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

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Disclaimer

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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
Part I.

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

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

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

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”
Inequity at the Community Level

At what level does your organization currently engage?

Credit: Dr. Camara P. Jones, “The Cliff of Good Health”
Inequity at the Community Level

Racism and other “-isms” affect community health
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.

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.

Inequity at the Community Level

Racism → Education
  ↓
  Job Opportunity
  ↓
  Socioeconomic Status
  ↓
  Environmental Exposure
  ↓
  Health Behaviors
  ↓
  Access to Health Services
  ↓
  Safe and Affordable Housing
  ↓
  Violence

Health Outcomes
Part II.

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

Example #1

Engaging marginalized communities in SUD recovery must address history and context, not just “treatment.”
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
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
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
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
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.
Example #2

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

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

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

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

Social Determinants of Engagement

The Big Picture – Levels of Engagement

• **Primary:** Addressing unequal **conditions**
• **Secondary:** Addressing **concerns arising from social context**
• **Tertiary:** Addressing **consequences of marginalization**
Part III.

Strategies for Alliance Building
Example #1—Substance Use

Context: Washington, DC Wards 7 and 8

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

Highest opioid overdose rates

Example 1 explains community partnerships conducted at Howard University
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).
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.
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.
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.
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.
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

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

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

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

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

Part IV.

Lessons from 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
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.
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
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.

www.kcrha.org
Example #3—King County Regional Homelessness Authority

King County Regional Action Framework

1. Strong Foundation for Coordination and Collaboration

2. Affordable and Supportive Housing
   - City/County Housing and Planning Depts.

3. Crisis Response
   - Regional Homelessness Authority

4. Mainstream Systems and Services
   - Behavioral Health, Recovery, Child Welfare, Criminal/Legal, Health Care

www.kcrha.org
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.

Principles of Equity-Centered Partnership

2. Trust

Trust is built on 3 levels:

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

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.
4. Attention to History and Context

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

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.
“It all starts with the community, because I am a product of my community.”
Thank You
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