is due in part to harsher sentencing and enforcement policies and increases in arrest rates for drug crimes.[1370] For example, even though police technology and management have changed significantly since 1980, "the ratio of arrests to crimes for the major crime types handled by states and localities has shown little change."[1371] During the same time, the crime rate likely declined due to numerous factors including "demographic changes, changes in policing tactics, and improving economic conditions."[1372] The U.S. incarceration rate is four times the global average and higher than any other country in the Organisation for Economic Co-operation and Development (OECD); no country incarcerates more people than the U.S.[1373]

Between 1980 and 2014, the U.S. **INCARCERATION RATE** increased by over **220 PERCENT**

From 2007-2017, the U.S. imprisonment rate declined by about 13 percent.[1374] Rates of juvenile incarceration also have decreased since 2001.[1375] These trends resulted from efforts to reduce juvenile arrests and policy reforms to reduce adult prison admissions and lengths of sentences in a handful of states.[1376] As of 2019, there are more than 2.3 million incarcerated individuals in the U.S.,[1377] at least another 4.7 million people on probation and parole (since 2015),[1378] and numerous others who face barriers in obtaining credit, housing, public benefits, and employment and are subject to practices such electronic monitoring,[1379] which could have implications for behavioral health as well. The vast majority of incarcerated people are at the state and local level (91 percent).[1380] The majority of incarcerated people in state prisons who are serving time for more than a year are there for violent crimes,[1381] while about 47 percent of people in federal prisons are serving sentences for drug offenses.[1382] Private prisons incarcerated about 128,000 additional people in 2016.[1383] The recidivism rate for state prisons is 37 percent over a three-year span and dropped by 23 percent from 2005-2015.[1384] For federal prisons, the rate is 49 percent over eight years.[1385]

FIGURE 6b. All levels of government have responsibility for the behavioral health of people who are incarcerated

The composition of prisons & jails at different levels varies, 2019



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Adapted from Sawyer, Wendy, & Peter Wagner. "Mass Incarceration: The Whole Pie 2019." Prison Policy Initiative, 19 March 2019. Available at https://www.prisonpolicy.org/reports/pie2019.html.

At-Risk Populations & Factors

This section discusses populations that are at particular risk of adverse outcomes due to the intertwined nature of behavioral health, socioeconomic disadvantage, and the CJ/JJ systems. Specifically, the section considers factors that a) increase the risk of involvement with the CJ/JJ systems in the first place, and b) contribute to harmful health and other outcomes once individuals and families become system-involved. These populations are more likely to face challenges ranging from economic insecurity to unmet behavioral health needs to discrimination based on identity and lived experiences—all of which increase the likelihood of interacting with the CJ/JJ systems.

FACTORS THAT INCREASE RISK OF INVOLVEMENT WITH CJ/JJ SYSTEMS

There are various factors that can influence whether children and families face a greater risk of contact with the CJ/JJ systems. These factors include the criminalization of poverty and other socioeconomic risk factors, un- and underaddressed behavioral health conditions, and adverse experiences.

Economic Insecurity, Behavioral Health, & the Justice Systems are all Connected, Particularly Due to the Criminalization of Poverty

When poverty intersects with behavioral health conditions, it also heightens individual risk of interaction with the justice system.[1386] A lack of economic opportunity[1387] can be the impetus for committing some crimes and the reason one stays in contact[1388] with the justice system. The systemic criminalization of poverty has increased the number of people imprisoned for crimes related to their lack of financial resources.[1389] For example, the bail system and the systematic imposition of fines and fees for minor crimes disproportionately harm low-income families and individuals—many of whom are people of color—who cannot afford to pay.[1390] Homelessness is still criminalized by some local governments through laws against actions such as trespassing and public urination.[1391] Unaddressed mental health and substance use conditions can precipitate economic insecurity and homelessness, presenting overlapping challenges for many.

The systemic criminalization of poverty has increased the number of people **IMPRISONED** for crimes related to their **LACK OF FINANCIAL RESOURCES**

Post-release, the risk of continuing the cycle of poverty is omnipresent. This is true for individuals with a criminal record regardless of gender or race, due to barriers such as: employment and credit,[1392] reductions in lifetime earnings, less access to health care and necessary medications,[1393] and ineligibility for public assistance programs, such as cash assistance, SNAP, and Section 8 Housing Vouchers.[1394, 1395] Individuals with behavioral health conditions may have lower employment rates once released;[1396] unemployment is associated with a higher risk of recidivating.[1397] Due to multiplied challenges, they also face a higher risk of having a drug overdose post-release, compared to individuals who more easily or quickly become re-integrated into society.[1398] Access to behavioral health treatment is also limited, especially if it is provided through public assistance programs, providing yet another barrier to re-integration.[1399]

Disability

People with intellectual, cognitive, or developmental disabilities are more likely to come into contact with the CJ system as victims and suspects and offenders than people without disabilities.[1400] They are overrepresented in the CJ system compared to their share of the general population.[1401] This trend is due to an overcriminalization of people with disabilities, starting from a young age. For example, students with disabilities made up just 12 percent of students in general, but made up 25 percent of students that were arrested or referred to law enforcement.[1402] Once within the justice system, exposure to factors such as untrained police and solitary confinement may worsen the mental health of individuals with intellectual disabilities further, particularly if staff do not have appropriate training and/or no treatment is administered at all.[1403, 1404] While incarcerated, individuals with intellectual disabilities may develop new psychological symptoms and have suicidal ideation,[1405] a pattern similar in juvenile facilities, which include youth with developmental disabilities.[1406] A Pennsylvania study found that in the majority of county jails, individuals with intellectual disabilities were likely to reoffend an average of two to four times post-incarceration, due to reasons such as drug and alcohol abuse, committing minor crimes, and increased barriers and a lack of resources, such as health care.[1407]

Housing

A lack of stable housing is also associated with CJ system involvement[1408, 1409] and behavioral health conditions for both youth and adults.[1410] A recent study found that 44 percent of runaway and homeless youth had been incarcerated at some point, often due in part to a lack of

economic resources.[1411] A lack of stable housing can be the cause of a youth's arrest for crimes such as truancy.[1412] Within the system, incarcerated individuals with a behavioral health condition were more likely to have experienced homelessness in the year before their arrest.[1413] They often lacked treatment while experiencing homelessness and once they were incarcerated.[1414] The cycle is likely to continue after released from prison because having a criminal record creates barriers to finding a job and stable housing.[1415]

Adverse Experiences Increase Likelihood of CJ/JJ System Involvement & Further Traumatization

Trauma is an underlying issue for many of the conditions discussed in this chapter. For example, many people in prisons and jails are themselves victims, and the crimes they are imprisoned for may have been committed in part as a result of the trauma they faced from when they were victimized.[1416] Research has linked adverse experiences to increased risk for physical health conditions, mental health conditions, substance abuse, repeat victimization, and risky behaviors across the lifespan (see the "Social Determinants of Health and Compounding Factors, Adverse Experiences" section for more information). Data collected between 2007 and 2012 from Florida found that each additional ACE was associated with an increased risk of the juvenile being involved with a serious or violent crime or chronically offending by more than 35 percent.[1417]

TRAUMA is so ubiquitous among people in contact with the justice system that it should be considered **UNIVERSALLY PRESENT**

SAMHSA advises judges that trauma is so ubiquitous among people in contact with the justice system that it should be considered universally present.[1418] The ways in which people interact with the behavioral health and CJ/JJ systems may contribute further to their trauma. Triggers for re-traumatization include, "strip searches, room searches that involve inspecting personal items, cuffs or restraints, isolation, sudden room changes, yelling, and insults."[1419] All these experiences trigger intense stress and may invoke habitual, self-protective responses, including violent outbursts and withdrawal from treatment.[1420]

DV/IPV

Low-income women, women of color, women with disabilities, and women who have formerly faced sexual or physical abuse are the most likely to face DV, and thus face an increased risk of interacting with law enforcement for DV-related crimes.[1421] Mandatory arrest procedures, designed to address the gaps in CJ protection for survivors of DV/IPV, may actually lead to survivors themselves being arrested, since at least one person must be arrested in response to a DV complaint.[1422]

In some cases, assailants also threaten women into participating in criminal activity,[1423] such as by using their knowledge of the CJ system's procedures or by threatening to turn the woman over to the immigration authorities.[1424] Victims of DV/IPV may also use violence against their partners as self-defense.[1425] Immigrant women who have experienced DP/IPV and may be eligible for permanent residence through the Violence Against Women Act of 1994 (VAWA) can be rendered ineligible because of a criminal conviction and be subject to deportation.[1426]

DV/IPV and behavioral health conditions, including depression, PTSD, SUD, and suicide are closely connected.[1427] For incarcerated survivors, there is often little or no transition planning as they are about to be released into the community.[1428] This can result in losing mental health services or prescriptions they may need.[1429] Lack of such health care may increase their risk

of reoffending or violating their conditions of release, which raises their likelihood of re-incarceration.[1430]

Parental Incarceration

Parental incarceration is associated with a host of factors mentioned in this chapter, including poverty and unemployment,[1431] parental SUD, DV/IPV, and other parental behavioral health conditions. For example, if a father is incarcerated, a family's risk of being in poverty increases by 40 percent.[1432] Parental incarceration's multigenerational effects also include negative mental health outcomes for children, such as depression and anxiety, and other negative outcomes, such as violent and anti-social behavior.[1433] Children of incarcerated parents are also more likely to come into contact with the JJ system, where they experience higher rates of behavioral health conditions than the general population.[1434] African American children are more likely to have a parent that is incarcerated than both Latinx and white children.[1435] When a parent is incarcerated, caregiving decisions for children have to be made based on that, which can lead to single parenting, grandparents or other chosen family members having to step in and provide care for these children (which one-fifth of these children do),[1436] or these children ending up in the child welfare system (see Chapter V for more information).[1437] These caregivers may be in need of behavioral health services themselves.[1438]

Community & Natural Environmental Factors

The built and social environment one grows up and lives in plays a key role in shaping mental health. Exposure to trauma, community violence, or adversity in the form of abuse, neglect, or economic hardship are contributing factors in developing a mental health condition.[1439] The factors that make up one's built and social environment are a combination of the physical, social, and environmental factors that make up a community, all of which have been shown to be relevant for crime rates. These factors range from community violence[1440] to housing design,[1441] neighborhood layout, land use patterns, neighborhood deterioration, neighborhood connection,[1442] and community resources. Another aspect is environmental justice-related factors such as pollution, which is associated with violent and interpersonal crime and economically-motivated crimes, among others.[1443] Children exposed to lead pollution are particularly likely to experience behavioral health conditions and are significantly more likely to have contact with the JJ system than children in general.[1444] Geographic segregation can also lead to different mental health outcomes based on race and income, as certain communities have "greater health resources, such as recreational facilities, green open spaces, mental health care providers, and lower crime rates."[1445]

CJ/JJ SYSTEM-RELATED FACTORS THAT CONTRIBUTE TO HARMFUL HEALTH & OTHER OUTCOMES

Interacting with the CJ/JJ system can exacerbate or lead to behavioral health and related challenges for individuals and families. Because of the structural challenges discussed previously, certain populations may experience adverse consequences. Below, some of these groups are profiled.

