Centering Racial Equity: The Role of Sustained Community Partnership in Behavioral Health

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Disclaimer

This webinar was developed [in part] under contract number HHSS283201200021I/HHS28342003T from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Community of Practice Intimate Dialogue

Join Us for Part Two

https://zoom.us/meeting/register/tJwscOurrDkjHdeH8csKpnWg-B30RX_h7I_P

Centering Racial Equity: The Role of Sustained Community Partnership in Behavioral Health

January 25, 2022 from 1:00-2:00pm ET

*Dive into your questions

*Coordinate your efforts

* Expand your network

Part Two will be via Zoom so you will have the opportunity to interact with the presenter and moderator verbally or via chat.

Neglected Communities: A Root Cause of Inequity

"We've been defined for a long time to be a community of deficits, you know, our whole existence was measured... based on poverty... That's how money came into the community... That's how we saw ourselves... just a community of deficit..."

"You can create an environment that's an empowering environment..."

Community Advisory Council – Howard University, Washington, DC

Today's Conversation

Centering Racial Equity through Sustained Community Partnership in Behavioral Health

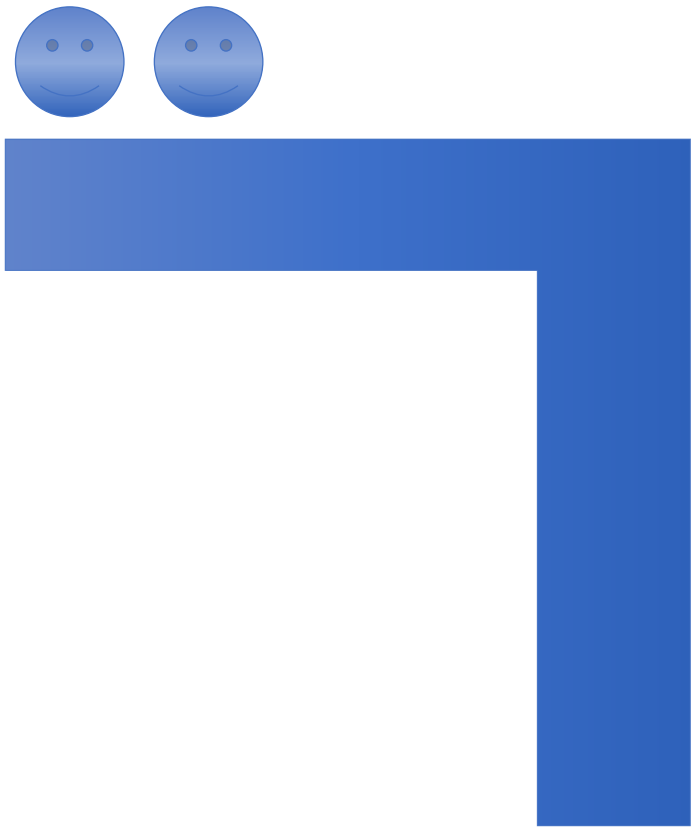
I. View of inequity from the community level
II. Social determinants of engagement
III. Strategies for alliance-building
IV. Lessons from national exemplars
V. Principles of equity-centered partnership

Centering Racial Equity: The Role of Sustained Community Partnership in Behavioral Health

Part I.

Inequity at the Community Level

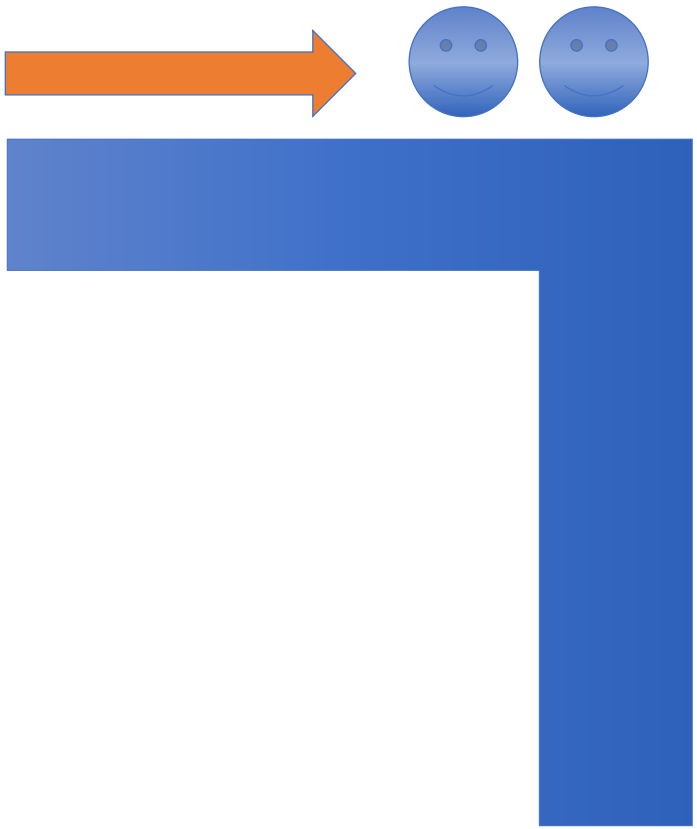
Inequity at the Community Level



Ideally, communities are healthy and thriving, at low risk of falling off the cliff of good health.

