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1-1-2021

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## Repository Citation

Sarah Vinson and Andrea L. Dennis, *Systemic, Racial Justice-Informed Solutions to Shift "Care" From the Criminal Legal System to the Mental Health Care System* , 72 Psychiatric Services 1428 (2021),
Available at: https://digitalcommons.law.uga.edu/fac_artchop/1479

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# Systemic, Racial Justice–Informed Solutions to Shift "Care" From the Criminal Legal System to the Mental Health Care System

Sarah Y. Vinson, M.D., and Andrea L. Dennis, J.D.

The current configuration and function of U.S. societal structures drives the overrepresentation of people with serious mental illness in the criminal legal system. Although the causes are multifactorial, the mental health system poorly serves those at highest risk of criminal legal system involvement. The growth of the mental health evidence base regarding the social determinants of mental health has ushered in greater understanding of their central role in the promotion and maintenance of mental illness and health. These academic strides, however, have failed to translate into widespread care and payment policy changes. Additionally, as is the case in the criminal legal system, structural racism shapes people's experiences in the mental health care system, contributing to inequitable mental health outcomes for persons with severe mental illness from racial and ethnic minority groups. This is a critical consideration for the population involved in the criminal legal system: Black and Brown people make up more than half of those incarcerated in the United States (despite comprising just 32% of the total population). In the absence of an intersectional, antiracist, structurally informed approach, any attempt by the mental health care system to stem the overrepresentation of people with serious mental illness in the criminal legal system will fail. This article provides an overview of the current mental health care system's shortcomings in serving this population. It proposes concrete steps to address these shortcomings, with a special focus on race and social determinants of health.

*Psychiatric Services 2021; 72:1428–1433;doi: 10.1176/appi.ps.202000735*

The current configuration and function of U.S. societal structures drive the overrepresentation of people with serious mental illness in the criminal legal system. Although the causes are multifactorial, the mental health system poorly serves those at highest risk of criminal legal system involvement. Asserting that the central problem is the division of labor between the mental health system and the criminal justice system, Bonfine et al. (1) articulated the need for an "integrated community health system—i.e., intercept 0" for the coordination and integration of services for this population. Intercept 0 is the first step in the sequential intercept model, which describes "how individuals with mental and substance use disorders come into contact with and move through the criminal justice system" and "helps communities identify resources and gaps in services at each intercept and develop local strategic action plans" (2). At intercept 0, individuals in crisis are diverted into local crisis care services without requiring a call to 911. They are paired with treatment or services instead of arrested or charged with a crime (2). Responsibility for addressing the needs of those with severe mental illness should rest with the mental health system rather than with the criminal legal system. However, the current division of labor between the two systems is just part of the problem. Simply put, the mental health system is not consistently accessible to or effective for those at highest risk of criminal legal system involvement.

The roots of mental health care inequities are myriad, intersecting with the roots of other inequitable systems that shape critical social determinants of mental health. Further,

### HIGHLIGHTS

- The overrepresentation of people with serious mental illness in the criminal legal system is driven by multisystemic failures, including factors in the mental health system.
- Based on racial demographics of the U.S. incarcerated population, reforms intended to divert people from the criminal legal to the mental health system must be antiracist and structurally informed.
- Medicaid policy shapes the care of many people with serious mental illness; thus Medicaid reforms can play a major role in engaging and treating this population more effectively.

**Editor's Note:** This article is part of the Think Bigger, Do Good series commissioned by the Thomas Scattergood Behavioral Health Foundation, Peg's Foundation, the Patrick P. Lee Foundation, and the Peter & Elizabeth Tower Foundation. The full series can be viewed at www.ThinkBiggerDoGood.org.

many in the populations most at risk of overrepresentation in the criminal legal system are not served by the mental health care system at all, because the health insurance safety net in the form of Medicaid does not reach all adults in need of coverage. This gap is particularly relevant in states that opted against expansion under the Affordable Care Act. Notably, as of summer 2020, six of the 10 states with the highest per capita incarceration rates had not implemented Medicaid expansion (3, 4), even with the current federal incentives.

