# EMERGENCY ROOM: HOW IT IMPACTS HEALTHCARE DISPARITIES IN AFRICAN AMERICANS

January 27, 2023

Phillip Murray MD, MPH

# DISCLOSURES

No conflicts of interest to report.

No financial disclosures to report.

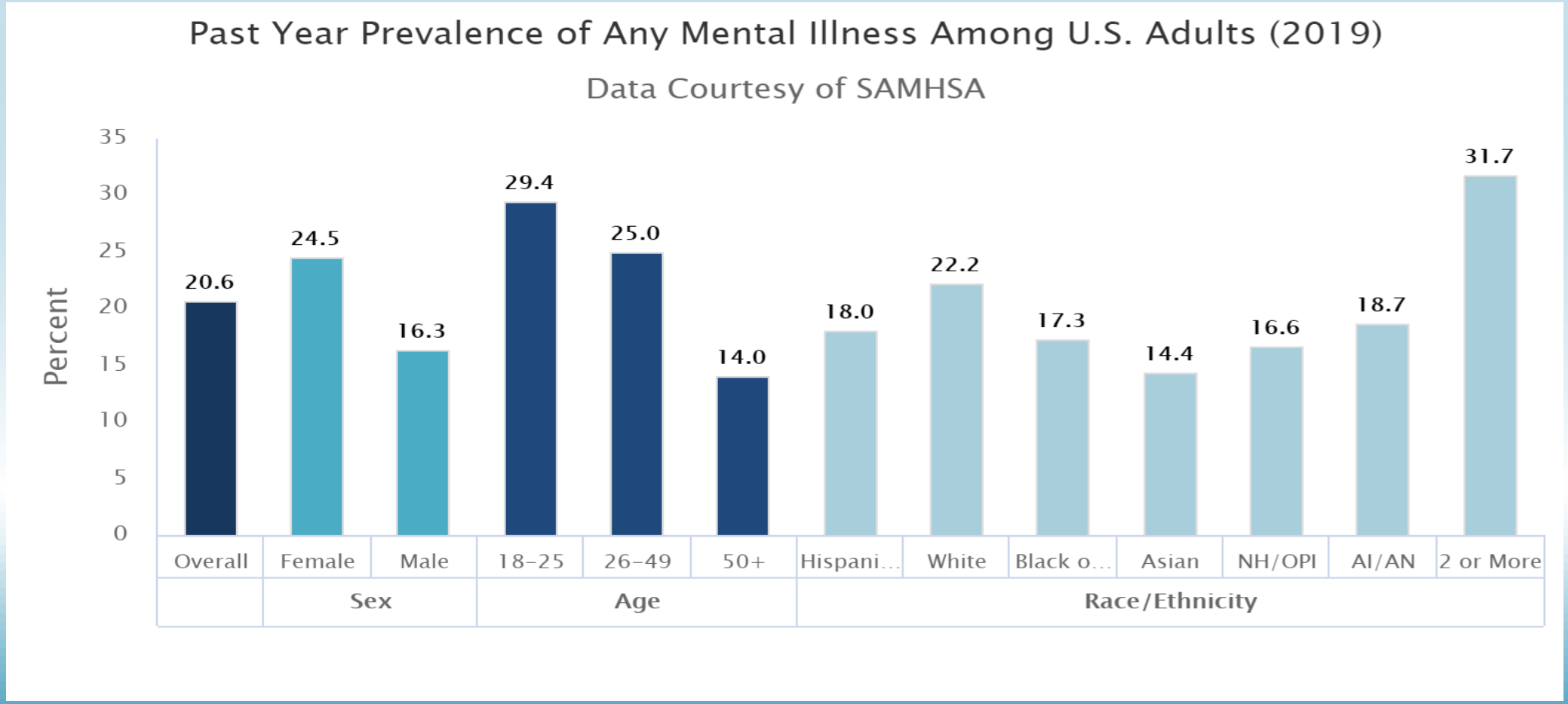
# LEARNING OBJECTIVES

- Define two areas of structural racism
- Identify one of the criteria related to the legal history for involuntary commitment
- Identify two outpatient factors that can improve emergency psychiatry use
- Identify two factors that can increase the likelihood of involuntary hospitalization

