



NO HEALTH *WITHOUT*
MENTAL HEALTH
& SYSTEMIC CHANGE

NO HEALTH WITHOUT MENTAL HEALTH: NO ADVANCEMENT IN HEALTH WITHOUT SYSTEMIC CHANGE

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FOREWORD

It was not all that long ago—given the history of modern civilization—that mental illness was considered a scourge, an affliction to be feared, denied, punished or hidden away. We have come a long way.

A long way, yet not far enough.

Today, we have come to understand much about the roots and treatment of psychological disorders. In the United States, the one-time reliance on overmedication, isolation and institutionalization has gradually given way to a more integrated approach, fueled by a growing recognition that mental health is inextricably intertwined with physical health and general well-being. We have embraced this burgeoning body of knowledge at The Chicago School of Professional Psychology (TCSPP), where we annually prepare thousands of psychology and health professionals to live out our university's mantra, that there is No Health Without Mental Health.

This report is the second of its kind produced by TCSPP and spearheaded by a team of faculty whose expertise, years of experience and in-depth research has led to the findings that comprise No Health Without Mental Health: No Advancement Without Systemic Change. It focuses on the challenges facing our nation's shifting demographics—specifically older adults, racial and ethnic minorities, and immigrants. It pulls together rich sources of data to delve into our society's mental health realities and deficiencies and to draw conclusions about what is needed to achieve systemic change.

Yes, we have progressed significantly from the days of asylums and inhumane treatments. We have advanced on many fronts, recalibrating our collective lens to gauge holistic health rather than pinpoint incidence of mental illness. But as time and demographics change, so must our approach. The goal of our report is to move our health system and our society one step closer to the fundamental changes that will lead to a healthier, happier world.

Michele Nealon, Psy.D.
President
The Chicago School of Professional Psychology

INTRODUCTION

**No Health without Mental Health:
No Advancement in Health without Systemic Change**

*“Health cannot be a question of income;
it is a fundamental human right”*

(Mandela, 2003, para. 3).

The meaning of health has evolved throughout the centuries. Traditionally, health has been understood as a state of being free from disease or illness. This framing of health underscored rigid boundaries, that measured only the absence or presence of physical ailments to determine health. Frameworks introduced in the late 1960s broadened the definition of what constitutes health; the World Health Organization (WHO) now defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, n.d.). This expansive view of health goes beyond the boundaries of biology and embraces the important roles that psychology, culture, and context play in people’s overall well-being.

Produced by The Chicago School of Professional Psychology (TCSPP), the goal of this report is to inform, educate, and disseminate information about health that underscores the importance of caring for the whole person, while examining the context in which people live, learn, and connect. Context includes the social realities experienced by the diverse groups that compose our racially, ethnically, and linguistically rich society; such social realities often impact both the physical and mental health of diverse individuals, families, and communities. Hence in this report we assert that there is no health without mental health, and there can be no advancement in health without systemic change. To achieve this goal, three main objectives are addressed. First, the report describes the changing demographic landscape of the United States (U.S.) with a focus on three populations that have shown a significant increase in the past few decades, including: older adults, racial and ethnic minoritized individuals, and immigrants. Second, a literature-based model is provided that illustrates (a) the factors that impact the social conditions in which people live and operate, (b) how they cope with chronic stress and poor quality of life, and (c) the ways that institutions and policies impact access to resources, including healthcare. Third, integrative and multidisciplinary approaches are described as a way to expand the definition of healthcare services. The report ends with future direction to meet the health needs of a changing America.

SECTION 1:



“In diversity, there is beauty and there is strength”

(Maya Angelou, 2014, para. 11).

NO HEALTH WITHOUT MENTAL HEALTH IN A CHANGING COUNTRY

The United States (U.S.) is currently in the midst of experiencing significant demographic shifts. For instance, the U.S. population is growing older while also becoming more racially and ethnically diverse than ever before. Together, these changes will undoubtedly have important implications for the delivery of health services in the country.

The Aging of the U.S. Population

According to the U.S. Bureau of the Census (2017), the median age in the U.S. rose from 35.3 years in 2000 to 38 in 2017. Interestingly, changes in the median age are happening in every state of the union. Changes in median age are partially due to the aging of the baby-boomer generation (people who were born between 1946-1965) who began to turn 65 years of age in 2011. As a result, older adults defined as people 65 years of age and older grew from 12.4% or 32 million in 2000 to 15.2% or 49.2 million in 2016 (U.S. Bureau of the Census, 2017). In 2018, there were 49.2 million people over the age of 65, or 15.2% of the population, living in the U.S. The increase in the older adult population is expected to continue, and it is predicted that by the year 2030, one in five Americans (20% of the population) will be over the age of 65. Additionally, the U.S. Bureau of the Census predicts that by 2035, and for the first time in the history of the U.S., older adults will outnumber children (U.S. Bureau of the Census, 2018). With regards to sex, the older adult population is predominantly composed of women, who tend to live longer than men. For instance, over half (56%) of people over the age of 65 were women in 2014. Sex differences become more robust over time. To illustrate, among people over the age of 85-years, 66% are women (Federal Interagency Forum on Aging-Related Statistics, 2016).

The Browning of the United States

In addition to growing older, the U.S. population is also becoming more racially, ethnically, and linguistically diverse (White & Henderson, 2008). In fact, since 1990 the percentage of People of Color in the U.S. has shown a significant growth with Latinxs and Asians; both populations are growing at a faster rate than other racial and ethnic groups including non-Latinx Whites, Blacks, and American Indian/Alaskan Natives (National Center for Education Statistics, 2017). For instance, within a period of 26 years, the Latinx population increased by 155%, from 22.6 to 57.8 million. In that same time period, Asian Americans increased by 204%, from 6.9 to 21 million. Alternatively, the non-Latinx white population increased by only 5%, African Americans by 37%, and American Indian/Alaskan Natives by 33%. As a result of these demographic changes, the racial and ethnic composition of the U.S. population has dramatically shifted, with Latinxs currently representing the largest ethnic minority group comprising 18% (58 million) of the total U.S. population. The growth of the Latinx population is expected to continue in the upcoming decades, with projections calculating that by 2030, 20% of the total population U.S. will be of Latinx descent (U.S. Census Bureau, 2004). Interestingly, Latinxs also represent the fastest-growing older adult population in the U.S., with 3.6 million individuals over the age of 65 being of Latinx descent (U.S. Department of Health and Human Services, Administration for Community Living, Administration on Aging, 2015). Moreover, the Administration on Aging reports that between 2008 and 2030, the Latinx aging population will increase by 224% compared to a 65% increase for non-Latinx Whites. Thus, it estimated that by 2060 there will be 21.5 million Latinx older adults, totaling 22% of the older U.S. population. In addition to being the fastest-growing aging population in the U.S., Latinxs also have a longer life expectancy than their African American and non-Latinx White American counterparts (U.S. Department of Health and Human Services, Administration for Community Living, Administration on Aging, 2015).

