

## Social & Racial Disparities in Mental Health

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### Disclosure

Presenters have no financial disclosures or professional conflicts of interest to report

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### Objectives

1. Define social determinants of mental health, mental health disparities, equity
2. Describe the role of social justice in achieving health and mental health equity
3. Introduce a framework for discussing health inequities and disparities as well as identified causes.

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## Health Disparities

Differences in health status among distinct segments of the population including differences that occur by gender, race or income, disability, or living in various geographic locations

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## Mental Health Disparities

- Minorities- Psychiatric symptom burden and disability
- Native American- Suicide, Alcohol use disorder & PTSD
- African American males – Schizophrenia
- Black youth-conduct disorder

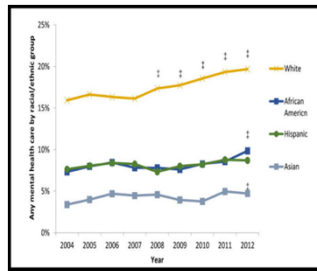


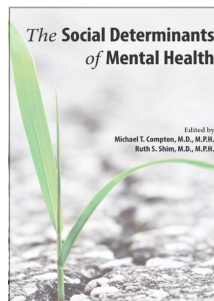
Figure 1. Unadjusted trends in any mental health care by race/ethnicity 2004-2012<sup>a, b, c</sup>. <sup>a</sup>2004-2012 Medical Expenditure Panel Surveys (N= 214, 597). <sup>b</sup>All differences between whites and blacks, Hispanics, and Asians are significant (p<0.05). <sup>c</sup>Any mental health care of black/Hispanic/Asian and whites in the marked year is significantly different from the same group's values in 2004.

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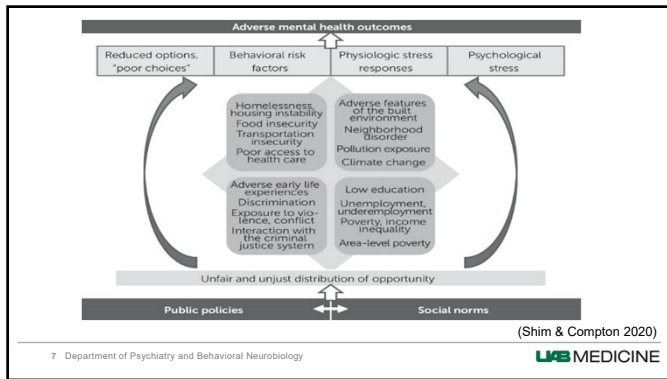
## Social Determinates of Health

- Those factors that impact upon health and well-being; the circumstances into which we are born, grow up, live, work and age including the health systems
- These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices
- The social determinates of health are prominently responsible for the health disparities and inequities experienced within and between countries



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**“The choices we make are based on the choices we have”**

David Williams, PhD: public health professor at the T. H. Chan School of Public Health at Harvard University

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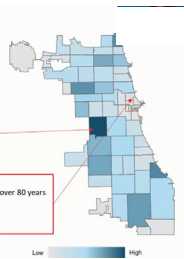
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### Blacks dying too soon even before COVID-19

ZIP code 60623: Brighton Park, South Lawndale, North Lawndale  
More than 95% BIPOC. Life expectancy lowest in N. Lawndale, at 68 years  
9.4% positivity for COVID-19  
154 deaths, or 1 in 558 residents

ZIP code 60610: Lincoln Park, Near North Side, Loop, West Town  
Less than 35% BIPOC. Life expectancy is among highest in the city, over 80 years  
3.6% positivity for COVID-19  
10 deaths, or 1 in 3,902 residents



Town Hall - APA Addresses Structural Racism, Part Two: The March Continues: <https://player.vimeo.com/video/451482274>

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### Share of Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic, by Race/Ethnicity



NOTES: \*Indicates a statistically significant difference relative to Non-Hispanic White adults at the  $p=0.05$  level. These adults (ages 18+) report symptoms of anxiety and/or depressive disorder generally occurring more than half the days or nearly every day. \*Other Non-Hispanic\* includes people of other races and multiple races. Data shown are for December 9 – 21, 2020.  
SOURCE: KFF analysis of the U.S. Census Bureau Household Pulse Survey, 2020.

