This book offers a unique, interdisciplinary, and thoughtful look at the challenges and potency of Black women’s struggle for inner peace and mental stability. It brings together contributors from psychology, sociology, law, and medicine, as well as the humanities, to discuss issues ranging from stress, sexual assault, healing, self-care, and contemplative practice to health-policy considerations and parenting. Merging theory and practice with personal narratives and public policy, the book develops a new framework for approaching Black women’s wellness in order to provide tangible solutions. The collection reflects feminist praxis and defines womanist peace in terms that reject both “superwoman” stereotypes and “victim” caricatures. Also included for health professionals are concrete recommendations for understanding and treating Black women.

“...this book speaks not only to Black women but also educates a broader audience of policymakers and therapists about the complex and multilayered realities that we must navigate and the protests we must mount on our journey to find inner peace and optimal health.”

—from the Foreword by Linda Goler Blount

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Translating Mental Health for African American Women

Health Policy Considerations

DANIEL E. DAWES AND KEISHA BRAITHWAITE HOLDEN

Introduction

Each year approximately 83,000 African Americans die as a result of poor health outcomes primarily related to health disparities; and as a nation we are spending an estimated $300 billion because of these disparities—$82.2 billion due to direct health care expenditures and loss of productivity (Satcher et al., 2005; Sutters, 2008; LaVeist, Gaskin, and Richard, 2011; Dawes, 2014).

These statistics provide only a sketch of a monumental problem that is multifaceted and arcane, especially when the social and physical determinants of health are considered. Indeed, the health disparities confronting other vulnerable populations are many and varied. Nevertheless, vulnerable populations may experience symptoms of health problems that are undiagnosed, under-diagnosed, or misdiagnosed in part because of a combination of various cultural, linguistic, sociopolitical, environmental, economic, or historical reasons.

Oftentimes, these health disparities result from laws and policies that fail to meaningfully assess the impact to health equity among vulnerable populations.

Efforts to eliminate racial and ethnic health disparities were initiated by the Heckler Report in 1985. This report led to the passage of the first federal legislation intended to tackle issues impacting minority health, the Disadvantaged Minority Health Improvement Act of 1990 post reconstruction (Dawes,
2016). Ten years later, as a result of the increased research around racial and ethnic health disparities, another more comprehensive legislation addressing minority health and disparities was signed into law, the Minority Health and Health Disparities Research and Education Act of 2000. Interestingly, this bill was informed by a landmark report that was released a year prior—Mental Health: A Report of the Surgeon General, which urged more attention to racial and ethnic disparities, diversity, and cultural competence.

In 2001, the William J. Clinton administration released a supplement to the Surgeon General’s report, Mental Health: Culture, Race, and Ethnicity. That report showed significant disparities in access to and availability of mental health services by race and ethnicity, and that racial and ethnic minorities experience a disproportionately high disability burden from unmet mental health needs. Minorities showed higher levels of tobacco use and less access to necessary mental health services compared to white members of the population. The report emphasized the role that cultural factors play in mental health, and showed the necessity of programs to deliver culturally, linguistically, and geographically accessible mental health services. Another major report, one that was mandated by the Minority Health and Health Disparities Research and Education Act of 2000, was promulgated by the Institute of Medicine (IOM) in 2002, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health (Smeldley et al., 2002), which highlighted the mounting evidence of a myriad of issues concerning access to health care services, quality of care received, and improvement in health outcomes among different groups. Collectively, these two reports proved highly impactful by laying the foundation for recommendations made two years later when the New Freedom Commission on Mental Health, which was established by President George W. Bush, released its report, Achieving the Promise: Transforming Mental Health Care in America. This 2003 comprehensive mental health report documented the disparities that were experienced by racial and ethnic minorities in the mental health system and made recommendations for addressing them effectively.

Furthermore, since 2003, the Agency for Healthcare Research and Quality (AHRQ) has released its annual National Healthcare Disparities Report (AHRQ, 2012), indicating that the United States health care system is designed to improve the physical and mental well-being of all Americans by preventing, diagnosing, and treating illness and by supporting optimal functioning. However, health disparities continue to exist and our system of health care distributes services inefficiently and unevenly across populations. As a result of these reports and other previous reports, the Obama administration went even farther in addressing health disparities when it enacted the Patient Protection and Affordable Care Act in 2010—the most comprehensive bill ever passed by Congress intended to steer the United States toward health equity.