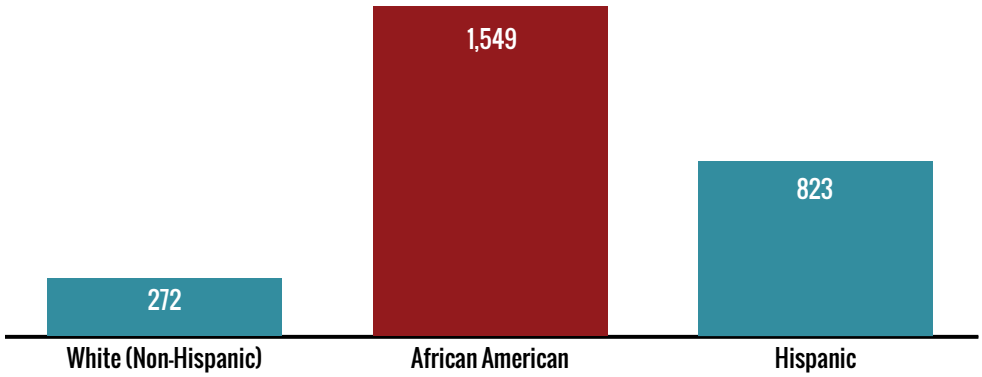
People of Color Are Disproportionately Incarcerated & Face Distinct Threats To Their Behavioral Health

As mentioned above, African Americans, as well as Latinx people and Native Americans,[1446] continue to be incarcerated at higher rates than the general population.[1447] As Figure 6c shows, the average incarceration rates for African Americans and Latinx people far outnumber the

rate for whites (by 5.1 and 1.4 times more, respectively).[1448] In fact, black men between the ages of 20 and 24 who did not graduate high school have a higher chance of being incarcerated than having a job.[1449] Additionally, many of the crimes committed by Native Americans are prosecuted federally since they take place on tribal lands, which generally means they face even harsher sentences than other communities of color.[1450] While Asian Americans appear to be underrepresented in the justice system, gaps in available data and a lack of data disaggregation may be obscuring the true rates.[1451] The causes of these present-day racial disparities can be attributed to a range of factors, including discriminatory policies (such as stop-and-frisk; disparate sentencing; and the targeting of certain offenses, like drug crimes), along with implicit bias and other structural factors mentioned in this chapter.[1452]

FIGURE 6c. Imprisonment rates for African Americans far outnumber Hispanics & Whites per 100,000 people

Imprisonment rates of sentenced prisoners at state or federal level per 100,000 adults, by race & ethnicity, 2017



Note: The data for African Americans presented includes only Non-Hispanic African Americans.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from Bronson, Jennifer, & Ann Carson. "Prisoners In 2017." Bureau of Justice Statistics, 25 April 2019. Available at https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6546.

People of color with behavioral health conditions are also more likely to come into contact with the system in the first place. For example, Native Americans are disproportionately arrested for alcohol-related offenses[1453] and do not have adequate access to alcohol abuse treatment; Native American youth have higher rates of alcohol use than youth generally.[1454]

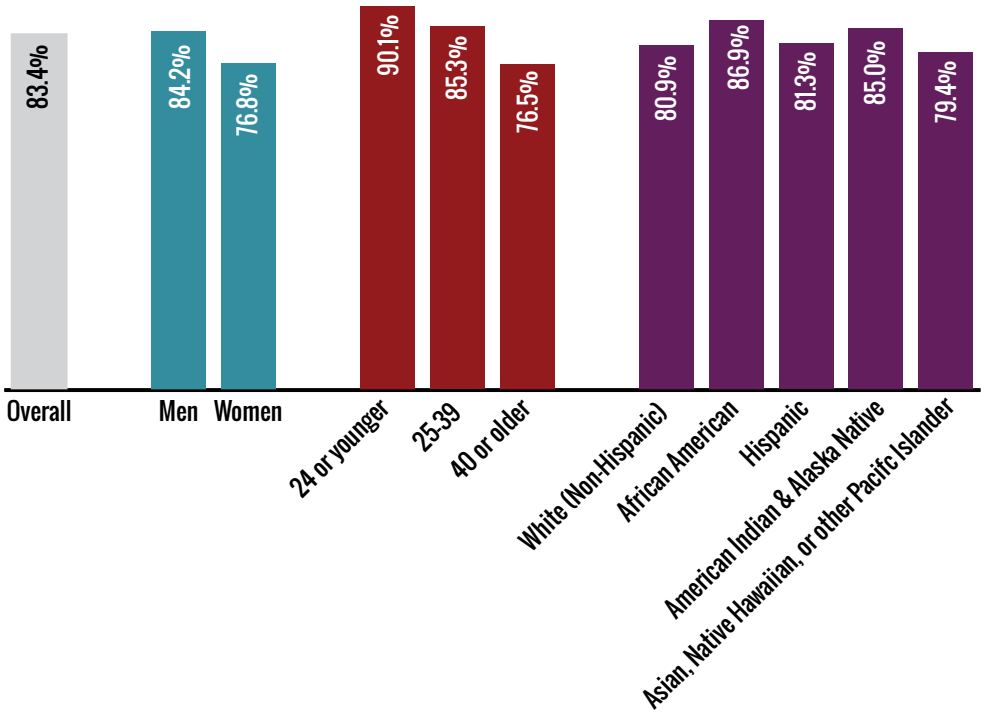
In recent years, law enforcement has engaged in targeted policing efforts based on race, ethnicity, and national origin. Such targeting may result in adverse behavioral health effects. Muslims have faced disproportionate surveillance and police contact since 9/11, along with an increase in Islamophobia and hate crimes,[1455] which has led to increased depression, anxiety, and paranoia within the community.[1456]

The post-release opportunities for individuals with behavioral health conditions differ by race. Among people in prison or jail already diagnosed with behavioral health conditions before release, African American and Latinx individuals are more likely to be arrested again within the next three years (see Figure 6d).[1457] This pattern holds among youth, as African American males with diagnoses had the shortest recidivism rates.[1458] African Americans and Latinx people are more likely to face stress regarding their transition back into society due to discrimination;

limited access to employment outside of high-turnover; low-paid jobs; and a lack of stable housing that can negatively affect their mental health and sobriety.[1459]

FIGURE 6d. Formerly incarcerated persons who are younger, African American, or men have the highest rates of recidivism

Share of prisoners in selected states released in 2005 who were arrested after release, by sex, age group, race, & ethnicity, 2005-2014



Note: The sample in the source study includes recidivism patterns of persons released in 2005 from state prisons in 30 states.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from Alper, Mariel, and Joshua Markman. "2018 Update on Prisoner Recidivism: A 9-Year Follow-up Period (2005-2014)." Bureau of Justice Statistics, May 2018. Available at https://www.bjs.gov/content/pub/pdf/18upr9yfup0514.pdf.

Immigration Enforcement

Another recent example of disproportionate targeting of people of color by the CJ system is the increase in immigration enforcement. About 15 percent of detainees are likely to have behavioral health conditions, and may not have a lawyer in immigration court, as the law does not require lawyer assignment if they cannot afford one.[1460] Much like other prisons, immigration detention facilities offer limited behavioral health care, screenings, and post-release planning, and even less staff than in other detention facilities.[1461] A report studying California's immigration detention facilities found inadequacies in "medical record accuracy and accessibility, nurses practicing outside their legal scope of practice, superficial medical examinations, delayed or inadequate medical care, inadequate mental health staffing and services, and unsafe suicide watch and disciplinary (solitary confinement) practices."[1462] Additionally, existing behavioral health services are often only available in English, even though the individuals needing services primarily speak Spanish or another language.[1463] For children detained or separated from their parents, the

risks of toxic stress are multiplied, and the effects of these experiences threaten to cause both immediate and long-term harm.[1464]

Female Prison Population Is Growing & Facing High Rates of Behavioral Health Conditions

Women in the CJ system were more likely than men to have faced behavioral health conditions before they came into contact with the CJ system (73 percent versus 55 percent for males).[1465] While incarcerated males outnumber incarcerated females by over 10 times,[1466] this gap has been shrinking over the past few decades.[1467] More women are incarcerated now than ever, due to the increased criminalization of drug use and trafficking.[1468] Many behavioral health conditions of women in the CJ system may be tied to past experiences of sexual and physical abuse.[1469] A recent DOJ study found that just over half of incarcerated women were likely to have PTSD during their lifetime, which is associated with experiences of violence—particularly interpersonal violence.[1470]

Some trauma can be correlated with particular types of crime. For example, women who have experienced IPV have higher risks of involvement with commercial sex work and drug crime.[1471] The vast majority of sex trafficking victims are women and girls (though victims identify across the gender spectrum), who are often experiencing poverty or come from low-income families.[1472] Many female trafficking victims faced trauma while trafficked, and develop SUDs as coping mechanisms.[1473] They report depression, anxiety, and PTSD.[1474] Women and girls involved with trafficking are also more likely to be involved with the justice system, as there often is nowhere else for them to go once they are picked up by law enforcement.[1475, 1476]

Once incarcerated, women are more likely to face SUDs, depression, and PTSD.[1477] Women may also feel their privacy is being violated by male guards through practices such as strip searches, which may trigger PTSD.[1478] Incarcerated women who are mothers face a higher risk of postpartum depression—especially if they are unable to continue lactation or obtain other necessary supports, such as follow-up appointments with specialists, counseling, and nutritional services.[1479] Over one-third of pregnant women in prison may use illicit drugs, while a significant amount also drink alcohol and smoke tobacco due to incarceration-related stress.[1480] The CJ system also has different response mechanisms for women and men for behavioral health screening and response. Compared to men, incarcerated women are more likely to be diagnosed with behavioral health conditions and receive behavioral health treatment.[1481]

The proportion of young girls in prison has been growing in the past two decades.[1482] Once incarcerated, they are also more likely to be *referred* to, and thus *participate* in, treatment, as they are more likely than boys to: 1) show the symptoms for internalizing disorders such as depression, anxiety, and suicide ideation, and 2) to self-report their disorders—though they still do not receive adequate treatment compared to their needs.[1483] However, this referral disparity ends when girls are released from prison and often lose access to treatment.

Prison staff have expressed concerns that a lack of gender-responsive programming and housing will cause women to relapse and recidivate.[1484] For example, prison staff have expressed the need for more safe transitional housing, particularly for formerly incarcerated women who are DPV/IPV survivors, to ensure they do not return to high risk environments after prison.[1485] Women have similar recidivism rates to men, with about one-fourth of women recidivating within six months, one-third recidivating within a year, and 68 percent recidivating within five

years.[1486] Women also face a higher risk of facing sexual victimization, including sex trafficking, once out of the system, re-locking them into a cycle of incarceration and trauma.[1487]

Based on Age, People in Contact with the CJ/JJ System May Have Distinct Behavioral Health Conditions

Within the CJ system, the rates of behavioral health conditions also differ based on age.

