RACE AND THE ISK SERVICE POPULATION

Prepared December 2020 by Amy Galick, ISK Senior Data Analyst

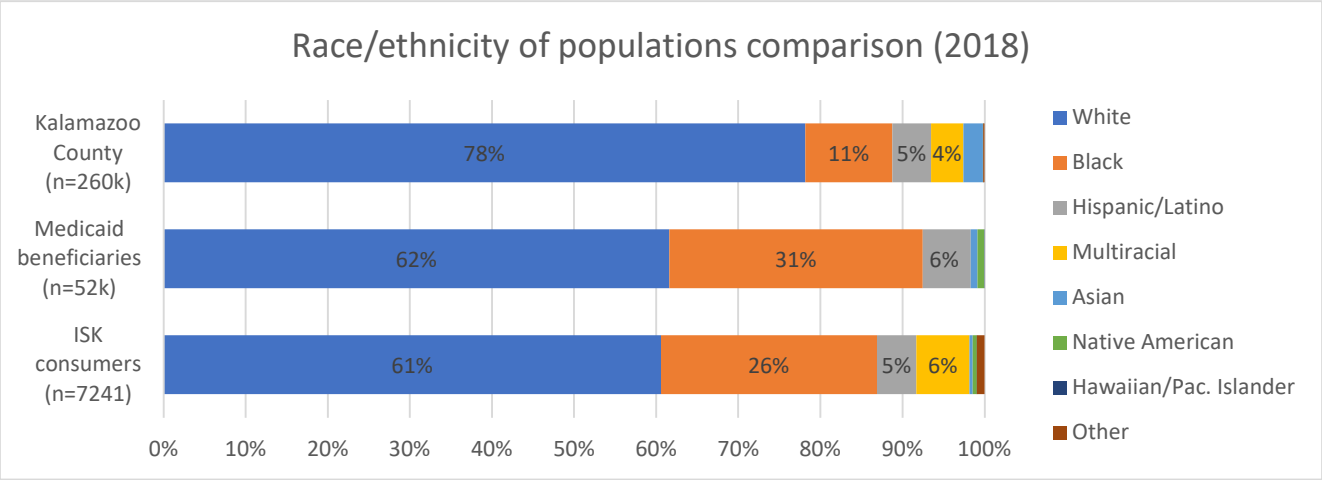
---

Integrated Services of Kalamazoo (ISK) understands racism to be a public health concern that contributes to negative health outcomes, including physical, mental, and behavioral health. The agency therefore makes a point to incorporate analyses of race and racial disparities into our work whenever we study various aspects of our system and service delivery. The purpose of this document is to collect some of ISK's past findings about race into one location and begin to illuminate how race affects our system as a whole.

The ISK service population

In order to understand the way race and racism affect the ISK service population, an important piece of context is that due to ISK's funding structure almost all of the individuals we serve are Medicaid recipients, qualifying due to poverty and/or disability. Because poverty is highly racialized, Black Kalamazooans are very over-represented in the Medicaid population. The result is that 38% of Medicaid beneficiaries in Kalamazoo county are people of color, compared to only 22% of the county overall. This population difference carries through into the ISK service population, where about 39% of the population are people of color.

Figure 1. Black individuals over-represented in the County's Medicaid population and ISK service population.



Disparities between the ISK service population and Kalamazoo County overall

Many racial disparities in America are mediated through or partially caused by an enormous wealth disparity that exists between the white population and Black, Latino, and Native American populations. This wealth effect is a key driver of racially inequitable outcomes, but it is much less present when focusing only within ISK's (primarily Medicaid) service population – because in fact, the majority of our consumers are marginalized and under-resourced to some extent, across all races. When we are able to find data that lets us compare the ISK service population to the overall county, we often find vast disparities between the two populations, equaling or exceeding any racial disparities that exist within one population or the other.

Figure 2 and Figure 3 illustrate two examples where such comparable data is available: employment status and educational attainment for adults (2018 data). These examples offer a partial illustration of the way that the entire ISK consumer population is generally underprivileged.