The growth of the evidence base regarding the social determinants of mental health has ushered in greater understanding of their central role in the promotion and maintenance of mental illness and health. These academic strides, however, have failed to translate into widespread care and payment policy changes. Additionally, as is the case with the criminal legal system, structural racism (i.e., "the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems . . . that in turn reinforce discriminatory beliefs, values, and distribution of resources" [5]) shapes people's experiences in the mental health care system, contributing to inequitable mental health outcomes for individuals from racial-ethnic minority groups with severe mental illness (6). Since Black and Brown people make up more than half of those incarcerated in the United States (despite being just 32% of the total population) (7), structural racism is a critical factor in preparing for the shift of care to the mental health system from the criminal legal system. Reform must not only promote, fund, and coordinate more person-centered, holistic care, it must also account for, and take corrective action against, the reality of racism in the mental health care system.

Given the demographics of populations that are disproportionately incarcerated, any examination of criminal legal system overrepresentation must consider the population's tremendous intersectionality with racial-ethnic minority and other marginalized groups, including those who are impoverished, poorly educated, and un- or underemployed (8). In the conceptualization of criminogenic risk factors, a structural lens, although highly relevant, is inconsistently applied. These risk factors, including many of those characterized as individualistic, are in fact influenced by inequitable societal structures, such as the housing, educational, and employment systems.

In the absence of an intersectional, antiracist, structurally informed approach, any attempt by the mental health care system to stem the overrepresentation of people with serious mental illness in the criminal legal system will fail. Medicaid policy plays a prominent role in this issue, given its influence in the care of those living with serious mental illness and those living in poverty. Although making changes in Medicaid can improve the mental health care system's ability to serve this population, multisystemic reforms would be required for truly equitable outcomes. This reality does not absolve the Medicaid and mental health care systems from doing their part. This article provides an overview of the current mental health care system's shortcomings in serving this population. It then proposes concrete steps that can be taken to address these shortcomings with a special focus on race and social determinants of health.

## MENTAL HEALTH SYSTEM PRACTICE AND POLICY SHORTCOMINGS FOR SERVING AS INTERCEPT 0

In sum, a mental health care system serving as intercept 0 would catch individuals with severe mental illness before they are ensnared in the criminal legal system. The premise is that an integrated, coordinated, community-based system would address illness, shape behaviors, and decrease the risk of criminal legal system contact for those with severe mental illness—contact that places the criminal legal system in the position of dictating mental health care service provision and parameters for those in its custody or under its supervision (1). Currently, the mental health system is ill equipped to function in this role.

### Medicaid Access Inequities

In nearly all states that have not implemented Medicaid expansion, childless adults are not able to qualify for Medicaid on the basis of low income (9). Although Supplemental Security Income (SSI) benefits may provide a path to Medicaid coverage in states that did not expand Medicaid under the Affordable Care Act, the complexity of the application process can prove challenging to people impaired by disabling symptoms of mental illness. Thus not all who would qualify for these benefits successfully apply for and receive them. Additionally, criminal legal system involvement, incarceration in particular, results in Medicaid suspension, and in 19 states, it results in termination (10). Furthermore, many people may not be disabled enough for disability benefits but not skilled enough to access a job with employer health care benefits. Under the disability definition used for SSI eligibility, the person must be unable to perform "substantial gainful activity" or must not have earnings averaging over $1,260 per month (11). Many individuals with severe mental illness could perform some kind of gainful activity; however, these positions may not have employer-based health coverage. In states that do offer Medicaid based on income, these same jobs can raise the workers' income to a level beyond the Medicaid income threshold.

### Disparities Between Covered Services and Needed Resources

For those fortunate enough to obtain Medicaid, there is frequently a lack of alignment between covered services and needed resources. Conceptualizations of illness and approaches to treatment that overemphasize an individual's psychiatric symptoms and traditional medical remedies fall short of appreciating and addressing the social determinants of mental health (12). Despite evidence that addressing these issues is beneficial to mental health outcomes (13), Medicaid reimbursement is inconsistently available for case management and interventions, such as supported employment and supportive housing, with direct impact on well-characterized social determinants, such as housing and vocational opportunities. Admittedly, sweeping improvements in these social determinants will require policy changes that go beyond the remit of Medicaid and the mental health system.