Youth

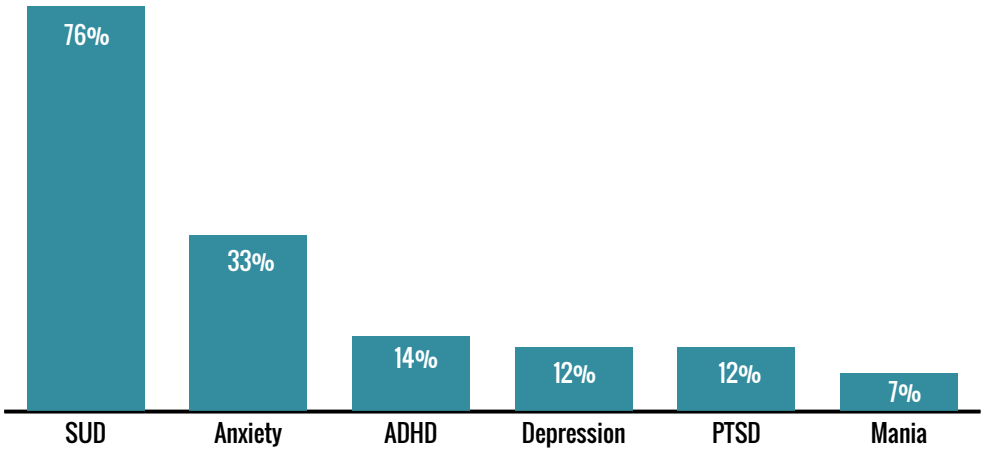
Thirty-three out of 50 states do not have a minimum age of criminal responsibility.[1488] Harsh, punitive punishments in school systems and for minor, school-related crimes like truancy funnel youth into the CJ system.[1489] Students who face a suspension or expulsion are almost three times as likely to interact with the JJ system in the next year,[1490] and students facing behavioral health conditions are disproportionately punished through suspension or expulsion compared to their relative share of the student population.[1491] Black girls in particular are 2.6 times more likely to be referred to law enforcement and almost four times more likely to be arrested compared to white girls.[1492] Suspensions and expulsions increased due to zero tolerance policies implemented in the 1990s, particularly around the time of the passage of the Gun Free Schools Act of 1994; these policies ended up penalizing smaller violations, not just those related to weapons.[1493] In recent years, there has been a decline in out-of-school suspensions overall; however, African American students and students with disabilities are still disproportionately likely to receive such punishments.[1494] In California, over 12,000 youth were assigned to a probation program for offenses such as school discipline incidents, behavioral health conditions, their academic record, and familial conflict from 2005 to 2016. In total, one-quarter of the youth assigned were accused of non-criminal offenses.[1495]

Students who face a **SUSPENSION OR EXPULSION** are almost three times as likely to interact with the **JUVENILE JUSTICE SYSTEM** in the next year

Behavioral health conditions are present for many youth before they make contact with the JJ system, while other youth may develop such conditions within the system itself. In particular, previous externalizing behavioral health conditions, such as conduct disorders, antisocial behaviors, and SUDs are correlated with initial justice system involvement and recidivism.[1496] Within the JJ system, up to 70 percent of youth are estimated to face at least one behavioral health condition; at least 39 percent face more than one.[1497] Among youth who committed the most serious offenses, the highest rates of behavioral health conditions are SUD (76 percent) and high anxiety (33 percent), followed by ADHD (14 percent), depression (12 percent), PTSD (12 percent), and mania (7 percent) (see Figure 6e).[1498] Suicide rates for incarcerated youth are two to three times higher than the general youth population,[1499] with even higher rates for youth in solitary confinement.[1500] Incarcerated youth are 10 times more likely to face psychosis.[1501] The risk of developing behavioral health conditions increases the longer one has been in the system.[1502] Within the system, access to treatment varies. People who were arrested under the age of 14 are more likely to be referred to treatment,[1503] and only 15 percent of youth with a serious behavioral condition receive treatment overall.[1504] There are racial disparities when it comes to receipt of treatment as well, as African American and Latino youth were less likely to receive care than white youth.[1505]

FIGURE 6e. Youth who are incarcerated have high rates of substance use disorders & mental health conditions

Behavioral health condition rates among incarcerated youth who committed the serious offenses in Philadelphia, PA & Phoenix, AZ, 2003-2010



Note: SUD stands for Substance Use Disorder; ADHD stands for Attention Deficit and Hyperactivity Disorder; & PTSD stands for Post-traumatic Stress Disorder.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Data from Schubert, Carol A., Edward P. Mulvey, and Cristie Glasheen. "Influence of Mental Health and Substance Use Problems and Criminogenic Risk on Outcomes in Serious Juvenile Offenders." *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(9): 925-937, 1 September 2011. Available at https://doi.org/10.1016/j.jaac.2011.06.006.

These behavioral health conditions can continue into adulthood once youth are released from the system.[1506] Youth who previously had suicidal thoughts and youth with SUDs were the most likely to re-offend, for reasons such as a lack of transitional care.[1507] One study of two metropolitan areas found that only thirty-five percent of youth utilized community-based services during the first six months of re-entry, as many faced a lack of health care coverage and accessible providers.[1508]

Seniors

While the incarcerated youth population has decreased, the incarcerated elderly population has increased recently, primarily because of the move toward longer sentences. Between 1995 and 2010, incarcerated people ages 55 and older quadrupled while the general prison population increased by less than half; many of these individuals received life sentences.[1509] This trend is projected to continue into the future, as by 2030 almost one-third of individuals in federal or state prison will be 55 or older.[1510] This population faces unique needs, as their behavioral health conditions may relate to aging and the physical health conditions associated with aging. Seniors in prison face an accelerated aging process and may face physical and mental aging conditions 15 years earlier than their counterparts in the general population, due to the lack of care and increased stress associated with CJ involvement.[1511] The most common conditions for seniors in contact with the CJ system were schizophrenia, MDD, dementia, and SUD.[1512] For individuals who do not have life sentences, release from the system can trigger unique challenges in finding adequate jobs, housing, transportation, and health care—all of which can increase their chances of re-offending, worsen their behavioral health conditions, or lead to a drug overdose.[1513]

The LGBTQ Community Faces Unique Risks & Obstacles Within the Justice System

The LGB population makes up about double their share of the total population in state and federal prisons and local jails (7.9 percent and 7.1 percent respectively), compared to 3.8 percent of adults in the general population nationally.[1514] The pattern is starker still in the JJ system. A 2014 National Council on Crime & Delinquency study found that 20 percent of incarcerated youth identified as LGBTQ or gender non-conforming.[1515] The rates may be even higher for girls, with up to 40 percent of all incarcerated girls potentially identifying as LGBTQ.[1516] Incarceration rates are also higher for LGBTQ adults and youth of color. For example, 85 percent of incarcerated LGBTQ or gender non-conforming youth are youth of color.[1517]

Generally, the factors that lead to LGBTQ overrepresentation in the CJ system are also factors that can lead to increased behavioral health conditions. These factors include discrimination in housing, employment, medical care, and schools, all of which can lead to homelessness and disproportionate interaction with the child welfare system;[1518] discriminatory laws that criminalize the LGBTQ community specifically; and policing strategies that target them based on these unfair laws.[1519] As a result, LGBTQ people, including LGBTQ youth, face higher rates of behavioral health conditions before contact with the justice system which further compounds their risk of interaction with the system.[1520, 1521, 1522]

Once LGBTQ individuals are in the justice system, there are many factors that can lead to or exacerbate their behavioral health conditions. The high rates of assault experienced by transgender people (24 percent report being assaulted, compared to two percent of the general prison population) puts them at a higher risk for the development of behavioral health conditions.[1523] Often, the CJ system's response is to place transgender individuals in solitary confinement ostensibly for their own safety, particularly if they are youth placed in adult facilities or if they are misgendered (meaning they are not recognized as the gender with which they identify, but instead as the sex they were assigned at birth).[1524] The LGBTQ population also lacks adequate and appropriate care in CJ facilities, particularly access to care for gender dysphoria for the transgender population. While they are supposed to receive mental and physical health evaluations and appropriate treatment from health professionals who have the proper training, in practice, these services are incomplete and inadequate.[1525] Lastly, LGB individuals have a longer average length of stay in the system, which can also negatively affect mental health.[1526]

Once they are out of the system, the factors that may have led to LGBTQ individuals' incarceration and behavioral health conditions reappear, and are often even worse.[1527] Possession of a criminal record makes it even harder for formerly-incarcerated LGBTQ individuals to get a job, education, adequate health care, and public assistance, and to maintain familial and community connections.[1528] If transgender individuals have been misgendered by public authorities, they may face even greater challenges since they will not have the correct identification documents at the time of release.[1529]

People In Rural Areas Are More Likely To Be Incarcerated & Less Likely To Have Access To Treatment

From 2000-2013, incarceration rates in rural jails and prisons[1530] have either increased or stayed the same, while decreasing in urban areas.[1531] Because of a lack of resources and/or geographical constraints in rural areas, law enforcement is often the primary responder for behavioral health crises. In these situations, people with behavioral conditions are unlikely to be diverted into

hospitals or other mental health treatment opportunities.[1532] Limited rural transitional housing for people with criminal records or behavioral health conditions may increase the likelihood of interaction with the CJ system.[1533]

Within rural jails, some people in jail have no access to treatment at all, due to the jails' lack of resources—even though people in rural jails may face higher rates of behavioral health conditions than people in non-rural jails.[1534] Most rural jails are smaller and have suicide rates almost four times higher than jails in general.[1535] Fifty-nine percent of these small jails did not have any counseling or psychiatric services.[1536] Rural jails were also less likely than non-rural jails to be equipped to provide treatment for the opioid epidemic and other rapid response needs.[1537]

Once out of jail, people in rural areas face unique barriers that can hamper attempts to stay out of jail and address behavioral health conditions. Rural areas are more likely to have inadequate housing, jobs, social services, and health care, particularly mental health and substance abuse treatment.[1538, 1539] Even if services do exist, rural areas tend to lack transportation.[1540]

BOX 6A.