In 2016, approximately five years after the passage of the Patient Protection and Affordable Care Act, similar multidimensional problems still exist, which continues to heighten the conundrum for multidisciplinary professionals in search of promising and innovative approaches to reduce and ultimately eliminate disparities in health status, care, and treatment. Addressing the multifaceted health and mental health needs of the United States population is a complex issue that warrants attention from clinicians, researchers, scientists, public health professionals, and policymakers that can offer unique perspectives and strategies to support efforts for greater well-being among individuals. With growing diversity, it is imperative that we delineate strategic health policies, focused community-based programs, and innovative multidisciplinary research that includes an examination of evidence-based models that may improve individuals’ longevity and quality of life. These issues have particular relevance for vulnerable and high risk populations, including African American women. Our chapter will provide a contextual framework for offering understanding about key issues to promote health/mental health and wellness among African American in general, and African American women in particular.

African American Women and Mental Health

Mental health issues affect a significant portion of the U.S. population, with an estimated sixty million Americans experiencing mental health conditions every year (NAMI, 2013). Mental health is defined by the U.S. Department of Health and Human Services as “the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity” (DHHS, 2001). According to the World Health Organization it is “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014). Mental and behavioral health issues are a growing area of interest in public health, particularly for many ethnically and culturally diverse populations. Gaining greater understanding about the various psychosocial, sociocultural, and environmental factors that may influence mental and behavioral health issues for African American women is imperative to help elucidate its significant impact on the overall health and wellness of this population. Several health disparities already
plague the African American community when compared to other ethnicities; mental illness and the lack of care only add to these disparities as it too affects access to and utilization of care and increased disability, which can affect one’s overall socioeconomic status.

The United States Department of Health and Human Services, Office of Minority Health reports that African Americans, when compared to non-Hispanic Whites, are approximately 30 percent more likely to report having some form of mental illness (DHHS, 2001) or more likely to report having serious psychological distress than Caucasians (Center for Disease Control, 2007). African Americans are also less likely to receive proper diagnosis and treatment for mental illnesses and are more likely to experience poorer functioning and greater disability from untreated mental illnesses (Alegria et al., 2008). Moreover, African American children and youth are more likely to receive a diagnosis of attention deficit hyperactivity disorder (Agency for Healthcare Research and Quality, 2012).

Major depressive disorder (MDD) is one of the most prevalent mental health problems in the United States that is associated with considerable impairment in functioning, and it affects approximately 14.8 million adults annually, with women eighteen to forty-five years of age accounting for the largest proportion of this group (NIMH, 2012). It is estimated that in the next twenty years, depression will be the leading cause of disability worldwide and in nations with high incomes, such as the United States (Gonzalez, Vega, Williams, Tarraf, West, & Neighbors, 2010). It is a disease that may be characterized as a pervasive psychiatric illness associated with episodes of long duration, high rates of chronicity, relapse and recurrence, psychosocial and physical impairment, and mortality and morbidity—with a 15 percent risk of death from suicide in patients with more severe forms of depression. Findings from the Summit on Women and Depression convened by the American Psychological Association suggest that examination of genetic factors, sex hormones, life stress and trauma, interpersonal relationships, and cognitive styles may provide greater insight into contributors to depression for women (Mazure, Keita, & Bichar, 2002). It is estimated that one woman in four is likely to suffer from a depressive episode at some time during her life (National Alliance on Mental Illness, 2012).

