

The Social Determinants of Mental Health

Definitions, Distinctions, and Dimensions for Professional Case Management: Part 1

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ABSTRACT

Purpose: The social determinants of health are a well-established health care industry priority. Robust data associated with psychosocial circumstances for populations validate poor health outcomes. However, another domain begs for inclusion and industry attention. A mental health chasm has emerged amid a post-COVID-19 landscape fraught with escalating health disparities, morbidity, and mortality. Themes of trauma, diversity, equity, and inclusion are major organizational imperatives. As a result, an expanded focus on the social determinants of mental health (SDoMH) mandates dedicated perspective. Part 1, of this 2 article series, on the SDoMH will provide distinct understanding of relevant industry terminology, historical drivers, and macro factors that influence mental health, along with health disparities. In addition, this article will set the foundation to advance the industry's quality compass, the Triple/Quadruple Aim.

Learning Outcomes: After reading this article, learners will be able to:

1. define the social determinants of mental health (SDoMH);
2. distinguish them from the social determinants of health (SDoH);
3. explore foundational concepts related to the SDoMH;
4. understand upstream drivers of the SDoMH; and
5. present evidence that validates attention to the wholistic health triad.

Finding/Conclusion: Access to quality wholistic health care encompasses pathophysiology, psychopathology, and psychosocial circumstances, and is a considerable challenge across populations. Mental health, along with health disparities, has been fueled by enduring systematic racism that has facilitated inadequate funding, poor reimbursement, decreased treatment options, and pervasive stigma across diverse patient populations (e.g., race, ethnicity, gender, sexual orientation, familial status, disability, socioeconomic status). These SDoMH mandate a critical fresh lens by case management to ensure the most proactive and comprehensive approach to care. To achieve the successful outcomes mandated by this approach, the industry's quality compass, the Triple/Quadruple Aim must be expanded to include a Quintile Aim of wholistic health equity.

Implications for Case Management Practice: Case management's unique transdisciplinary composition has the workforce well positioned to effect grand change in population health perspectives. Wider attention to clinical and fiscal outcomes for health and mental health inequities mandates innovative approaches to patient care, which encompass a wholistic health triad of pathophysiology, psychopathology, and psychosocial circumstances.

Key words: behavioral health, mental health, mental illness, social determinants of health (SDoH), social determinants of mental health (SDoMH), systematic racism, wholistic health triad

The health care industry remains fixated on the social determinants of health (SDoH), the nonclinical psychosocial and socioeconomic circumstances that contribute to health outcomes. The five long-standing SDoH domains were updated for Healthy People 2030 (U.S. Department of Health & Human Services, 2020a) at the end of 2020 and continue to top the priority list for every organization:

1. Economic stability
2. Education access and quality

3. Health care access and quality
4. Neighborhood and built environment
5. Social and community context

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Case management's unique transdisciplinary composition has the workforce well positioned to effect grand change in population health perspectives.

Abundant evidence across populations, practice settings, and disease states validates how SDoH impact the industry's financial bottom line. Healthy People 2030 places greater emphasis on the impact of health literacy and language proficiency in the context of health prevention and wellness outcomes across populations. The coronavirus pandemic has been a solid reminder of how both factors have shaped the public health effort to minimize virus transmission. Evolving data reveal how communities of color and regions with persons having limited to no English language literacy experienced fierce rates of coronavirus transmission due to lack of trust in, and understanding of, public health mandates and infection protocols (Cangussú et al., 2020; Ramos et al., 2020). The year 2020 has left an indelible mark on health inequities and will continue to prompt further chapters of the SDoH to be written.

Prior articles in this journal have focused exclusively on the SDoH (Fink-Samnack, 2018a, 2018b). A new dimension of these inequities in care beckon for case management's focal point. These social determinants of mental health (SDoMH) result from the same endemic upstream factors that contribute to the SDoH and are as costly an imperative to tackle. The novel coronavirus pandemic and recent shift in societal narratives have further amplified preexisting disparities across every practice setting and population.

This first article on the SDoMH, of a two-part series, will provide case managers their comprehensive foundation on the topic. Definitions, distinctions, and related concepts specific to mental health disparities will be provided. A review of upstream drivers will encompass systematic racism's impact on access of needed care. Manifestations of mental health stigma will be addressed through discussion on reim-

bursement, provider shortages, delayed response, and lack of mental health parity. The Part 2 article will offer strategic recommendations and assessment models for case management that advance health care's quality compass, the Triple/Quadruple Aim, to incorporate a fifth or Quintile Aim.

By virtue of case management's transdisciplinary workforce composition, unparalleled opportunities exist to ensure more successful metrics across patient and program outcomes through wholistic health equity—a concept to promote patient-centric, safe, equitable care across populations, providers, and profit margins.

FOUNDATIONAL CONCEPTS AND HISTORICAL CONTEXT

Expanding Social Determinants of Health to Incorporate Mental Health

The SDoH are the conditions in which people are born, live, grow, work, and age (World Health Organization, 2012). They are the primary driver of excessive and escalating health care utilization (e.g., costs, length of stay, readmissions) across the industry:

- National health expenditures of \$3.6 trillion annually (Centers for Medicaid & Medicare Services, 2020)
- More than 50% of hospital readmissions (Evans et al., 2021; Zhang et al., 2020)
- \$200 billion in premature deaths (Ayanian, 2015)
- Inadequate chronic illness management, with
 - 4.3 million preventable emergency department (ED) visits;
 - 30% of unnecessary visits; and
 - 86% of chronic health spending overall (Premier, 2019).

A variety of factors predispose patients and their communities to poor health and reflective outcomes including discrimination and social exclusion, adverse childhood experiences (ACEs), poverty, poor quality and access to education and health care, housing insufficiency, health and language literacy, and neighborhood deprivation (Compton & Shim, 2015). Yet, these same social and socioeconomic factors are associated with substantial mental health disparities, or SDoMH.

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Definitions and Key Constructs

Developing any sound foundation for SDoMH involves first mastering specific concepts and themes. The World Health Organization (2018a) frames mental health as a person's overall well-being and effective daily functioning in the context of daily activities. How well can an individual manage academic as well as occupational functioning? How effective is the person at balancing ongoing life stressors with parenting responsibilities? What about the quality of other family or social interactions? How able is the person to bounce back from stressors triggered by change or adversity, such as unemployment, divorce, or even domestic violence, or personal death or loss from a pandemic?

