BEFORE WE BEGIN

Today’s webinar is being recorded and you will find slides and recording posted at www.nyaprs.org within a few days.

NYAPRS is offering 1 CE for LMSW, LCSW, CPRP and LMHC.

In order to obtain the CE:
- You must be logged into the zoom room for the duration of the webinar
- Complete and return the evaluation form within 48 hours
- Indicate which CE you are seeking

Use the chat box to enter your questions
DR. PHILLIP MURRAY
DISCLOSURES

None
LEARNING OBJECTIVES

• Increase knowledge of historical context for barriers within the current mental health system

• Introduce the concept of social determinants of health and connect it to current treatment

• Highlight racism as a core social determinant of health

• Provide a framework for advocacy in the context of structural challenges for health equity
OUTLINE

• Overview of the mental health system
• Cultural Competence
• Health Disparities
• Social Determinants of Health
• Consumer Movement
• Potential Solutions
MENTAL HEALTH HISTORY

(FRANK & GLIED 2014)
(GOLDMAN & MORRISSEY 1985)
(MECHANIC 2006)

• Deinstitutionalization

• Community Mental Health Centers Act of 1963

• Transinstitutionalization

• Insurance Based System
  • Mental Health Parity

• Limited Federal Reforms
“The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders.”

“DSM has been periodically reviewed and revised since it was first published in 1952. The previous version of DSM was completed nearly two decades ago; since that time, there has been a wealth of new research and knowledge about mental disorders.”
MENTAL HEALTH AND MORTALITY
(FOND 2021)
(HEDEGAARD 2020)
(WALKER 2015)

• Increase In Suicide Rates
  • 35% Increase Over The Past 2 Decades

• At Least 2 Times The Risk of Premature Death

• Estimated 10 Years of Life Lost

• Due to Preventable Conditions

• Twice As Likely To Die From COVID
TRIESTE MODEL

(MEZZINA 2014)
(PORTACOLONE 2015)

• Started in Trieste, Italy
• Focuses on the Person Instead of Symptoms
• Treatment Planning Focuses on Client Goals
• Social Inclusion
• Budget Priorities
  • 94% Social Services (Including Supported Employment and Housing)
  • 6% Acute Care
• Reduction in Suicide and Symptoms
• WHO Collaborating System
<table>
<thead>
<tr>
<th>Location</th>
<th>Adults with Mild Mental Illness in the Past Year Who Did Not Receive Treatment</th>
<th>Adults with Moderate Mental Illness in the Past Year Who Did Not Receive Treatment</th>
<th>Adults with Serious Mental Illness in the Past Year Who Did Not Receive Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>67.9%</td>
<td>53.5%</td>
<td>35.0%</td>
</tr>
<tr>
<td>New York</td>
<td>68.8%</td>
<td>57.2%</td>
<td>34.3%</td>
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</table>
“HEALTH DISPARITIES ARE PREVENTABLE DIFFERENCES IN THE BURDEN OF DISEASE, INJURY, VIOLENCE, OR OPPORTUNITIES TO ACHIEVE OPTIMAL HEALTH THAT ARE EXPERIENCED BY SOCIALLY DISADVANTAGED POPULATIONS”

-CDC
DISPARITIES IN CARE

Race and Ethnicity
- Less Treatment
- Poor Engagement in Care

Sexual Orientation
- Increased Mood Disorders

Lower Socioeconomic Status (SES)

Social Determinants of Health

Figure 4. Percentage of children, ages 5–17, with treatment for mental health disorders by demographic characteristics, 2009–2011 (average annual)

Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2009-2011
MENTAL HEALTH DISPARITIES

- Stigma associated with mental illness
- Lack of providers from diverse backgrounds
- Health Insurance
- Distrust of the healthcare system
  - Legacies of mistreatment still relevant
“Cultural Competence”
(Joint Commission, 2010)

- “The ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter.”

“Cultural Competence”
Essential Elements of the Journey

- **Self assessment** about one’s own cultural identity, values, prejudices, biases, etc.
- **Humility** about the limits of one’s assessment and treatment knowledge/skills
- **Value diversity** via awareness of and sensitivity to cultural differences
- **Ensure safety** about the power dynamics that result from cultural differences
- **Responsiveness** to cultural differences via adaptation of assessment and treatment
CULTURAL IDENTITY: INQUIRE DON'T ASSUME

OCF Part A: Cultural identity of the individual (DSM-IV)

- “Describe the individual’s racial, ethnic, or cultural reference groups”
- “For immigrants and racial or ethnic minorities, ...degree of involvement with both the culture of origin and the host or majority culture”
- “Language abilities, preferences, patterns of use...”