Even when it comes to narrowly defined, traditional medical interventions for mental illness, Medicaid coverage does not necessarily guarantee access. Service network inadequacies—i.e., too few providers and facilities that participate in Medicaid networks—can preclude the actual provision of care. Mental health provider shortages are more likely to exist in lower-income communities (14). Medicaid would be of particular importance to this population that contends with a larger burden of adverse social determinants of mental health (such as segregationist housing policies) and where the population experiences the greatest impacts of mass incarceration. Additionally, office-based mental health care providers often opt out of providing care to publicly insured patients (and in many cases even to privately insured patients) (15). Low Medicaid reimbursement relative to Medicare and private insurance reimbursement plays a role (16), but one must also consider the make-up of the licensed, clinical mental health workforce (e.g., those with graduate or professional school education, such as master's and doctoral-level clinical degrees).

### Representation and Racism in Mental Health Care

Physicians have been shown to be less likely to accept Medicaid in areas where the poor are non-White (17). Providers from racial and ethnic minority groups, when provided the opportunity to gain medical and mental health professional expertise, treat a higher proportion of minority and underserved patients than do White providers (18). Yet mental health workforce diversity is lacking—with the starkest underrepresentation being that of Black and Latinx providers (19). Notably, these populations are the same ones that are grossly overrepresented in the criminal legal system, with a Latinx-White state imprisonment disparity of 1.6 to 1.0, and a Black-White disparity of 5.1 to 1.0 (20). Consequently, the lived experiences of professionals providing mental health care, choosing whom to care for, and making mental health procedural and policy decisions (largely middle- and upper-class White people) are significantly disparate from the lived experiences of those with mental illness who are overrepresented in the criminal legal system. This has implications not only for where care is provided, but how.

As defined by Ibram X. Kendi (21), racism is "a marriage of racist policies and racist ideas that produces and normalizes racial inequities." The racially inequitable products of the mental health care system are well documented and have been for decades (18). At every stage of mental health care system involvement—i.e., access, engagement, assessment, treatment choice, and retention—the racial and ethnic groups overrepresented in the criminal legal system, Black and Latinx people (20), have poorer outcomes compared with Whites. When systems purport to be taking steps to address these problems, the approaches are often superficial and focused on the underserved populations (i.e., cultural competency training focused on cultural differences, mistrust, and stigma), rather than on the underserving *system*.

Accounting for structural racism should be a key consideration in any health reform effort, but it is absolutely essential for a population with racial- and ethnic-minority overrepresentation. Stark inequities permeate every stage of the criminal legal process (i.e., law enforcement officer contact, investigation, arrest, detention, charging, adjudication, and sentencing). In the absence of antiracist incentives from payers, mental health care providers and systems often fail to identify, let alone address, the role of their ideas and policies in the creation and maintenance of inequities. Thus structural racism is perpetuated through the mental health care system.

### Evidence-Based Treatment Access

Even when treatment is accessible, evidence-based treatment may not be. A study by Bruns et al. (22) using data from state mental health authority (SMHA) administrators found significant interstate variability in rates of evidence-based treatment (EBT) funding, supportive policies, and adoption. In states that had implemented EBTs, penetration of these services was poor. In other words, most of those who needed evidence-based services did not receive them. The results of a follow-up study suggested that states' *funding* of EBT and associated infrastructures was predicted by state per capita income, expansion of Medicaid under the Affordable Care Act, Democratic political control, the presence of state behavioral health research entities, and the degree of interagency collaboration; states' EBT supportive *policies* were predicted by interagency collaboration and the presence of SMHA research entities; and EBT *adoption* was predicted by the SMHA directly operating community-based programs (as opposed to merely funding services) (23).