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”

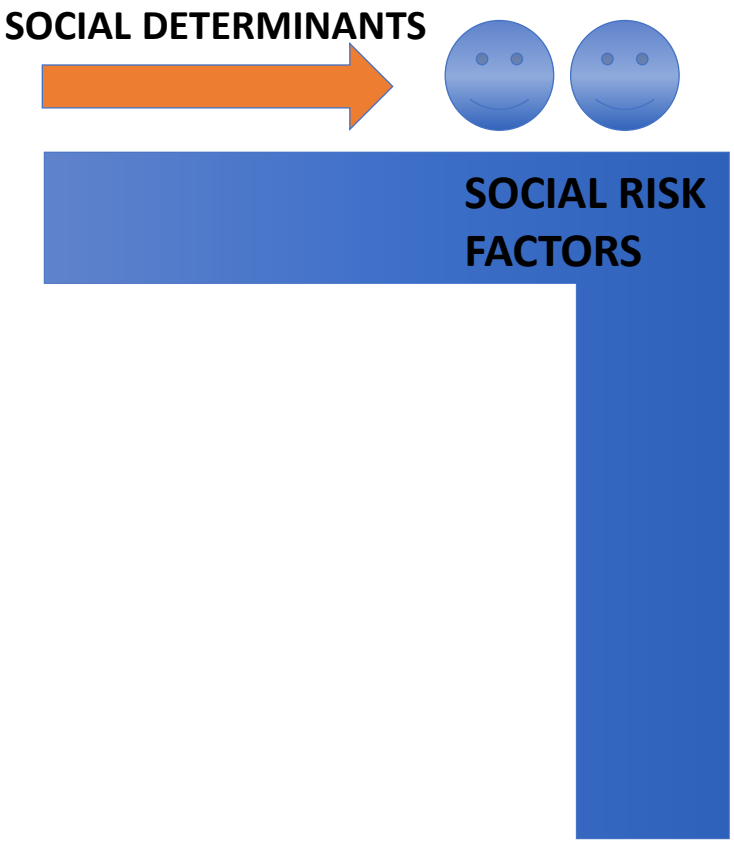
Inequity at the Community Level



Marginalized communities are pushed to the edge of the cliff by social forces.

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”

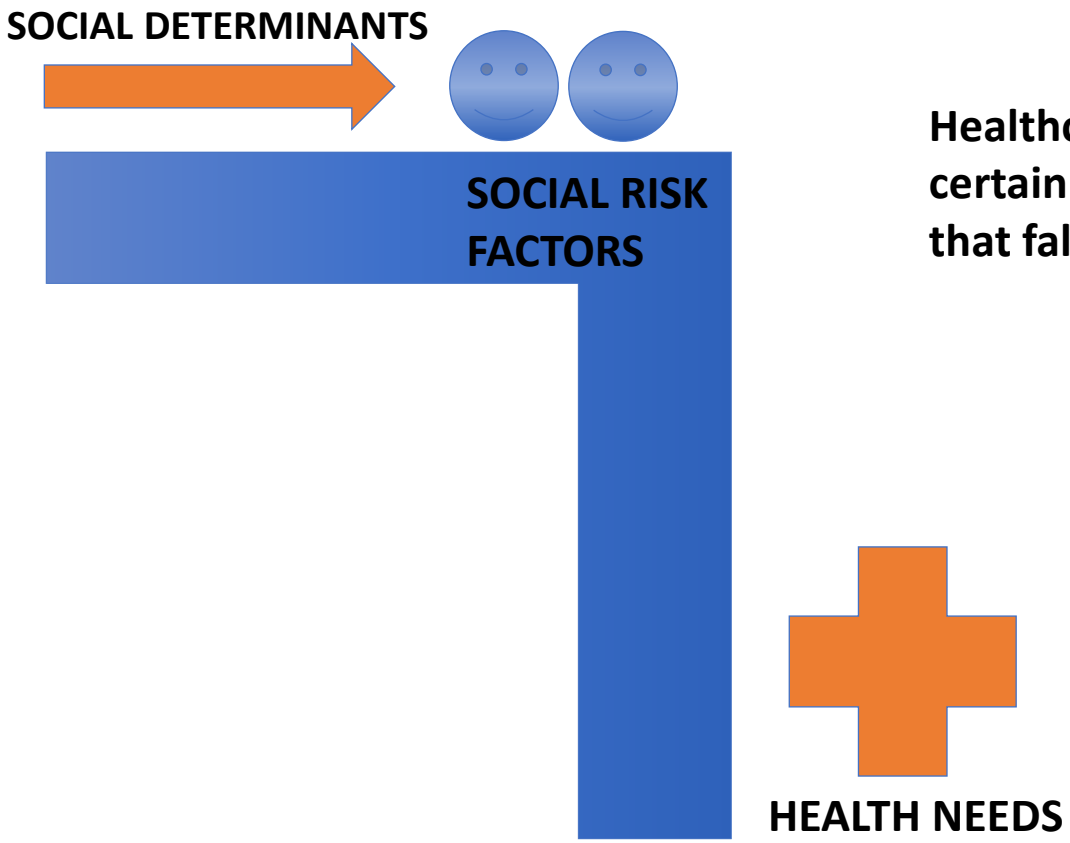
Inequity at the Community Level



Without intervention, these communities are at higher risk of falling off the cliff.