OCF Part A: Cultural identity of the individual (added in DSM-5)

- “Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.”
OCF Part D: Cultural features of the relationship between the individual and the clinician-1

• “Identify differences in culture, language, and social status between an individual and a clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter.”

OCF Part D: Cultural features of the relationship between the individual and the clinician-2

• “Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.”
Step 1: Understand the cultural identity of the clinician through self-reflection

- Be aware of and understand one’s own personal and professional cultural identity development.
- Be aware of biases and limitations of knowledge and skills that might affect the clinical encounter.

Step 3: Assess the cultural features of the relationship

- Respect, degree of intimacy, rapport, and empathy
- Communication
  - verbal including limited English proficiency
  - non-verbal
  - health literacy
- Eliciting symptoms and history gathering
- Dealing with stigma and shame
- Transference and Counter-transference
LIMITS OF CULTURAL COMPETENCY

(Tervalon 1998)

To be avoided, however, is the false sense of security in one’s training evidenced by the following actual case from our experience: An African American nurse is caring for a middle-aged Latina woman several hours after the patient had undergone surgery. A Latino physician on a consult service approached the bedside and, noting the moaning patient, commented to the nurse that the patient appeared to be in a great deal of postoperative pain. The nurse summarily dismissed his perception, informing him that she took a course in nursing school in cross-cultural medicine and “knew” that Hispanic patients overexpress “the pain they are feeling.” The Latino physician had a difficult time influencing the perspective of this nurse, who focused on her self-proclaimed cultural expertise.
CULTURAL HUMILITY
(YEAGER 2013)
(TERVALON 1998)

• Lifelong Process
• Self Reflection and Self Critique
• Checks Power Imbalances
• Minimizes Stereotyping
• Institution Must Be Consistent
SOCIAL DETERMINANTS OF HEALTH

• Social Determinants of Health: Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health -CDC

Thomas McKeown
• 1955
• Rise of Populations

• Education
• Unemployment
• Housing Discrimination
• Mass Incarceration

Mental Illness in Correctional Settings

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>General Population</th>
<th>Local Jail</th>
<th>State Prison</th>
<th>Federal Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental illness</td>
<td>18.6%</td>
<td>64.2%</td>
<td>56.2%</td>
<td>44.8%</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>9%</td>
<td>76%</td>
<td>74%</td>
<td>64%</td>
</tr>
<tr>
<td>Severe mental illness</td>
<td>4.1%</td>
<td>24%</td>
<td>15.3%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years).

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection.

Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

ACEs are common. About 61% of adults surveyed across 25 states reported that they had experienced at least one type of ACE, and nearly 1 in 6 reported they had experienced four or more types of ACEs.

ACEs can have lasting effects on...

- Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)
- Behaviors (smoking, alcoholism, drug use)
- Life Potential (graduation rates, academic achievement, lost time from work)

ACEs have been found to have a graded dose-response relationship with 40+ outcomes to date.