Immigrants Contributing to the Changing Fabric of the U.S.

The U.S. has a long history of people coming to its borders (Chavez-Dueñas & Adames, 2018), and as the U.S. population continues to age, immigrants are expected to become one of the primary drivers of this nation's population growth (Ortman, Velkoff, & Hogan, 2014). For instance, in 2016, the foreign-born population reached a record high, with 44 million immigrants (13.5% of the total population) living in the country (Pew Research Center, 2018). Contrary to widely held stereotypes, most immigrants in the U.S. (76%), reside in the country legally, with only about 24% being undocumented. The foreign-born population is diverse with regards to race, ethnicity, and country of origin, representing almost every country in the world.

The geographical origin of immigrants has changed significantly over the last decade. For instance, while many the foreign-born population currently in the country are from Latin American, (51%), immigration from these countries has decreased, and since 2010, there have been more people from Asia migrating to the U.S. than from Latin America (Pew Research Center, 2018). A noteworthy fact about immigrants is that they are less likely to have access to health insurance when compared to native-born people. To illustrate, in the states with the fastest growing immigrant population (e.g., Nebraska, Nevada, Florida), approximately 20% of immigrants lacked health insurance compared to between 6-7% of U.S. born individuals (Batalova & Alperin, 2018). In addition, older adult immigrants are more likely to belong to families with low socioeconomic status (40% compared to 30% among U.S. born) and live below the poverty line (16% vs. 8%; Farrell, 2016).



SECTION 2:

A person is shown in a meditative pose, sitting cross-legged on a dark mat outdoors. The background is a soft-focus sunset with warm orange and yellow light. The person's hands are in a mudra, with fingers interlaced. The overall mood is peaceful and contemplative.

“Health is a state of complete harmony between the mind, the body, and the spirit”

(Iyengar, 2006, p. 48).

THE INTERPLAY BETWEEN PHYSICAL HEALTH AND MENTAL HEALTH

Globally, we are a planet that is focused on health. For centuries, various groups around the world have described the link between physical health and people’s mental state. History provides us with ample examples of this connection. For instance, the Aztecs and ancient Greeks believed that all illnesses of the body impacted the mind (Padilla & Salgado de Snyder, 1988). To illustrate, the Aztecs believed that all feelings and thoughts originate from the heart while the Greeks believed that the heart was the center of a person’s soul (Padilla & Salgado de Snyder, 1988). Similarly, philosophers like Aristotle also believed in the physical and mental connection—asserting that the center of psychological life was also in the heart (Roccatagliata, 1975). Sigmund Freud’s work in the 19th century follows a similar line of thinking, describing how phobias and unconscious conflicts can lead to physical problems and symptoms (McWilliams, 2011). Together these ancient and Indigenous ideologies served as a strong foundation upon which Freud and others built several fields and specialties of health over time, including: (a) psychosomatic medicine, (b) behavioral medicine,

(c) behavioral health, (d) medical sociology, (e) medical anthropology, (f) neuropsychology, and (g) health psychology. A description of these seven fields of health and specialties are briefly provided below.

- **Psychosomatic Medicine:** A branch of medicine developed in the 1930s that studies and focuses on the ways in which emotional, social, and psychological factors impact the development of illness like gastrointestinal problems, asthma, headaches, arthritis, and other physical ailments (Lipowski, 1986; Sanderson, 2004).
- **Behavioral Medicine:** A branch of health developed in the 1970s that centers on the integration of biomedical and psychological sciences to treat, manage, and rehabilitate patients via behavioral techniques and interventions (Gentry, 1984; Sanderson, 2004).
- **Behavioral Health:** A subfield of Behavioral Medicine that focuses on the prevention of illness in healthy individuals instead of waiting for an illness or psychogenic condition to emerge (Sanderson, 2004).
- **Medical Sociology:** This branch of health focuses on the reaction that social groups have to illnesses and healthcare service organizations. Topics studied in the field include the impact of social stress on health and illness, along with broader attitudes about health (Adler & Stone, 1979; Sanderson, 2004).
- **Medical Anthropology:** This field focuses on understanding the how illness and health are viewed and described by different cultural groups across the globe and within a single culture (Sanderson, 2004).
- **Neuropsychology:** This specialty field within the larger umbrella of clinical psychology focuses on understanding and assessing the connection between brain, behavioral function, and cognition (American Academy of Clinical Neuropsychology, 2018). Following the scientific principles and concepts of neuropsychology, clinical neuropsychologists focus on both evaluation and treatment.
- **Health Psychology:** A relatively new discipline, health psychology integrates biomedical information about health and illness with both basic and clinical psychological research to advance the understanding of health and illness in the lives of people (APA, n.d.).

Together, all the aforesaid health disciplines and specialties provide the public with increasing evidence and knowledge of the strong bidirectional relationship among psychological and bio-social processes. A recent report published by the American Psychological Association titled, *Stress in America™*, provides evidence for the role of chronic stress on health (American Psychological Association, 2018a). The report describes that two-thirds or 66% of U.S. adults cite the cost of health insurance as a stressor for themselves or their loved ones. Five additional sources of stress for adults and youth were described, including: the increase in suicide rates (44% to 62% respectively), mass shootings (62% to 75% respectively), climate change (51% to 58% respectively), separation and deportation of immigrants and immigrant families (45% to 57% respectively), and widespread sexual harassment and assault (39% to 53% respectively).