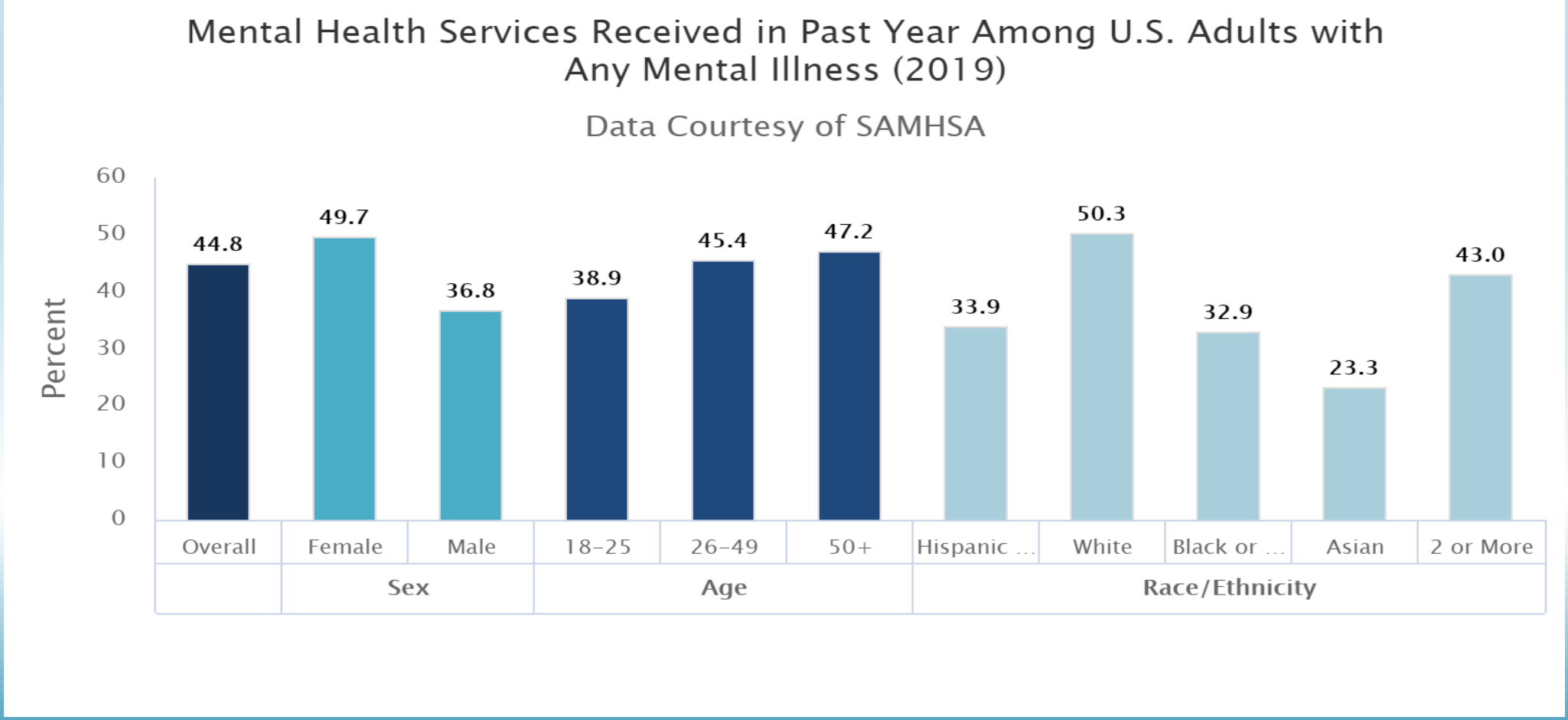
# OUTLINE

- Overview of Mental Health System
- Health Disparities and Social Determinants of Health
- Emergency Department
- Disparities within the Emergency Department
- Potential Areas of Improvement

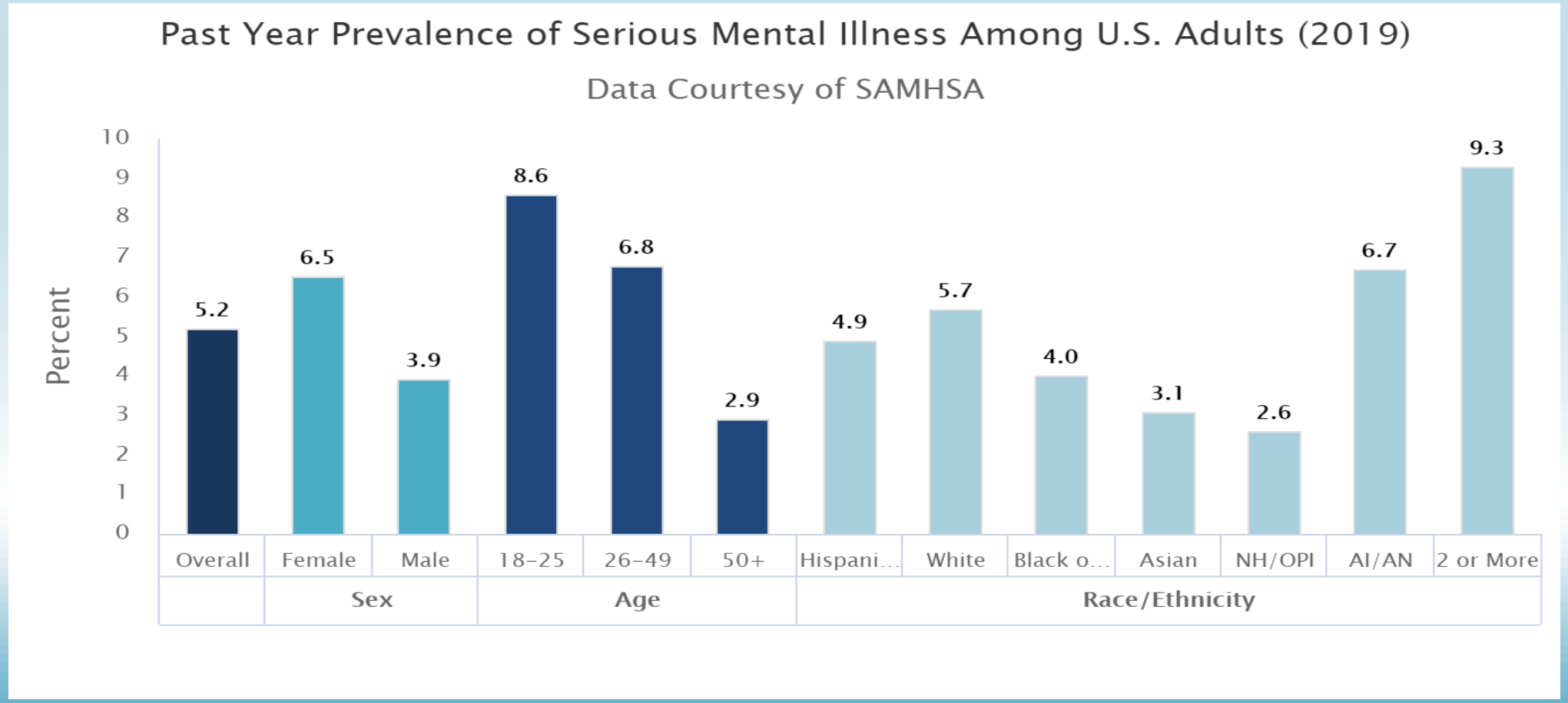
# PAST YEAR PREVALENCE OF ANY MENTAL ILLNESS AMONG U.S. ADULTS (2019)