African Americans are less likely than Whites to report symptoms of major depressive disorder, and when they do, it tends to be more chronic and severe, and they are also much less likely to undergo mental health treatment (Williams, Gonzalez, Neighbors et al., 2007). This may in part be due to stigma and less trust with the medical community, poor or no insurance coverage for mental health services, problems accessing culturally responsive mental health professionals, and overreliance on family, friends, and/or religious communities for support (Holden & Xanthos, 2009). Also, cultural influences shape how people of different races deal with and/or cope with the depression (Williams, 2008). Although it is well documented that depression affects women at higher rates than men, research continues to explore the disparate effects of depression as it relates to women within different racial/ethnic groups (Hirth & Berenson, 2012; Lewis et al., 2012; Morris et al., 2011; MHA, 2010; NIMH, 2008; McGrath et al., 2001; Peden et al., 2000). Depression among African American women may be disproportionately underrecognized and undertreated (NAMI, 2009; Levin, 2008; Carringtong, 2006; Bender, 2005; Dwight-Johnson et al., 2001). Additionally, Furer & Craig (2009) report that depression rates for African American women are typically inconsistent and cannot be generalized to a specific population due to insufficient recognition of depressive symptoms. Gender, low socioeconomic status, relationship status and social support, and access to care and insurance coverage create even more of a disproportionate risk for depression and depressive symptoms (Heinen, 2014; Rai et al., 2013; Holden et al., 2012; DHHS, 2001). African American women are not frequently confronted with isolated stressors, but with a constellation of multiple issues that can engender stress, such as balancing work and home life demands, handling difficult life circumstances, managing personal relationships, nurturing identity development, and creating a purpose in life that motivates them toward positive goals and an orientation for achievement and success (Holden et al., 2015; Taylor & Holden, 2009). Dissimilar to Caucasian women, African American women’s generally low socioeconomic and structural position in U.S. society, and weathering of institutional racism and sexism may provoke mental and emotional distress that can add to their vulnerability for depression (Holden et al., 2013; McKnight-Eily et al., 2009).

Untreated depression increases the chance of risky behaviors such as drug or alcohol addiction; it can ruin personal relationships, contribute to problems at work, make it difficult to overcome serious illnesses, and increases one’s risk for suicide (Boschloo et al., 2012; WebMD, 2011). Furthermore, co-morbidities exist for depression and selected chronic diseases which may negatively impact the quality of life and life expectancy of individuals (Parekh et al., 2011; Norberg, 2008; Moussavi et al., 2007). There is no health without mental health (Crompion & Shim, 2015; WHO, 2014). Mental health plays a major role in individuals’ ability to maintain good health; and mental illnesses may affect individuals’ ability to participate in overall health-promoting behaviors (Dolan, Robinson, & Chafeza, 2013; Naylor et al., 2012; Thornicroft, 2011; Mauer, 2003). A spectrum of psychological/personality, emotional, and Transformative Mental Health for African American Women
behavioral constructs (Blatt, 2005; McGrath et al., 1990) interpersonal expectations, maladaptive motivations, negative beliefs about self, others, and situations (Nolen-Hoeksema et al., 2007; Hammer & Brennan, 2007) increase risk for depression among women. Mental health disorders such as major depression are costly in both human and financial terms. The direct and indirect costs of depression on work absenteeism and reduced productivity are estimated to be $52 billion per year in the United States alone (Fogerty, 2006); and the financial burden continues to expand.

Toward Integration of Mental and Behavioral Health in Primary Care to Reduce Disparities

Mental health plays a major role in individuals’ ability to maintain good physical health, and mental illnesses may affect individuals’ ability to participate in health-promoting behaviors (Mauer, 2003). In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease an individual’s ability to participate in treatment and recovery (Lando et al., 2006). Although mental illness is an important public health problem in itself, many mental health problems may be associated with chronic medical diseases such as cardiovascular disease, diabetes, and obesity (Shim et al., 2013; CDC, 2012; Freeman, 2007). There are a myriad of psychosocial issues and considerations for disentangling the multidimensional relationships between physical and mental health (Holden et al., 2013; Mezuk et al., 2010). Research centered on improving mental health outcomes in the primary care setting is considered a public health priority (Menke & Flynn, 2009). As indicated in the World Health Organization (WHO) report, Integrating Mental Health into Primary Health Care: A Global Perspective (2008), “More than 50 percent of patients currently being treated receive some form of mental health services from a primary care provider, and primary care is now the sole form of health care used by over 50 percent of patients with a mental disorder accessing the health care system.” Not only does a large percentage of individuals receive all or part of their mental health treatment in primary care settings (Cooper-Patrick, 1997; Unutzer, 2006), but racial minorities in particular are more likely to report depressive symptoms to primary care physicians than to mental health specialists (Hogg Foundation for Mental Health, 2013; Holden & Xanthos, 2009; Snowden, 2001).