When stress and other psychological forms of distress are left unattended, they can have dire consequences for groups and individuals. Hence, it is important for policymakers, healthcare providers, and community members to generate productive and effective forms of prevention and intervention that consider how resources such as money, power, and accessibility impact people's stress level and overall health.

SECTION 3:



“Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane”

(Dr. Martin Luther King, Jr., 1966, para. 8).

THERE IS NO HEALTH WITHOUT MENTAL HEALTH AND SYSTEMIC CHANGE: A CONCEPTUAL MODEL

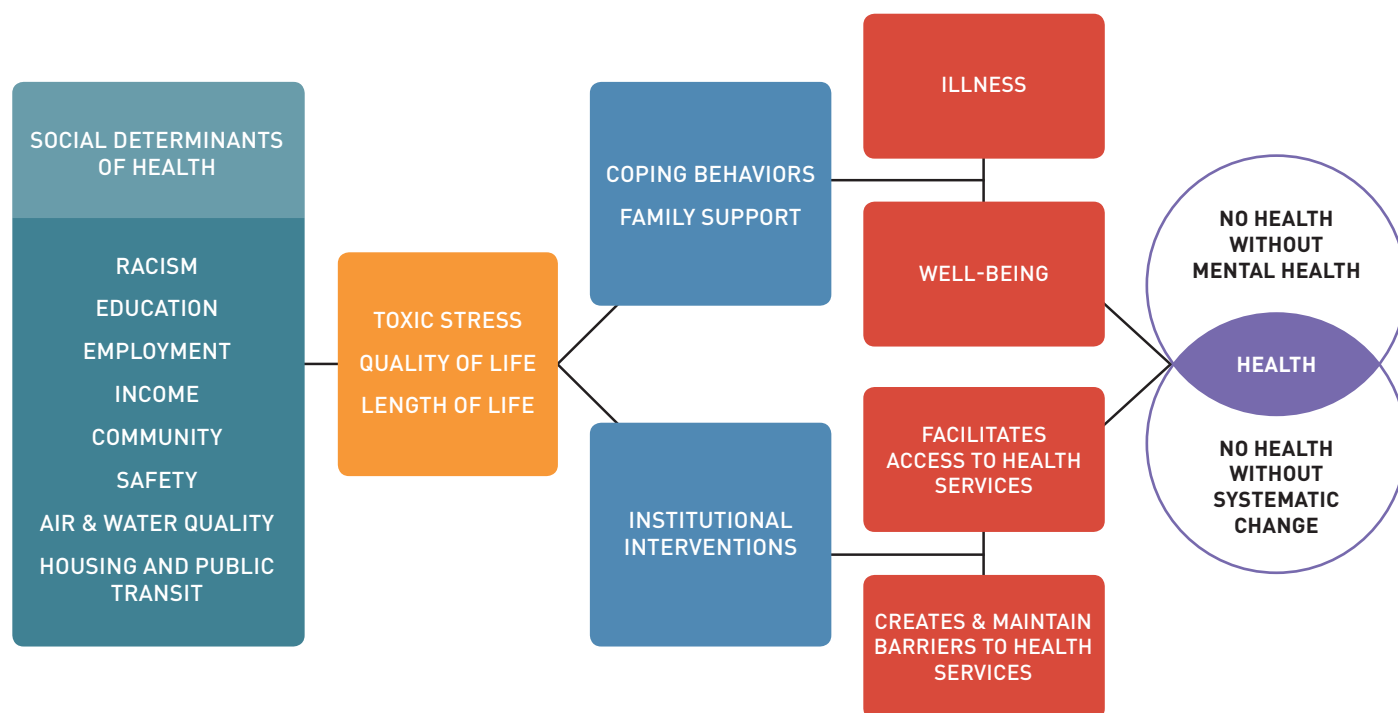
The struggle for dignity, equality, and the end to segregation led People of Color in the U.S. towards the Civil Rights Movement. While the Civil Rights Movement resulted in many gains, including greater human rights, the effects of Jim Crow continue to reverberate today in many social structures including education, housing, and healthcare. The structural distribution of resources such as money, power, and accessibility shape “the conditions in which people are born, grow, live, work, and age” (World Health Organization, n.d., para 1). Together these factors are described by the WHO as social determinants of health (SDoH).

Social Determinants of Health

The most identified and responsible SDoH are racism, poor education, low employment, and lack of community safety, housing, and public transit, which influence both physical and mental health inequities (Fraze, Lewis, Rodriguez, & Fisher, 2016; Hood, Gennuso, Swain, & Caitlin, 2016; Magnan, 2017; Priest et al., 2013; Walsemann, Gee, & Ro, 2013). Although the association between SDoH and health is well established in the social sciences of health (e.g., psychology, public health), the overall medical field has been slow to incorporate these social concepts and the importance of social context into their understanding of people's health. While these concepts have begun to gain traction over the past few years, some health providers continue to believe that structural social forces are too large and deep-seated to be changed (Meltzer, 2018). This problematic ideology supports the notion that addressing SDoH is beyond the scope of practice for healthcare professionals (Finnegan, 2018), hence leading to a suboptimal healthcare delivery system. Healthcare professionals, who devote their lives and careers to healing and doing no harm, must not be bystanders to the ways in which SDoH impact the lives of their clients and patients. The following sections highlight the importance of considering structural forces and SDoH in clinical practice. Each section describes the SDoH included in Figure 1 along with empirical information about its impact on both physical and mental health.



Figure 1. No Health Without Mental Health and Systemic Change Conceptual Model



Note. This conceptual framework illustrates the ways in which social determinants of health (teal) contribute to toxic stress, quality of life, and length of life (orange) for individuals. When people experience chronic levels of stress they are likely to use their social support networks as well as their coping behaviors (e.g., top blue) to ameliorate and manage stress. The effectiveness with which people are able to cope with stressors can contribute to illness or wellness (top red); hence, mental health is a pivotal aspect of health as there is no health without psychological resources to cope with life's challenges (top circle). While the top half of the model describes the effect that social determinants of health can have on toxic stress, quality of life, and length of life, the bottom depicts the need for institutional interventions that can facilitate people's access to professional health services including medical and mental health (bottom blue). Access to health services is a critical component to preventing, coping with, and healing from acute and chronic physical and mental health conditions (bottom red). Contrarily, barriers that prevent people from seeking or accessing health care services contribute to the development, exacerbation or maintenance of illness (bottom blue). Hence, there is no health without systemic change (bottom circle). Overall, the figure illustrates that both the top and bottom portion of the model are equally important when considering health. Thus, there is no health without mental health, and there can be no advancement in health without systemic change (center of overlapping circles).