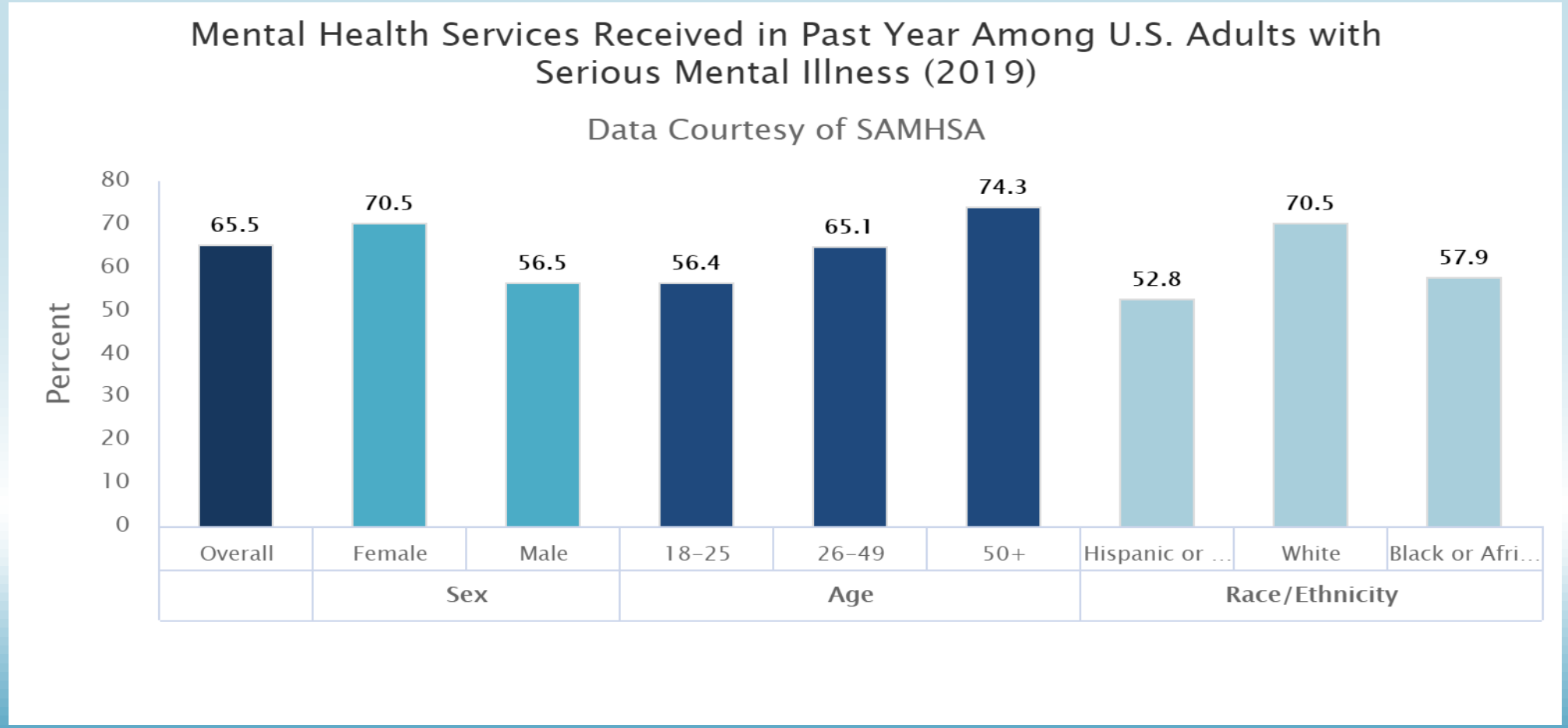
# MENTAL HEALTH SERVICES RECEIVED IN THE PAST YEAR FOR U.S. ADULTS (2019)