Behavioral health refers to the actual behaviors that impact health conditions. Consider how depression and stress impact any chronic illness, such as chronic renal failure. A patient becomes increasingly despondent about the need for dialysis three times weekly. The treatments wear on the person's endurance and capacity to tolerate a full work day. Despondency evolves into a diagnosable depression (e.g., adjustment disorder with depressed mood, major depressive disorder) that could manifest in the person's resistance to participate in recommended treatments, as an exercise routine or special renal diet. Medication management falls by the wayside. A nightly beer or cocktail eases the patient's pain level. With alcohol known to be a depressant, there will most likely be further deterioration in the patient's mental health, as well as health. Poor treatment outcomes become a case manager's dread and patient reality.

Imagine how anxiety and stress contribute to asthma exacerbation. Internalized and repressed emotions prompt increased inflammatory responses of the immune system, lungs, and other respiratory challenges. Perhaps the patient is prescribed a benzodiazepine to manage rapidly escalating anxiety, such as a drug like Klonopin with short-term benefit but potential adverse side effects (e.g., repressed respiratory function, cardiac arrhythmias; Prescribers' Digital Reference, 2020). The patient becomes caught in a vicious cycle of health and mental health crises, with a psychosocial crisis tossed in, courtesy of the inability to work and engage in occupational and social activities. Table 1 shows the definitions for each term.

Mental illnesses are diagnosable mental health conditions according to the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders*

(currently 5th ed.; 2013), known as *DSM-5*. A common error across the industry involves this seminal resource being identified as *DSM-V*. The presentation may be consistent with the roman numeral system used in prior editions of the *DSM*, though is incorrect. The revised numbering system was instituted for the latest *DSM* version with the goal to accommodate more frequent updates; there have been as many as 13–15 years between the publication of *DSM* versions (e.g., *DSM IVTR* in 2000 to *DSM-5* in 2013). Rather than await publication of a new version, updates were to be released as 5.1, 5.2, and so forth. The *DSM* codes for mental illness diagnoses each have an aligned code from the current *International Classification of Diseases (ICD)* for each disorder, better known as *ICD-10*. Depending on their role and practice setting, case managers may need to be familiar with both diagnostic classification systems.

Any Mental Illness and Severe Mental Illness

Among the primary categories of mental illness are

- any mental illness (AMI) and
- severe mental illness (SMI).

TABLE 1
Distinctions for Mental Health Definitions^a

Term	Definition
Behavioral health	An umbrella term that includes mental health. The connection between behaviors, plus health, and well-being of body, mind, and spirit. Includes how behaviors (e.g., eating habits, drinking, exercise) impact physical or mental health
Mental health	State of well-being where an individual realizes his or her own abilities and is able to: cope with normal stresses of life; work productively; and make a contribution to his or her community.
Mental Illness	Health conditions and diagnosable mental disorders involving changes in emotion, thinking, and behavior (or combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.

^aDefinitions from American Psychiatric Association. (2021). *What is mental illness*. <https://www.psychiatry.org/patients-families/what-is-mental-illness>; and World Health Organization. (2018b). *Mental health*. <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>

The domain of AMI refers to all recognized mental illnesses, with the scope of impairment ranging from mild to moderate and severe impairment. Approximately 51.5 million, or 20.6% adults older than 18 years were diagnosed with an AMI in 2019. A subcategory of AMI is SMI, which includes mental, behavioral, or emotional disorders that result in serious functional impairment and substantially interfere with, or limit one or more major life activities. This subcategory is a far smaller composition than AMI, with approximately 13.1 million adults older than 18 years, or 5.2% of adults diagnosed. Case managers may also hear the SMI category referred to as severe and persistent mental illness (National Institute of Mental Health, 2020).

Persons diagnosed with an SMI are often subject to a lifetime of issues that compromise their academic, occupational, and social functioning. The persons included in this subcategory are diagnosed with schizophrenia, schizoaffective disorder, plus severe forms of other disorders that include but are not limited to autism and major depressive and bipolar disorders. The SMI patient population is well known to case managers, particularly those individuals employed in hospital emergency departments or other community-based programming. The population frequently are forced to deal with fragmented and disjointed care that leads to delays in accessing identified providers, practitioners, and thus medication and treatment. Rapidly escalating psychotic symptoms (e.g., hallucinations, delusions, paranoia, magical thinking) can often accompany disease manifestation and further hamper care. Only 66% of persons diagnosed with an SMI received the necessary treatment for their condition last year (Mental Health America, 2021a).

Mental Health America (2021a) completes an annual report of factors related to the care and treatment for persons across the AMI and SMI populations. The measures addressed in this report are displayed in Box 1. The report reveals the current status of mental health access, care, and treatment across the United States. The entire document is accessible free of charge through the website that appears in the report reference.

Systematic Racism

Systematic racism is embedded within the health and mental health industry and refers to racism that exists across a society within and between institutions and organizations across society. Gee and Ford (2011) frame the term in the context of complex interactions of larger scale societal systems, practices, ideologies, and programs that produce and perpetuate inequities for racial minorities. The central theme of systematic racism involves upstream factors (e.g.,

Box 1 Mental Health in America Measures, 2021^a

1. Adults with Any Mental Illness (AMI)
2. Adults with Substance Use Disorder in the Past Year
3. Adults with Serious Thoughts of Suicide
4. Youth with At Least One Major Depressive Episode (MDE) in the Past Year
5. Youth with Substance Use Disorder in the Past Year
6. Youth with Severe MDE
7. Adults with AMI who Did Not Receive Treatment
8. Adults with AMI Reporting Unmet Need
9. Adults with AMI who are Uninsured
10. Adults with Disability who Could Not See a Doctor Due to Costs
11. Youth with MDE who Did Not Receive Mental Health Services
12. Youth with Severe MDE who Received Some Consistent Treatment
13. Children with Private Insurance that Did Not Cover Mental or Emotional Problems
14. Students Identified with Emotional Disturbance for an Individualized Education Program
15. Mental Health Workforce Availability

^aFrom Mental Health America. (2021b). *MHA guidelines and ranking measures*. <https://mhanational.org/issues/2021/ranking-guidelines>

social and economic policies, legislation, regulatory guidelines, reimbursement) that operate independent of the intentions and actions of distinct individuals or employers. When individual racism is not present, adverse inequalities for racial and other minorities may continue to exist.