## REFORMING HEALTH CARE TO SERVE AS INTERCEPT 0

Efforts to reduce recidivism and improve mental health outcomes often focus on "fixing" the so-called "noncompliant" or "difficult" patients and their criminogenic risk factors. Effective solutions may be found instead by questioning systemic deficiencies and barriers to better serving this

population: How do we change the system to improve mental health outcomes, particularly for those with serious mental illness and criminal legal system involvement? Initially, reforms should target four core areas: expanding access to coverage through Medicaid reforms, increasing service provision through health care workforce diversification, enhancing the effectiveness of Medicaid through incentivizing antiracist practices, and providing more support for wraparound and evidence-based services.

**Medicaid Coverage and Access**

Reform must expand access to and consistency of Medicaid coverage for all who need it but especially for those with serious mental illness who are involved in the criminal legal system or at risk of involvement. Coverage of these individuals needs protection from fluctuations in incarceration, SSI, or employment status. In every state, every adult, including the working poor who do not have SSI, should be given access to Medicaid. This change would also remove a potential disincentive (losing Medicaid eligibility) to working, an activity that promotes successful community reentry and mental health recovery. In order to cover the working poor and to support recovery-oriented care for those with serious mental illness, the Medicaid income eligibility for working individuals should be raised to 250% of the federal poverty level. In furtherance of successful reentry programming, incarcerated individuals' Medicaid benefits should be suspended on a time-limited basis and not terminated. Efforts should also be made to identify and begin the enrollment process for eligible individuals before release. Notably, of the 12 states that have not expanded Medicaid access, two are in the top five for incarceration rates (Mississippi and Texas), and three are in the top five for numbers of incarcerated individuals (Texas, Florida, and Georgia) (3, 4). Given the sheer number of current and formerly incarcerated people in these states, Medicaid expansion in all states is critical for those with serious mental illness and criminal legal system involvement. For states that have not expanded Medicaid to do so and for those that have to further increase their Medicaid rolls, a significant investment at both the state and the federal levels is necessary. State participation could be incentivized by an increase in the federal match for newly covered individuals back to 100% and a federal commitment to permanent matching.

Without more mental health clinicians willing to provide care to patients with Medicaid, the impact of expansion on access will be limited. As noted above, low Medicaid reimbursement is a contributor to low provider participation. States control Medicaid spending by setting provider reimbursement rates lower than Medicare and private market rates, which in turn deters providers from joining Medicaid services and practicing in the communities most affected by criminal legal system involvement. This is especially true for outpatient services (24), a key component in both early intervention and continuity of care for individuals with serious mental illness and in successful community reintegration. Medicaid reimbursement increases can incentivize both systems and providers to serve these highly vulnerable individuals. At current rates, reimbursement sometimes does not even cover the costs of service provision. It is recommended that states be required to reimburse providers at the same rate that Medicare does for comparable services or, at the very least, for the federal government to offer earmarked grants for states so that they can raise reimbursement to a uniform percentage of Medicare rates.

**Expansion and Diversification of the Mental Health Workforce**

Not only is an expanded mental health workforce needed, but effective reform that serves those disproportionately incarcerated will also require a diversified workforce—one that better mirrors the populations that the system purports to serve. For the population with serious mental illness and carceral system involvement, lived experience with mental illness and with structural racism are two important considerations. Increased involvement of people with such experiences can be accelerated by government programs and reimbursement structures.

Peer support specialists can play a critical role in engaging and providing care to populations that the mental health care system has historically failed. Peer support specialists may draw on common lived experiences and backgrounds to aid Medicaid enrollees (25), and their use is endorsed by the Substance Abuse and Mental Health Services Administration (25). Additionally, the Center for Medicare and Medicaid Services advises that peer support specialists can offer both mental health and substance use disorder services to Medicaid beneficiaries (10). As of 2019, however, many states do not pay for these services. This is despite the fact that states have a number of funding options for doing so (10, 25).