Racism

There is growing evidence that racism, or the ideology used to justify harmful practices of inequity and the belief that one race is superior to another based on skin color and phenotype, impacts the health of People of Color (Carter & Pieterse, 2005; Chavez-Dueñas, Adames, Perez-Chavez, & Salas, 2019; Brondolo, Ng, Pierre, & Lane, 2016; Kaholokula, 2016). These covert and overt experiences of racial discrimination have generated mistrust and fear of the healthcare system by racial minority groups and have also been associated with stress (Sue, 2010; Sue & Capodilupo, 2008).

Over time, chronic stress – the state of experiencing mental strain resulting from persistent, repeated, and unceasing exposure to stressful events, situations, and experiences – releases a surplus of stress hormones (i.e., cortisol) which has been linked to poorer physical and mental health (Berger & Zoltan, 2015). To illustrate, exposure to chronic stress due to racial discrimination has been associated with physical symptoms and illnesses such as obesity (Hunte & Williams, 2009), high blood pressure (Brondolo, Rieppi, Kelly, & Gerin, 2003; Dolezsar, McGrath, Herzig, & Miller, 2014; Din-Dzietham, Nembhard, Collins, & Davis, 2004), cardiovascular disease (Chae, Lincoln, Adler, & Syme, 2010; Lewis, Williams, Tamene, & Clark 2014), coronary artery calcification (Lewis et al., 2006), and decreased immune response (Szanton, et al., 2012). In addition, studies have indicated that experiences of individual or interpersonal discrimination are associated with physiological processes that are believed to speed up the aging process (Colen, Ramey, Cooksey & Williams, 2018). Racism can also have a negative impact on mental health across the lifespan. For instance, several meta-analyses provide support for the relationship between racial discrimination and poor mental health outcomes among adolescents and adults (Paradies, 2006; Pascoe & Richman, 2009; Williams & Mohammed, 2013; Williams, Neighbors, & Jackson, 2003).

Education and income. Education attainment, often defined as the number of formal education and academic degrees earned by individuals, has been extensively studied due to its relationship to socioeconomic status, health (Elo, 2009; Kawachi, Adler, & Dow, 2010), and for its malleability to systemic interventions (Muennig, Robertson, Campbell, Pungello, & Neidell, 2011; Muennig, Schweinhart Montie, Neidell, 2009). Several randomized controlled trials and longitudinal studies (e.g., Muennig, Johnson, & Wilde, 2011; Muennig et al., 2009) provide evidence to support the practice of developing programs to improve educational attainment, which in turn help reduce health disparities and improve population health (Kawachi et al., 2010). To illustrate, higher educational attainment is associated with better overall health including lower prevalence in symptoms of anxiety and mood disturbance (Melkevik, Hauge, Bendtsen, Reneflot, Mykletun, & Aarø, 2016; Walsemann, Gee, & Geronimus, 2009), lower cardiovascular risk (McKee, McKee, Winters, Sutter, & Pearson, 2014; Rehkopf, Dow, & Rosero-Bixby, 2010), less functional limitations (Asada, Yoshida, & Whipp, 2013), and longer lifespan or life expectancy (Montez, Hummer, & Hayward, 2012).

While there is a plethora of evidence to support a causality between formal education and health outcomes, there is also data to support that higher income and access to material resources (e.g., purchasing higher quality goods, better housing, living in a low crime neighborhood) also improves people's health (Kawachi et al., 2010; Subramanian & Kawachi, 2006). Thus, there is a need to study and consider the role of systemic inequities to further understand the complex interplay between educational attainment, income, and health. Walsemann, Gee, and Ro (2013) posit that the quality of education, school segregation, and place where immigrants receive and complete their education contribute to academic attainment and overall health which undoubtedly affects income levels. Hence, without purposefully considering contextual and systemic factors, educational attainment as a predictor of health and income becomes less viable, useful, and optimal.

Poverty

In general, poverty is often described in either relative or absolute terms. The United Nations defines and measures absolute poverty as “in relation to the amount of money necessary to meet basic needs such as food, clothing, and shelter,” whereas relative poverty “defines poverty in relation to the economic status of other members of the society: people are poor if they fall below prevailing standards of living in a given societal context” (UNESCO; 2017, para 2). There is an abundance of research showing that poverty levels predict greater risk for developing mental health problems in women, children, and ethnic minorities (Kim, Lee, Jung, Jaime, & Cubbin, 2018; Osypuk, Schmidt, Kehm, Tchetgen, & Glymour, 2018) as well as chronic health conditions and mortality (Harriss & Salway, 2009; Ram, 2005).

While poverty is undoubtedly associated with money, the reasons for poverty are also connected to power and other systemic factors that often are outside individual control. In other words, the philosophy “Pull yourself up by your bootstraps” is not an effective strategy to reduce economic disparities. Instead, innovative systemic changes that help with providing access to healthcare services, job training, formal education, and housing for the poor are ways to alleviate poverty which can improve the overall health of a population. In 1993, the United Nations established October 17th of each year as World Poverty Day. This important and global designation was motivated as a step to help eradicate poverty while bringing attention to the important ways in which poverty impacts the lives and wellness of people. More recently, the 2019 APA President, Rosie Phillips Davis, Ph.D., has appointed a Working Group on Deep Poverty, and is focusing her presidential initiatives on “dismantling deep and extreme poverty and its violation of human rights” (APA, 2018b, para. 1).