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”

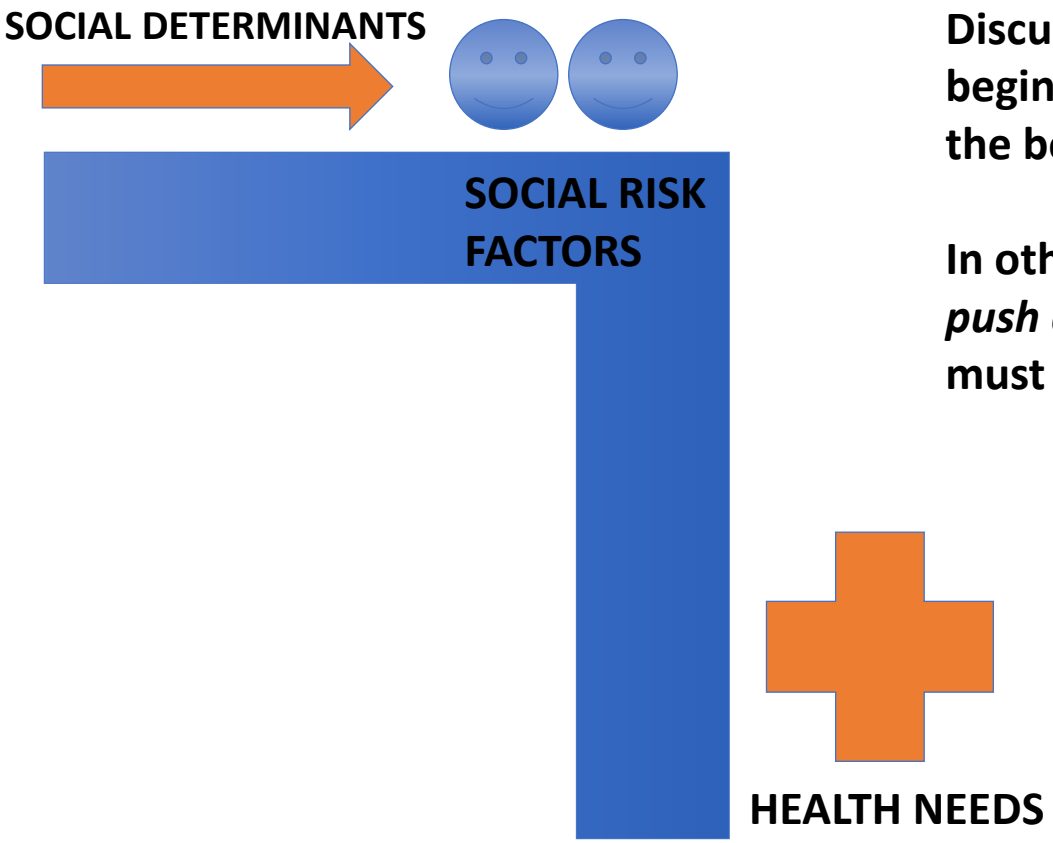
Inequity at the Community Level



Healthcare interventions are certainly needed for communities that fall off the cliff.

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”

Inequity at the Community Level



Discussions about equity must begin at the top off the cliff, not the bottom.

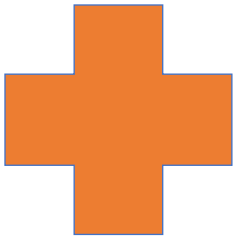
In other words, the forces that *push communities to the edge* must be addressed.

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”

Inequity at the Community Level

INEQUITIES = CONDITIONS

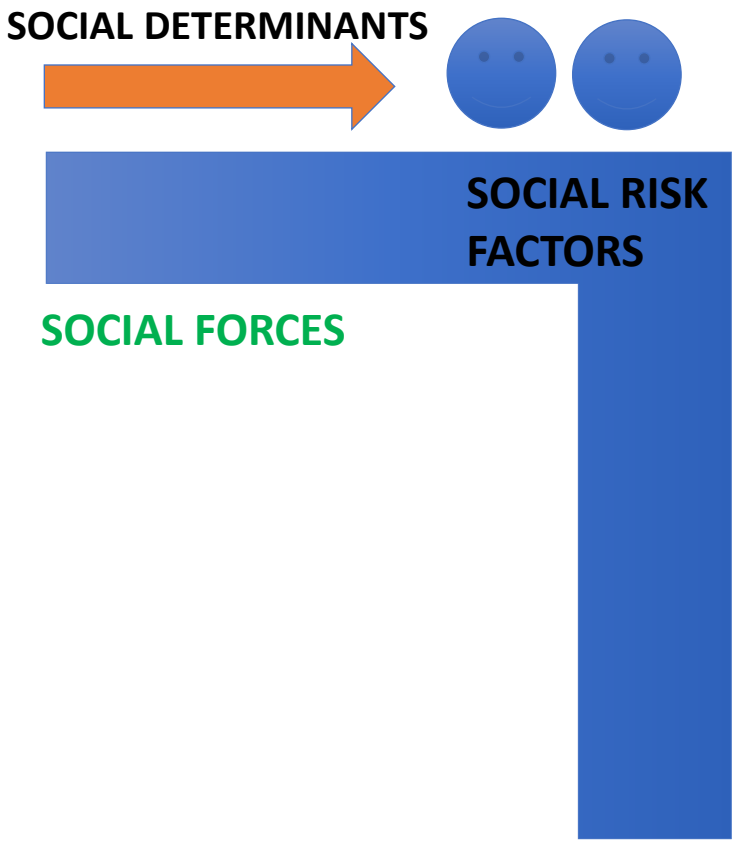
Disparities are the differences in a community's health that are due to unjust causes (inequities).