The SDoMH have been exacerbated by long-standing patterns of systematic racism demonstrated through inadequate funding and poor reimbursement. Case managers are often faced with the need to advocate on behalf of patients with providers who may reject insurances typically accessed by those persons in lower socioeconomic groups (e.g., Medicaid, Medicare Advantage). There may be disincentives for providers to accept these forms of payments (e.g., delays in or appeals to access accurate reimbursement, rigorous administrative processes, and oversight). Individuals who report experiencing racism have greater rates of illness morbidity and mortality (Gee & Ford, 2011; Wan et al., 2020). The manifestations of systemic racism yield decreased treatment options and pervasive stigma across diverse patient populations (e.g., race, ethnicity, gender, sexual orientation, familial status, disability, socioeconomic status).

Mental Health Stigma

Stigma against persons with mental illness is among the prime factors to impact quality of, and access to necessary care and treatment. The collective stereotyped views, beliefs, and prejudiced attitudes associated with stigma contribute to negative perspectives of patient populations who have overall health concerns, but especially those related to behavioral health. Patients can easily have symptoms minimized or devalued. Resulting discriminatory behaviors manifest across systems levels, including those of the provider,

system, and patient. Four types of stigma have been addressed in the literature (Cardoso et al., 2020):

- Anticipated
- Experienced
- Perceived
- Internalized

The stigmas are shown in Table 2 and experienced by any member of the workforce rendering care, as readily as by patients. Each of the four stigmas has been associated with poor patient outcomes including delays in care provision, treatment adherence by patients, and both quality and quantity of the care and treatment (Cardoso et al., 2020). For example, when patients are unable to access timely evaluations for needed psychopharmacological medications, they are easily prone to risk of psychiatric escalation and emergencies. The presence of these stigmas also detracts from heeding the industry's Triple/Quadruple Aim by hindering access to patient-centric care, provided at the right cost, right time, and by professionals who find joy through their efforts.

When a patient's mental health diagnosis contributes to any of the four stigmas, a chain reaction of missteps ensues across the entire treatment process from initial prevention and screening, diagnosis, and treatment to symptom management and to counseling intervention. Emergency departments are busier than ever. Not all of these sites possess staff with the necessary behavioral health expertise to ensure effective management of complex mental health behaviors. Members of the treatment team can mistakenly attribute medical conditions to a patient's psychiatric disorder, especially if the patient is unable to accurately

assess the site or intensity of the pain. Patients amid a psychotic episode can present in a disheveled state of appearance, with poor hygiene. Think how this presentation can bias a professional, and potentially limit the appropriate clinical evaluation and intervention. Vital laboratory work and diagnostic tests to confirm etiology of the presenting complaint may be avoided to minimize contact by staff or hasten the patient's departure from the treatment site. The bar for a patient's quality of care is set dangerously below any minimum allowable standard.

In the end, patients with SMI or AMI often experience disjointed and deplorable care that is reminiscent of a building erected without an unstable foundation. Cracks and other liabilities in that vital base emerge, grow, and ultimately weaken the structure's stability. The building collapses from a faulty foundation system that should have maintained it for a lifetime (Fink-Samnack, 2020).

The Impact of Integrated Care and Reimbursement

Despite industry efforts to integrate health and behavioral health, the two domains have remained polarized, particularly for more vulnerable and marginalized populations. When the Patient Protection and Affordable Care Act was passed in 2010, the industry posed a clearly defined integrated care vision. Hefty emphasis of the legislation was on anticipated cost savings that could be achieved by providing coordinated and integrated care for patients diagnosed with complex, co-occurring health and mental health conditions. Druss and Walker (2011) identified that more than 68% of adults diagnosed with a mental health disorder also suffered from

TABLE 2
Types of Stigma Across Health Care^a

Types of Stigma	Definition	Example
Perceived	Perceptions of social beliefs (e.g., stereotypes, prejudice, discrimination)	A patient believes they are disrespected due to insurance status, race, sexual orientation, or other cultural perspectives.
	Can occur on part of patient or provider	A psychiatrist opts to accept patients with Medicaid and self-pay. Other providers question the quality of practitioner competence.
Experienced	Perceptions of being a victim of stereotypes, prejudice, discrimination.	A patient who is homeless enters the emergency department with a self-reported pain rating of 10 out of 10; the patient does not receive the same assessment and treatment as domiciled patients.
	Occurs on part of the patient	A patient has pain and other symptoms dismissed.
Internalized	Internalization of stereotypes, prejudice, and social discrimination to self	A patient is reluctant to obtain necessary care from the only in-network provider in the region for fear of bias (by the provider) against persons of color.
	Occurs on the part of the patient	
Anticipated	Expectation of discrimination, often associated with internalized stigma	A person with a severe mental illness has lived on the street for a decade. Despite feeling ill, the person may defer seeking treatment due to concerns regarding judgment by providers or treatment staff.
	Occurs on the part of the patient	

^aDefinitions from "Instruments for Measuring Perceived and Experienced Mental Illness Stigma: A Systematic Review," by N. O. Cardoso, B. Sanvincente-Vieira, V. V. I. Ferracine, and L. I. A. Irançema de, 2020, *Psychology Theory and Practice*, 22(1), pp. 64–68. <http://dx.doi.org/10.5935/1980-6906/psicologia.v22n1p64-88>

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medical conditions. Their seminal research revealed dramatic variations in the total monthly health care expenditures for individuals experiencing both depression and chronic (medical) illness compared with patients with solely a medical condition: \$1,420 compared with \$860 for an individual without depression—a difference of \$560 (Druss & Walker, 2011).