KFF

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JAMA Network Open | Psychiatry

Reports of Mental Health, Substance Use, and Suicidal Ideation During COVID-19

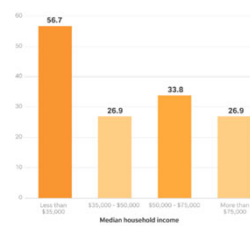
Table 1. Prevalence of Adverse Mental and Behavioral Health Symptoms, by Respondent Characteristics

Characteristics	No. (%)	Anxiety or depression	COVID-19 TSD	Substance use	Suicidal ideation	% of those
June 2020*	1475 (100)	1652 (18.9)	1437 (26.3)	726 (11.3)	584 (10.7)	2238 (46.9)
September 2020	1186 (100)	1710 (13.0)	1536 (29.6)	781 (15.1)	618 (11.9)	2237 (43.1)
Sex						
Female	2641 (56.9)	887 (33.6)	764 (28.9)	327 (12.4)	240 (9.1)	1156 (43.8)
Male	2545 (49.1)	821 (32.3)	771 (30.4)	454 (17.8)	378 (14.9)	1081 (42.3)
Sexual orientation						
Heterosexual	4568 (88.1)	1373 (30.1)	1261 (27.6)	570 (12.5)	436 (9.5)	1818 (39.8)
Lesbian or gay	242 (4.7)	121 (50.0)	101 (41.8)	73 (30.4)	55 (22.7)	148 (61.1)
Bisexual	202 (3.9)	131 (64.8)	90 (45.0)	95 (47.1)	79 (39.0)	159 (78.6)
Other or unknown <sup>b</sup>	174 (3.4)	84 (48.3)	75 (43.3)	42 (24.1)	49 (28.0)	112 (64.2)
Age group, y						
18–24	593 (11.4)	376 (63.4)	309 (52.2)	168 (28.4)	118 (19.9)	441 (74.4)
25–44	1837 (35.4)	886 (48.2)	813 (44.2)	493 (26.8)	426 (23.2)	1122 (61.1)
45–64	1831 (35.3)	366 (20.0)	327 (17.8)	95 (5.2)	64 (3.5)	536 (29.3)
≥65	926 (17.9)	82 (8.9)	88 (9.5)	24 (2.6)	11 (1.2)	138 (14.9)
Race/ethnicity						
White non-Hispanic	3349 (64.6)	952 (28.4)	857 (25.6)	418 (12.5)	341 (10.2)	1238 (37.0)
Black non-Hispanic	634 (12.2)	244 (38.4)	243 (38.3)	117 (18.5)	92 (14.5)	346 (54.5)
Asian non-Hispanic	261 (5.0)	58 (22.3)	64 (24.6)	14 (5.3)	13 (4.8)	93 (35.7)
Other race or multiple races, non-Hispanic <sup>c</sup>	159 (3.1)	59 (36.8)	45 (28.1)	14 (8.7)	10 (6.6)	74 (46.7)
Hispanic, any race or races	782 (15.1)	397 (50.8)	328 (41.8)	218 (27.9)	163 (20.8)	496 (62.1)

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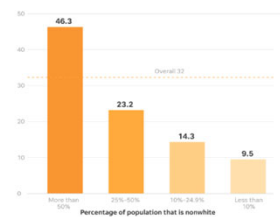
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In the poorest neighborhoods, where median household income is less than \$15,000, the COVID-19 infection rate was twice as high as in the nation's wealthiest ZIP codes, with income more than \$75,000.