# PAST YEAR PREVALENCE OF SERIOUS MENTAL ILLNESS AMONG U.S. ADULTS (2019)

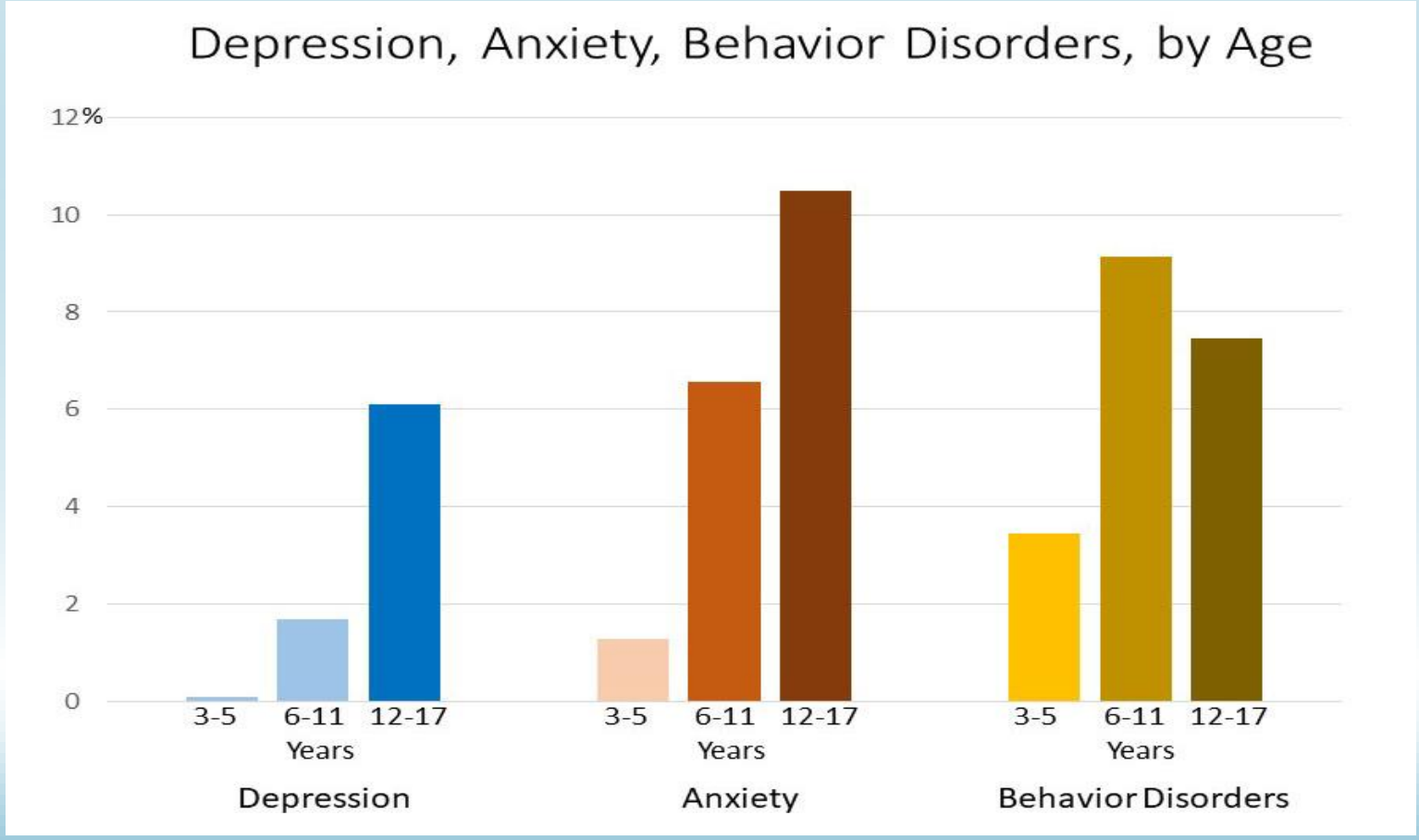


# MENTAL HEALTH SERVICE RECEIVED IN PAST YEAR AMONG U.S. ADULTS WITH SERIOUS MENTAL ILLNESS (2019)

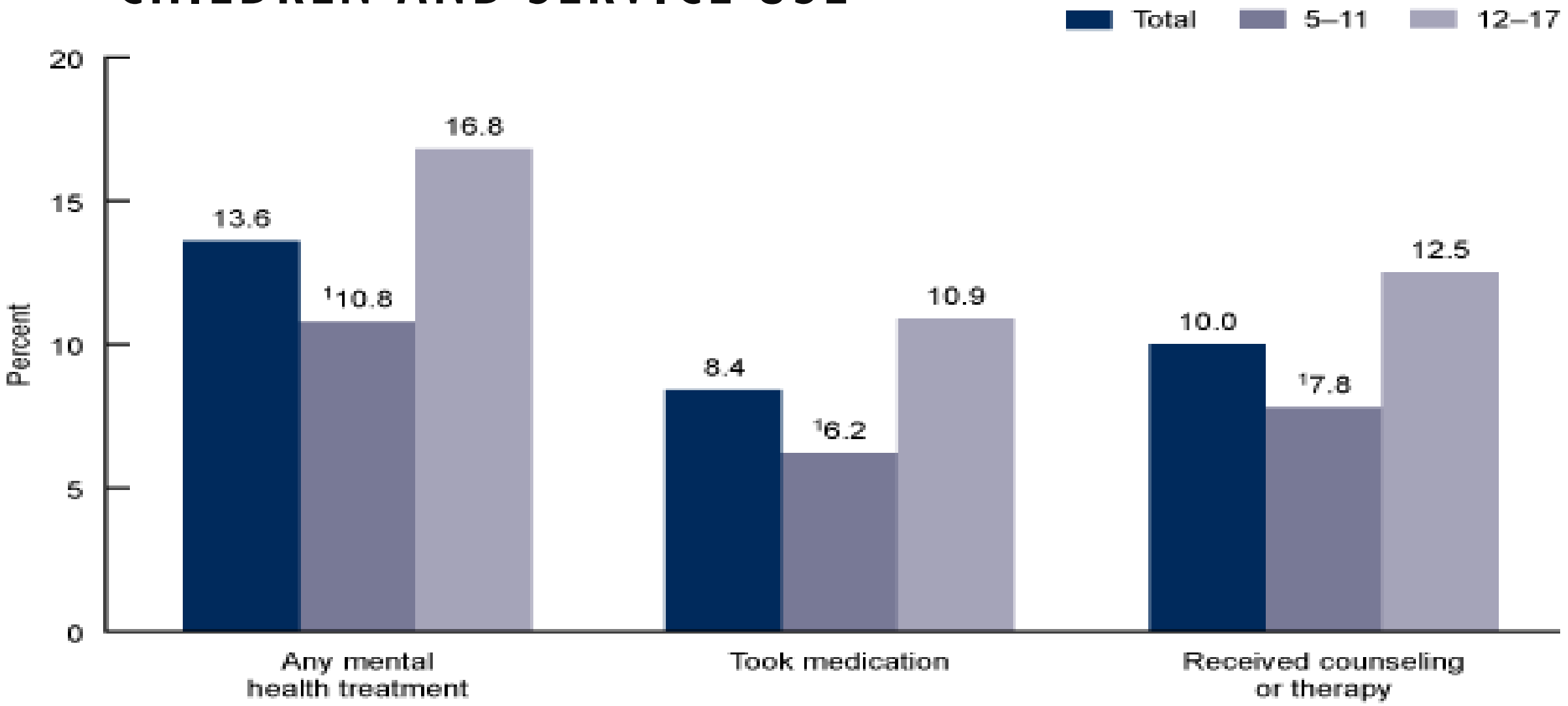


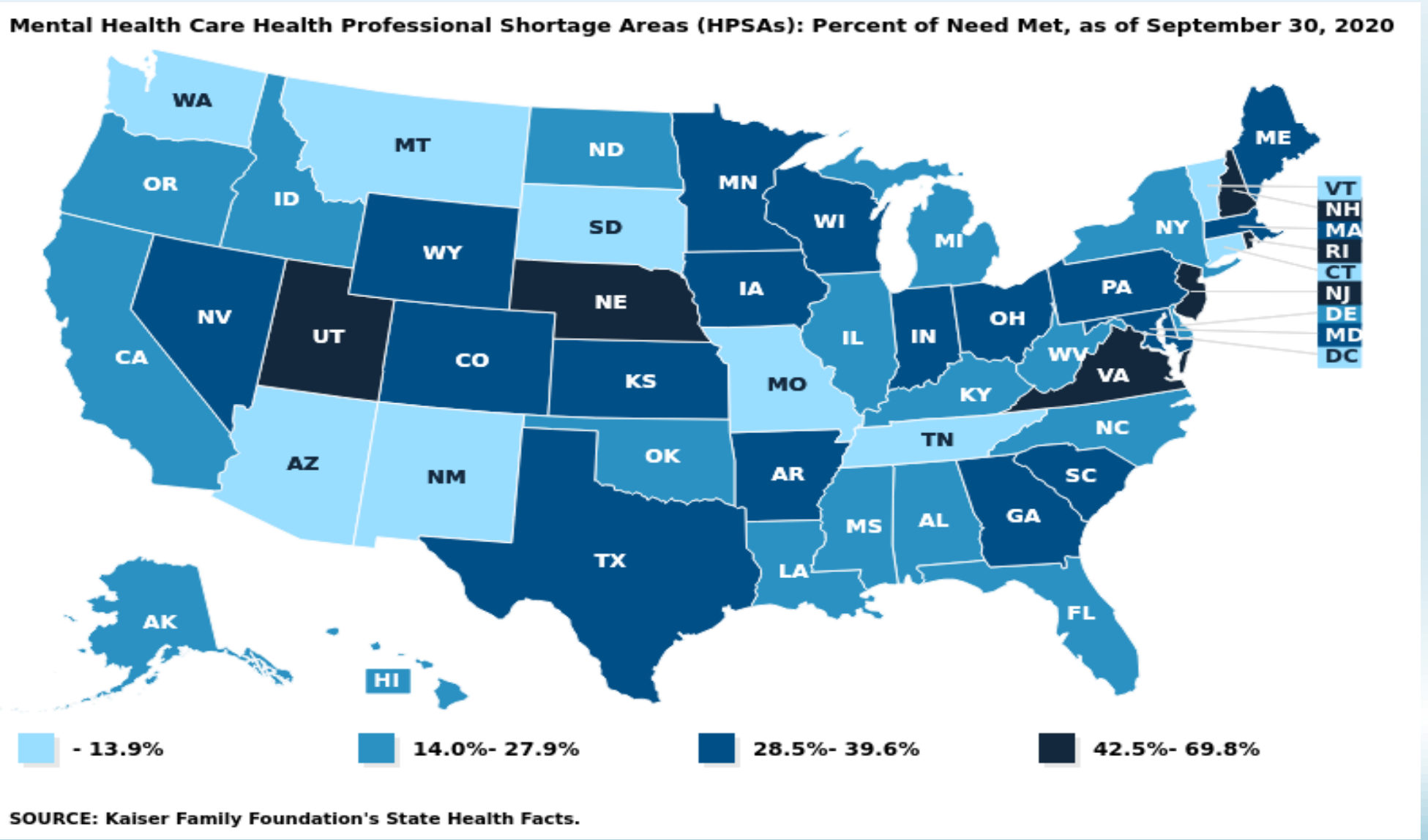
# CHILD AND ADOLESCENT MENTAL HEALTH

- Increasing Prevalence
  Estimates 13% - 20%
- Suicide as a leading cause of death
  -Second Among Adolescents
- Increasing Use of Treatment