In 2010, more than 70% of the \$91.7 billion paid in acute care costs for Medicare beneficiaries accounted for only 10% of patients: often the sickest persons from more vulnerable and marginalized communities (Bartels et al., 2015). Individuals with psychiatric conditions from these same communities were found to incur costs that were twice as expensive as in the general population (Bartels et al., 2015; Druss & Walker, 2011).

An ambitious plan emerged for the industry; accountable care organizations would share financial accountability for fiscal rewards. Medicaid and dual-eligible Medicare programming would address comorbid and complex health and mental health needs of older adults through innovative programs (e.g., patient-centered medical homes, health homes) and reimbursement for wellness visits. Substance use treatment would receive greater focus and funding, as would programs for patients simultaneously experiencing behavioral health issues with chronic illnesses. Comorbid depression and anxiety were identified to raise annual health care costs for patients with chronic obstructive pulmonary disease (COPD) as high as \$6,000 annually (Panagioti et al., 2014). Case managers might recall considerable emphasis placed on outcomes for patients experiencing congestive heart failure and depression, diabetes and substance use, and chronic respiratory illnesses (e.g., COPD, asthma, and emphysema) and anxiety. Extensive funding was targeted by the industry toward programs targeting these co-occurring conditions.

A graphic published by the Substance Abuse Mental Health Services Administration (SAMHSA) was developed to show the six levels of integrated care, an iteration of which appears in Table 3. Reimbursement for integrated care models was provided by Medicare through traditional fee-for-service encounter payments and new collaborative care current procedural terminology codes. Monthly services provided were given permission to use codes under the Psychiatric Collaborative Care Model. This particular model allowed for behavioral health integration that enhanced primary care by adding key services to the primary care team, particularly regarding patients whose conditions are not improving. A team of three main individuals to provide care was recommended: behavioral health care case manager, psychiatric consultant, and treating primary care practitioner.

What presented as a sound idea in theory translated to considerable problems in practice. Yet, inconsistent implementation of models and programming across sites was only part of the puzzle. Although mental health parity became federal law in 2008 under the Paul Wellstone and Pete Domenici Mental Health Parity Equity and Addiction Act (MHPEA), payment between health and mental health was anything but equal. The law was geared to prevent group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Other payment factors erupted that found integrated care rapidly descending from the most popular industry buzzword to the “illusive butterfly.” Differences in coverage between clinical health and mental health services across public and private health insurance plans had been long-standing and impacted care delivery. Neither

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TABLE 3
Levels of Integration^a

Coordinated Key Element: Communication		Colocated Key Element: Physical Proximity		Integrated Key Element: Practice Change	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration On-site With Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed/Merged Integrated Practice
Behavioral health, primary care, and other health care providers work					
In separate facilities where they:	In separate facilities where they:	In same facility not necessarily the same offices where they:	In same space within the same facility where they:	In same space within the same facility (perhaps shared space), where they:	In same space, within same facility, shall all practice space, where they:
<ul style="list-style-type: none"> • Have separate systems • Communicate about cases rarely, under compelling circumstances • Communicate on the basis of provider need • May never meet in person • Have limited understanding of mutual roles 	<ul style="list-style-type: none"> • Have separate systems • Communicate periodically reshared patients • Communicate on the basis of specific patient issues • May meet as part of a larger team or community • Value each other's roles as resources 	<ul style="list-style-type: none"> • Have separate systems • Communicate regularly reshared patient (e.g., virtually, phone, email) • Collaborate on the basis of need for mutual services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of larger yet nonformal team 	<ul style="list-style-type: none"> • Share some systems (e.g., scheduling, electronic medical or health record) • Communicate in person, as needed • Collaborate on the basis of need for consultation and coordinated plans for difficult patients • Have basic understanding of roles and culture 	<ul style="list-style-type: none"> • Actively seek system solutions together, or develop work-a-rounds • Communicate frequently in person (or virtually) • Collaborate on the basis of need to be a member of the care team • Have regular team meetings to discuss patient care and specific patient issues • Have in-depth understanding of roles and culture 	<ul style="list-style-type: none"> • Have resolved most or all system issues, functioning as single, integrated system • Communicate consistently as the system, team, and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

^aAdapted from SAMHSA. (2014). *Standard framework for levels of integrated care*. Health Resources & Services Administration (HRSA). <https://www.hrsa.gov/behavioral-health/standard-framework-levels-integrated-healthcare>

reimbursement of mental health as an essential health benefit nor expansion of mental health parity was guaranteed under even the most recent interpretations of short-term insurance and state insurance waivers.

Simply stated, mental health parity did, and still does not exist across most insurers, including Medicare and Medicaid. The prevailing coverage gaps in public and private insurance continue to discourage integration of services. Many beneficiaries of these programs endure considerable psychosocial hardships across the SDoH. More than 2.5 million U.S. adults diagnosed with SMI alone live below the poverty level, \$12,760 for one person, \$17,240 for two, and up to a maximum of \$44,120 for a family of eight persons (SAMHSA, 2016; U.S. Department of Health & Human Services, 2020b).

Decreased Psychiatric Care and Treatment

Psychiatric beds steadily decreased over the past several decades, with inadequate beds and treatment programs for mental health being the current norm. In 1955, there were well more than 500,000 inpatient state and country psychiatry beds. Mass closure

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of psychiatric hospitals and deinstitutionalization of the 1970s had a significant impact on the total bed count. Shifts in insurance reimbursement further contributed to program closures. By 2016, the number of inpatient state and county psychiatric beds was 37,679; the psychiatric bed census in some regions of the United States averages a mere 22 beds per 100,000 residents (Gibbons et al., 2017; National Council of Behavioral Health, 2017). Although it can be easy to view patients as not adherent to mental health treatment, the real reason for their failure to follow through on appointments and other recommendations may be due to the sheer lack of available psychiatric care.

When programs have been able to maintain dedicated psychiatric beds, the quality of the treatment program has been negated by insufficient reimbursement. Rates of reimbursement for inpatient psychiatric programs have historically been inadequate to substantiate their existence in general acute hospitals. For-profit private psychiatric hospitals have been able to offer far lower rates due to lesser administrative costs. In these settings, higher patient-to-staff ratios, lesser quality staff, or potentially unlicensed staff (based on state regulations) can be the reality. Low rates of reimbursement for inpatient services impede care access, for example, when a per diem reimbursement amount is significantly less than the daily rate for care. As a result, appropriate staffing levels, treatment interventions (e.g., individual, isolation, groups), and effective psychopharmacological management are unable to be met.