Community residential segregation

The U.S. has a long history of residential segregation practices. A study by the U.S. Department of Housing and Urban Development (HUD) found biases in 30 metropolitan areas in the United States (HUD, 2012; Pager & Shepherd, 2008). The report describes how racial and ethnic individuals are more likely to face discrimination. For instance, when looking for an apartment to rent or a home to buy, racial and ethnic groups are provided with fewer options, less likely to be offered financing options, and actively discouraged from affluent neighborhoods (HUD, 2012; Pager & Shepherd, 2008). Together, these housing practices lead to residential segregation and are considered fundamental determinants of inequities and inequalities in access to quality education, healthcare, transportation, and employment opportunities (Santiago-Rivera, Adames, Chavez-Dueñas, & Benson-Florez, 2016; Williams & Collins, 2001; Phelan & Link, 2015).

SECTION 4:



*“Do the best you can until you know better.
Then when you know better, do better”*

(Maya Angelou, n.d., para. 1).

MEETING THE NEEDS OF DIVERSE COMMUNITIES THROUGH AN INTEGRATED HEALTHCARE APPROACH

The current and predictive changes in demographics in this country suggest that the future population of the U.S. will be vastly different in regards to race, ethnicity, and language of origin from that of the last century. Faced with such rapid changes in the U.S. population, the system of health care delivery will require a re-thinking of both the process and the strategies utilized to prevent illness, provide services, and promote wellness among diverse groups of people with various and vast differences in beliefs and ways of understanding health, wellness, and illness. Hence, the training of healthcare providers will necessitate the integration of

culturally-congruent and racially-conscious service provision designed to meet the needs of culturally, racially, and linguistically diverse patients. Two models of health care delivery have been described as effective in addressing clients' unique experiences – these include multidisciplinary healthcare and integrated healthcare. The next section provides a brief description of both models of care with a specific focus on how these can be adapted to meet the needs of diverse patients.

Multidisciplinary Versus Integrated Healthcare

According to the Institute of Medicine (IOM), the current “health care delivery system is poorly organized to meet the challenges at hand” (Institute of Medicine, 2001, p. 1) with a dearth of programs that offer the structure necessary to provide competent services to a diverse group of people. Currently, several approaches have been developed to help restructure and reform the ways in which healthcare is delivered. For instance, initiatives that reflect the importance of tending to the individual needs of diverse populations help improve the quality of care and reduce the cost associated with providing traditional and fragmented services (Amadeo, 2011). Integrated and multidisciplinary healthcare are two approaches designed to address some of these challenges.

A multidisciplinary healthcare service delivery is often described as a system where individuals from a variety of health professions bring their own expertise to patient care. For instance, healthcare organizations often employ a multidisciplinary approach to care whereby patients can find a wide variety of services by a variety of professionals (e.g., cardiologists, urologists, nutritionists, gastroenterologists, psychiatrists, neurologists, neuropsychologists) working in the same facility or network. However, the multidisciplinary system approach to care has some drawbacks. One major criticism of this approach highlights the lack of a cohesive team or unit that could together develop a “holistic treatment plan to address the inter-related problems each patient presents” (APA Presidential Taskforce on Integrated Healthcare for Aging Population, 2008, p. 16). In other words, the healthcare team lacks a unified voice and consistency in patients' care. Thus, an integrated healthcare approach has been introduced as an alternative to coordinate the many facets of healthcare service provision.

Integrative healthcare is an innovative delivery system aimed at improving and preserving the overall health and wellbeing among children, youth, and older adults through the collaboration of an interprofessional team with regards to all aspects of care including: assessment/diagnosis, coordination, treatment, and outcome evaluation (Kelly & Coons, 2012). Overall, integrated healthcare is defined by the (IOM) as “healthcare that is comprehensive, continuous, coordinated, culturally competent, and customer centered” (Institute of Medicine 2001, as cited in Kelly & Coons, 2012, p. 536). Moreover, integrated healthcare expands the definition of healthcare services to include factors that contribute to illness instead of only focusing on the healing and treatment of specific symptomatology. Systems utilizing an integrative healthcare approach have been effectively used in a variety of settings including The Department of Defense (DOD) and The Department of Veterans Health Administration (Trivedi & Gebra, 2011).


One of the hallmarks of integrated healthcare is the praxis of combining primary medical healthcare with behavioral/mental healthcare services in the same setting or location. The integration of behavioral and medical care addresses the needs of a person as a whole and recognizes that “behavioral health is essential for positive health outcomes” (National Institute of Mental Health, 2017, para. 6). This integrative approach yields several benefits including: cost reduction, increase in quality of care, and reduction of barriers that prevent people from seeking mental health services (National Institute of Mental Health,

2017). To illustrate, stigma associated with seeking mental health services is likely to be reduced when all health professionals are working together in one setting. Moreover, access to behavioral health services and reduction in the cost of seeking mental health are more likely (e.g., transportation, child care, flexibility in hours).

Despite these advantages, there continues to be some important limitations that require attention when considering an integrated healthcare praxis in a demographically changing nation. For instance, specific systemic challenges need to be considered and addressed when designing integrated healthcare delivery systems for older adults, for members of racial and ethnic minoritized groups, and for the foreign born/immigrant population. Some of these limitations are beginning to be addressed. One professional group addressing the provision of integrated healthcare is the American Psychological Association (APA) which has played a key role in the discussion on the provision of integrated healthcare for the older adult population.



SECTION 5:



“Just as despair can come to one only from other human beings, hope, too, can be given to one only by other human beings”

(Elie Wiesel, 1990, p. 249).

DELIVERING INTEGRATED HEALTHCARE FOR OLDER ADULTS, PEOPLE OF COLOR, AND IMMIGRANTS

The following section provides a brief argument for the need to deliver services in an integrated model of healthcare to older adults, People of Color, and immigrants. First, a brief synopsis of APA’s work on integrated healthcare with older adults is offered as a prelude to a discussion on the importance of also addressing racial, cultural, and immigration experiences in the design and implementation of integrated healthcare.