# CHILDREN AND SERVICE USE



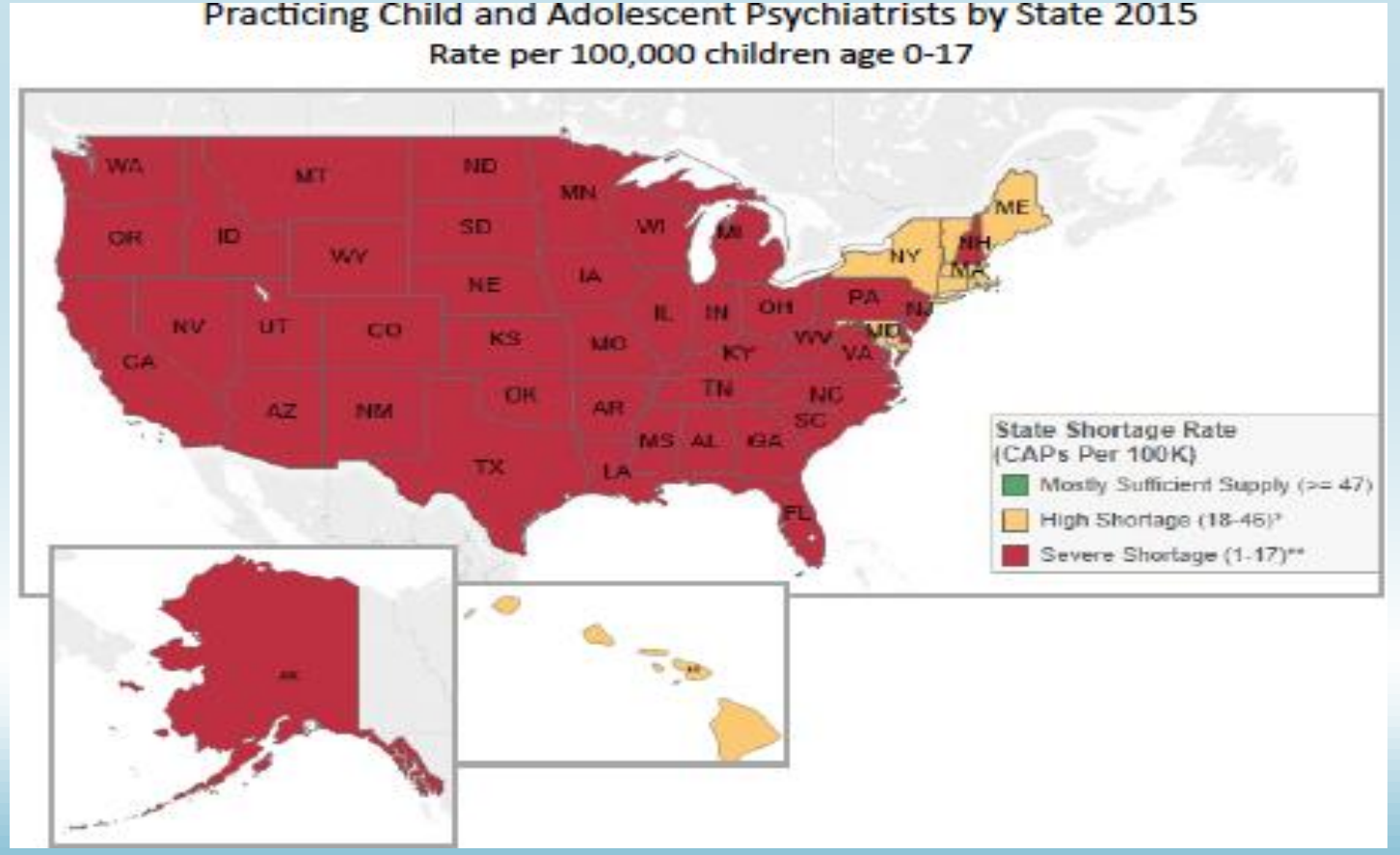



## HEALTH PROFESSION SHORTAGE AREAS

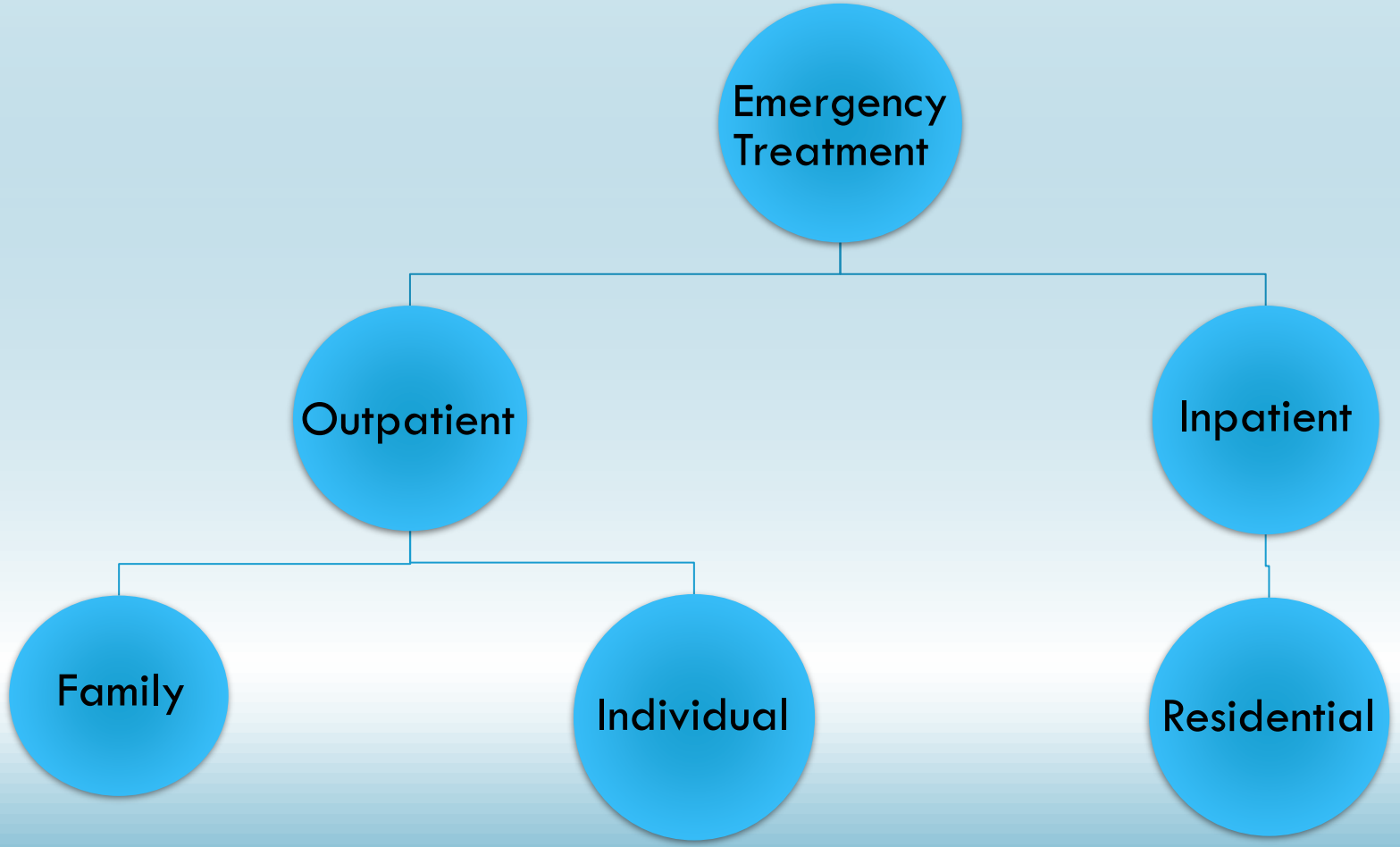
30,000 PEOPLE PER PSYCHIATRIST
5,287 HPSAS IN THE UNITED STATES
122 MILLION PEOPLE

# CHILD AND ADOLESCENT PSYCHIATRIST SHORTAGE

- Estimated need of 30,000+
  -8,300 Currently
- Wait times average 7.5 weeks
- Poor Distribution
  -Concentrated in Urban Areas