ENVIRONMENTAL FACTORS & BEHAVIORAL HEALTH

Extreme weather is linked to worsening behavioral health. One of the most recent examples is in Puerto Rico. After Hurricane Maria, suicide rates increased by 29 percent over one year due to factors such as anxiety, the loss of home and possessions, and, for elderly residents in particular, the loss of routine.[1541] Another example of increased behavioral health needs was after the wildfires in Sonoma County, California in 2017. In the first month after the wildfire, victims were provided 13,000 hours of counseling.[1542] Disasters leave survivors who already face barriers to financial stability with more economic challenges, and put them at greater risk of criminalization and/or developing behavioral health conditions.[1543] Within the first year after Hurricane Katrina, less than half of African American residents were able to return to their homes, while 70 percent of New Orleans' white residents returned the following year after the storm, maintaining existing inequities.[1544] Additionally, during the storm and its aftermath, the media portrayed African American survivors as looters, which may have contributed to instances of police brutality[1545] and the militarized response against the African American community.[1546] In general, disasters and the resulting displacement, loss of home, or other personal damage,[1547] and police brutality are also associated with anxiety, PTSD, substance use, depression, suicide ideation,[1548, 1549, 1550] and increased DV.[1551] Children under age eight have an increased risk of developing PTSD, anxiety, and depression.[1552]

The consequences of climate change, such as rising temperatures and extreme precipitation, also have a negative impact on human behavior, including increasing the frequency of aggressive behavior, interpersonal violence, and intergroup violence.[1553] Such shifts may also lead to an increase in violent crime, which may affect individual and societal behavioral health through increased anger, anxiety, dissociation, withdrawal, and more.[1554] Recent analysis has projected that climate change could be responsible for up to 26,000 suicides in the U.S. by 2050, as warmer weather is associated with higher suicide rates[1555] and increased anxiety and depression.[1556] Climate change's role in increasing environmental disasters and the ripple effects on already-vulnerable communities also raise concerns. Research suggests that the burden of PTSD is also significant among survivors of natural and man-made disasters. An estimated 30 to 40 percent of survivors of natural and man-made disasters experience PTSD.[1557] Rescue workers can also suffer from higher rates of PTSD.[1558] As natural and man-made disasters are becoming more frequent due in part to climate change,[1559] the prevalence of PTSD is likely to increase.

Other environmental factors can impact behavioral health. A study from China found that air pollution is correlated with increased rates of behavioral health conditions.[1560] Seasonal change can also affect behavioral health through seasonal affective disorder (SAD), as individuals with the condition may experience depressive symptoms during the fall and winter.[1561] A person's surrounding environment can also contribute to improved behavioral health. For example, there is evidence that areas with more green space have lower suicide rates.[1562]

Behavioral Health Conditions & Challenges

The first part of this section provides an overview of behavioral health in the CJ/JJ systems. The section then covers environmental impacts that contribute to the development of these conditions in individuals who come into contact with the CJ/JJ systems and descriptions of the conditions themselves.

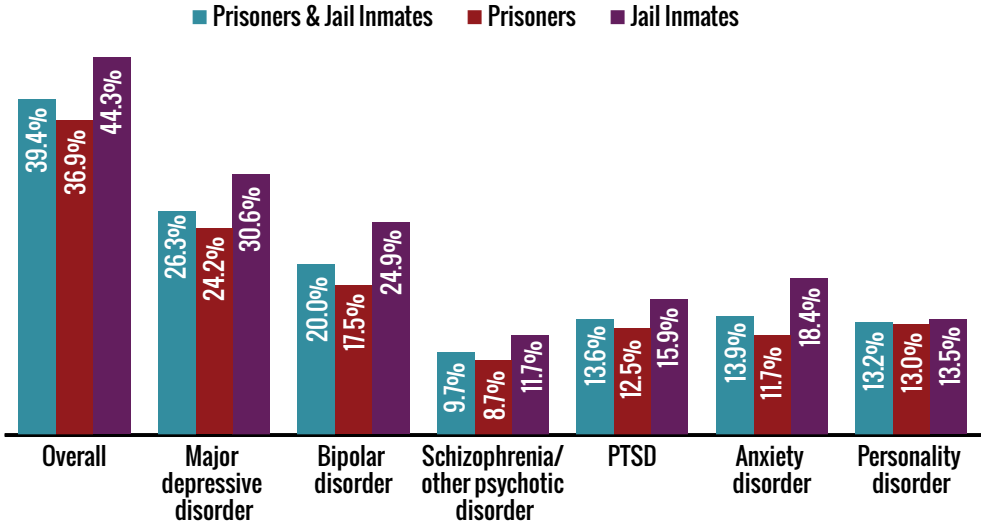
OVERVIEW

According to SAMHSA estimates, in 2017, 46 million adults in the U.S. had a behavioral health condition.[1563] Within the portion of the population that has some justice system involvement (about two percent),[1564] the proportion of individuals with a behavioral health condition is even higher.[1565] For example, a 2017 Bureau of Justice Statistics (BJS) report found high rates of mental health conditions among people in prison or jail (see Figure 6f for a breakdown of conditions).[1566] That study also found that 37 percent people in state and federal prisons, and 44 percent of people in jails had been diagnosed with a mental health condition.[1567]

Unfortunately, no reliable data exist on the prevalence of mental and behavioral health conditions prior to or following interactions with the CJ system. The CJ system is designed in such a way that cities, counties, and the federal government all have varying systems for collecting data on people in prison or jail as they enter into the system and have different processes for sharing information when people leave the system. Most systems do not collect data on whether their populations have had a prior diagnosis or past mental health care. Differences in the provision of health care in jails and prisons and a lack of resources and standardized processes for diagnosing problems contributes to difficulty with identifying the prevalence of behavioral health conditions while individuals are incarcerated.[1568]

FIGURE 6f. Large share of people who are incarcerated have experienced one or more mental health conditions

Lifetime incidence of selected mental health conditions among prisoners & jail inmates, 2011-2012



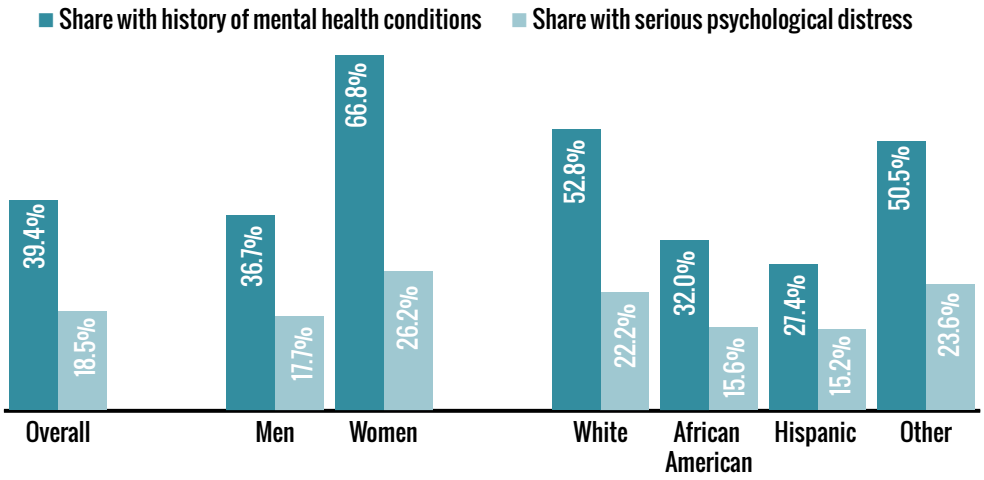
Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Authors' calculations using data from Bronson, Jennifer. "Indicators Of Mental Health Problems Reported By Prisoners And Jail Inmates, 2011-2012." Bureau of Justice Statistics, 22 June 2017. Available at https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946.

MENTAL HEALTH

The following subsections profile conditions diagnosed prevalently among the prison population,[1569] provides an overview of the conditions, and discusses factors that may make the prison population more likely to experience them (see Figure 6g for a breakdown by sex, race, and ethnicity). Suicide is also the leading cause of death in local jails, and rates have increased over time.[1570]

FIGURE 6g. Majority of incarcerated women & Whites have history of mental health conditions

Share of prisoners & jail inmates with serious psychological distress & history of mental health conditions, by sex, race, & ethnicity, 2017



Note: The category of White only includes Non-Hispanic White. The category of Other includes American Indian or Alaska Natives; Asian, Native Hawaiian, or Other Pacific Islanders; & persons of two or more races. Serious psychological distress was measured using the Kessler 6 (K6) nonspecific psychological distress scale. Inmates were asked how often during the 30 days prior to the interview they felt nervous, hopeless, restless or fidgety, & depressed.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Authors' calculations using data from Bronson, Jennifer. "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12." Bureau of Justice Statistics, 22 June 2017. Available at https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946.

Common Mood Disorders

Some of the most common mood disorders among people in contact with the CJ/JJ systems are profiled below.

Anxiety & PTSD

Common anxiety disorders (panic disorder and OCD) are experienced by 11.7 percent of the prison population and 18.4 percent of people in jail,[1571] compared to 1.2 percent of adults who experience OCD in general[1572] and 2.7 percent of adults who experience panic disorder in general.[1573] PTSD is experienced by 12.5 percent of people in prison and 15.9 percent of people in jail,[1574] compared to 3.5 percent of the general U.S. population.[1575] Incarcerated individuals may develop these conditions because of their adverse experiences and other factors that may have impacted them prior to incarceration (such as poverty or maltreatment), along with their experiences with the justice system and inside prison, such as physical and sexual assault.[1576]

Depression

An estimated 7.1 percent of adults ages 18 or older in the U.S. had at least one MDE in the past year[1577] compared to the 24.2 percent of the prison population and 30.6 percent of people in jail who suffer from depression.[1578] Risk factors for depression include abuse, sudden death of a close relationship, separation from parents or children, poor social networks, social isolation, genetic predisposition, and high emotional volatility.[1579] Incarcerated individuals are especially likely to experiencing these factors during their lifetimes,[1580] once incarcerated,[1581] and following their release.[1582]

Bipolar Disorder

Among people in prison or jail, 17.5 percent and 24.9 percent, respectively,[1583] are affected by bipolar disorder, compared with 2.8 percent of U.S adults in general.[1584] The manic phase of bipolar disorder, during which an individual faces feelings of irritability, exaltation, and increased energy, can lead to a higher risk of having contact with law enforcement.[1585] The high co-occurrence rates of bipolar disorder and addiction can also contribute to a higher risk of CJ system contact.[1586] Once incarcerated, individuals with bipolar disorder may be more likely to face disciplinary actions and less likely to receive adequate treatment, as symptoms of their condition may be seen as acts of defiance.[1587]

Up to **HALF OF THE ADULT PRISON POPULATION** may be affected by **ADHD**

Other Common Mental Health Conditions

In this section, some other common mental health conditions experienced by children in contact with the child welfare system are profiled. Compared with around three percent of the general U.S. population,[1588] 8.7 percent of people in prison and 11.7 percent of people in jail[1589] experience psychosis. The higher rates of psychosis may be linked to the prevalence of ACEs.[1590] Factors such as solitary confinement may also increase incarcerated individuals' likelihood of experiencing psychosis.[1591] Up to half of the adult prison population may be affected by ADHD,[1592] and studies have shown that children with ADHD have higher chances of being in contact with the justice system.[1593] Individuals with ADHD have may have disproportionate contact with the justice system due to lower educational attainment, poverty, substance use, and antisocial behavior.[1594]

Justice Systems-Related Factors that Exacerbate Behavioral Health Conditions

Though numerous factors can exacerbate behavioral health conditions or cause them to develop, two factors have particularly high correlations with the behavioral health conditions of people in contact with the justice system.