Studies have suggested that individuals with severe mental illness die eleven to thirty-two years prematurely from largely preventable co-morbid medical conditions—for example, heart disease, diabetes, cancer, pulmonary disease, and stroke—which occur more frequently and have earlier onset in this vulnerable population. In addition, low rates of prevention, detection, and treatment of co-morbid conditions further compound such health disparities (Azrin, 2012). Moreover, the burdens of functional impairment and increased medical costs in clinical settings are often severe (NIMH, 2006). This is a particular concern since psychiatric illness may be associated with great physical, emotional, and functional burden. Since there remains a stigma attached to seeking mental healthcare (Holden, Hall, & Robinson, 2012; Hasin et al., 2006; DHHS, 2001), many individuals may not seek mental health treatment and suffer subsequent negative consequences, particularly those of racial, ethnic, and cultural minority (Interian, Lewis-Fernandez, & Dixon, 2012). As the primary care setting may be a critical link to aid in identifying and addressing depression and associated issues for ethnically and culturally diverse individuals (Thota, 2012; Shim et al., 2009), there is a critical need to establish comprehensive methods about delivery of quality and effective mental health services within the context respecting patients’ culture.

Moreover, it is imperative to strive toward the use of collaborative, integrated care, and patient-centered models. Over the past several decades, examples of coordinated care service delivery models (those that connect behavioral and physical health) have led to promising approaches to integration and collaboration (Unutzer et al., 2002; Felker et al., 2006; Luck et al., 2009; US Preventive Services Task Force, 2002; AHRQ, 1993a; AHRQ: 1993b). Integrated collaborative care is a multicomponent, health care system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. Primary care providers receive consultation and decision-making support for diagnosis and treatment from mental health specialists that form a supportive network of peers and professionals at the primary care level. Integrated collaborative care is designed to (1) improve routine screening and diagnosis of mental health disorders; (2) increase provider use of evidence-based protocols for proactive management of the disorder(s); and (3) improve clinical and community support for active client engagement in treatment goal setting and self-management (Thota et al., 2012; Goodrich et al., 2013). Collaborative care is effective in improving quality of life and a range of behavioral health conditions; and it empowers patients by engaging them to manage their care through community linkages (Interian et al., 2013; Cooper et al., 2012). It is also efficacious for treating depression in underserved racial/ethnic minority populations (Gilbody et al., 2006). In one study, patient-centered integrated collaborative care resulted in better ratings of care by African Americans who were receiving treatment for depression (Cooper et al., 2012).
In more than seventy randomized controlled trials, integrated collaborative care for common mental disorders, such as depression, has been found to be more effective and cost-effective than usual care, across a variety of practice settings and patient populations. In addition, this approach has been implemented by large health care organizations and plans in both commercially insured and low income/safety-net populations (Unutzer et al., 2013). Moreover, various National Institute of Mental Health–funded research initiatives are testing approaches to integrated collaborative care to address disparities in care in underserved ethnic/racial populations (Jacob et al., 2012; Katon et al., 2010). Furthermore, integrated collaborative care models show promise for cost effectiveness. Mental illness and substance abuse annually cost employers an estimated $80 to $100 billion in indirect costs (American Psychiatric Foundation, 2006). There is a societal economic burden due to lost work productivity. This is a consequence of impaired work performance that would otherwise respond to treatment for depression. Multiple studies demonstrate the cost effectiveness and cost savings of integrated collaborative care models in a variety of treatment settings (Katon, 2012; Katon et al., 2006; Unutzer et al., 2008).

Emerging evidence from a variety of care models has stimulated the interest of both the public and private sectors to better understand the evidence underpinning these integrated collaborative care models. What is lacking from many of the comprehensive models is a cultural underpinning that may yield better engagement of patients, better adherence to prescribed treatments, and improvement in their general well-being and quality of life. In addition, due to lack of resources for formal evaluation and limited incentives to invest in wider dissemination, little is empirically known about existing successful implementation in nonacademic public/private sectors. Failure to formally evaluate community-based health care systems that have successfully implemented culturally tailored integrated collaborative care models has led to critical gaps in knowledge about implementation strategies that are likely to work in real-world, diverse, resource constrained settings. In addition to recognizing the importance of providing culturally tailored integrative health care to address mental, emotional, and behavioral problems, particularly for ethnic minorities, our multidisciplinary investigative team acknowledges that leveraging existing knowledge is inherently a culturally sensitive approach.