DISPARITIES = CONSEQUENCES

Credit: Dr. Camara P. Jones, "The Cliff of Good Health"

Inequity at the Community Level

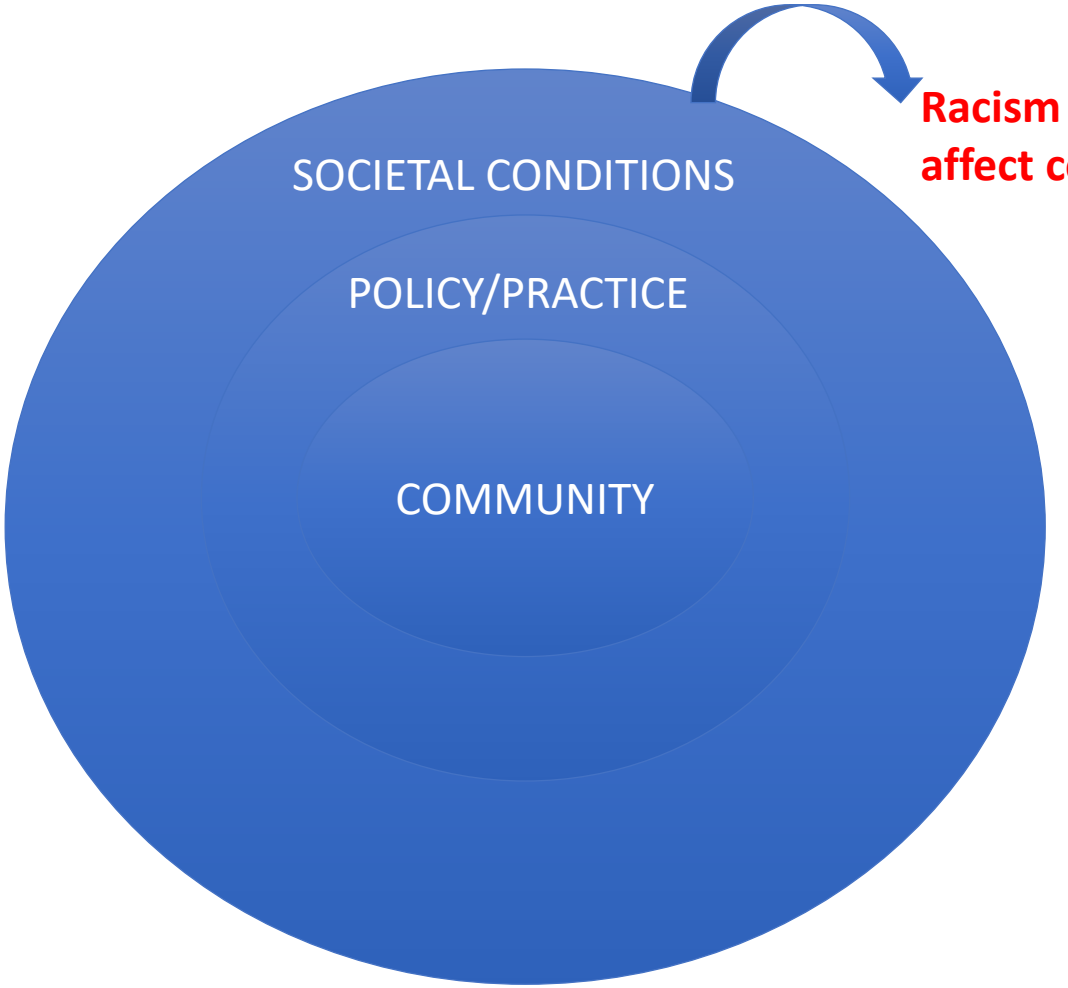


At what level does your organization currently engage?

SAFETY NET
QUALITY
ACCESS

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”

Inequity at the Community Level



Inequity at the Community Level

One of the most powerful societal forces

Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call “race”), that unfairly advantages or disadvantages some individuals or communities.

Jones CP. Confronting institutionalized racism. *Phylon*. 2003;50(1): 7-22.