Traumatic Brain Injury (TBI)

TBI results from external force being applied to the head such that the brain is injured.[1595] The most common form of TBI is a concussion.[1596] According to the CDC, TBI contributed to around 56,800 deaths in 2014.[1597] Symptoms of TBI include the impairment of thinking, memory, movement, sensation, and emotional functioning.[1598] These symptoms can last anywhere from days to the remainder of life.[1599] Rates of TBI are much higher among people with histories of interacting with the justice system. Estimates place the incidence of TBI among people currently in prison or jail anywhere from 25 to 87 percent, despite only 8.5 percent of the general public having a history of TBI.[1600] TBI is associated with behavioral health conditions such as depression, anxiety, SUDs, and suicide.[1601]

Many of the behavioral changes resulting from TBI can lead to additional problems.[1602] Attention and memory problems may lead to difficulty following directions or remembering rules.[1603] Further, difficulties regulating anger and other emotions may result in fights between people in prison or jail.[1604] However, the 2011 National Survey of Prison Health Care found that just 23 out of 45 states surveyed had some screening in place for TBI during the admissions process.[1605]

Solitary Confinement

Solitary confinement typically involves the separation of people in prison or jail into 80-square-foot cells for 23 hours at a time. Solitary confinement places people at risk of serious psychological harm. It leads to mental health conditions,[1606, 1607] higher risks of suicide,[1608, 1609] and is not an effective punishment for advancing safety.[1610] It has been deemed "cruel, inhuman or degrading treatment or punishment and even torture" by the Special Rapporteur of the United Nations Human Rights Council.[1611] Approximately 80,000 people in prison each year get placed in solitary confinement.[1612] The average stay is 37 days.[1613] During solitary confinement, people in prison or jail lack any substantial social interaction and structure—elements which can exacerbate symptoms of existing mental health conditions or instigate a relapse.[1614] For these reasons, Ohio has banned the use of solitary confinement for some individuals with behavioral health conditions, youth, and pregnant women for more than 30 days,[1615] and the Obama Administration banned solitary confinement for juveniles in federal prisons.[1616]

SOLITARY CONFINEMENT places people at risk of **SERIOUS PSYCHOLOGICAL HARM**

Additionally, mental health treatment options during solitary confinement are severely limited.[1617] For example, individual and group therapy become difficult to implement, due to restrictions on people in prison or jail leaving cells.[1618] The result of these restrictions is that the most common mental health care provided to people in prison or jail in solitary confinement is in the form of psychotropic medication.[1619] One large-scale study found that 53 percent of acts of self-harm and suicidal behavior were committed by people in solitary confinement, despite only seven percent of the population experiencing any solitary confinement.[1620]

SUD

The National Center for Addiction and Substance Abuse at Columbia University places the prevalence of SUD across U.S. prisons and jails at 65 percent, with an additional 20 percent of people in prison or jail who use substances but do not have an SUD.[1621] Data collected as part of the National Inmate Survey found that nearly 6 in 10 (58 percent) people in state prisons and two-thirds (63 percent) of sentenced people in jail met the criteria for drug dependence or abuse from 2007-2009.[1622] Juvenile drug arrest rates have consistently dropped since 2010.[1623] Underlying reasons behind substance use among the incarcerated population include genetics,[1624] co-occurring mental health disorders, environmental factors, the lack of treatment options that could divert people from the CJ/JJ systems,[1625] and historical/systemic factors that led to the over-criminalization/over-incarceration of certain populations, as mentioned in the key populations section.

According to a 2011 report from SAMHSA's Treatment Episode Data Set (TEDS), the justice system was a major source of referrals to substance use treatment, with probation or parole treatment admissions representing the largest proportion of justice system referrals.[1626] The 2011 TEDS report also found that most probation or parole admissions were males between the ages of 18 and 44.[1627] The most common substances reported by these referrals were

alcohol, marijuana, and methamphetamine. Similarly, JJ is the most frequent referring agency in SAMHSA's adolescent substance abuse treatment grant programs.[1628]

Opioid Epidemic

The percentage of people in jail reporting past regular use of heroin or opiates increased to 18.9 percent during 2007-09 compared to 12.2 percent in 2002.[1629] One study found that taking opiates is associated with a 13 times greater chance of interacting with the justice system, though further research needs to be conducted.[1630, 1631] People who take opiates are more likely to be white, low-income, and have a chronic condition, such as a disability or co-occurring mental health condition—which may further increase chances of interacting with the justice system.[1632]

Many prisons and jails in the justice system refuse to offer MAT to their populations.[1633] Despite the increased need for treatment within the justice system, only 55 percent of U.S. prisons offered MAT as of 2009.[1634] Fifty percent of those prisons offer methadone treatment to pregnant women only and only 14 percent offer buprenorphine.[1635] As of 2018, 28 states offered no MAT at all in their prisons.[1636] Absent this and other evidence-based practices, many remain at risk of relapse and/or overdose.[1637, 1638]

Co-Occurring Mental Health Conditions & SUDs

Rates of concurrent mental health and substance use conditions are higher in the justice system.[1639] Of individuals with a mental health condition in the justice system, three-quarters had a co-occurring SUD.[1640] People facing co-occurring conditions may self-medicate. Marijuana can be used to cope with anxiety and psychosis, methamphetamines and other stimulants can be used to cope with mood disorders, and opioids can be used to cope with pain, depression, and trauma.[1641] Self-medicating with these drugs may heighten risk of interaction with the justice system.

Recommendations to Improve Behavioral Health in the CJ/JJ Systems

This section offers recommendations for providing continuous services to families before, during, and after contact with the CJ/JJ systems. The recommendations re-imagine the CJ/JJ systems through different mechanisms and by changing the current norms and consequences of the system itself, with a focus on restorative justice. They also reflect the deep connections between the CJ/JJ systems and poverty and the many other systems that families and communities come into contact with, such as the child welfare, health care, and education systems.

1. END COLLATERAL CONSEQUENCES OF INCARCERATION

There are various definitions, laws, and procedures particularly related to housing and employment that punish formerly incarcerated individuals and create barriers to financial stability, which can exacerbate behavioral health conditions. For example, formerly incarcerated individuals, who are already frequently weighed down with fines and fees and child support debt, may be banned from participating in certain social services—such as Section 8 Housing Vouchers if convicted of a felony, which can affect whether they can live with their family.[1642] Also, when individuals who have historically experienced homelessness are released from prison, they are precluded from accessing relevant and needed services[1643] due to the current

federal definition of "chronic homelessness," which does not count incarceration as experiencing "homelessness."

People leaving prison face significant employment barriers, due to employer discrimination and regulations restricting them from working in certain jobs or attaining certain occupational licenses.[1644, 1645] These policies can prevent returning individuals from obtaining quality jobs that provide career advancement opportunities and engagement in the labor market.[1646] Limited employment prospects can further undermine economic security, and put formerly incarcerated people at risk of behavioral health conditions.[1647, 1648]

All of these regulations should be overturned. As an intermediate step, affordable housing providers can also limit their background checks to what is actually required by the law, not requiring applicants to disclose additional information that could cause providers to be biased against them.[1649] Additionally, crimeless revocation provisions at the state level, which put individuals back on probation, parole, or in jail or prison for violating minor rules should be repealed.[1650]

2. DECRIMINALIZE SURVIVAL BEHAVIOR & INVEST IN COMMUNITIES

Decriminalizing survival behaviors, such as sex work, loitering, truancy, homelessness, substance use, being Human Immunodeficiency Virus (HIV) positive, and selling drugs, at all levels of government can prevent individuals from entering the system, as can getting rid of mandatory arrests for DV and nuisance ordinances. Such ordinances put survivors of DV/IPV at further risk of housing instability, homelessness,[1651] and barriers to employment,[1652] which can raise the risk of negative behavioral health conditions. There should also be an effort to reform bail practices to ensure that low-income individuals are not incarcerated for a failure to pay their bail.[1653] There should be an investment in efforts to identify and implement new crisis intervention models (besides law enforcement) that are more focused on peer supports. Additionally, mental health professionals should be embedded as core staff at police departments, or accompany patrol officers on missions to respond to crises on site, as a potential intervention in local police departments.[1654] Rigorous evaluations of such interventions should be prioritized to share knowledge and make sure stakeholders are being held accountable and not perpetuating the same injustices that push individuals experiencing mental health conditions into jails and prisons.

Funding

While the impacts of these new intervention models remain to be seen, funding is needed to test and evaluate these approaches to uncover the most effective interventions. For example, dollars could be directed to federally-run pilot programs in cities and localities that replace police as the primary point of contact, including in schools with zero tolerance policies, such as a specific LGBTQ law enforcement liaison or a Department of Public Health liaison who may be more trusted to provide data on the LGBTQ population.[1655]

3. INITIATE CJ/JJ-ORIENTED VALUE-BASED PAYMENT

When health care and justice systems collaborate to divert individuals from unnecessary justice involvement and toward effective treatment, it improves outcomes and reduces costs across sectors. To better align financial incentives for health care and justice systems toward diversion or integration with effective care, states and counties can pilot models of cross-sector value-based payment. In the same way that value-based payment offers incentives to hospitals for

reducing unnecessary admissions and keeping people healthy in the community, contractual partnerships between health care and justice can offer shared savings when they reduce costs associated with prevented incarceration and improve health outcomes. The Centers for Medicare and Medicaid Innovation can spur local pilots by collaborating with the Department of Justice to give states guidance on potential payment model designs.

4. AVOID DETENTION OF IMMIGRANT CHILDREN

Various sectors and systems must focus on meeting immigrant children's behavioral health needs, particularly as recent U.S. policies have increased trauma and stress experienced by children as they immigrate to the U.S.[1656, 1657, 1658] Efforts should focus on family reunification and stopping family separations. Legal representation should be guaranteed for all children applying for asylum, and eligibility for services should be guaranteed if they are successful asylum applicants.

Efforts should focus on increasing sponsorship to integrate children into their communities. Policies should promote therapeutic foster care for children whose parents were deported,[1659] instead of using large immigration detention facilities, as therapeutic care is a proven model when adequately funded.

Funding

Existing health care funding sources, such as Medicaid, should be identified to help these immigrant children, as has been done in California.[1660] Schools that these children can access should also be supported and adequately funded, including for special education and nutritional services, as schools were unprepared for the sudden influx of children.[1661]

5. LEVERAGE COMMUNITY RESOURCES FOR DIVERSION & REINTEGRATION

Communities should focus on integrating individuals back into their communities post-release. One strategy is to use "welcome home circles" led by the local community where formerly incarcerated individuals can tell their stories and focus on their mental health.[1662] Religious leaders or other credible messengers can talk about behavioral health and help with post-CJ system involvement. By providing these sorts of behavioral health supports and destigmatization in accessible locations such as faith institutions, religious leaders can also help play a preventive role and divert people away from the CJ/JJ systems and instead direct people in crisis to behavioral health services.