As health care reform is implemented, there is an opportunity to improve behavioral health care. The crucial next step in advancing our scientific knowledge within selected populations is to establish multidimensional strategies that include communities, clinic systems, and patient collaboration that may bolster the potential for successes in the reduction of disparities in mental health among vulnerable populations. Specifically, part of the solution entails utilizing proven and promising collaborative integrated care models that integrate primary care and behavioral health by coordinating care in a seamless system, while also addressing the cultural needs of ethnic minorities. To achieve a national environmental reach where culturally relevant collaborative care models are widely adopted in diverse practice settings, a multilevel approach to implementation informed by existing successful systems is needed. Furthermore, leveraging technology to build implementation science and capacity in emerging integrated care systems can help to operationalize gains and facilitate adoption of evidence-based methodologies.

Why Culturally Centered Care Is Imperative to Prevention for Ethnic Minority Populations

The concept of a patient-centered medical home (PCMH), two promising evidence-based models, MacArthur Initiative on Depression and Primary Care, Re-Engineering systems for Primary Care Treatment of Depression Project (RESPPECT-Depression; Dietrich et al., 2004) model and Improving Mood: Providing Access to Collaborative Treatment (IMPACT; Unutzer et al., 2002), and principles of clinician training with the CRASH model (Rust et al., 2006) of culturally competent care are useful. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physicians, and, when appropriate, the patient's family, so that they can receive care when and where they need it in a culturally and linguistically appropriate manner. The PCMH is an approach that respects patients by including them as equal partners in the team decision-making process of care. RESPPECT-Depression launched a variety of projects to better understand current approaches to primary care management of depression and to develop strategies to enhance that management. RESPPECT-Depression explored the impact, dissemination, and sustainability of an evidence-based approach to enhancing depression management. In this model, prepared primary care clinicians and their practices forge close relationships with mental health and care management professionals. Together, the primary care clinician, a care manager, and mental health professionals cooperate and work with the patient in providing care.

Patients treated for depression in primary care centers showed significant improvement and increased satisfaction with care when clinicians employed a quality improvement approach that coordinates modest resources already available at many community practices (Dietrich et al., 2004). The clinical
trial of the RESPECT-Depression approach—short for “Re-Engineering Systems for the Primary Care Treatment of Depression”—reported that 60 percent of patients responded substantially to the approach within six months, with 90 percent rating their care as good or excellent (Dietrich et al., 2004). IMPACT is an evidence-based model for treating depression in primary care. The five essential elements are as follows: Collaborative care, Depression Case Manager, Designated Psychiatrist, Outcome measurement, and Stepped Care. While usual care for depression involves two people: the primary care provider and the patient, IMPACT adds two more people: the care manager and the consulting psychiatrist. The care manager supports the patient and the primary care physician. This individual educates patients about depression, monitors their medication, provides supportive counseling, and creates a relapse plan when patients improve: CRASH, which is a mnemonic for: considering Culture, showing Respect, Assessing/Affirming differences, showing Sensitivity/Self-Awareness, and do it all with Humility. Use of CRASH provides a values-driven foundation that promotes respect and culturally centered approaches for addressing behavioral health problems for the target population. Collectively, these complementary evidence-based health care delivery models and values-based approaches incorporate a cultural worldview that forms the basis for a culturally centered collaborative integrated care model.

A culturally congruent model of health recognizes core values and ways of being. The cultures of racial and ethnic minorities influence many aspects of mental illness, including how patients from a given culture communicate and manifest their symptoms, their style of coping and their willingness to seek treatment (DHHS, 2001). The current project’s investigative team recognizes the importance of cultural sensitivity as a central component of an effective integrated model of care capable of achieving improvements in physical health and behavioral health outcomes of ethnic minorities. We suggest that the following proposed culturally centered collaborative integrated care model has promise for addressing mental health disparities for ethnically and culturally diverse populations. A key issue for clinicians and researchers will be conducting the appropriate background research on cultural tenets that may have significance for various groups (Holden et al., 2014). It is imperative that any culturally centered collaborative integrated care model consider the multifaceted aspects of sociocultural, environmental, and psychosocial issues that may be encountered by the target population of interest. This systemic approach will require focused attention, active participation, strategic collaboration, and sharing of resources among stakeholders from multiple sectors. This is particularly important for African American communities to support the reduction of stigma about mental health treatment. Thus, community education and prevention efforts about mental health issues can be enhanced through a values-based and values-driven approach to collaborative integrated health care for ethnic minorities.