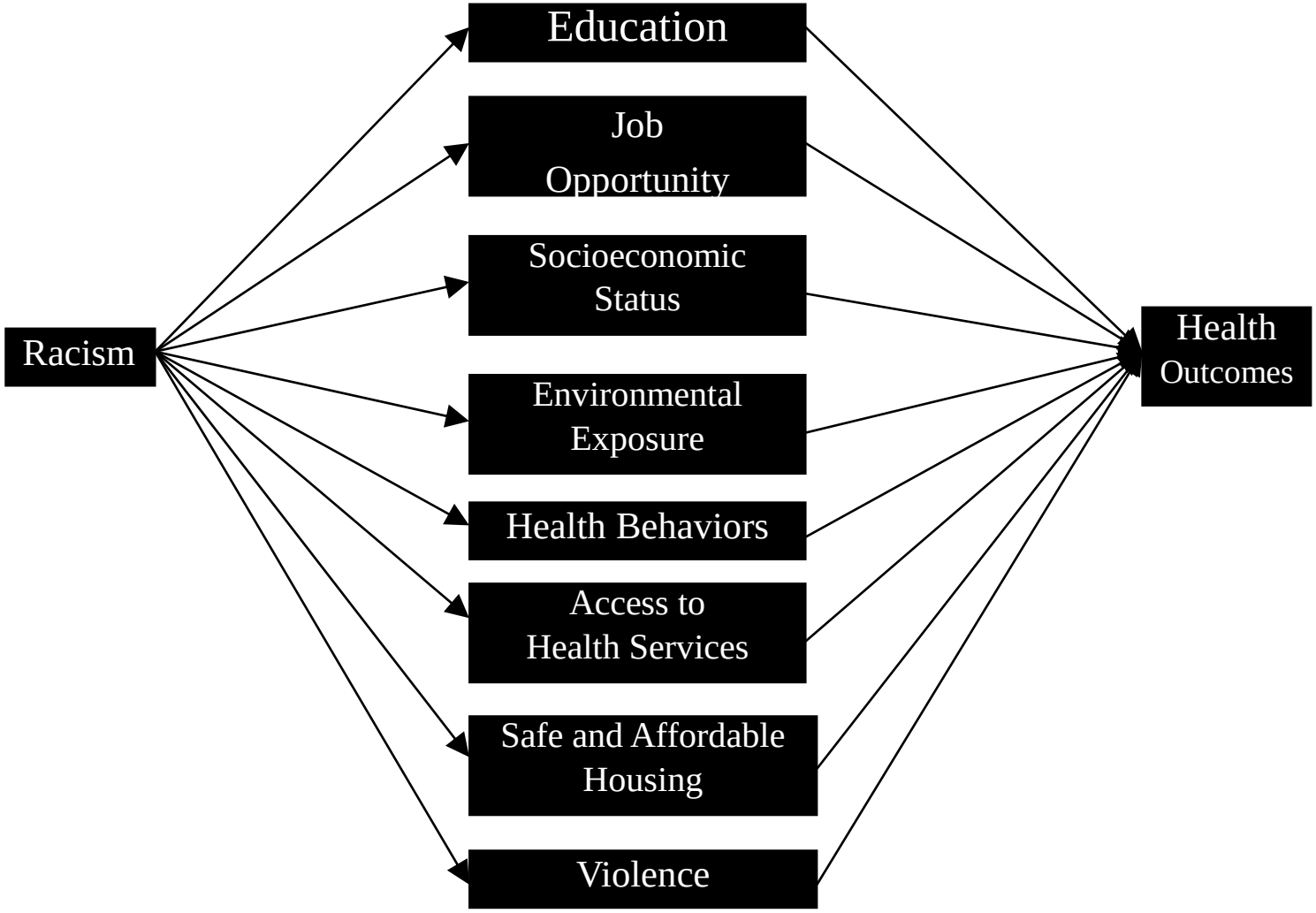
Inequity at the Community Level

Structural racism

The totality of ways in which societies foster racism through mutually reinforcing institutions, which then energize the racism which occurs institutionally, interpersonally, and internally – making racism a self propelling system.

Bailey, ZD et al. Structural racism and health inequities in the USA: evidence and interventions. *The Lancet.* 2017;*389*(10077):1453–1463.

Inequity at the Community Level



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Part II.

Social Determinants of Engagement

Social Determinants of Engagement

Engagement must occur across the spectrum of the social determinants of health.

Concept adapted from Williams DR, Mohammed SA, 2013. *Racism and health I: pathways and scientific evidence.* Am. Behav. Sci. 57, 1152-1173

Social Determinants of Engagement

Example #1

Engaging marginalized communities in SUD recovery must address history and context, not just "treatment."

Social Determinants of Engagement

Example #1—Substance Use

History: War on Drugs

- Began in 1971 by President Nixon and grew under President Reagan
- Decades of the disproportionate arrest and incarceration of black Americans
- The Anti-drug Abuse Act of 1986 created a 100 to 1 sentencing disparity for crack vs powder cocaine use *(this disparity reduced to 18:1 in the Fair Sentencing Act of 2010)*

https://drugpolicy.org/issues/brief-history-drug-war
https://www.aclu.org/issues/criminal-law-reform/drug-law-reform/fair-sentencing-act

Social Determinants of Engagement

Example #1—Substance Use

History: War on Drugs

- By 2001, over 80% of federal "crack" defendants were black
- Black children nearly 9x more likely, Latino children 3x more likely to have a parent in prison, compared to white children

ACLU, "Race and War on Drugs" Position Paper. https://www.aclu.org/other/race-war-drugs

Social Determinants of Engagement

Example #1—Substance Use

History: What changed?