Industry reports on psychiatry shortages (Kaiser Family Foundation, 2020; National Council of Behavioral Health, 2017) revealed undeniable care gaps. The public pool of psychiatrists across the United States has decreased over 10%, whereas other medical specialties have increased during the same time period: neurologists by 15% and primary care physicians by 1.3%. A psychiatrist desert exists across most states and age groups (e.g., child and adolescent, general psychiatry) that translate to profound delays in care when they are available. High percentages of patients with AMI and especially SMI rely on public insurance (e.g., Medicaid, Medicare Advantage),

and many providers are no longer accepting these payors. In Massachusetts, only 33% of the practitioners accept Medicaid-managed care plans, whereas upwards of 95% are paneled with other private commercial group insurance plans (Benson et al., 2020). When individuals are not able to obtain the appropriate and timely mental health treatment, their stabilization and prescription management is grossly compromised.

Health Professional Shortage Area Designations

Health Professional Shortage Area (HPSA) designations in the United States are developed at the federal level to identify areas and population groups that experience a shortage of health professionals. There are three health category Health Resources & Services Administration (HPSA) designations that experience shortages: mental health, primary medical, and dental care. The number of HPSA-designated regions are calculated on July 1 annually by the U.S. HRSA (2020). As of August 2020, there were more than 5,559 areas in the United States identified with mental health shortages and 119 million persons were impacted by this shortfall of mental health practitioners.

The HPSA number for any area is based on the number of health care professionals available, relative to the region's population or the percentage of need. The **percentage of need met** for any region is calculated by dividing the number of psychiatrists available to serve the population, group, and facilities of the area by the number of psychiatrists who would be required to eliminate the mental health HPSA designation. Federal regulations mandate that for any region to be identified as having a shortage of providers, the area must have a population-to-provider ratio of a certain threshold, which for mental health is at least 30,000 to 1; 20,000 to 1 if there are unusually high needs in the community (Kaiser Family Foundation, 2020).

A minimum of 6,431 mental health practitioners are needed to remove all HPSA designations around the country. The numeric of practitioners needed to remove any HPSA designation is based on the number of additional psychiatrists that would be needed to have a population-to-psychiatrist ratio of 30,000 to 1 in all the designated mental health HPSAs; 20,000 to 1 where high needs are indicated. For 2020, California and Texas included the highest number of HPSAs in the United States—at 544 and 419, respectively. The mental health HPSA designation can include core mental health providers as well as psychiatrists. However, it should be noted that the majority of mental health HPSA designations is based on the psychiatrists-to-population ratio only and does not take into account the availability of additional mental health services provided by other providers in the

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area (e.g., clinical psychologists, clinical social workers, psychiatric nurse specialists, marriage and family therapists). This fact makes for a key point when case managers consider the high number of mental health patients who require psychopharmacological intervention. Reliable, accessible, and consistent prescription medication management by psychiatrists is basically lacking in many areas of the United States. It is common for patients (and their case managers) to identify as much as a 4- to 6-month waiting list to access psychiatric appointments. Table 4 displays the HPSA state rankings for mental health in the United States. Of particular note is that the majority of mental health shortage areas are across states without Medicaid expansion and rural states (Kaiser Family Foundation, 2020). An interactive dashboard of all provider shortage areas lives on the HRSA website at www.hrsa.gov.

POPULATION-BASED EVIDENCE

Complex, Increasing, and Unmet Care Needs

To incorporate a revised framing of SDoMH, the culture of mental health must shift from individual patient issue to a more public, population-based approach (Shim et al., 2015). Part of this cultural shift entails using the abundance of rapidly appearing relevant data across the industry.

Mental health has become the most significant driver of unnecessary ED visits with the costs for patients with behavioral health needs upwards of \$2,264 per visit (Schall et al., 2020). These numbers are unsurprising, given data that validates how racial and ethnic minority groups are less likely to access to mental health care or community mental health, more likely to obtain care from EDs, and have that care be emergent, short-term fixes only (National Institute of Mental Health, 2016-2020; Schall et al., 2020).

As noted earlier in this article, the incidence of SMI across the population is far less than AMI. However, high numbers of persons with SMI experience a long-term disability from their diagnosis. This reality translates to a significant fiscal burden on practice settings and sectors of care, across education and law enforcement, to the health care sector itself. A person's level of disability related to SMI is defined by assessment of the severity of the illness compared with lifetime costs, a total that can register in the millions. The age of a person

TABLE 4
State Rankings of HPSAs: Mental Health^a

State	HPSAs
California	544
Texas	419
Michigan	299
Alaska	269
Missouri	266
Arizona	212
Florida	202
Washington	187
North Carolina	184
Illinois	171
New York	170
Louisiana	153
Oklahoma	150
Wisconsin	148
Kansas	131
Kentucky	131
Pennsylvania	131
Oregon	124
Iowa	115
Montana	113
West Virginia	109
Minnesota	107
Nebraska	101
Georgia	95
Indiana	92
New Mexico	85
Tennessee	84
Mississippi	83
Colorado	77
North Dakota	76
Virginia	75
Idaho	64
Alabama	63
Maine	60
Nevada	59
Massachusetts	57
Utah	55
Arkansas	48
Puerto Rico	44
Maryland	41
New Jersey	35
Connecticut	32
Wyoming	30
Hawaii	27
New Hampshire	22
Vermont	20

(continues)

TABLE 4**State Rankings of HPSAs: Mental Health^a**
(Continued)

State	HPSAs
Rhode Island	12
Delaware	9
District of Columbia	9
Federated States of Micronesia	8
U.S. Virgin Islands	4
Guam	2
Marshall Islands	2
Northern Mariana Islands	2
American Samoa	2
Republic of Pau	2

Note. HPSAs = Health Professional Shortage Areas.