*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.*
Early Death

Disease, Disability, & Social Problems

Adoption of Health Risk Behavior

Social, Emotional, & Cognitive Impairment

Disrupted Neurodevelopment

Adverse Childhood Experiences

Social Conditions / Local Context

Generational Embodiment / Historical Trauma

Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Approach</th>
</tr>
</thead>
</table>
| Strengthen economic supports to families     | • Strengthening household financial security  
                                           | • Family-friendly work policies                                           |
| Promote social norms that protect against   | • Public education campaigns  
                                           | violence and adversity                                                    |
                                           | • Legislative approaches to reduce corporal punishment  
                                           | • Bystander approaches                                                    |
                                           | • Men and boys as allies in prevention                                    |
| Ensure a strong start for children           | • Early childhood home visitation                                         |
                                           | • High-quality child care                                                 |
                                           | • Preschool enrichment with family engagement                            |
| Teach skills                                 | • Social-emotional learning                                               |
                                           | • Safe dating and healthy relationship skill programs                    |
                                           | • Parenting skills and family relationship approaches                    |
| Connect youth to caring adults and activities| • Mentoring programs                                                     |
                                           | • After-school programs                                                  |
| Intervene to lessen immediate and long-term  | • Enhanced primary care                                                  |
| harms                                        | • Victim-centered services                                                |
                                           | • Treatment to lessen the harms of ACEs                                   |
                                           | • Treatment to prevent problem behavior and future involvement in violence|
                                           | • Family-centered treatment for substance use disorders                   |
"They then discussed additional “societal factors” that could have contributed to the disparity, including unconscious provider bias, patient distrust, and financial stress. But this analytical framing ignores racism as the mechanism by which racial categorizations have biological consequences. And despite exploring potential “societal” drivers, the term “racism” is never mentioned in the piece. This is unfortunately common and occurs across disciplines."

"The academic publication process, through authors, reviewers, and editors, has legitimized scholarship that obfuscates the role of racism in determining health and health care. This renders racism less visible and thus less accessible as a preventable etiology of inequity."

"The solution to racial health inequities is to address racism and its attendant harms and erect a new health care infrastructure that no longer profits from the persistence of inequitable disease."
GLOSSARY - KEY TERMS

Racism is not to be confused with “race” and other related terms:

➢ Race - a social construct based on skin color

➢ Bias - a preference (may be favorable or unfavorable)

➢ Prejudice - a belief that is often rooted in unfair assumptions

➢ Discrimination - an action that is motivated by prejudice
FOCUS ON RACISM, NOT MERELY “RACE”

Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call “race”)

- Core similarities across different races and ethnicities
  - Reflected in laws and policies
  - Core to disparities
RACISM IS A SYSTEM

Three levels of racism:

1. Institutionalized
2. Personally-mediated (i.e., interpersonal)
3. Internalized

RACISM AND HEALTH: MECHANISMS

Racism creates conditions that increase exposure to traditional stressors (e.g. unemployment).

Institutional discrimination restricts socioeconomic attainment and group differences in socioeconomic status and health.

Segregation creates pathogenic residential conditions.

Discrimination leads to reduced access to desirable goods and services.

Experiences of discrimination are a neglected psychosocial stressor.

Internalized racism (acceptance of society’s negative characterization) adversely affects health.
Reducing Disparities in Severe Maternal Morbidity and Mortality

Elizabeth A Howell, MD, MPP
Women’s Health Research Institute, Department of Population Health Science & Policy, and Department of Obstetrics, Gynecology, and Reproductive Science, Icahn School of Medicine at Mount Sinai, New York, New York

Abstract

Significant racial and ethnic disparities in maternal morbidity and mortality exist in the United States. Black women are three to four times more likely to die a pregnancy-related death as compared with white women. Growing research indicates that quality of healthcare, from preconception through postpartum care, may be a critical lever for improving outcomes for racial and ethnic minority women. This article reviews racial and ethnic disparities in severe maternal morbidities and mortality, underlying drivers of these disparities, and potential levers to reduce their occurrence.

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver

*Department of Psychology, University of Virginia, Charlottesville, VA 22904; †Department of Family Medicine, University of Virginia, Charlottesville, VA 22908; and ‡Department of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

Edited by Susan T. Faile, Princeton University, Princeton, NJ, and approved March 1, 2016 (received for review August 18, 2015)

Black Americans are systematically undertreated for pain relative to white Americans. We examine whether this racial bias is related to false beliefs about biological differences between blacks and whites (e.g., “black people’s skin is thicker than white people’s skin”). Study 1 documented these beliefs among white laypersons and revealed that participants who more strongly endorsed false beliefs about biological differences reported lower pain ratings for a black (vs. white) target. Study 2 extended these findings to the medical context and found that half of a sample of white medical students and residents endorsed these beliefs. Moreover, participants who endorsed these beliefs rated the black (vs. white) patient’s pain as lower and made less accurate treatment recommendations. Participants who did not endorse these beliefs rated the black patient’s pain as higher and made more accurate treatment recommendations. These disparities in pain treatment could reflect an overprescription of medications for white patients, underprescription of medications for black patients, or, more likely, both. Indeed, there is evidence that overprescription is an issue, but there is also clear evidence that the underprescription of pain medications for black patients is a real, documented phenomenon—established by the World Health Organization guidelines—compared with 50% of nonminority patients (4). Broadly speaking, there are two potential ways by which racial disparities in pain assessment and treatment could arise. The first involves
“Tuskegee Study of Untreated Syphilis in the Negro Male.”
- Started in 1932 by the Public Health Service
- Initiated under the guise of treatment
- Supposed to be for 6 months
- Lasted for 40 years*