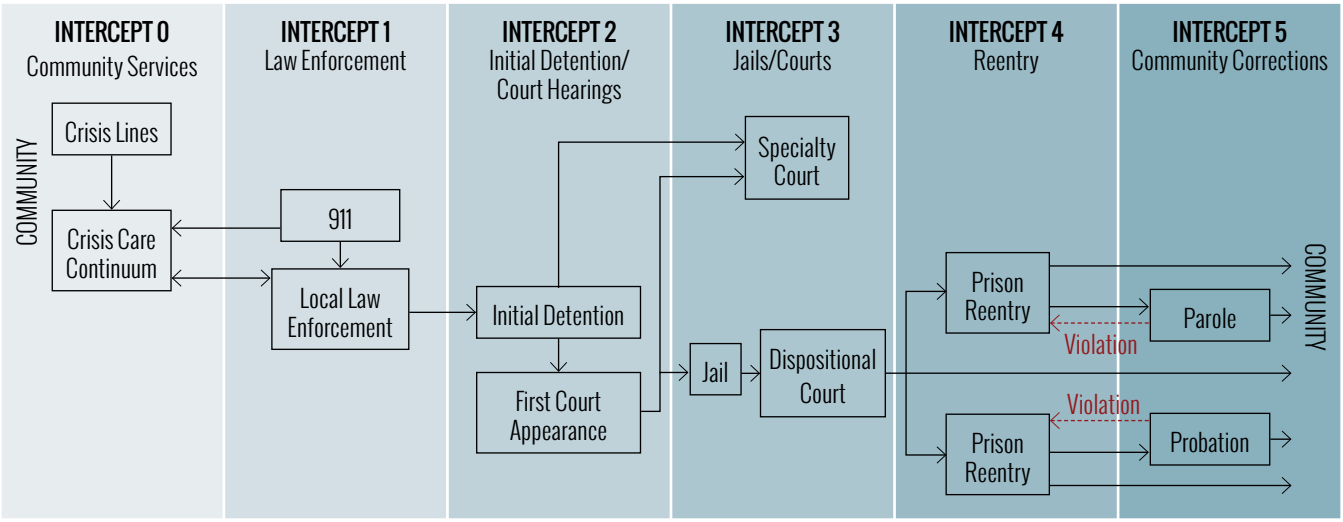
Funding

Such interventions can be paid for by increasing pre-allocated state incentives for reaching rural populations (such as by increasing the Medicaid FMAP) and through innovative billing strategies (such as not billing based on a person or their condition, but based on their family or community instead). SAMHSA could help fund such strategies within rural and urban communities with an eye toward restorative justice.

Sequential Intercept Model

FIGURE 6h. Sequential Intercept Model offers multiple opportunities for behavioral health interventions in the CJ/JJ systems

Sequential Intercept Model Diagram



Note: CJ stands for Criminal Justice; JJ stands for Juvenile Justice.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Recreated from "Sequential Intercept Model." SAMHSA, U.S. Department of Health and Human Services, 1 August 2018. Available at https://www.prainc.com/wp-content/uploads/2015/10/sequential-intercept-model.pdf.

The Sequential Intercept Model is a community-based approach designed to help reduce the burden on individuals with behavioral health conditions at each stage of interaction with the CJ system (see Figure 6h).[1663] Using the Sequential Intercept Model framework, communities develop customized strategic plans based on their needs and resources. Below are some prevailing programs used to prevent and support justice-involved individuals with behavioral health conditions in the linear Sequential Intercept Model compiled by SAMHSA:[1664]

- **Stages 0-1:** Diversion Programs vary in implementation but serve to keep people with mental and behavioral health conditions out of the CJ system and in treatment.
  - » Pre-booking Diversion: a "police officer has the discretion to refer the arrestee to a designated case worker in lieu of booking the individual into jail to await trial."[1665]
  - » Crisis Intervention Team: police officers who are trained in de-escalation without the use of force. These officers typically receive trainings from community mental health centers on topics such as properly restraining an individuals and making judgements on how to handle a given circumstance from a crisis intervention perspective.[1666, 1667] Dispatchers can also be trained to identify people with behavioral health conditions to further help the Crisis Intervention Team.
  - » Mental Health Urgent Care: a walk-in outpatient clinic for people experiencing behavioral health crisis and need help.

- **Stages 2-3:** Before the individual goes further into the system, there are behavioral health screenings and pre-trial services so lower-level defendants can avoid further incarceration. Mental Health Courts and Collaborative Courts[1668] use legal means to address the root causes of criminal behavior through the use of treatment and community resources. Judges should receive training as well to make these courts as culturally competent and trauma-informed as possible. There is also jail-based programming and services at this stage.
- **Stages 4-5:** Before the individual is released, there is transitional planning and making sure that they have access to their necessary medications along with MAT. Community Re-entry Programs work with incarcerated individuals to ease their transitions into the larger community through specialized community supervision.
  - » Peer-run Respite: people with lived experience staff programs designed to address mental health crises.
  - » Supported Employment: a team works to ensure that people can join the workforce and promote individual recovery.

6. REFORM MEDICAID INMATE EXCLUSION POLICY TO PROVIDE BETTER CARE WITHIN THE SYSTEM & POST-RELEASE

States are prohibited from covering incarcerated adults in their Medicaid plans,[1669] which leads to low quality services in jails and prisons, as well as interruptions in continuity of care during transitions. The Medicaid statute should be amended to allow for Medicaid coverage of incarcerated individuals. Steps should be taken to ensure assessments and continuity of care between prisons and jails and post-release, including use of telehealth or other modalities to encourage ongoing therapeutic alliance.[1670] Thirty-three states and the District of Columbia have opted to suspend Medicaid benefits for individuals who are incarcerated while they are in prison or jail, rather than fully terminating the benefit.[1671] Suspension allows the individual to have their benefits more quickly reinstated post-release. States and localities can also expand the suspension of benefits as an incremental step. Many times, jails and prisons are supposed to but do not often provide mental health treatment,[1672] so the federal government, states, and localities should ensure that prisons and jails comply with what is required of them rather than opting not to adequately screen and diagnose individuals who are incarcerated with behavioral health conditions.[1673]

Telehealth has been shown to provide quicker referrals to treatment and treatment itself for youth who are incarcerated, along with reduced outpatient visits.[1674] Strategies that worked for individuals while they were incarcerated should be continued once they are released, including the necessary medications they need to address their behavioral health conditions and therapeutic.[1675] One way to coordinate care between systems is through case management services for formerly incarcerated individuals with behavioral health conditions, such as those provided in the Department of Justice's Justice and Mental Health Collaboration Program Grant.[1676]

Conclusion

Any agenda to improve behavioral health must address poverty, and any agenda to reduce poverty must address behavioral health. Poverty and behavioral health challenges are both causally linked and mutually reinforcing—economic insecurity often means greater need and lesser means to address behavioral health challenges, while behavioral health challenges often mean greater social and economic challenges. To address either, solutions must tackle both, considering socioeconomic well-being, context and communities, and families and social networks of every individual—a whole family, whole community approach.

Evidence across disciplines offer concrete and actionable policy, programmatic, and practice recommendations that improve the functioning of key systems, create a positive social and economic context for individuals and families, and empower communities to participate more fully in supporting the behavioral health of individuals and families. For example, in the three Opportunity Areas, we highlight the behavioral health needs of three populations—mothers and their families, families involved with the child welfare system, and people involved with the CJ/JJ systems—and offer holistic, population-specific recommendations that involve cross-sector and cross-system collaboration. Underlying these specific recommendations are general themes that stakeholders could apply to other policy opportunities to produce reform in their settings, with a particular focus on children and families. Together, they indicate a coherent and achievable vision of a society that adequately supports the behavioral health and development of each individual across the lifecourse and maximizes their social and economic potential.

Stakeholders across sectors have the opportunity to advance a united policy agenda at the federal, state, and local levels that would address the intertwined issues of behavioral health and poverty to improve outcomes for individuals and families across domains and ultimately increase health and socioeconomic equity. Collective advocacy that centers voices that are less often heard can apply growing evidence to make measurable and population level changes in the lives of individuals and families in areas that are critical to their well-being and that have often been viewed as intractable from a societal perspective.

Appendices

Appendix I. Summary of Report Recommendations

Figure A. Summary of report recommendations

Chapter	Recommendation #	Topline
Chapter III. An Agenda for Whole-Family, Whole-Community Behavioral Health	**1**	**Health Sector & Systems Should Account for & Respond to Realities of Behavioral Health & Compounding Factors**
	1.1	Ensure Access to Needed Health Services & Supports
	1.2	Leverage Opportunities to Improve Holistic Health Services Delivery
	1.3	Establish Shared Goals & Hold Health Stakeholders Accountable
	1.4	Strengthen & Expand the Health Workforce
	1.5	Re-orient Systems to Prioritize Agency of Individuals & Families in Health Sector
	2	**Health-Adjacent Sectors & Systems Should Support & Improve Behavioral Health**
	2.1	Strengthen & Establish Foundational Economic Security & Opportunity Supports
	2.2	Nurture the Relationship Between Employment & Behavioral Health
	2.3	Help Families Meet Their Intertwined Caregiving & Behavioral Health Needs
	2.4	Re-Orient Health-Adjacent Sectors & Systems to Be Responsive to Behavioral Health
	3	**Health & Health-Adjacent Sectors Should Close Gaps & Smooth Transitions Between Them**
	3.1	Create Seamless User Experiences Across Sectors
	3.2	Promote Effective & Efficient Cross-Sector Collaboration
	3.3	Ensure Accountability for Effective Service Delivery & Handoffs
	4	**Communities Should Support Behavioral Health & Well-Being at All Times & for Everyone**
	4.1	Leverage Community Assets for Holistic Service Delivery
	4.2	Build Supportive & Inclusive Social Environments
	4.3	Build Supportive & Inclusive Social Environments
	4.4	Universalize Access to Behavioral Health Information & Supports

Chapter	Recommendation #	Topline
Chapter IV. OPPORTUNITY AREA: Maternal Behavioral Health	1	Promote Behavioral Health Screenings for Mothers & Expectant Mothers
	2	Increase the Use of Integrated & Collaborative Care for Mothers
	3	Expand Home Visiting Services
	4	Promote Access to Reproductive Health Care
	5	Increase Access to Diapers & Menstrual Products
Chapter V. OPPORUNITY AREA: Behavioral Health & Child Welfare	1	Change the System From Child Welfare to Family Well-Being
	2	Provide Coordinated Preventive Support Systems for Families
	3	Provide Culturally Competent Support for Families
	4	Integrate Practices Promoting Continuous Improvement in the Child Welfare System
	5	Improve Housing for People Involved With the Child Welfare System
Chapter VI: OPPORTUNITY AREA: Behavorial Health & Criminal Justice/ Juvenile Justice	1	End Collateral Consequences of Incarceration
	2	Decriminalize Survival Behavior & Invest in Communities
	3	Institute CJ/JJ-Oriented Value-Based Payment
	4	Address Needs of Children Held in Immigration Detention Holistically
	5	Ensure That Every Community Has the Capacity for Effective Diversion & Reintegration
	6	Reform Medicaid Inmate Exclusion Policy to Provide Better Care Within the System & Post-Release

Appendix II. Medicaid & CHIP

Medicaid is a joint state-federal program that provides health insurance to individuals and families who are low-income. It covers 1 in 5 people with low-incomes in the U.S. and one-fifth of health care costs.[1677] It is also the primary provider of LTSS for the elderly, people with disabilities, and people with chronic conditions.[1678] One of the benefits provided to children up to age 21 is EPSDT services, which can be crucial in identifying behavioral health conditions early on.[1679] For funding, states receive a federal match on the funds they spend based on a formula based on a FMAP[1680] (starting at 50 percent) and can receive waivers from the federal government giving them the flexibility to try new strategies while being more cost-efficient than private insurance.[1681]

Medicaid pays the most for mental health services in the U.S. and is a growing payer for SUDs.[1682] In 2015, Medicaid covered 21 percent of adults with a mental health condition and 17 percent with SUD. [1683] Medicaid is also able to respond quickly to crises where behavioral health care may be needed more urgently, such as during disaster relief and the opioid epidemic.[1684] There have been studies that people with Medicaid are almost two times more likely to use behavioral health services and also report less unmet behavioral health needs, though at least 2.5 million still have unmet needs. [1685] The barriers to accessing care may go beyond not having insurance, such as the lack of providers and the lack of providers who accept insurance.[1686] The Medicaid Institutions for Mental Diseases (IMD) exclusion, "prohibits federal Medicaid funds from being used to provide

care to most patients in behavioral health residential facilities larger than 16 beds."[1687] While the exclusion was carved out in order to ensure that states would be the primary funder for inpatient psychiatric services instead of the federal government, it is a barrier to accessing these services for individuals ages 21-64.