^aData from Kaiser Family Foundation. (2020). *Mental health professional shortage areas*. September 30, 2020; State Health Facts. <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

at the onset of the SMI factors heavily in this equation; the median age for diagnosis is anywhere from 15 to 30 years (National Institute of Mental Health, 2020). The age of persons impacted by SMI makes them far more vulnerable to the presence and severity of chronic and acute physical illnesses (de Mooij et al., 2019; National Institute of Mental Health, 2016).

Morbidity and Mortality Across Disease States

Pre-COVID

Patients with AMI are more prone to live with comorbid health and behavioral health conditions; 50% of people diagnosed with an SMI have coexisting medical morbidities and higher mortality (Butler & O'Brien, 2018; de Mooij et al., 2019). The literature notes a relationship between all classes of psychotropic medications and the increased risk of physical health conditions in patients with SMI. A diagnosable depressive disorder (e.g., major depressive disorder, persistent depressive disorder, substance-medication-induced depressive disorder) has been identified in 17% of patients with cardiovascular disorders, 23% of patients experiencing a cerebrovascular event, 27% of patient with diabetes, and more than 40% of patients diagnosed with cancers (Centers for Disease Control and Prevention, 2012). When patients with SMI are prescribed antipsychotics, they experience a higher prevalence and incidence of cardiovascular disease, diabetes, and cerebral vascular accidents profoundly. In addition, the mortality data are compelling for this population with patients far more likely to die at a younger age, over a decade earlier for women, and closer to 20 years for men (Heald et al., 2016; Lawrence et al., 2013).

The weave of health and mental health disparities is particularly high for patients experiencing socioeconomic and psychosocial stressors. The high number of people with SMI who live at, or below, the poverty level translates to unaffordable health and behavioral health care costs, whether due to copays or from being uninsured. The correlation between poverty and SMI has been identified as a causal factor to intensify mental illness impairment for persons aged 26 years and older (SAMHSA, 2016). These persons face chronic struggles with housing sufficiency, being forced to rely on shelters and hotels to avoid homelessness. However, lack of available housing options can leave these persons residing in unsafe communities or living circumstances (e.g., the street, tent cities, abandoned buildings), which factor heavily in susceptibility to illness onset and severity. Lack of financial support from unstable employment translates to an inability to access healthy food options that contributes to nutritional deficiencies, subsequently low immunity, and high vulnerability to physical illness. Poor nutrition has been identified as a significant factor in the exacerbation of mental illness and ultimately further health challenges across the life span. Afulani et al. (2020) found an especially high incidence of SMI in nonelderly adults (aged 18–64 years) who experienced food insecurity; those persons with very low food security had two times higher odds of being able to afford or access mental health treatment.

Chronic Illness

Costs of care for patients with comorbid chronic illnesses (e.g., chronic respiratory ailments, cardiovascular diseases, chronic kidney disease, diabetes) and formally diagnosed mental illnesses (e.g., schizophrenia, bipolar disorder, delusional disorder, major depression) are higher than for populations without similar conditions. Substantial literature validates a greater incidence of chronic illness onset and higher fiscal tally for these populations, with elevated rates of pathophysiological acuity and decreased life expectancy, as much as 20 years less than the remainder of the population (Butler & O'Brien, 2018; Iwagami et al., 2018; Sporinova et al., 2019; Wainberg et al., 2017). These diseases were identified as the leading cause of death and disability and main driver of health care costs in the United States pre-COVID, impacting six out of 10 adults (Centers for Disease Control and Prevention, 2020).

Case managers should be cognizant of the vital connection between chronic illnesses and mental health. Conclusive data reveals that when mental health issues are untreated, patients have greater ED visits, hospital admissions, readmissions, and mortality rates. Health behaviors that contribute to poor self-care (e.g., poor nutrition, smoking, alcohol use, lack of

exercise) are associated with an increased occurrence of depression, schizophrenia, and bipolar disorders; individuals with chronic schizophrenia are as much as three times more likely to smoke than persons without other mental illnesses (Heald et al., 2016; Prochaska et al., 2017). These behaviors also factor heavily into the development of congestive heart failure, chronic kidney disease emphysema, and diabetes (Celano et al., 2018; Centers for Disease Control and Prevention, 2020; Heald et al., 2016; Iwagami et al., 2018).

Sporinova et al. (2019) reviewed hospitalization and physician billing claims for 156,296 adults across Canada who were diagnosed with comorbid chronic diseases (e.g., asthma, congestive heart failure, myocardial infarction, diabetes, epilepsy, hypertension, chronic pulmonary disease, or chronic kidney disease) and mental health diagnoses (e.g., depression, schizophrenia, alcohol use disorder, or drug use disorder). There was a clear correlation identified between these diagnoses, including higher health care resource utilization and expenditures. The presence of a mental health disorder was directly associated with more frequent hospitalization and ED visits, particularly when the visits were associated with chronic disease management (Sporinova et al., 2019). Average reimbursement rates across diagnostic groups varied,

though were significantly higher when patients were diagnosed with a mental illness—\$38,250 compared with \$22,280. The highest cost categories across the various groups were for hospitalizations, prescription drugs, and physician visits.

Intersection of COVID-19, SDoMH, and Trauma

The coronavirus has had a remarkable impact on both health and mental health exacerbation. The pandemic and SDoMH are now considered co-occurring epidemics of historic proportion. The Band-Aid approach to public health has meant grossly limited access to health and mental health care, whether from

- program closures due to safety at home orders;
- social distancing mandates;
- virtual health inaccessibility; and
- inadequate technology to access necessary care.