# CURRENT CARE PATHWAYS



# MENTAL HEALTH HISTORY

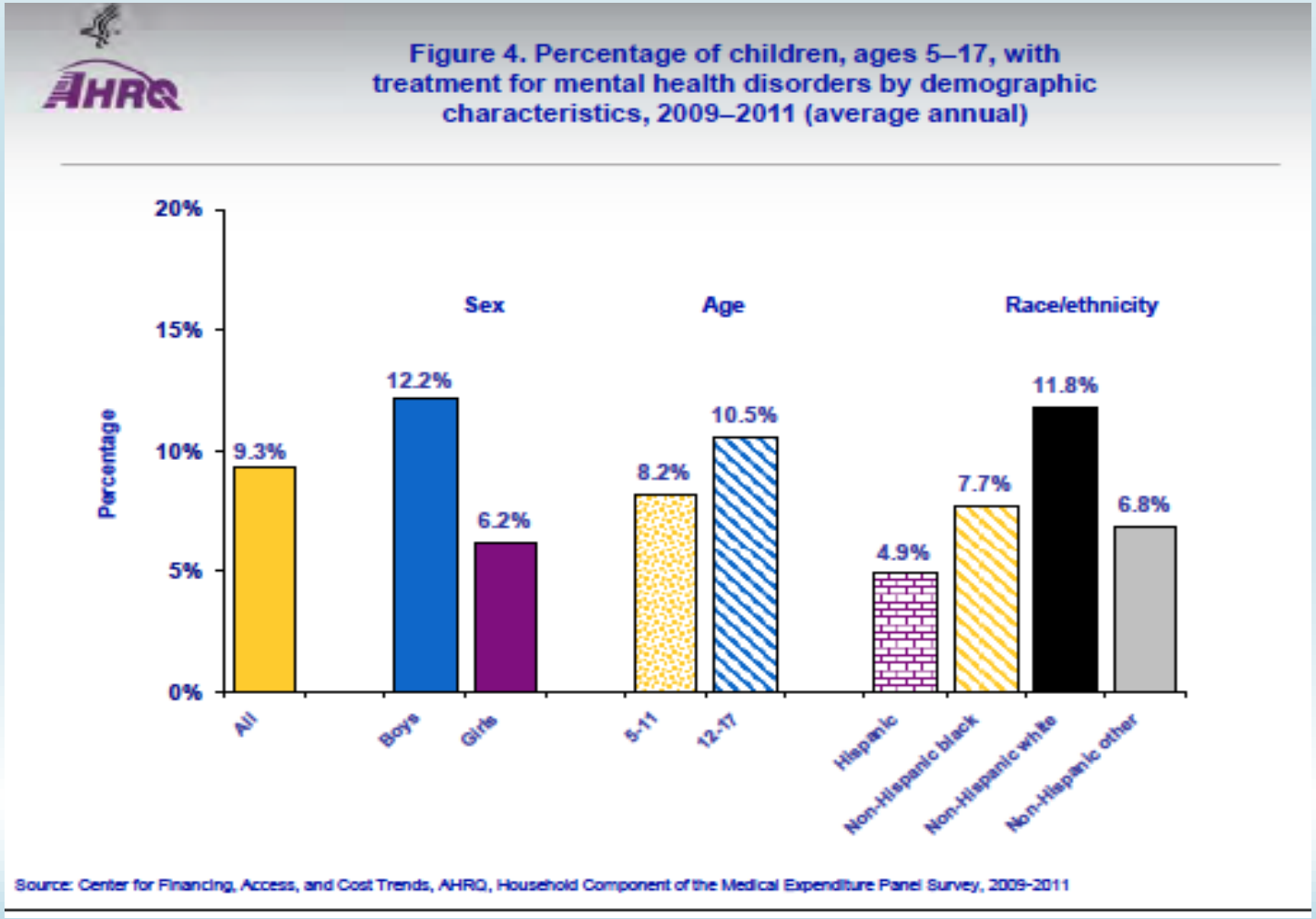
- Drapetomania (1850s)
  - -Condition leading to slaves running away
- Dysesthesia Aethiopis (1850s)
  - -Disrespect for master's property
  - -Cured by extensive whipping
- Protest Psychosis (1968)
  - -Walter Bromburg and Franck Simon
  - -Black Power Movement drove "Negro men insane"
- Schizophrenia
  - -Transition of diagnosis