Drug use in the 1980s:

Character flaw

Criminalization

Sentencing disparities

Punishment

Drug use in the 2010s:

Disease

De-criminalization

Sentencing reform

Treatment

Slide Credit: M. Medlock et al, “Racism and Black Mental Health” CME. American Psychiatric Association.

Social Determinants of Engagement

Example #1—Substance Use

- Increasing opioid overdose deaths among white persons widely reported and led to infusion of funding and resources
- Cocaine-related overdose deaths among black persons have been at high levels for decades but have been neglected and ignored

Shiels MS, Thomas D, Berrington de Gonzalez A. Trends in U.S. Drug Overdose Deaths in Non-Hispanic Black, Hispanic, and Non-Hispanic White Persons, 2000–2015. *Annals of Internal Medicine.* 2018 Mar;168(6): 453-5.

Social Determinants of Engagement

Example #1—Substance Use

How do we engage communities who experienced this history?

Hint: Harm reduction may not only refer to substance use but reducing harm from unjust policies that created conditions of exclusion.

Social Determinants of Engagement

Example #2

Partnerships to address housing insecurity must address the racial dimensions of homelessness.

Social Determinants of Engagement

Example #2—Homelessness

Drivers of homelessness

- Cuts in affordable housing
- De-institutionalization of the mental health system
- Challenges facing specific subgroups (e.g., veterans, youth aging out of care, single adults with mental health or substance use problems)

Racial dimensions of homelessness have largely been left out of the conversation...

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Social Determinants of Engagement

Example #2—Homelessness

Racial dimensions

- More than half of all people currently experiencing homelessness are people of color
- Native Americans and African Americans - two historically oppressed populations - most over-represented
- African Americans: 40% of the homeless population
- African Americans continue to be over-represented when controlling for poverty

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Social Determinants of Engagement

Example #2—Homelessness

Racism and homelessness: intentional acts of exclusion

- Blocking people of color from securing the financing necessary to open small businesses, which are associated with neighborhood growth
- Locking people out of participation in the mortgage system and, as a result, out of property ownership – the principal wealth-building mechanism for most Americans
- Creation of a "race of renters," meaning that blacks and other people of color were disproportionately forced to rent

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Social Determinants of Engagement

Example #2—Homelessness

The isolation of housing instability to black people has deleterious effects on mental well-being:

- Contributes to minority stress
- Homelessness in itself is a significant trauma
- Barriers to accessing mental health care
- Reduced quality of care and poor health outcomes

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Social Determinants of Engagement

The Big Picture – Levels of Engagement

- **Primary:** ***Addressing unequal <u>conditions</u>***
- **Secondary:** ***Addressing <u>concerns</u> arising from social context***
- **Tertiary:** ***Addressing <u>consequences</u> of marginalization***

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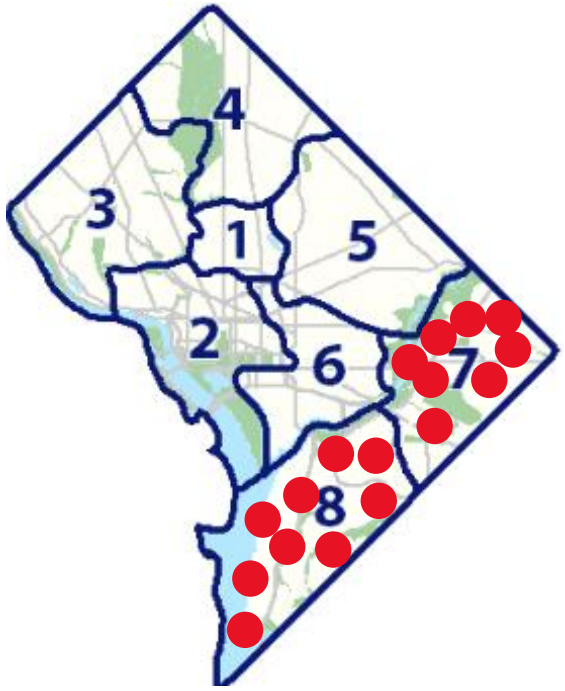
Part III.

Strategies for Alliance Building

Strategies for Alliance Building

Example #1—Substance Use

Context: Washington, DC Wards 7 and 8



Example 1 explains community partnerships conducted at Howard University

ZONE OF INEQUITY

>90% African American

>80% of food deserts

1/3 live below poverty line

Highest HIV prevalence rates

Mental health resource shortage area

<u>Highest opioid overdose rates</u>

Strategies for Alliance Building

Example #1—Substance Use

Community-Centered Data Collection

- **Objective:** Engage individuals with lived experience, neighbors, family members, and leaders, in the interview process.

- **Lesson:** Community members were concerned about more than "treatment." They were seeking systemic solutions to economic disinvestment (a root cause of SUD).

Strategies for Alliance Building

Example #1—Substance Use

Community's Vision and Mission

- The **vision** of the Washington, DC "Reach, Engage, Retain" project is for Wards 7&8 to be a healthy, thriving community where residents experience freedom from problems with substance use and addiction.
- Our **mission** is to increase access to effective recovery and treatment services; reduce stigma; and deal with the root causes of unhealthy drug use.