Additionally, efforts should be undertaken to increase the pool of mental health care providers invested in treating Black and Latinx patients. Coordinated efforts to fill the pipeline with mental health service providers who have diverse backgrounds is a vital step toward doing so. A natural potential partner in this effort is the National Area Health Education Center (AHEC) Organization, "developed by Congress in 1971 to recruit, train and retain a health professions workforce committed to underserved populations" (26). The group's "network consists of more than 300 AHEC program offices and centers, serving over 85% of the counties in the United States" (26). Through the AHEC Scholars Programs, local and regional offices are focused on diversifying the health care workforce. Increased support of AHEC is recommended through earmarked programs for those from underrepresented minority groups and for people from disadvantaged backgrounds with an interest in mental health.

**Race-Based Tracking and Antiracist Initiatives**

Understanding a problem is a prerequisite to addressing it. For the mental health care system to play its role in remedying the incarceration of a population that is disproportionately Black and Latinx, the extent of racial inequities in this population's mental health treatment must be fully

characterized. However, the system's current functioning does not support such understanding. Programs supported by federal dollars are not required or incentivized to track and report race or ethnicity as they relate to engagement, retention, evidence-based service provision, or outcomes in health care. Future reform efforts would be better informed by consistent data collection on a national scale through state-level tracking of these metrics by race and ethnicity. The federal government should connect continued Medicaid funding to such data collection. Once inequities are identified and characterized, state access to federal funds should be contingent upon the development, implementation, and evaluation of antiracist policies and procedures. This approach would be similar to the policy aimed at decreasing disproportionate minority contact with the juvenile justice system, as enacted by the Juvenile Justice Delinquency Prevention Act of 2002 and amended by the Juvenile Justice Reform Act 2018 (27).

**Wraparound Services and EBT Provision**

Essential to improving mental health outcomes, particularly for those with serious mental illness involved in the criminal legal system, is access to supportive, wraparound services that promote stability and address the social determinants of mental health, i.e., those "conditions in which people are born, grow, live, work, and age," including (but not limited to) poor education, poverty, suboptimal housing, un- and under-employment, job insecurity, and food insecurity (28). Medicaid often provides more coverage options than does private insurance for certain community-based treatment interventions (9). States can and should opt for their Medicaid plans to fund holistic, ameliorative services for noninstitutionalized persons with mental health disabilities and substance use disorders, especially individuals involved in the criminal legal system or reentering society from incarceration. In addition to expanding access, plans should offer evidence-based interventions, such as supportive housing, supported employment, crisis services, and assertive community treatment. Given study findings regarding EBT adoption, federal incentives for SMHAs to administer rather than just fund these programs is recommended. Ideally, the federal government would take steps to remove any barriers preventing states from making these reforms. Cost, however, can act as a deterrent. State officials may become concerned that provision of these services will exceed funding levels. Although some states have identified a workaround (i.e., limiting eligibility) and rely on natural limits (i.e., lack of service providers), as discussed herein such approaches undermine the ultimate goals of expanded mental health care access. Thus a more suitable solution would be to increase funding levels for these services so that more individuals can benefit from them.

## CONCLUSIONS

The implementation of any new policy should be followed by empirical evaluation for efficacy in addressing the matter at hand—i.e., to what extent does increased access to coverage and broader service options along with provider diversification reduce criminal legal system involvement? Data collection and analysis are vital to determining which interventions position the mental health care system to better serve those with severe mental illness at highest risk of criminal legal system involvement. Data and analysis are also prerequisite for the mental health care system to meaningfully address its own structural racism—a task that is critically important for this population. Progress is possible in the decriminalization of severe mental illness. The mental health care system can, and should, lead the way. However, a problem of this magnitude that affects such a highly marginalized group will not be solved with incremental, "race-neutral," or budget-neutral approaches. A paradigm shift in mental health care—one that encompasses service scope, racial equity, and funding levels and mechanisms—is a prerequisite for this system's taking its rightful place as intercept 0.

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Dr. Vinson is the owner of Lorio Forensics. Ms. Dennis reports no financial relationships with commercial interests.

Received October 3, 2020; revisions received January 22, February 27, 2021; accepted March 4, 2021; published online May 11, 2021.

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