# MENTAL HEALTH AND THE LAW

- Donaldson v O'Connor (1974)
  -Involuntary Commitments
- Tarasoff v. Regents of University of California (1976)
  -Reporting Potential Violence
- Mandated Reporting
- Competency vs Capacity

# 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



# RACIAL DISPARITIES IDENTIFIED IN HEALTHCARE

SAEM Academic Emergency Medicine
Official Journal of the Society for Academic Emergency Medicine

ORIGINAL CONTRIBUTION

## 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



WJP World Journal of Psychiatry

Submit a Manuscript: http://www.wjgnet.com/esps/
Help Desk: http://www.wjgnet.com/esps/helpdesk.aspx
DOI: 10.5498/wjp.v4.i4.133

*World J Psychiatr* 2014 December 22; 4(4): 133-140
ISSN 2220-3206 (online)


*MINIREVIEWS*

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

Robert C Schwartz, David M Blankenship

PNAS

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

Kelly M. Hoffman[a,1], Sophie Trawalter[a], Jordan R. Axt[a], and M. Norman Oliver[b,c]

[a]Department of Psychology, University of Virginia, Charlottesville, VA 22904; [b]Department of Family Medicine, University of Virginia, Charlottesville, VA 22908; and [c]Department of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

Edited by Susan T. Fiske, 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

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 (1, 4). For example, a study examining pain management among patients with metastatic or recurrent cancer found that only 35% of racial minority patients received the appropriate prescriptions—as 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 management could arise. The first possibility is

# DISPARITIES

- Most mental healthcare is provided by primary care physicians
- 20% of African-Americans do not have a regular source of healthcare
- 27% of African-American families live in poverty and 25% are uninsured
- Depression is often overlooked
- Referrals for specialized procedures differ by race

# DIAGNOSIS

- Over diagnosis of Schizophrenia
  - -Disappears when based on structured DSM Dx Criteria
  - -May result from higher incidence of hallucinations in depressed African Americans
  - -May also be related to occult alcohol and substance abuse

# TREATMENT CHALLENGES

- African Americans may have a more negative attitude towards psychiatry and mental health care
- Clinicians may encounter difficulties in establishing rapport with patients depending on interethnic and intercultural circumstances

# CULTURALLY SENSITIVE CARE

- 1600 African American psychiatrists in the US
- This represents only 2% of all psychiatrists
- Numbers are similar for psychologists (2%) and Social Workers (4%)
- Many are retired or do not practice in the African American community

# SOCIAL DISPARITIES

- Homelessness (3.5 x Whites)
- Severe Poverty (3 x Whites)
- Violence
  - 1993 study showed that 25% of African American youth who were exposed to violence had symptoms sufficient to warrant a dx of PTSD

# POLICE KILLINGS AND SPILLOVER EFFECTS ON THE MENTAL HEALTH OF BLACK AMERICANS

## Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study

*Jacob Bor*, Atheendar S Venkataramani*, David R Williams, Alexander C Tsai*

*Lancet* 2018; 392: 302–10

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http://dx.doi.org/10.1016/S0140-6736(18)31130-9

See Comment page 258

*Contributed equally

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### Summary

**Background** Police kill more than 300 black Americans—at least a quarter of them unarmed—each year in the USA. These events might have spillover effects on the mental health of people not directly affected.

**Methods** In this population-based, quasi-experimental study, we combined novel data on police killings with individual-level data from the nationally representative 2013–15 US Behavioral Risk Factor Surveillance System (BRFSS) to estimate the causal impact of police killings of unarmed black Americans on self-reported mental health of other black American adults in the US general population. The primary exposure was the number of police killings of unarmed black Americans occurring in the 3 months prior to the BRFSS interview within the same state. The primary outcome was the number of days in the previous month in which the respondent's mental health was reported as "not good". We estimated difference-in-differences regression models—adjusting for state-month, month-year, and interview-day fixed effects, as well as age, sex, and educational attainment. We additionally assessed the timing of effects, the specificity of the effects to black Americans, and the robustness of our findings.

**Findings** 38 993 (weighted sample share 49%) of 103 710 black American respondents were exposed to one or more police killings of unarmed black Americans in their state of residence in the 3 months prior to the survey. Each additional police killing of an unarmed black American was associated with 0·14 additional poor mental health days (95% CI 0·07–0·22; p=0·00047) among black American respondents. The largest effects on mental health occurred in the 1–2 months after exposure, with no significant effects estimated for respondents interviewed before police killings (falsification test). Mental health impacts were not observed among white respondents and resulted only from police killings of unarmed black Americans (not unarmed white Americans or armed black Americans).