Rising rates of mental health have become a major concern across populations and chronic disease states. Forty percent of admitted COPD admissions have had co-occurring depression and anxiety (Ahmed et al., 2020). Case managers have been faced with the need to assess a wholistic health triad of pathophysiology, psychopathology, and psychosocial circumstances, as shown in Figure 1. The triad offers

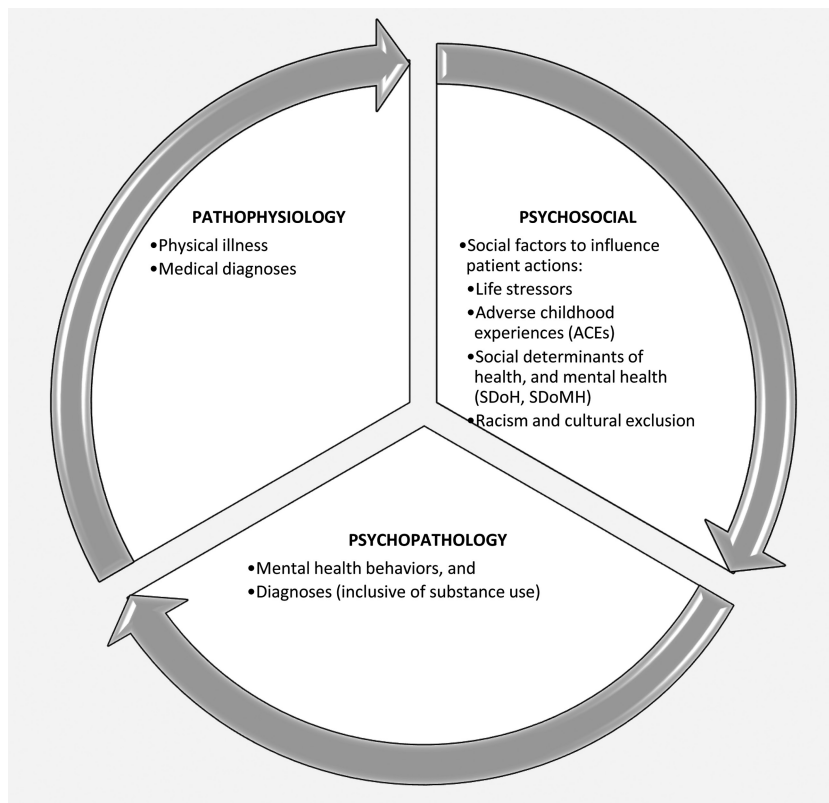


FIGURE 1

Wholistic health triad. Adapted from Chapter 8, mental health, *End of Life Care for Case Management*, by E. Fink-Samnick, 2020, HCPro.

an expansive and more organized outlook of complex patients that fosters effective population health management. The integration of these three distinct domains forges a comprehensive view of the human condition: physiological processes that influence disease, along with mental health diagnoses (e.g., *DSM-5*, *ICD-10*) and behaviors (e.g., depression, anxiety, stress, insomnia, agitation), and social factors that contribute to both and health and behavioral health disparities. The perspective reinforces two clear concepts. First, use of the term “wholistic” versus “holistic” is intentional, emphasizing the value of a whole person approach care that minimizes holes in care. The second premise informs the workforce of a decisive mantra; there can be no true health without equal attention to mental health and the psychosocial circumstances in which persons live (Fink-Samnack, 2020).

More socially disadvantaged groups have experienced financial ramifications of the pandemic far quicker than more socially advantaged counterparts, with increased incidence of behavioral health manifestations (e.g., suicidal ideation, substance use; Purtle, 2020). Unprecedented rates of unemployment have left racial and ethnic populations who earn incomes and/or have less than \$5,000 in savings coping with severe symptoms of depression (Ettman et al., 2020). The intense levels of strain experienced by families courtesy of job loss, potential eviction, and viral transmission fears are contributing to concern for unprecedented levels of family and intimate partner violence, whether child and adult abuse, domestic violence, or sexual assault (Brooks et al., 2020; Evans et al., 2020; Lawson et al., 2020). The enormity of COVID-19’s financial impact across all socioeconomic groups cannot be overstated. More of society’s “haves” are now “have-nots” with those previously marginalized populations at even greater risk of succumbing to severe forms of mental health exacerbation.

A revolving door of studies speaks to unprecedented levels of mental health emergencies appearing in response to the pandemic (Czeisler et al., 2020; Kira et al., 2020); almost half of respondents report a least one adverse mental health condition. Rapidly rising numbers of persons who have experienced historical trauma and discrimination are having that fierce construct retriggered by the pandemic. These persons have endured intergenerational, systematic oppression that leaves a wrath of cumulative psychological and emotional wounding stemming from massive group trauma (BraveHeart et al., 2011). More than 26.3% of persons in one study presented with symptoms of a new onset of trauma- and stressor-related disorders, including depression, anxiety, and insomnia, and another 13.3% started or increased

substance use to cope with stress or emotions (Czeisler et al., 2020).

Kira et al. (2020) studied the direct effects of COVID-19 and the impact of its collective identity trauma on 1,374 participants. The data revealed how the dyad of virus-specific traumatic stress and intersected discriminations increased death anxiety, while also contributing to lower social status, reduced well-being, and increased behavioral health manifestations (e.g., posttraumatic stress disorder, anxiety, depression; Kira et al., 2020). COVID-19’s wrath exacerbates the vicious cycle of inequities and disparities in care access, treatment, and outcomes. A new generation of multilayered traumatic stress impacts individuals, whether directly and/or vicariously, particularly those across minority populations. Encompassed within this latest iteration of trauma are three elements of fears of present and future infections, pervasive economic impact, and routine disruption and isolation, as shown in Figure 2. Fear of the unknown and lack of control influence the vulnerability and coping capacity of those persons and populations already most marginalized and at risk.

The population-based impact of ACEs and trauma on morbidity and mortality of these populations across all age groups has been extensively addressed in the literature (Centers for Disease Control and Prevention, 2020; Fink-Samnack, 2020).