Figure 2. ISK adult consumers have much higher unemployment rates, regardless of race.

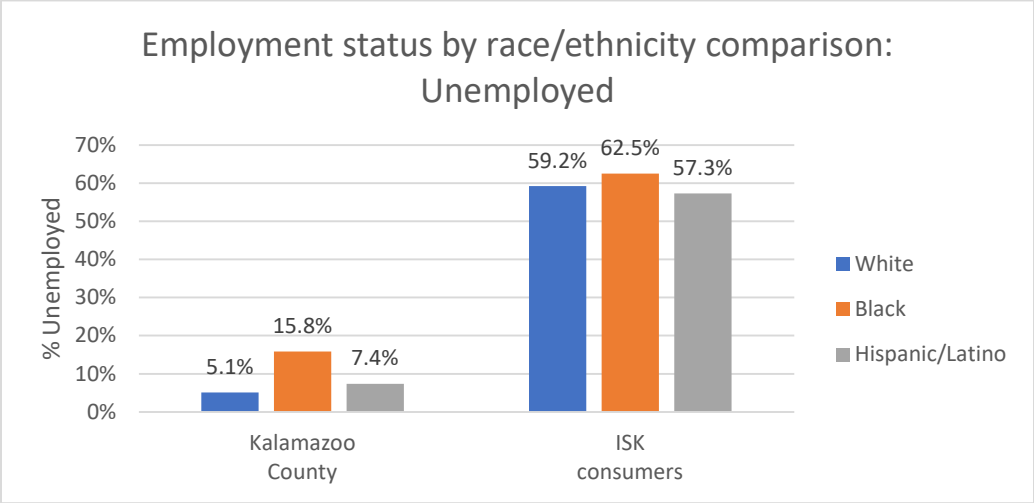
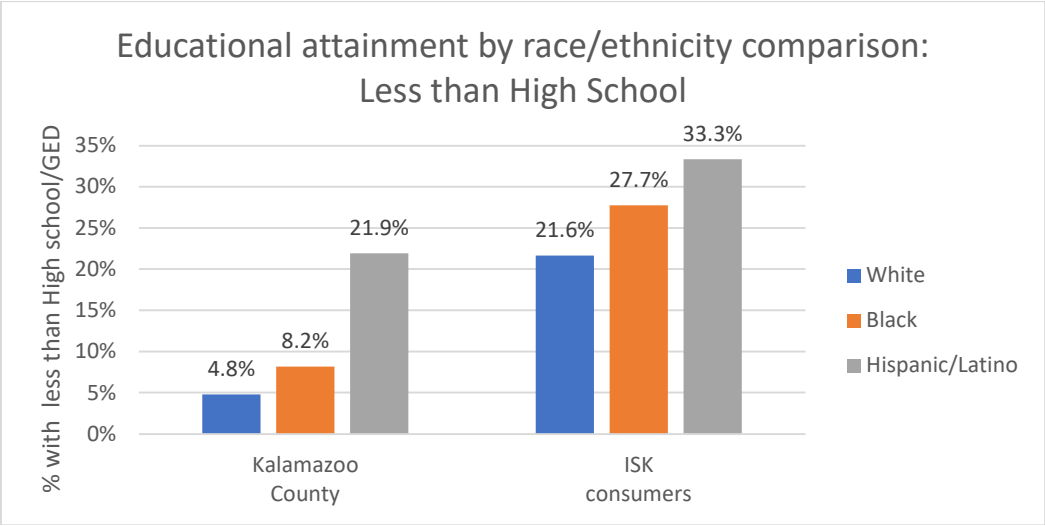


Figure 3. ISK adult consumers less likely to have completed high school, across all races.



Disparities within the ISK service population

While the ISK service population overall is high-need and high-risk, we do also find additional racial disparities within the population putting ISK consumers of color at even higher risk. These internal racial disparities are easier for ISK to gather data on, track, and influence directly, so most of our analysis of racial equity has concentrated on within-population disparities.