SOURCE: State and county health departments' ZIP code-level COVID-19 case data through 4/20/2020; U.S. Census 2018 American Community Survey (5-year averaged) demographic data.  
CREDIT: Ramon Padilla/USA TODAY

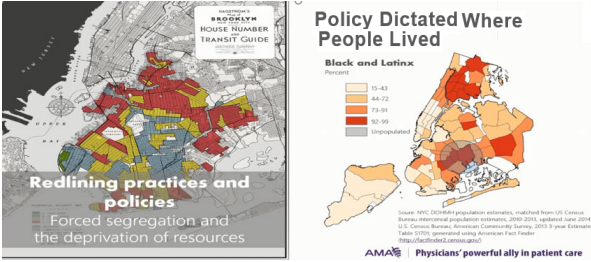
Infection rates were five times higher in majority-minority ZIP codes than in ZIP codes with less than 10% nonwhite population.



SOURCE: State and county health departments' ZIP code-level COVID-19 case data through 4/20/2020; U.S. Census 2018 American Community Survey (5-year averaged) demographic data.  
CREDIT: Ramon Padilla/USA TODAY

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**Redlining practices and policies**  
Forced segregation and the deprivation of resources

**Policy Dictated Where People Lived**

**Black and Latinx Percent**

10-43  
44-52  
53-61  
50-99  
Unpopulated

Source: NYC DOCHMH population estimates, matched from US Census Bureau decennial population estimates, 2000-2010, updated June 2014. U.S. Census Bureau, American Community Survey, 2010 5-year estimates. <https://data.cityofnyc.gov/dataset/american-community-survey-2010-5-year-estimates-99n3-99n3-99n3>

AMA Physicians' powerful ally in patient care

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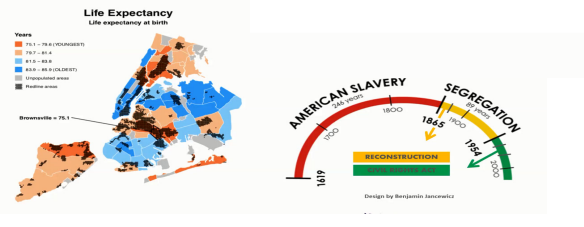
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**Life Expectancy**  
Life expectancy at birth

**Years**

75.1 - 76.0 (red)  
76.1 - 77.0 (orange)  
77.1 - 78.0 (yellow)  
78.1 - 79.0 (blue)  
79.1 - 80.0 (dark blue)  
Unpopulated area  
Water area

Brooklynville = 75.1

**AMERICAN SLAVERY**  
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2020-2021

Design by Benjamin Isaacowitz

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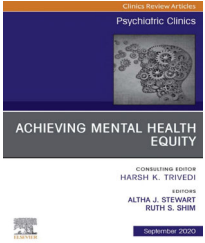
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## Health Inequity



**ACHIEVING MENTAL HEALTH EQUITY**

CONSULTING EDITOR  
HARSH K. TRIVEDI

EDITORS  
ALTHA J. STEWART  
RUTH S. SHIM

September 2020

- Health inequities are *avoidable* differences in health status or in the distribution of health resources between different population groups arising from social conditions in which people are born, grow, live work and age

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"Even when they are living in the same city, blacks and whites are living under very different environmental conditions. If you could eliminate residential segregation in America, you would completely erase black-white differences in income, education and unemployment, and reduce single motherhood by two-thirds. All that is driven by the opportunities linked to geographic..."

David Williams, PhD: public health professor at the T. H. Chan School of Public Health at Harvard University

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## Cardiovascular Disease in African American and White Physicians: The Meharry Cohort and Meharry-Hopkins Cohort Studies



[https://home.mmc.edu/event/meharry-celebrates-black-history-month/meharry\\_alumni\\_1941/](https://home.mmc.edu/event/meharry-celebrates-black-history-month/meharry_alumni_1941/)

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<https://www.hopkinsmedicine.org/about/history/>

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## Social Determinates & Racial discrimination



<https://www.youtube.com/watch?v=MT16QJabLlY>

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## Achieving Mental health Equity... What do we do??