Moreover, a social ecological conceptual framework for addressing the myriad of complex and interrelated factors that can influence help-seeking behaviors among African American women should be considered to help foster interdisciplinary approaches to discovery science that elucidate the etiology of mental health disparities and social determinants of mental health, and create innovative interventions to enhance the health and well-being of ethnic minorities. The social ecological model (SEM; McLeroy, 1988) of health is a multilevel approach with multiple bands of influence. At the core of the model is the individual, surrounded by four realms of influence representing the individual, interpersonal, organizational, and community levels. These four levels of the SEM maximize synergies of intervention for the greatest impact. The SEM presumes that it is important to handle these important influences simultaneously, as well as the barriers in an individual’s environment that may influence their quality of life and likelihood of engaging in health-promoting behaviors.

Another useful theoretical framework to help to understand the significance of the impact of integrated care is the Collaborative Chronic Care Model (Wagner et al., 2005). This model aims to provide provision for community and clinical interactions in delivering collaborative care. The goal is to shift the orientation and design of practice in order to promote a systematic, planned approach to care for those with ongoing health problems through productive (planned) interactions between informed, active patients (and families) who are prepared and proactive to support integrated clinical teams. To be productive, interactions must assure consistent delivery of evidence-based treatments in tandem with support for patient self-management. The literature on effective self-management support, with its emphasis on patient activation and/or empowerment involves goal setting and development of realistic action plans. Our premise is that good outcomes (shown at the bottom portion of the model) include result from productive multidimensional interactions of various collaborative structures. To have productive interactions, the system needs to have developed four areas at the level of the practice (shown in the middle): self-management support (how we help patients live with their conditions), delivery system design (who’s on the health care team and in what ways we interact with patients), decision support (what is the best care and how do we make it happen every time), and clinical information systems (how do we capture and use critical information for clinical care). These four aspects reside in a health care system, and facets of the organization influence care.
Proliferation of Health Laws and Policies Impacting Behavioral Health Equity: Addressing a Critical Need

Since the founding of our nation, there have been laws and policies that have been developed without regard to the impact that such laws and policies would have on minorities and other marginalized groups. In a similar vein, there have been laws and policies that have been implemented without consideration for the impact on health equity. In addition, there are existing laws and policies that have yet to be executed, which would positively impact health and behavioral health equity. This is especially true of various health laws and policies promulgated by the legislative, executive, and judicial branches. While discrimination in health services has become less overt over time, the disproportionalities and inequities experienced by vulnerable populations continue to widen at alarming rates. This result is, arguably, due in part to the political determinants of health and the impact of health laws and policies on vulnerable and underserved groups. To date there has been little understanding about the impact that laws and policies have on vulnerable populations who have long endured discrimination in health services or experienced health disparities. Indeed, the promulgation of policies by the government has serious health implications for vulnerable populations because they may either hamper or advance health equity.

Health law and policy is an evolving area and will have serious implications for vulnerable populations over the next decade. Recently, several key pieces of federal legislation were passed by Congress that were designed to have positive health and behavioral health implications for underserved populations, including the Mental Health Parity and Addiction Equity Act of 2008, Americans with Disabilities Act Amendments Act of 2008, Genetic Information Nondiscrimination Act of 2008, and the Patient Protection and Affordable Care Act of 2010. Although collectively these health laws and other health policies support the promotion of better access and utilization of health and behavioral health services, as well as provide a bridge to health equity, the extent to which policies related to these legislative mandates are implemented or implemented appropriately remains questionable and sometimes disconcerting. In the case of the Mental Health Parity and Addiction Equity Act, it took more than five years for final regulations to be promulgated, which not only hindered the full implementation of this law, but also the implementation of the health reform law relative to mental health and substance use benefits.