The ACA provided a Medicaid expansion to individuals with incomes up to 138 percent of the FPL.[1688] Medicaid coverage has been associated with declining infant, child, teen, and adult mortality and less disability, intergenerational health mobility,[1689] and better health outcomes later in life, along with better non-health outcomes, such as better education attainment, due to access to necessary health care.[1690] Medicaid expansion also strengthened funding at both reservation-based IHS facilities, as well as urban Indian-serving clinics, helping reduce the uninsured rate among this population.[1691] Low-income adults in Medicaid expansion states were also less likely to report having any unmet medical needs or financial barriers to necessary care and were more likely to have a usual place of care than low-income adults in non-expansion states.[1692] A recent study even found that Medicaid expansion reduced poverty rates, and Medicaid as a whole has demonstrated anti-poverty effects.[1693] 5.3 million persons with a behavioral health condition became eligible for health coverage under the Medicaid expansion in 2015.[1694] Medicaid expansion also ensured that behavioral health services can be utilized as easily as other medical services.[1695] Preventive services now covered by non-grandfathered plans include alcohol misuse screenings and counseling, depression, and tobacco use screenings.[1696] Coverage expansion is the foundation for how to close behavioral health gaps, as seen in states such as Oregon where undiagnosed depression went down by 50 percent and untreated depression went down by 60 percent, with treatment decreasing the number of people screening positive for depression by 9.2 percentage points.[1697]

Children and pregnant women also receive health coverage through CHIP. In FY2017, about 9.4 million children utilized CHIP[1698] and 370,000 pregnant women do so each year, including in 15 states where CHIP provides behavioral health services for women.[1699] CHIP also covers behavioral health services for children, including inpatient detoxification and residential and outpatient treatment for SUD.[1700] A study of children with physical and behavioral health conditions in New York found that enrollment in CHIP was associated with "improvements in access to care, continuity of care, and use of prescription drugs, as well as reduced unmet health care needs."[1701] CHIP does have some limitations when it comes to the provision of behavioral health care. One study found that almost "two-thirds of states used day or visit limits for some or all behavioral health services in 2009" and that the limits were more likely to be for SUD services and outpatient services.[1702] Additionally, half of states also had cost sharing for some behavioral health services, which could discourage low-income families from pursuing treatment.[1703]

Appendix III. Emphasizing Similarities in Behavioral Health-Related Concepts Across Sectors

The sectors and research literature involved in the promotion of behavioral health involves competing terminologies,[1704] which can pose a barrier to cross-sector collaboration.[1705] For example, various research literature and sectors describe progress and outcomes in child cognitive,[1706] socio-emotional,[1707] and behavioral development[1708] differently, which has made on-the-ground cross-sector alignment a challenge.[1709] Pediatrics and clinical psychology often understand development in terms of psychosocial distress, such as internalizing or externalizing behavior.[1710] Education can focus on school culture and climate or on child mindsets,[1711] self-regulation skills,[1712] or pro-sociality.[1713] Early care and education emphasize kindergarten readiness or third grade reading as indicators.[1714] All of these approaches capture similar underlying concepts, but the differences can impede collaboration and shared learning.[1715] While there is merit to exploring and understanding behavioral health in a number of ways, the following sections draw parallels among a synthesis of evidence-based approaches to allow individuals across disciplines and sectors to engage and best support individuals in need.[1716]

Appendix IV. Economic Security & Opportunity Programs & Behavioral Health

Besides Medicaid, other economic security programs that increase household resources are also associated with improved behavioral health.[1717] As mentioned above, poverty is associated with higher rates of behavioral health conditions[1718] and the poverty-reduction effects of these programs are associated with a reduction in stress, which leads to better behavioral health.[1719]

- **The Supplemental Nutrition Assistance Program (SNAP**) provides food assistance to low-income families and has helped decrease food insecurity.[1720] Food insecurity is associated with negative behavioral health outcomes, particularly increased depression for seniors,[1721] increased anxiety and depression in children, and worse maternal behavioral health.[1722]
- **Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)** both provide supplemental income and health insurance for individuals who are unable to work due to a serious medical condition, including behavioral health conditions, and their families.[1723, 1724] For SSDI, over 35 percent of participants are in the program due to a mental health condition.[1725]
- **Section 8 Housing Vouchers** can help provide housing security, which is associated with better behavioral health as well.[1726]
- **Head Start** helps provide early childhood education, health, and nutrition services to low-income families with children up to five years old.[1727] Almost two-thirds of Head Start sites also provide behavioral health care on-site, such as through the placement of early childhood mental health specialists in classrooms[1728] and through social-emotional development screenings.[1729] The program also provides care during home visits, specifically for postpartum depression and through referrals to help address SUD, which are also provided on-site many times.[1730]

- **The Temporary Assistance for Needy Families program (TANF)** provides cash assistance to both individuals and families.[1731] TANF has had mixed effects on reducing poverty, particularly due to punitive work requirements placed on participants[1732] and because of funding levels lost over the past two decades, due to the program's nominally fixed and capped block grant structure.[1733, 1734, 1735] However, when it has been paired with behavioral health interventions in the past, it has seen success in reducing rates of behavioral health symptoms and economic hardship. For example, the Building Wealth and Health Network Randomized Control Trial provided simultaneous financial education and trauma-informed peer support for 28 weeks alongside standard programming for TANF recipients.[1736] The population was made up of caregivers of children under six, many of whom who had a high number of ACEs, and through this program, they had decreased depressive symptoms, less economic hardship, and greater earnings.[1737]
- **The Earned Income Tax Credit (EITC)** provides low-paid workers an annual lump sum payment as a part of their tax returns.[1738] The program has had positive impacts on behavioral health. For example, one study found that mothers who lived in states that recently expanded or passed EITCs saw decreases in mental stress and tobacco use during pregnancy.[1739]
- **The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)** provides supplemental food along with nutrition education to low-income pregnant and postpartum women and children ages five and under who face nutritional risk.[1740] WIC can also help women address depression through screenings, referrals, breastfeeding promotion and assistance, and information about nutrition as it relates to maternal depression.[1741]

Appendix V. Funding Sources

FIGURE B. Federal expenditures on maternal behavioral health-related programs, FFY 2017

Program Name	Obligations (In Billions of Dollars)
Health[1742]	
Medicaid	$378.5
Children's Health Insurance Program (CHIP)	$16.9
Healthy Start Program	$0.1
Title V Maternal and Child Health Block Grant Program	$0.6
Maternal, Infant, and Early Childhood Home Visiting (MIECHV)	$0.4
Community Mental Health Services Block Grant	$0.5
Income Security[1743]	
Temporary Assistance for Needy Families (TANF)	$17.1
Early Education & Care[1744]	
Head Start/Early Head Start	$9.2

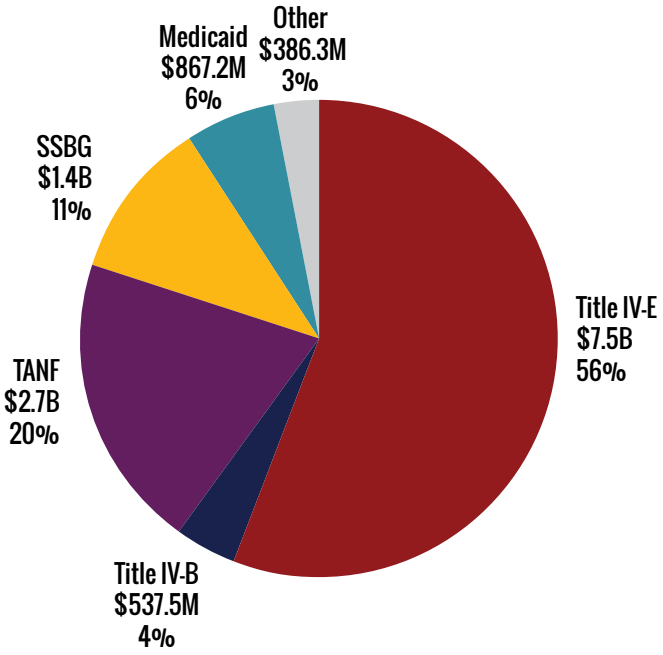
Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

MAJOR CHILD WELFARE FUNDING SOURCES

The child welfare system is funded through multiple streams and at different levels of government. Federal funding comes from a variety of sources, the largest of which is Title IV-E of the Social Security Act, which is dedicated solely to child welfare (see Figure C).[1745] States also spend their own dollars on child welfare to match federal dollars or to meet the maintenance of effort requirement in order to receive federal dollars.[1746] State and local dollars accounted for 56 percent of child welfare spending in SFY2016.[1747] How much local funding is state-mandated depends on who administers the child welfare system in a specific state.[1748] Some states do not have local funding at all.[1749]

FIGURE C. Just over half of public child welfare spending comes from Title IV-E

SFY 2016 survey of federal, state, & local child welfare financing



Note: Total SFY2016 spending was $13.5 billion. TANF stands for Temporary Assistance for Needy Families; & SSBG stands for Social Security Block Grants. Data does not include Puerto Rico. Missing data for Vermont (TANF, SSBG, Medicaid, Other), North Dakota (SSBG), & Nebraska (Medicaid, Other). Title IV-E of the Social Security Act focuses on providing provisional safe & stable out-of-home care for children, who experience maltreatment or other such difficult circumstances.