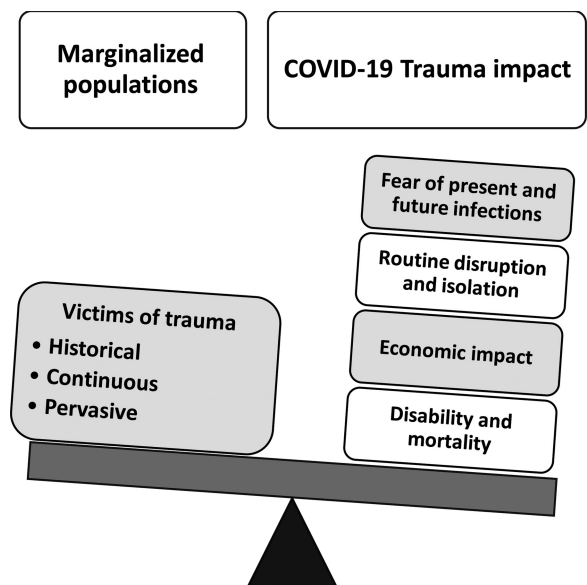


FIGURE 2 COVID-19’s multilayered traumatic stress. Adaption of concepts from “The Effects of COVID-19 and Collective Identity Trauma (Intersectional Discrimination) on Social Status and Well-Being,” by I. A. Kira, H. A. M. Shuwiekh, A. Alhuwailah, J. S. Ashby, M. S. Fahmy Sous, S. B. Ali Baali, C. Azdaou, E. M. Oliemat, and H. J. Jamil, 2020, *Traumatology*. American Psychological Association. Advance online publication. doi.org/10.1037/trm0000289

Data show that as high as 61% of adults surveyed across 25 states reported experiencing at least one ACE—one out of six persons experiencing four or more ACEs (Centers for Disease Control and Prevention, 2020). Women across racial and ethnic minority groups are at a greater risk of experiencing four or more ACEs. The toxic stress from ACEs alone can alter brain development; affect attention, decision making, learning, and response to stress; exacerbate depression and anxiety; and contribute to addiction and substance use disorders (whether alcohol and/or narcotic or illicit drug use) and severe mental illness (Centers for Disease Control and Prevention, 2020). The stress of a person's poor circumstances and exposure to those social determinants put them at a higher risk of severe mental illnesses such as schizophrenia and bipolar and other psychotic disorders. For the 9.8 million adults with a serious mental illness, 2.5 million lived below the poverty level (SAMHSA, 2016).

The pandemic's morbidity and mortality data continue to reveal mental health impact across poorer and more disparate communities over the urban, suburban, and rural landscape. Black, Indigenous, Persons of Color (BIPOC) and Latinx communities have been hardest hit. Greater shares of Black and Latinx people are experiencing adverse behavioral health symptoms, considering suicide, and new or increased substance use compared with Whites. Among children, the average number of ED visits for mental health is more than 40% higher from mid-March through mid-October compared with that time period in 2019. Native American youth die by suicide at nearly twice the rate of their White peers in the United States. Included in these grim numbers are vulnerable children on remote reservations who are cut off from their larger families and communities by COVID-19–caused restrictions (Reardon, 2020).

Coping with the pandemic and racial tensions have emphasized how the power and influence of upstream disruptors drive downstream challenges, especially in the form of mental health assessment, intervention, and treatment. Virtual health platforms are an asset but less accessible for SDoMH populations. The digital divide between populations is a chasm, with close to 21.3 million persons in the United States lacking broadband access in 2019 (Federal Communications Commission, 2019). Connectivity in rural communities is grossly hampered with close to 30% of persons in those regions unable to access the internet due to lack of a home broadband connection (Turner-Lee, 2020).

The dyad of the pandemic and the SDoMH are yielding infinite difficulties for the most at-risk populations. In the interest of space, the following challenges have been compiled as additional key areas for case management's concern:

- Increased incidence of SMI among the most vulnerable populations and those affected by the virus, with rising rates of major depressive disorder, treatment stigma, increased unemployment, and housing insufficiency for persons with SMI (Druss, 2020; Shim, 2020).
- Disaster-related quarantines that imposed negative psychological effects across the developmental life span (e.g., posttraumatic stress disorder symptoms, confusion, anger, agitation; Brooks et al., 2020).
- Deeper levels of economic stress, social isolation, escalating anxiety prompting increasing firearms sales, access, and suicide rates (Reger et al., 2020).
- Hampered psychopharmacological care due to prescription access challenges (e.g., delays with renewals, lack of access to telehealth assessments, medication evaluation; Kahl & Correll, 2020).
- Far higher incidence of COVID-19 infection and deaths among Blacks, Latinx, and lower socioeconomic groups compared with more socially advantaged populations (Muñoz-Price et al., 2020).
- Mental health disruptions for persons living in poverty, rural regions, lack of digital devices, use of outdated devices or platforms, health and language literacy challenges, and poor technology proficiency (Fink-Samnack, 2020).

LEVERAGING WHOLISTIC HEALTH EQUITY AND BEYOND

Mental health and its accompanying disparities are being viewed in the context of a public health crisis. The pandemic has torn through the world's poorest communities and ripped the Band-Aid off of reactive and short-term efforts to address public health. Disproportionate numbers of persons are now suffering health and behavioral health disparities across the racial, ethnic, and cultural divide.

High levels of advocacy are being invoked across the globe and every industry stakeholder. Providers, practitioners, professional associations, and credentialing entities are engaged in cross-sector collaborations to mitigate the sizeable gaps across the wholistic health triad. Racism has been formally identified as a public health emergency by more than 30 states and 900 counties across the United States. (American Public Health Association, 2020). Mental health and racism are intrinsically linked, responsible for existing inequities in diagnosis, treatment, and management of mental health illness (Compton & Shim, 2015). The ripple effect of these issues on an individual's physical health status becomes yet another casualty of a dysfunctional, discriminatory health and mental health system that only contributes to more invasive disease progression.

The industry and its consumers can no longer afford to tolerate a system whose outcomes fail to meet minimal thresholds or standards of care. Access to necessary treatment and resources can no longer be obstructed by the mighty macro disrupters of systematic racism, inadequate providers, insufficient reimbursement, lack of mental health parity, and pervasive practitioner and provider stigma. Clinical and fiscal outcomes paint a vibrant picture of opportunity to bridge the cost, ethos, and quality divide. A fierce rally cry speaks to health and mental health equity, but the means to ensure this intrinsic goal remain to be reconciled.

CONCLUSION

The industry's quality compass of the Quadruple Aim is now more than 20 years old. However, despite strong efforts to do so, it remains a dream to attain appropriate health, as well as mental health for all persons, at the right time, right cost, and rendered by professionals who embrace the work. The time is ripe to expand the Aims in a way that more accurately reflect societal narratives of racial and social intolerance and ensure more equitable reimbursement and concordant treatment approaches that incorporate inclusive practices. Join me in Part 2 of this article series where a fifth aim of wholistic health equity will be presented as a means to encompass an industry quality framework for the future.

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