Strategies for Alliance Building

Example #1—Substance Use

Community Education and Empowerment

- **Objective:** Educate community champions and DC residents at-large regarding key aspects of opioid treatment and recovery. Disseminate knowledge about treatment resources.

- **Lesson:** A great deal of stigma regarding OUD treatment was present on the Community Board. We started there with our educational efforts.

Strategies for Alliance Building

Example #1—Substance Use

Community-Centered Intervention

- **Objective:** Communicate findings, seek feedback, and apply revisions to the intervention and evaluation process, guided by community stakeholders.

- **Lesson:** SBIRT Intervention is in process at a local church and non-profit community center.

Strategies for Alliance Building

Example #1—Substance Use

Sustained Community Partnership

- **Objective:** Nurture relationships with community advisors and partners that will guide long-term strategy and decision-making within the Department.

- **Lesson:** The community must feel valued beyond the deliverables of the project.

Strategies for Alliance Building

Example #2—Homelessness

Community-Centered Data Collection

Examine homeless service system data by race to understand:

- Rates of homelessness for each racial/ethnic group compared with the general population
- Prior living situations and patterns of inflow by race
- Factors connecting homelessness with other systems
- Patterns of service utilization
- Distribution of public housing units and vouchers by race

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Strategies for Alliance Building

Example #2—Homelessness

Community's Vision and Mission

Preventing homelessness at the population level for marginalized communities must include:

- Perspectives of people of color who have experienced homelessness
- Racial equity language and strategies in all federal, state, and local plans

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Strategies for Alliance Building

Example #2—Homelessness

Community Education and Empowerment

- **Power**
  - Individuals with lived experience given seats on boards, paid positions within an organization, community advisory groups, consulting roles
- **Practice**
  - Comprehensive view of the intersection of homelessness with other areas such as substance use, mental health disorders, trauma, and general distress

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Strategies for Alliance Building

Example #2—Homelessness

Community-Centered Intervention

- **Using community data to drive decision making and allocation of resources**
- **Exploring upstream prevention strategies that bring together population health and individual risk assessment and response**

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

Strategies for Alliance Building

Example #2—Homelessness

Sustained Community Partnership

- **Developing funding streams designed to respond to the pressing needs of people of color experiencing homelessness**
- **Creating equitable housing policies at the federal, state, and local levels that begin to move the needle on high rates of homelessness among people of color**

J. Olivet et al, Chapter 4: The Intersection of Racism, Homelessness, and Mental Illness," in Medlock et al (ed.) *Racism and Psychiatry: Contemporary Issues and Interventions*, 2019.

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Part IV.

Lessons from National Exemplars

National Exemplars

Example #1—Purpose Built Communities

Changing neighborhoods, changing lives.

We serve as a bridge, connecting community leaders with resources and partner organizations that share a vision to make holistic, at-scale investments in defined neighborhoods to achieve excellent and equitable outcomes for the people who live there.

Our collaboration with innovative thinkers is driven by a collective desire to advance communities, improve the lives of residents of neighborhoods made vulnerable, end a cycle of intergenerational poverty, and set a new course for cities across the country.

Purpose Built Communities helps local leaders create greater racial equity, economic mobility, and improved health outcomes for families and children.

www.purposebuiltcommunities.org

National Exemplars

Example #1—Purpose Built Communities

www.purposebuiltcommunities.org

National Exemplars

Example #1—Purpose Built Communities

https://www.youtube.com/watch?v=GDybErEk8XY&list=TLPQMjcxMjIwMjFTWjk0hpR-Nw&index=2

National Exemplars

Example #2—Boston Public Health Commission

RACISM: A PUBLIC HEALTH CRISIS

On June 12, 2020, the city of Boston declared racism a public health crisis. BPHC is committed to addressing the impact that racism has on the lives of all of our neighbors and how it impacts the overall health of our residents.