Social determinants of health

One notable way that racism affects health is by way of "social determinants of health." Social factors such as where people live and work, what food and transportation they can access, or in what ways they interact with their community, have been shown in extensive research to have measurable impacts on various health outcomes. Racism creates disparities in these social factors, which then carries forward into similar disparities in the affected health outcomes.

The previous section presented data for two social determinants of health that ISK tracks within our service population, employment and educational attainment. Next, Table 1 below shows the proportion of people, by racial group, who had either documented or self-reported involvement with the criminal justice system. Finally, another notable social determinant of health – homelessness – is discussed in more depth in the next section. For all of these social factors, we see an overall high level of risk across the ISK service population, with additional racial disparities resulting in ISK consumers of color having the highest risk.

Table 1. ISK consumers of color more likely to experience involvement with the criminal justice system.

ISK Regular/Ongoing Service Population	Population N	Rate of any criminal justice system involvement during the year
Adults with Mental Illness	2365*	24%
White	1604	22%
Black	692	28%
Hispanic/Latino	129	30%
Native American	54	43%
Youth with Mental Illness	799*	14%
White	426	11%
Black	275	20%
Hispanic/Latino	73	14%
Native American	14	36%

* Populations do not sum to the total due to multiple race identification as well as other races not reported here.

ISK has also confirmed the correlation of these social determinants with some health outcomes in our population. Unemployment is associated with moderately higher rates of hypertension, high cholesterol, and diabetes among those we serve, and people with recent criminal justice involvement report somewhat higher rates of suicidal ideation and are somewhat more likely to use an emergency room. We have found homelessness to have the greatest impacts of all of these social determinants, which are detailed in the last section of this report.

Diagnosis populations

ISK has found within the populations we serve some diagnostic differences by race that are hard to explain. As a rule, the conditions we treat have not been found to have different underlying prevalence rates in the general population, and so when we discover such differences in our own service population we can assume that some kind of racially biased process is in play (either inside of ISK or in the larger systems within which we operate).

Table 2 shows the prevalence by race of some of the most common diagnoses in our three main treatment populations. Among adults with mental illness, we see that the Black population is more frequently diagnosed with schizophrenia or other psychotic disorders, and less frequently diagnosed with anxiety disorders. Among youth with mental illness, the Hispanic/Latino population is more frequently diagnosed with major depression. Among adults with intellectual or developmental disabilities, the Black population is more frequently diagnosed with autism or pervasive developmental disorders (PDD), while the White population is more frequently diagnosed with epilepsy, anxiety, and major depression.

Table 2. Some diagnoses have different prevalence by race in the ISK service population.

		Prevalence of diagnosis within each demographic population			
	Diagnosis type	**White**	**Black**	**Hispanic/ Latino**	**Native American**
Adults with mental illness	Substance use disorders	51%	53%	53%	57%
	Major depressive disorder	40%	37%	41%	41%
	Bipolar disorder	41%	33%	35%	41%
	Schizophrenia / other psychotic disorders	23%	41%	28%	28%
	Anxiety disorders	21%	11%	23%	15%
Youth with mental illness	Major depressive disorder	45%	47%	62%	57%
	Attention deficit hyperactivity disorder (ADHD)	44%	45%	44%	64%
	Conduct disorders	27%	32%	27%	14%
	Anxiety disorders	29%	20%	26%	29%
	Bipolar disorder	10%	5%	7%	7%
Adults w intellectual/ developmental disabilities	Mild/moderate intellectual disabilities	78%	85%	82%	*
	Severe or profound intellectual disabilities	15%	13%	18%	*
	Autism and Pervasive developmental disorders	21%	33%	18%	*
	Epilepsy	25%	10%	12%	*
	Anxiety disorders	26%	11%	18%	*
	Major depressive disorder	24%	11%	15%	*

* Population is too small to report diagnosis prevalence.