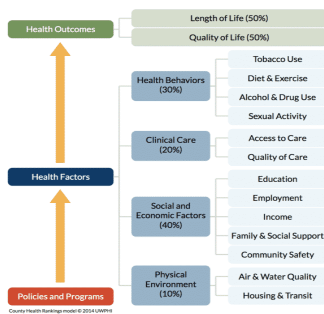
Components of an effective strategy to achieve mental health equity include:

- Increasing population-based care
- Increasing community-based health care services
- Addressing the social determinates of health
- Engaging the community
- Enhancing the pipeline and supporting a diverse structurally competent workforce

(Alves-Bradford et al. 2020)

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### Utilizing Race in the Medical Record

- Self Identified Demographic Information
- Social History: Improving understanding of the patient's experience as they move through society
- Developing a cultural and structural formulation
- Research purposes

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### Historical Origins



<https://www.youtube.com/watch?v=VnffgR27U>

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*Towards the Abolition of Biological Race in Medicine and Public Health: Transforming Clinical Education, Research, and Practice*

#### **Section 1: Racism, not Race, Causes Health Disparities**

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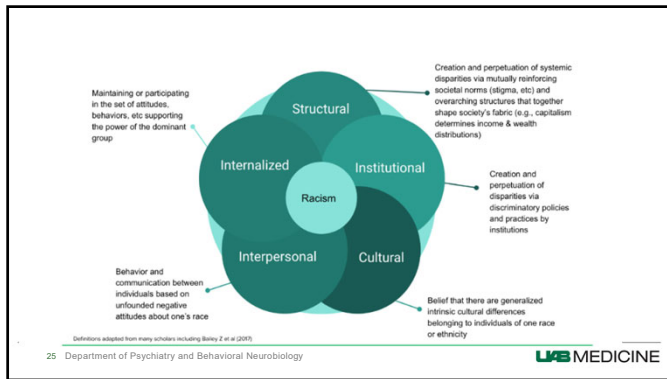
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### Clinical Case

**Identifying info:** The patient is a 19-year-old male recent high school graduate who currently lives with his mother and father. He has no prior psychiatric history. Currently employed in retail store stocking shelves.

**CC:** "There has been a misunderstanding"

**History of Present Illness:** 19-year-old male with history of asthma, was brought into the ER by police for "bizarre behavior" and making threats towards his co-workers.

According to the police report, on the day of admission, the patient reported to his job as usual. At lunch break, he was sitting by himself in a corner of the break room. He suddenly started shouting at other co-workers, "What are you saying?! ... Stop talking about me!" He accused his co-workers of talking behind his back and calling him slurs. The co-workers reported his behavior to the manager who then called the police. He accused the police of following him unfairly. He claimed that the co-workers were being biased towards him and conspiring to get him fired.

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### Clinical Case

The patient arrived in the psych ER restlessly pacing and saying, "There has been a misunderstanding ... I am not supposed to be here!" He was able to be redirected back to his room. He reports that his co-workers were talking about him behind his back and that he should be discharged. He initially denies any problems other than his coworkers' behavior. He voices frustration that he is being blamed for their harassment. He reports sometimes feeling sad but says, "Who doesn't?" He reports some problems falling asleep at times. According to patient's parents, they had not noticed any acute changes in his behavior or personality. However, they noticed an increase in social isolation starting around his time of graduation. They attributed this to his feeling sad because his friends went away to college or moved away. He now plays more video games in the basement than usual. Recently, he did mention that he thinks his co-workers are saying bad things about him and bullying him.

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## Clinical Case



**Past psychiatric history:** None.

**Substance use:** Regular marijuana use starting at age 16. Smokes 2 marijuana cigarettes a day. He denies alcohol use. Denies tobacco or any other illicit substances.

**Past Medical History:** Asthma. **Medications:** Albuterol PRN.

**Family history:** Mother and maternal aunt - anxiety and alcohol use.

**Social and developmental history:** No prenatal exposures. Born at term. Always had 1-2 best friends. Parents are married and generally supportive of him.