Henrietta Lacks
- Died From Cervical Cancer in 1951
- Tissue Sample Taken Without Consent
- HeLa Cells Integral to Cancer Research
- Wasn’t Discovered Until Decades Later
HISTORICAL RACISM IN MENTAL HEALTH

Drapetomania (1850s)
- Condition leading to slaves running away

Dysaesthesia aethiopis (1850s)
- Disrespect for master’s property
- Cured by extensive whipping

Protest Psychosis (1968)
- Walter Bromburg and Franck Simon
- Black Power Movement drove “Negro men insane”

Schizophrenia
- Transition of diagnosis
Disparities in Care: The Role of Race on the Utilization of Physical Restraints in the Emergency Setting

Kristina Schnitzer MD, Flannery Merideth MD, Wendy Macias-Konstantopoulos MD, MPH, Douglas Hayden PhD, Derri Shtasel MD, Suzanne Bird MD

First published: 20 July 2020 | https://doi.org/10.1111/acem.14092

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Racial disparities in psychotic disorder diagnosis: A review of empirical literature

Robert C Schwartz, David M Blankenship
INTERVENTIONS

Interpersonal
- Implicit bias education
- Cultural competency

Institutional
- Policy

Internal
- Treatment encounter

Transitioning toward Anti Racism

Fig. 1 | The framework for an anti-racism action plan. Academic medical centres committed to being anti-racist must critically examine and reform the education and engagement of their students, trainees, faculty, staff and community as well as institutional policies and practices. Funding and evaluation are central to the sustainability and continuous improvement of these efforts, respectively.
CONSUMER MOVEMENT
(BUEBIRD 2017)
(TOMES 2006)

• Mirrored Other Historic Movements
• Came From Treatment and Policy Failures
• Initially With Consumers/Survivors
• Coalition Broadened Over Years
• Policy Victories
• Role As Stakeholders
NYAPRS

• Founded in 1981
• Reaching Over 20,000 People
• Promoting Recovery, Rehabilitation and Rights
• Intensive Psychiatric Rehabilitation Treatment Programs
• Multifaceted Approach
  • Direct Services
  • Social Conditions
  • Policies
• Coalition
REHABILITATION FOCUSED TREATMENT
(SANCHES ET AL 2018)
(SWILDENS ET AL 2011)

• Psychiatric Rehabilitation is Better Than Care As Usual for Reaching Goals
  • Methodology to Help Identify and Pursue Goals in Multiple Areas
  • Randomized Trial in The Netherlands
  • Also Improved Societal Participation

• Attaining Personal Goals Impacts Quality of Life
  • Working Alliance More Important than Bond or Task Subscales
ROLE OF RESEARCH
(JONES 2007)

• History of Exploitation
• Conflicting Priorities Between Institutions and Community
• Community Partnered Participatory Research
  • Changing Dynamics
  • Incorporates Community Preferences
  • Longer Term Relationships and Coalition Building
SOCIAL JUSTICE IN MENTAL HEALTH

• Multilevel Approach
  • Individual
  • Policies
  • Systems

• Partnerships and Coalitions

• Empowering Individuals

• Education At Every Level

• Incremental Victories

• Self Care

Adapted from “Interaction Institute for Social Change | Artist: Angus Maguire.”
interactioninstitute.org and madewithangus.com
SUMMARY

• Barriers within the current system
  • Access to care
  • Health disparities
  • Social determinants of health

• Slow progress

• Evidence based improvements

• Importance of the consumer movement

• Strategic partnerships
CONCLUSION

It is our responsibility to be mindful of social determinants of health and their potential impacts
- Mindfulness of personal bias
- Each case is unique
- Cultural Competence vs Cultural Humility

Social determinants of health are tied to laws and policies
- Be aware of historical factors

It is impossible to overcome these challenges through individual effort alone

Interventions can require a multifaceted approach
- Advocacy at multiple levels
- Collaboration across disciplines
THANK YOU!

Contact

DrPhillipMurray@gmail.com