Older adults

As individuals age, their healthcare needs become more complex. Older adults typically see several different healthcare providers who are responsible for the treatment of each condition they experience. For instance, in addition to their primary care physician (PCP), a patient with numerous chronic health conditions (e.g., diabetes mellitus type-II, hypertension, hyperlipidemia) may also see a cardiologist, a podiatrist, an ophthalmologist and the like. In a traditional model of care, there is likely to be no coordinated way for all healthcare providers to communicate with each other. As a result, the older adult often becomes responsible for organizing and juggling multiple appointments at different locations, communicating information to each specialist, and keeping track of the various medication prescribed for each condition. Given the challenges inherent in a fragmented model of care, health experts argue that integrated healthcare delivery is especially important among older adults (APA Presidential Taskforce on Integrated Healthcare for Aging Population, 2008; DiGilio & Vincent, 2015). A 2008 report, published by the American Psychological Association, underscores how integrated healthcare can effectively address the major challenges inherent in the traditional model of healthcare delivery to older adults. Five points to address challenges are listed below, including:

- **Integrated healthcare benefits all.** Within the older adult population, an integrated approach improves access to services, optimizes quality of care, and helps reduce overall healthcare costs (APA, 2007; Katzelnick et al., 2000; Strain, Bigelow, Liebson & Stitzer, 1999).
- **Integrated healthcare helps streamline services.** To illustrate, integrated health teams can both assess and address the multiple needs of older adults (i.e., biological, psychological, social) across multiple disciplines and health specialties (e.g., medicine, psychology, social work, neuropsychology; APA, 2007) in one location.
- **Interdisciplinary teams explicitly welcome divergent perspectives.** For instance, interdisciplinary teams typically include psychologists and other mental health professionals, who are specifically trained to assess and understand the role of human development, behavioral function, and cognition. Hence, psychologists and other mental health professionals are uniquely equipped to enhance the services provided to the older adult population.
- **Communication is paramount for integrated healthcare teams.** The regular sharing of information that is characteristic of interdisciplinary groups ensures that assessments and results of exams, testing, and the like are integrated into the client's treatment plan. As stated by APA, "Easy access to information on health services by other professionals makes it more likely that new treatments and assessments will be complementary to what is already being done" (APA, 2007, p. 32).
- **There can be no integrative care without mental health.** Integrative healthcare improves access to mental health services among older adults who express a preference for receiving treatment for mental health conditions in healthcare settings (Davidson & Meltzer-Brody, 1999).

People of Color

In 2003, the Institute of Medicine (IOM) published a report highlighting the vast health disparities among racial and ethnic communities including the challenges People of Color experience when accessing health services and the discrepancies in the quality of care they receive. Since then, the literature on health disparities has increased dramatically with a myriad of reports and articles documenting the increased need for healthcare to be efficiently and equitably distributed across populations (Agency for Healthcare Research and Quality [AHRQ], 2016; Holden et al., 2014). As the number of People of Color in the U.S. continues to grow, the need for healthcare providers and organizations to identify and develop strategies that address specific factors that are likely to impact the physical and mental health of ethnic and racial minorities will concurrently increase. Some of the specific factors disproportionately affecting Communities of Color include higher rates of poverty, experiences of systemic oppression, segregation in housing, unequal access to quality education, and lack of health insurance. Integrative healthcare has been identified as a promising approach to help decrease the health disparities among Communities of Color in the following four ways:

- Given the multiple systemic issues that many Patients of Color often experience, they are likely in need of several different services (e.g., case management, medical, psychological). Thus, having access to all of the services they need in the same place may not only serve to increase clients' cooperation and compliance, but it may also help to reduce confusion and ultimately improve their overall health.
- Integrative healthcare closely aligns with the many ways in which Communities of Color in the U.S. (e.g., Indigenous, Latinx, African-American) understand and conceptualize health and wellness. For instance, many ethnic minority communities value the important connection between the concepts of the mind, body, and spirit--these groups often believe in the importance of considering all three concepts when addressing health concerns. An Integrative healthcare approach works to provide services that address all three components of health.
- Integrative healthcare emphasizes the need for providers to develop an understanding of patients' cultural traditions and values. Such knowledge is considered critical to the effective treatment of People of Color (APA, 2007).
- While People of Color are more likely to first seek mental health services from primary health care providers (Bridges, Andrews, & Deen, 2012; Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999), the disparities in access to mental health services abound (Hurt et al., 2012; Safran et al., 2009; U.S. Department of Health and Human Services, 2001). Moreover, they are more likely to express somatic complaints in response to psychological distress (Escobar et al., 1987; Holden et al., 2012). Hence, having access to mental health services in the same setting as medical care will help (a) improve access to psychological services among Communities of Color and (b) reduce the stigma associated with seeking and receiving mental health care. Because integrated healthcare is more comprehensive, providers are also able to address the comorbidity between mental health disorders and physical health that patients are likely to experience (Benuto & O'Donoghue, 2016).

Immigrants

Several scholars including Kirmayer et al. (2011) and Okie (2007) have identified several factors that impact the physical and mental health of immigrants including: (a) Pre-Immigration experiences (e.g., poverty, exposure to violence, psychological trauma), (b) events experienced while In-Transit to the U.S. (e.g., extortion, abuse, lack of food and shelter), and (c) Post-Immigration challenges (e.g., acculturative stress, loss of family and social support, economic uncertainty). Once in the U.S., immigrants may face several barriers when seeking healthcare. These barriers often include linguistic and cultural differences as well as disparities in access to services. Undocumented immigrants face additional challenges related to their immigration status. For instance, undocumented immigrants are not eligible for most federally funded health insurance programs (e.g., Medicare, Medicaid, Affordable Care Act) except for some emergency care which can lead to medical repatriation, a practice not well known for professionals who do not work directly in hospital settings. Medical repatriation is defined as practice wherein hospitals and healthcare facilities cooperate with immigration law enforcement to deport undocumented immigrant patients back to their country of origin without their consent (Chavez-Dueñas & Adames in press; Donelson, 2015; Frank, Liebman, Ryder, Weir, & Arcury, 2013). Integrative healthcare can help to decrease the challenges experienced by immigrants within the healthcare system in the following ways:

- Navigating a fragmented healthcare system can be a challenge for immigrants as each setting may have different sets of rules, policies, and organization. Thus, having all services provided in the same setting can help simplify an already complex process for individuals who may not be familiar with the U.S. health system and its piecemeal way of operating.
- One of the benefits of integrative healthcare is that it helps reduce the cost of the services offered, thus allowing for important ancillary services to be funded. For instance, having a department of translation and interpretation may help address linguistic barriers between immigrants and healthcare providers.
- Access to advocacy services is another important ancillary service that is critical for immigrant patients. Such services can help immigrant patients connect to available resources in the community (e.g., housing, jobs, schooling). In addition, advocacy services can include access to information related to immigration status, deportation proceedings, medical repatriation, and “know your rights” information for individuals residing in the United States.