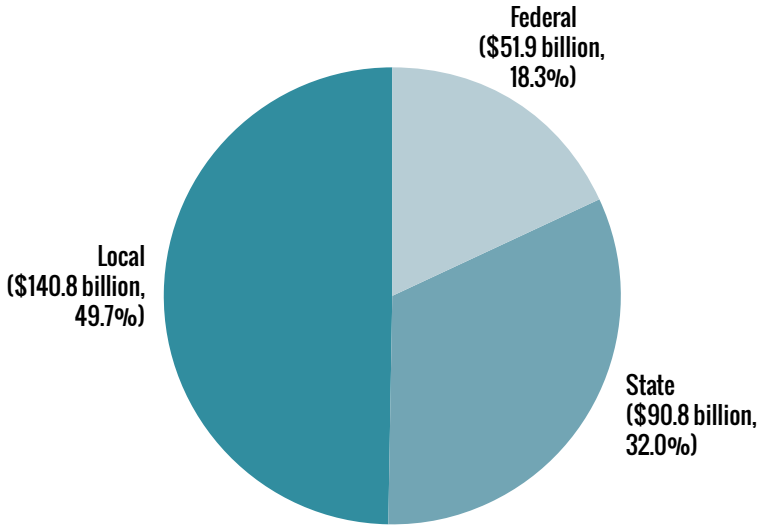
Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Rosinsky, Kristina, & Sarah Catherine Williams. "Child Welfare Financing SFY 2016: A Survey of Federal, State, and Local Expenditures." Child Trends, December 2018. Data from: https://www.childtrends.org/wp-content/uploads/2018/12/CWFSReportSFY2016_ChildTrends_December2018.pdf.

MAJOR JUSTICE SYSTEM FUNDING STREAMS

The justice system makes up about four percent of all federal expenditures, and about four percent of individual states' budgets.[1750] However, local governments provide about 50 percent of total expenditures; total expenditures for the justice system were approximately $284 billion in FY2015.[1751] The justice system's funding from state and local sources has increased by 324 percent from 1980-2012; comparatively, the education system's funding from state and local sources has increased by only 107 percent over the same time.[1752]

FIGURE D. Nearly half of all criminal justice system expenditures in the U.S. are at the local level

Total justice system expenditures by level of government, FY 2015



Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Justice system expenditure data from Bronson, Jennifer. "Justice Expenditure and Employment Extracts, 2015 - Preliminary." Bureau of Justice Statistics, 29 June 2018. Available at https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6310.

FIGURE E. Federal expenditures on family-supporting programs, FFY 2017

Program Name	Obligations (in Billions of Dollars)
Health[1753]	
Medicaid	$378.5
Children's Health Insurance Program (CHIP)	$16.9
Vaccines for Children	$4.4
Health Center Programs	$4.9
Substance Abuse Prevention and Treatment Block Grant	$1.9
Nutrition[1754]	
Supplemental Nutrition Assistance Program (SNAP)	$78.5
Supplemental Nutrition Program for Women, Infants, and Children (WIC)	$6.4
Commodity Supplemental Food Program (CSFP)	$0.2
National School Lunch Program (NSLP)[1755]	$12.3

Program Name	Obligations (in Billions of Dollars)
Income Security	
Social Security[1756]	$945.0
Temporary Assistance for Needy Families (TANF)[1757]	$17.1
Supplemental Security Income (SSI)[1758]	$59.9
Unemployment Compensation (UI)[1759]	$2.7
Veterans Disability Compensation[1760]	$80.4
Child Support Enforcement (CSE)[1761]	$4.2
Education[1762]	
Title 1 Grants to Local Education Agencies	$15.5
Special Education	$11.9
School Improvement	$0.5[1763]
Impact Aid	$1.3
Education Innovation and Research (EIR)	$0.1
Early Education & Care[1764]	
Head Start/Early Head Start	$9.2
Child Care and Development Fund	$8.5
Social Services[1765]	
Title IV-E (Social Security Act)	$8.3
Housing[1766]	
Section 8 Housing Vouchers	$20.3
Section 8 Project-Based Rental Assistance	$11.1
Tax Expenditures[1767]	
Earned Income Tax Credit (EITC)	$63.8
Child Tax Credit (CTC)	$54.5
Exclusion for Employer-Sponsored Health Insurance[1768]	$280.0
Child and Dependent Care Tax Credit (CDCTC)	$4.6

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019.

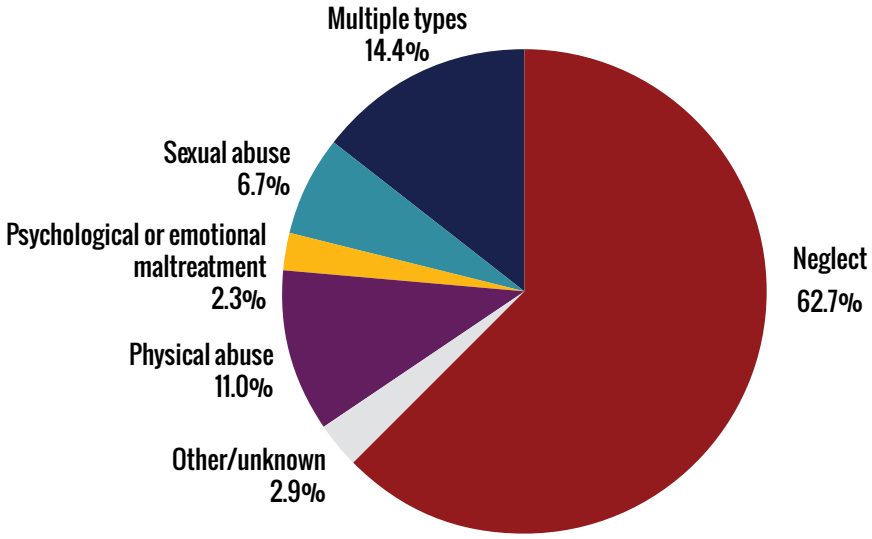
Appendix VI. Child Welfare System Overview

The following section describes how a family may interact with the child welfare system if it functions as intended at each stage or decision point. As part of the report's holistic approach, the report also focuses on the prevention/pre-interaction stages of involvement with the child welfare system. However, as the intersection of behavioral health and child welfare matters at each stage of interaction and in different ways, it is important to first establish a shared understanding of how the system is currently set up to function.

A family's first interaction with the child welfare system typically follows a child maltreatment claim filing.[1769] HHS defines grounds for a claim as "neglect, physical abuse, sexual abuse, and emotional abuse or neglect caused to children by parents or primary caregivers, such as extended family members or babysitters," or that a caregiver allows to take place.[1770] Neglect is the most common form of maltreatment (see Figure F for a more detailed breakdown of how often each type of abuse occurs).[1771] The majority of people who report abuse to CPS are designated mandatory reporters who are required by law to report any suspicions of abuse or neglect they have.[1772] These mandatory reporters frequently work with children in a professional capacity and include social workers; teachers and other school personnel; physicians, mental health professionals, and other health care workers; law enforcement officers; and child care providers.[1773] As of August 2012, 18 states and Puerto Rico require anybody who suspects misconduct to report it to CPS.[1774] As discussed in the following section, the underlying issue impacting families in contact with CPS is often poverty or the inaccessibility and unaffordability of behavioral health care. Parents or guardians, including in middle class families, have relinquished custody of their children to the child welfare system in an effort to make sure their children receive necessary mental health and substance use treatment.[1775] Some states, like New Jersey, have enacted laws or adopted practices in an effort to limit this practice and provide in-home or community-based services to children without their parents having to relinquish custody.[1776]

FIGURE F. "Neglect" comprises the vast majority of substantiated child welfare cases

Substantiated child welfare claims with single maltreatment type by proximate cause, 2017



Note: Single type cases only are shown; these cases represent 576,495 of 673,830 substantiated cases. Includes data from 50 states & D.C.

Source: Georgetown Center on Poverty and Inequality & Mental Health America, 2019. Adaptation of "Child Maltreatment 2017." U.S. Department of Health and Human Services, 2016. Available at https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf.

Typically, after a claim is filed, a CPS caseworker investigates the claim and assesses whether the abuse claim was unsubstantiated or substantiated.[1777] In jurisdictions with a differential or alternative response system and when a child is not in immediate danger, a caseworker may recommend supports and services based on an assessment of family strengths and difficulties instead of focusing on substantiating a claim.[1778] If a claim is substantiated, a court proceeding may be initiated by CPS in order to determine the next steps for the family.[1779] Services that the court could decide to provide to the family include education, child care, counseling, and safety planning,[1780] which would entail the CPS caseworker outlining a plan with actions that each family member will take and who they will work with to guarantee the child's safety, such as a child care provider or other relatives. During court proceedings, a child may be in temporary protective care if deemed necessary.[1781]

Generally, if a child is found to face a low to moderate risk of future abuse, CPS' policy is to recommend community-based or voluntary in-home services for the family.[1782] If a child faces a moderate to high risk, they could be placed with a relative or into foster care, while their family continues to receive services and possibly CPS familial visitation.[1783] The police may also investigate the charges of abuse or neglect if they are serious enough, and the caretaker's name may be placed on a maltreatment registry.[1784]

Ultimately, the state or county provides each child a permanency plan that sets out where they will be placed for the rest of their time in the system.[1785] Their family works with the agency to come up with a plan detailing which services they will use, with family reunification generally the ultimate goal. A concurrent plan is developed if family reunification is unlikely, often outlining a path to adoption or permanent placement with a relative.[1786] A permanency court hearing takes place within 12 months of placement into the foster care system to make sure the plan is

implemented.[1787] When the system works well, youth in the foster care system receive services while in the foster care system to help achieve economic stability before they leave the system between the ages of 18 and 21.[1788] Visitation with family members is encouraged following the plan set out by all parties involved.[1789]

Schools are integral in dealing with child maltreatment. Mandatory reporters, such as teachers and other school personnel in most states, are tasked with identifying, reporting, and preventing abuse in the students they see routinely.[1790] After a report is filed, schools can still play a part in helping CPS develop a plan for the child and the family. They may also support a child and their family throughout the process with programs such as supportive services (like providing free or reduced-price breakfasts and lunches; emergency supplies of clothing and shoes; medical supplies such as eyeglasses, hearing aids, and prosthetic devices; and access to support groups).[1791]

Once a child enters the child welfare system, child welfare agencies must have an educational stability plan for every child in foster care.[1792] When deciding on placements, agencies must work with schools to ensure that children remain in their current school if that is best for the child.[1793] If a transfer to a new school is necessary, the child's case plan must include assurances that the child will be enrolled in a new school with up-to-date educational records.[1794] Even with the enactment of these requirements through "The Fostering Connections to Success and Increasing Adoptions Act of 2008," the Children's Hospital of Philadelphia found that Philadelphia students in foster care miss twice as much school as children in their district overall, and attend an average of 2.7 schools in a 2-year period, though absenteeism is higher for these students before their foster care placements and if they are reunified with their family.[1795] Changing schools[1796] and absenteeism[1797] are correlated with behavioral health conditions for both the child and their family and can also exacerbate behavioral health conditions.

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