**Vital Signs:** WNL

**Mental status exam:** Appearance: young adult patient appearing stated age, reasonable grooming, casual dress, untucked shirt. Behavior: seated on bed, looks around the room, seems distracted at times, poor eye contact, answers questions tersely. Speech: Sparse, monotone, normal rate/volume. Mood: "Fine." Affect: Anxious, irritable. Thought content: feelings of being harassed- ?paranoia. Denies SI/HI/AVH. Thought Process: Terse answers but no gross disorganization. Cognition: alert, oriented, recent memory intact, good vocabulary Insight/Judgment: Limited.

**Labs:** Utox positive for THC

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## Clinical Case



# Initial thoughts?

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## References to Culture in DSM-5

Outline for Cultural Formulation (OCF): revised from DSM-IV/-IV-TR

Cultural Formulation Interview (CFI): new

Appendix

Glossary of Cultural Concepts of Distress replaced the Glossary of Culture-Bound Syndromes

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### DSM-5 Definition of Culture

**Values, orientations, knowledge, and practices that individuals use to understand their experiences, based on their identification with diverse groups, such as:**

- Ethnic groups, faith communities, occupational groups, veterans, etc.

**Aspects of a person's background, experience, and social contexts that may affect his or her perspective, such as:**

- Geographical origin, migration, language, religion, sexual orientation, race/ethnicity, etc.

**The influence of family, friends, and other community members (the individual's social network) on the individual's illness experience**

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### Cultural Competence Essential Elements

Self assessment about one's own cultural identity, values, prejudices, biases, etc.

Humility about the limits of one's assessment and treatment knowledge/skills

Valuing diversity via awareness of and sensitivity to cultural differences

Vigilance towards the power dynamics that result from cultural differences

Responsiveness to cultural differences via adaptation of assessment and treatment

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### Culture in Mental Health

- **Culture** is NOT ONLY geographic origin, race or ethnicity.
- **Culture** is dynamic, not static.
- **Cultural identity** varies from person to person.
- **Cultural Competence** refers to the ability of mental health professionals and services to provide person-centered care to patients by taking into account the multiple, ever-changing, and highly individualized cultural identities of each person receiving services.

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### The DSM-5 Outline for Cultural Formulation (p. 749-750)

- A. Cultural identity of the individual
- B. Cultural conceptualizations of distress (Cultural explanations of the individual's illness)
- C. Psychosocial stressors and cultural features of vulnerability and resilience (Cultural factors related to psychosocial environment and functioning)
- D. Cultural features (elements) of the relationship between the individual and the clinician
- E. Overall cultural assessment (for diagnosis and care)

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### DSM-5 Supplementary Modules (12)

- Cultural Identity
- Explanatory Model
- Coping and Help-Seeking
- Psychosocial Stressors
- Social Network
- Caregivers
- Level of Functioning
- Patient–Clinician Relationship
- School-Age Children and Adolescents
- Older Adults
- Religion, Spirituality, and Moral Traditions
- Immigrants and Refugees

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#### Cultural Formulation

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##### Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted with underline.

##### GUIDE TO INTERVIEWER

The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the patient and other members of the patient's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.

##### CULTURAL DEFINITION OF THE PROBLEM

##### CULTURAL DEFINITION OF THE PROBLEM

##### Explanatory Model, Level of Functioning

Elicit the patient's view of core problems and key concerns.

Focus on the patient's own way of understanding the problem.

Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").

Ask how patient frames the problem for members of the social network.

Focus on the aspects of the problem that matter most to the patient.

##### INTRODUCTION TO THE PATIENT:

I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

##### 1. What brings you here today?

IF PATIENT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE.

People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?

2. Sometimes people have different ways of describing their problems to their family, friends, or others in their community. How would you describe your problem to them?

3. What trouble do you most about your problem?

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### Cultural Formulation Interview Questions

**Cultural Definition:**

What brings you here today? Sometimes people have different ways of describing their problem. How would you describe your problem to your family, friends, or a member of your community? What troubles you most about your problem?

**Cultural Identity:**

Why do you think this is happening to you? What do others in your family, friends, or others in your community say are the causes of your problem?