FUTURE DIRECTIONS: POSSIBILITIES FOR CHANGE



*“We cannot become what we want
by remaining what we are”*

(Max de Pree, n.d., para. 1).

As we look ahead towards the future of the United States with its rapidly changing demographics, including significant increases in communities that have been historically oppressed, it becomes more and more apparent that access to comprehensive quality healthcare is important. A focus on social determinants of health which, are more likely to affect the wellbeing of minoritized groups is particularly important in a racially, ethnically, and linguistically diverse society that is also aging. While focusing solely on the impact of social determinants of the health on minoritized groups is important, going beyond this level of analysis, to include targeted efforts that address the systemic barriers which impede access to equitable healthcare services is equally vital. Although integrative healthcare has been described as a potential solution to address barriers in access to healthcare, many communities continue facing a multitude of obstacles in accessing health related services. Thus, making integrative healthcare available to all people would require changes at the systemic level. In other words, for oppressed communities, there is no health without systemic change.

To achieve the aforesaid goal, we need to look no further than history and the ways in which ancient civilizations thought about healing through the connection of mind, body, and spirit. In many ways, integrative

healthcare is a form of healing that has been around for centuries, albeit with different names. Hence, “sooner or later, everything old is new again” (King, 2005, p. 45), which affirms that there is no health without mental health. Today, integrative healthcare, which translates science into action while planfully centering the mental, emotional, and physical health needs of a changing America, offer patients the possibility of receiving services that address their complex needs in a simplified, organized, and holistic manner.

Together, we can envision a future where integrative healthcare is not only a common practice in the field of health, but also one that is available to everyone in the United States. This approach requires an expansion in our thinking about what constitutes healthcare services and who are considered essential members of a healthcare team. For instance, the term healthcare professionals often exclude individuals who the patient may view as critical to their healing process (e.g., spiritual and traditional healers, clergy). This may lead to the healthcare team not integrating the knowledge and healing practices that come from the community, cultural, and spiritual sources. Table 1 provides a list of healers that can be included in an integrative healthcare team. These additional healing professionals can assist patients in meeting the needs that western systems of healthcare often leave unaddressed. In closing, there is no health without mental health, there is no health without systemic change, and there is no health without expanding who is invited to be members of integrative healthcare teams.

Table 1. Redefining Who is Invited to Integrative Healthcare Teams

CURRENT MEMBERS	RECOMMENDED MEMBERS
NURSES	TRADITIONAL HEALERS
MEDICAL SPECIALISTS	MEMBERS OF THE CLERGY
SOCIAL WORKERS AND CASE MANAGERS	SHAMANS & SPIRITUAL GUIDES
PHYSICIANS	PROMOTORAS DE SALUD (HEALTH PROMOTERS)
NUTRITIONISTS & DIETICIANS	EXPRESSIVE ART THERAPISTS
PSYCHOLOGISTS & OTHER MENTAL HEALTH PROFESSIONALS	LAUGHTER/HUMOR THERAPISTS
PHYSICAL THERAPISTS	ANIMAL ASSISTED THERAPISTS
PHARMACISTS	ACUPUNCTURISTS
OCCUPATIONAL THERAPISTS	ACUPRESSURISTS/MASSAGE THERAPISTS
MEDICAL TECHNICIANS	SOCIAL ADVOCATES




AFTERWORD

To echo President Nealon's initial sentiments, this edition of The Chicago School of Professional Psychology's (TCSPP) No Health Without Mental Health report provides not only a detailed illustration of how far the field of mental health has evolved through the years, but also a clear vision of how much further it needs to go if we are committed to addressing the needs within our surrounding communities. Drs. Chavez-Dueñas and Adames describe the subtle interconnection between the changing demographic of the United States (U.S.) and the mental and physical stressors that lie within the changing population. Most importantly, however, they provide a well-researched framework for meeting the needs of diverse communities through a model that stresses the importance of inter-professional practice and a focus on culture and context.

In many ways, this report underscores much of the progress The Chicago School has made as a university, both through its annual goals and the five-year strategic plan that began in 2015. As we enter the final years of that visionary and aspirational plan, TCSPP celebrates numerous accomplishments related to inter-professional education, allied health field programming, and a real commitment toward multiculturalism, diversity, and inclusion. In the area of inter-professional education and practice, TCSPP will host its third edition of its annual inter-professional conference in 2019, where faculty and staff highlight their research and practice in multiple disciplines including, but not limited to the fields of psychology and health sciences. In addition, our Institute of Professional and Continual Education now regularly offers CE's and CEU's for mental health professionals who want to develop models and treatment approaches that treat clients holistically. Similarly, my office now offers an annual grant for faculty who wish to develop curriculum and teaching models that focus on interdisciplinary approaches to training and practice. Lastly, TCSPP has made a concerted effort to advance goal 2 of its strategic plan, which is to "increase the emphasis on health sciences professional education through the integration of mental health and public health" and has since developed health science programs including a registered nurse (RN) to bachelor of science in nursing (BSN) program, health service programs like its Masters in Public Health, and truly innovative interdisciplinary programs like its online master of science (MS) in clinical psychopharmacology.

TCSPP has also advanced in the area of diversity and inclusion. One such accomplishment was the institution's commitment to revising its Institutional Learning Outcome on Diversity to include a more global and international perspective. This change carried with it the ripple effect of program and course learning outcomes mapped to diversity to be less "westernized" and course curriculum to be more inclusive of different cultures and world views. Within the past year, the Diversity Advisory Board created



the institution's first Diversity and Inclusion survey and received input from the TCSPP community on its diversity and inclusion initiatives across the university. Data received from the survey and focus groups will guide recommendations for diversity initiatives for the next strategic plan. TCSPP also launched TCSPP Global this past year with the intent to expand its reach internationally through international partnerships, increased outreach and support for international students, and increased international opportunities for TCSPP faculty, students, and staff as a whole. Lastly, 2019 marks a longstanding tradition at TCSPP, as it prepares to host another biennial Cultural Impact Conference. The 2019 conference theme will explore "how the complex and multifaceted problem of gun violence prevention can be addressed by various systems (e.g., mental health providers, community advocates, public health, policy leaders, educators, and students) to work together and promote a comprehensive approach that will keep individuals, families, and communities safe."