www.bphc.org

National Exemplars

Example #2—Boston Public Health Commission

2005
Anti-Racism Internal Working Group

2008
Anti-Racism Advisory Committee Est.

Staff Training on Anti-Racism Approaches

2011
Racial Justice & Health Equity Initiative – Strategic Priority

2016
Office of Health Equity Oversees Community Engagement

2018
Health Equity in All Policies Initiative

2021
Racial Equity Centered in Strategic Plan

www.bphc.org

National Exemplars

Example #3—King County Regional Homelessness Authority
Strategic Priorities

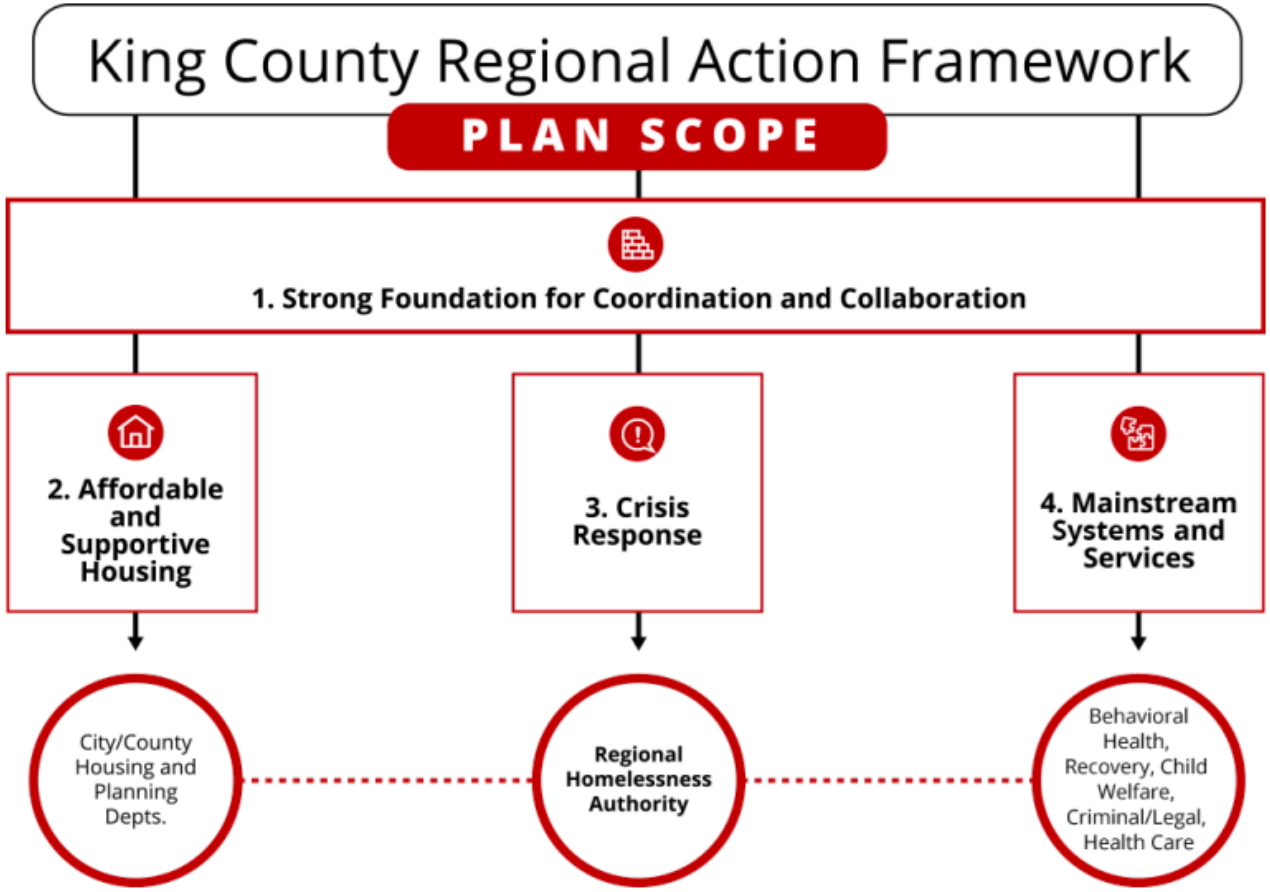
1. ***Consolidate*** funding and policy regarding homeless *crisis response* activities to provide an accountability mechanism for community-wide action and alignment.

2. ***Develop*** an External Partners Group centered on those with lived experience with homelessness and advocates to cultivate, share, and promote solutions to homelessness.

3. ***Design*** a shared vision and priorities, sufficiently resourced, with specific strategies and actions that work for the whole community.

National Exemplars

Example #3—King County Regional Homelessness Authority



www.kcrha.org

Centering Racial Equity: The Role of Sustained Community Partnership in Behavioral Health

Part V.

Principles of Equity-Centered Partnership

Principles of Equity-Centered Partnership

1. ***Empowerment***

Community-level empowerment utilizes a strengths-based approach to provide tools and resources for the community to act in its own best interest.

This is directly opposed to a top-down, deficit-based approach.

Wallerstein N. Empowerment to reduce health disparities. Scandinavian Journal of Public Health Supplement. 2002;59:72-77

Principles of Equity-Centered Partnership

2. Trust

Trust is built on 3 levels:

- ***Structural:*** *Workforce, Power-sharing*
- ***Relational:*** *Participatory decision-making*
- ***Individual:*** *Values, motivation*

Minkler M, Wallerstein N (editors). Community-based participatory research for health: from process to outcomes (2nd ed). San Francisco: Jossey-Bass; 2008.

Principles of Equity-Centered Partnership

3. Centering Lived Experience

The experiences of community members should be centered at every level of the engagement process, including leadership and policy-making.

Note that this corresponds to the notion of “peer support” in a trauma-informed framework.

Principles of Equity-Centered Partnership

4. Attention to History and Context

Direct engagement of the social, political, and economic forces that have contributed to inequitable health outcomes is mandatory.

Hansen H, Metzl J (eds). Structural competency in mental health and medicine. Springer, 2019.

Principles of Equity-Centered Partnership

5. Long-term Capacity Building

Strong partnership structures must be developed to support the community's final decision-making to act on the social determinants of health.

Principles of community engagement 2nd edition, p. 22

Empowered Communities: The Center of Equity

"It all starts with the community, because I am a product of my community."

Community Advisory Council – Howard University, Washington, DC

Thank You

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Special Thanks to SAMHSA for Sponsoring This Webinar