**Cultural Cause:**

For you, what are the most important aspects of your background or identity? Are there any aspects of your background or identity that make a difference to your problem?

**Past Help Seeking:**

In the past, what kinds of treatment, help, advice or healing have you sought?

**Current Help Seeking:**

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

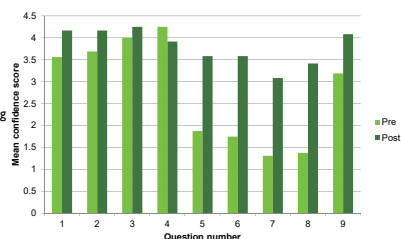
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### DSM-5 Cultural Competence Grand Rounds by Dr. Francis Lu

1. How confident are you in being aware of cultural factors during therapeutic interactions?
2. How confident do you feel interacting with people culturally different from yourself?
5. How confident are you in defining the 5 parts of the DSM-5 outline for Cultural Formulation?
7. How confident are you in citing the 16 questions of the DSM-5 Cultural Formulation Interview?
9. Overall, how do you rate your cultural awareness, knowledge and skills in treating patients?

n=16 Pre and n=12 Post



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### Structural Competency-Attention to Forces Above Individual

**Five Core Competencies:**

1. Recognize the structures (economic, physical, and sociopolitical forces) that influence medical care.
2. Develop extra-clinical language of structure by infusing the language into case formulations.
3. Rearticulate "cultural" formulations with structural language
4. Create structural interventions
5. Develop structural humility

Metzl, J.M. & Hansen, H. 2014. Structural competency, Social Science and Medicine, 103:126-133

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### How Might This Impact Patients?

- Understanding/connection with their clinician
- Trust/Investment in their treatment
- Increased Agency
- Better outcomes through development of a cultural formulation and a structural formulation

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### Returning to the case ...



**Social history:** The patient self-identifies as African-American, and recently he has felt racially targeted at his place of employment. He reports having been called racial slurs on multiple occasions. Most of colleagues are white, and he feels that they exclude him from social activities. In addition, the patient reports he was recently pulled over by the police and subject to a random search.

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### Structural Formulation:



The patient describes his symptoms as stemming from his experiences of racial discrimination at his place of employment and from law enforcement. The experience of racial discrimination is a risk factor for a variety of mental health outcomes. As many of these communities have been historically targeted by law enforcement, his recent interaction with the police prior to admission may have triggered a highly anxious, agitated state, which might be seen as a reasonable, non-pathological response. While admitted, feelings of anxiety were exacerbated by hospital security who patrolled the unit.

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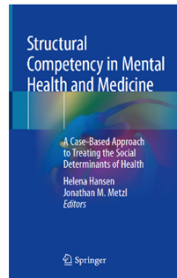
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### Structural Competency

*In the healthcare world, structural competency relates closely to public health, as interventions that address the structures that pervade and create society are often found in a policy or system level; these issues aren't addressed (solely) by training medical professionals to recognize "cultural" differences between groups or people.*



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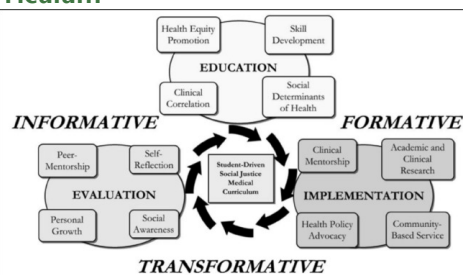
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### Framework of the Student-Driven Social Justice Curriculum



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### Conclusions:

- Racial Disparities in health are created by larger inequalities in society, of which racism is one determinant.
- Social inequalities in health reflect the successful implementation of social policies.
- We need to examine how exposure to institutional and individual forms of racism relate to each other, and combine with other risks factors and resources, and cumulate over the life course, to affect health
- We need to identify how innate & acquired biological factors interact with conditions in the psychological, social and physical environment to affect health risks.

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## A Call to Action

“The only thing necessary for the triumph [of evil] is for good men to do nothing.”

Edmund Burke, British Philosopher