So where do we go from here? While TCSPP has accomplished so much during these past 40 years, this report shows us that there is still so much good work to be done. As the University prepares to bring on its first College of Nursing, there are numerous opportunities to delve into new innovative programs that focus on integrative approaches to health and mental health care. Similarly, our curriculum and professional practice outcomes should be audited and examined with the intent of creating learning experiences for our students that are interdisciplinary, globally focused, and relevant to a population that is underserved, underrepresented, aging, and increasingly racially and ethnically diverse. Lastly, we need to further our commitment to the final pages of this report...to committing as a University community towards "systematic change." That change comes as a result of developing curriculum that speaks to social justice, inclusion, and integrated practice. It comes from admissions and teaching practices that are not "colonial" or "oppressive" but instead inclusive and respectful of students from all academic and demographic backgrounds. Lastly, it comes from our work in our professional practices and in our service to the communities that surround us, a commitment to real social change, and applying our knowledge and skills in new and powerful ways to serve the greater good.

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The Chicago School of Professional Psychology

RESOURCES:

Where To Go For More Information

Guidelines for Psychological Practice in Health Delivery Systems
<https://www.apa.org/pubs/journals/features/delivery-systems.pdf>

Competencies for Psychology Practice in Primary Care
<http://www.apa.org/ed/resources/competencies-practice.pdf>

American Psychological Association Guidelines for Psychological Practice with Older Adults
<https://www.apa.org/pubs/journals/features/older-adults.pdf>

Center for the Study of Immigrant Integration
<https://dornsife.usc.edu/csii/blog-justin-scoggins-healthcare/>

Psychotherapy for Older Adults
<https://gerocentral.org/clinical-toolbox/psychotherapy-for-older-adults/>

Report of APA Primary Care Training Task Force
<http://www.apa.org/ed/graduate/task-force-report.pdf>

SAMSHA Integrated Health Care Models
<https://www.integration.samhsa.gov/integrated-care-models>

Patient Centered Primary Care Collaborative
<https://www.pcpcc.org/resource/behavioral-health-integration-pcmh>

Migration Policy Institute: Immigrant Integration
<https://www.migrationpolicy.org/topics/immigrant-integration>

National Institute of Mental Health:
 Transforming the Understanding and Treatment of Mental Illnesses
<https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml>

Eliminating Behavioral Health Disparities and Improving Outcomes For Racial and Ethnic Minority Populations
https://www.integration.samhsa.gov/news/Eliminating_Behavioral_Health_Disparities_and_Improving.pdf

Race, Ethnicity, Culture, and Disparities in Health Care
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924616/>

Pathways to Integrated Health Care: Strategies for African American Communities and Organizations
<https://www.minorityhealth.hhs.gov/Assets/pdf/Checked/1/PathwaystoIntegratedHealthCareStrategiesforAfricanAmericans.pdf>

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THE PEOPLE BEHIND THE REPORT

Michele Nealon, Psy.D.

President

As president of The Chicago School of Professional Psychology, Dr. Nealon has strategically positioned the university to broaden its focus on psychology education to include the preparation of integrated health care professionals trained to address the mental and physical needs of patients. She spearheaded the development of an ambitious five-year strategic plan, *Leading the Way Toward a Healthier World*, which serves as a blueprint for that expansion. A native of Ireland, she completed her doctoral studies at The Chicago School, and served as faculty, department chair, and the founding president of the institution's Los Angeles Campus before assuming the national presidency in 2010. She is an accomplished writer and speaker on a variety of psychology-related topics.

Hector Y. Adames, Psy.D.

Neuropsychologist & Associate Professor of Counseling Psychology, Chicago Campus

As a lead co-author of the report, Dr. Adames drew on his clinical training at Wright State University and Boston University School of Medicine, and his experience as the lead of the Health Psychology concentration at The Chicago School. His research focuses on the ways in which systems of oppression impact people's health and wellness. He has several peer reviewed publications including a co-authored book on Latinx Mental Health. He has earned several awards including the 2018 American Psychological Association (APA) Distinguished Emerging Professional Contributions to Research Award from the Society for the Psychological Study of Culture Ethnicity, and Race.

Nayeli Y. Chavez-Dueñas, Ph.D.

Clinical Psychologist & Associate Professor of Counseling Psychology, Chicago Campus

As a lead co-author of the report, Dr. Chavez-Dueñas drew on her clinical training at Southern Illinois University at Carbondale and her experience as the lead of the Latinx Mental Health concentration at The Chicago School. Her research focuses on immigration, skin-color, and multiculturalism. She has several peer reviewed articles and is the co-author of a book on Latinx Mental Health. She has earned several awards including the 2018 American Psychological Association (APA) Distinguished

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Ted Scholz, Ph.D.

Vice President of Academic Affairs/Chief Academic Officer

Ted Scholz currently serves as the Chief Academic Officer and Vice President of Academic Affairs at The Chicago School of Professional Psychology. Since joining The Chicago School in 2007 he has served in a number of leadership roles within Academic Affairs: Associate Vice President of Academic Affairs, Associate Vice President of Faculty Development and Training and the Director of the National Center for Teaching and Learning to name a few. Before The Chicago School, Dr. Scholz served as Program Manager, Faculty, and Chair of the English and Humanities Department at Robert Morris University. He is also a graduate of the Teaching Institute Fellowship Program from Robert Morris University. Dr. Scholz received a Bachelor's degree in English with a minor in Philosophy from The University of Wisconsin-Oshkosh, a Master's degree in Literature from DePaul University and a PhD in Organizational Leadership at The Chicago School of Professional Psychology. He has given numerous presentations at both regional and national conferences and is a certified trainer and consultant in the areas of Emotional Intelligence and the administration of the Inter-Cultural Development Inventory. His areas of interest include faculty development and pedagogy, student support, organizational commitment, organizational leadership, change management and Inter-cultural competency.

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