The implementation of the landmark health care reform law—the Patient Protection and Affordable Care Act (PPACA) and the accompanying Health Care Education and Reconciliation Act—also raises concern relative to health equity. Although the law includes provisions addressing health equity and the elimination of disparities in health status and health care among vulnerable populations, many of them have not been accorded priority status during the implementation phase to date, nor have many of the regulations for other PPACA insurance reforms, delivery system reforms, or payment system reforms been developed in consideration of the impact to health equity. The PPACA includes health equity-related provisions, which provide a bridge to health equity that affords marginalized groups—particularly racial and ethnic minorities—access to culturally appropriate quality health and behavioral health care, preventative care, and comparative effectiveness research. The PPACA provides a unique opportunity to expand the scope of research related to health disparities, increase diversity in clinical trials, and identify, develop, and distribute appropriate interventions and solutions to address these disparities. The law also provides new investments to increase the number of culturally competent health and behavioral health professionals.

For these reasons, the implementation of the PPACA offers a critical opportunity to realize the goal of achieving health equity throughout our country. However, the success of these health equity provisions, like other health policies and laws, depends on whether they are implemented and implemented well. Interestingly, there has been a disconnect between the advocacy involved during the development and passage of policy and the advocacy involved during the implementation of the respective policy. Too frequently, health equity advocates allow themselves to be disengaged from the process once legislation has been developed and become law—failing to realize the importance of continuing to monitor a law or policy once it is passed or helding the government accountable for delays in implementation or ineffectual implementation of health equity policies. Regardless of the reasons for this occurrence, attention, careful analysis, and constant advocacy are needed to ensure development and implementation of robust and enduring health equity laws and policies. When coupled with state and local policy activities, the urgency for a comprehensive assessment and promotion of these policies becomes even more pronounced.

Call to Action: Harnessing the Power of Collaboration among Health Equity Champions

Despite the fact that health equity is a key component of the transforming journey of health care that our nation is embarking on, little has been done to comprehensively, transdisciplinarily, and collaboratively coordinate health equity policy and advocacy at the local, state, regional, and national levels. In addition,
there is a great need to collaboratively engage racial and ethnic minority communities and organizations, which often have limited resources to meaningfully address the inequities experienced and observed. These inequities are oftentimes due to a failure to review and analyze laws, policies, and programs through a health equity lens. With the introduction and passage of several health-related laws and policies in recent years, the focus has been on bending the cost curve and becoming more efficient with less moving forward. While it may be difficult to predict the unintended consequences of many of these policies, by leveraging the collective strengths and expertise of partners across the United States one can tackle the grave health inequities confronting racial and ethnic minorities and other vulnerable populations through informed laws and policies.

Researchers, clinicians, public health professionals, and policymakers have a responsibility to implement action-oriented steps that may be a catalyst for changes in diverse communities. In particular, we must:

- Design, implement, and evaluate culturally sensitive research models to provide empirical evidence about strategies to encourage better mental health and wellness for African American women.
- Design and establish innovative models and wellness toolkits for prevention of mental illness and the promotion of stigma reduction in ethnically and culturally diverse communities.
- An important consideration for addressing health disparities and advancing health equity includes the identification, development, implementation, education, monitoring, and tracking of local, state, and federal health laws, policies, and programs. Therefore, more diverse and nontraditional collaborations and partnerships among various organizations and agencies that promote health policies with a goal of reducing health disparities and advancing health equity is needed.
- A comprehensive and meaningful approach to addressing health disparities recognizes the significance of not only nurturing the development and sustainability of cutting-edge pioneering research, evidence-based practices, and programmatic models to encourage community health and reduce health disparities, but also the identification, development, implementation, and promotion of health laws, policies, and programs that will proliferate and support access to quality health care/behavioral health care and achieve health equity.

Notes

1. Social determinants of health are conditions in which people are born, live, learn, work, play, worship, and age that impact health status and quality of life, such as safe housing, fresh and healthy foods, quality education, transportation, exposure to crime, etc. Physical determinants of health include the natural environment such as green space, built environment such as buildings, sidewalks, and bike lanes, exposure to toxic substances, etc. Center for Disease Control & Prevention, "Healthy People" (2020).
2. Sometimes referred to as ObamaCare.

References


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Unutzer, J., Harbin, H., Schoenbaum, M., Druss, B. (2013). The collaborative care model: An approach for integrating physical and mental health care in Medi-