Homelessness

Homelessness is one of the most dramatic and damaging ongoing racial inequities that afflicts the Kalamazoo community. According to recent data, the majority – about 60% – of Kalamazoo county's homeless population is Black, while only 11% of the population overall is Black. Additionally, Native American residents make up about 1.5% of the homeless population while only being 0.03% of the county population overall. [1]

Among the population served by ISK, who are primarily Medicaid recipients in poverty who also have a mental illness and/or substance use disorder, we see very high rates of homelessness and housing insecurity. Fully 14% of our entire service population reported an episode of homelessness during the past year, representing over 1000 individuals. Like other Kalamazoo-area health care entities, ISK has also identified homelessness as a key risk factor that dramatically affects a person's health and makes it harder to access care. Because of its prevalence and importance to our population, ISK now generally includes an analysis of the effect of homelessness anytime we investigate questions of health equity.

Table 3 shows that ISK consumers of color have experienced homelessness at higher rates than white consumers. Among adults with mental illness, the overall prevalence of homelessness is very high and the additional impact of racial disparities is somewhat less, though still significant. Among youth with mental illness as well as among adults with intellectual or developmental disabilities, the overall rates of homelessness are much lower, but there are dramatic disparities by race.

Table 3. ISK consumers of color experience higher rates of homelessness.

ISK Regular/Ongoing Service Population	Population N	Rate of self-reported homelessness during the year
Adults with Mental Illness	2365*	24%
White	1604	22%
Black	692	31%
Hispanic/Latino	129	34%
Native American	54	41%
Youth with Mental Illness	799*	3%
White	426	1%
Black	275	5%
Hispanic/Latino	73	1%
Native American	14	7%
Adults with Intellectual/ Developmental Disabilities	657*	2%
White	504	0.2%
Black	115	7%
Hispanic/Latino	34	0%

* Populations do not sum to the total due to multiple race identification as well as other races not reported here.

[1] 2017 Annual Count, Housing Resources Inc.
https://www.housingresourcesinc.org/wp-content/uploads/2018/10/kalamazoo_2017_annual_count.pdf

Homelessness stands out as a risk factor almost every time we look at its impact on health outcomes. Homeless adults are more than twice as likely to experience inpatient psychiatric hospitalization, the most intensive crisis service offered by our system – which is almost as strong of an association as that of inpatient hospitalization with diagnosed psychotic mental illnesses such as schizophrenia. Similarly for emergency room use, homeless adults served by ISK are about 1.5 times more likely to use the ER and they use it for more days per year. The homeless adults we serve have higher rates of diagnosed trauma, substance use disorders, and chronic pain, and they are more likely to report suicidal ideation. They are less likely to be employed and more likely to experience involvement with the criminal justice system, both of which are also important social determinants of mental health. Table 4 displays these and some other data points illustrating the health impacts of homelessness. The data is presented here as raw comparisons, but ISK has also confirmed that homelessness still has a large impact even when we statistically control for other factors such as age, sex, and mental health diagnosis.

Table 4. Many health outcomes negatively impacted by homelessness. (Adults with mental illness)

Outcome/population measure	Individuals who experienced homelessness	Individuals with no homelessness reported
Rate of experiencing inpatient psychiatric hospitalization during a year-long time frame	19%	8%
Average number of days hospitalized per year for those who had inpatient psychiatric hospitalization	13.4	11.5
Rate of using an emergency room during a year-long time frame	78%	52%
Average number of ER days per year for those who used the ER	6.3	3.8
Diagnosed with PTSD or other trauma condition	40%	29%
Diagnosed with substance use disorder	66%	46%
Diagnosed with chronic pain	60%	47%
Evidence of a depressive episode during a year-long time frame (whether diagnosed with depression or not)	61%	51%
Reported suicidal ideation during a year-long time frame	48%	31%
Reported past suicidal behavior at any point during their lifetime	29%	24%
Reported being employed, in school, or otherwise engaged in the community	18%	28%
Self-reported or documented involvement with the criminal justice system during a year-long time frame	38%	19%
Had a mental health emergency/crisis contact during a year-long time frame	49%	29%
Average number of months per year where a mental health crisis occurred, for those with a crisis contact	1.7	1.4
Service continuity: Average number of months per year that any ISK mental health services were received	5.4	6.4