**Interpretation** Police killings of unarmed black Americans have adverse effects on mental health among black American adults in the general population. Programmes should be implemented to decrease the frequency of police killings and to mitigate adverse mental health effects within communities when such killings do occur.

**Funding** Robert Wood Johnson Foundation and National Institutes of Health.

# EXPOSURE OF POLICE VIOLENCE WITH MENTAL HEALTH SYMPTOMS AMONG URBAN RESIDENTS

JAMA Network | Open.

Original Investigation | Public Health

## Association of Exposure to Police Violence With Prevalence of Mental Health Symptoms Among Urban Residents in the United States

Jordan E. DeVylder, PhD; Hyun-Jin Jun, PhD; Lisa Fedina, PhD; Daniel Coleman, PhD; Deidre Anglin, PhD; Courtney Cogburn, PhD; Bruce Link, PhD; Richard P. Barth, PhD

### Abstract

**IMPORTANCE** Police violence is reportedly widespread in the United States and may pose a significant risk to public mental health.

**OBJECTIVE** To examine the association between 12-month exposure to police violence and concurrent mental health symptoms independent of trauma history, crime involvement, and other forms of interpersonal violence exposure.

**DESIGN, SETTING, AND PARTICIPANTS** This cross-sectional, general population survey study of 1221 eligible adults was conducted in Baltimore, Maryland, and New York City, New York, from October through December 2017. Participants were identified through Qualtrics panels, an internet-based survey administration service using quota sampling.

**EXPOSURES** Past 12-month exposure to police violence, assessed using the Police Practices Inventory. Subtypes of violence exposure were coded according to the World Health Organization domains of violence (ie, physical, sexual, psychological, and neglectful).

**MAIN OUTCOMES AND MEASURES** Current Kessler Screening Scale for Psychological Distress (K6) score, past 12-month psychotic experiences (World Health Organization Composite International Diagnostic Interview), and past 12-month suicidal ideation and attempts.

**RESULTS** Of 1221 eligible participants, there were 1000 respondents (81.9% participation rate). The sample matched the adult population of included cities on race/ethnicity (non-Hispanic white, 339 [33.9%]; non-Hispanic black/African American, 390 [39.0%]; Hispanic/Latino, 178 [17.8%]; other, 93 [9.3%]), age (mean [SD], 39.8 [15.2] years), and gender (women, 600 [60.0%]; men, 394 [39.4%];

### Key Points

**Question** What is the prevalence of police violence exposure in cities in the United States, and what is the association of police violence exposure with adverse mental health outcomes independent of other forms of trauma exposure and crime involvement?

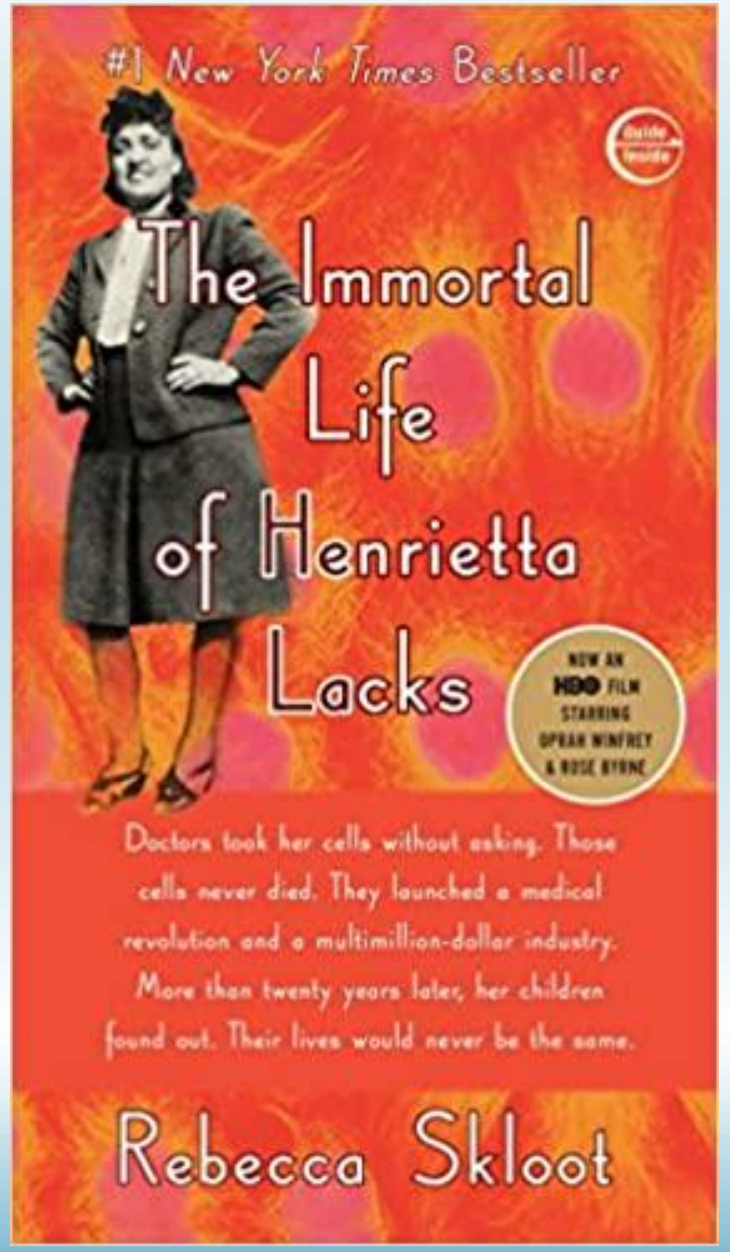
**Findings** In this cross-sectional, general population survey study of 1000 adults residing in Baltimore, Maryland, and New York City, New York, police violence exposure was reported at a prevalence ranging from 3% for sexual violence to 15% for neglect, inequitably distributed across demographic groups, and was associated with concurrent mental health symptoms.

**Meaning** The findings suggest that police violence is experienced by many urban residents in the United States and may be associated with mental health disparities.

# MISTRUST REVISITED

- **"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



# 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
- Education
- Unemployment
- Housing Discrimination
- Mass Incarceration

**Mental Illness in Correctional Settings**

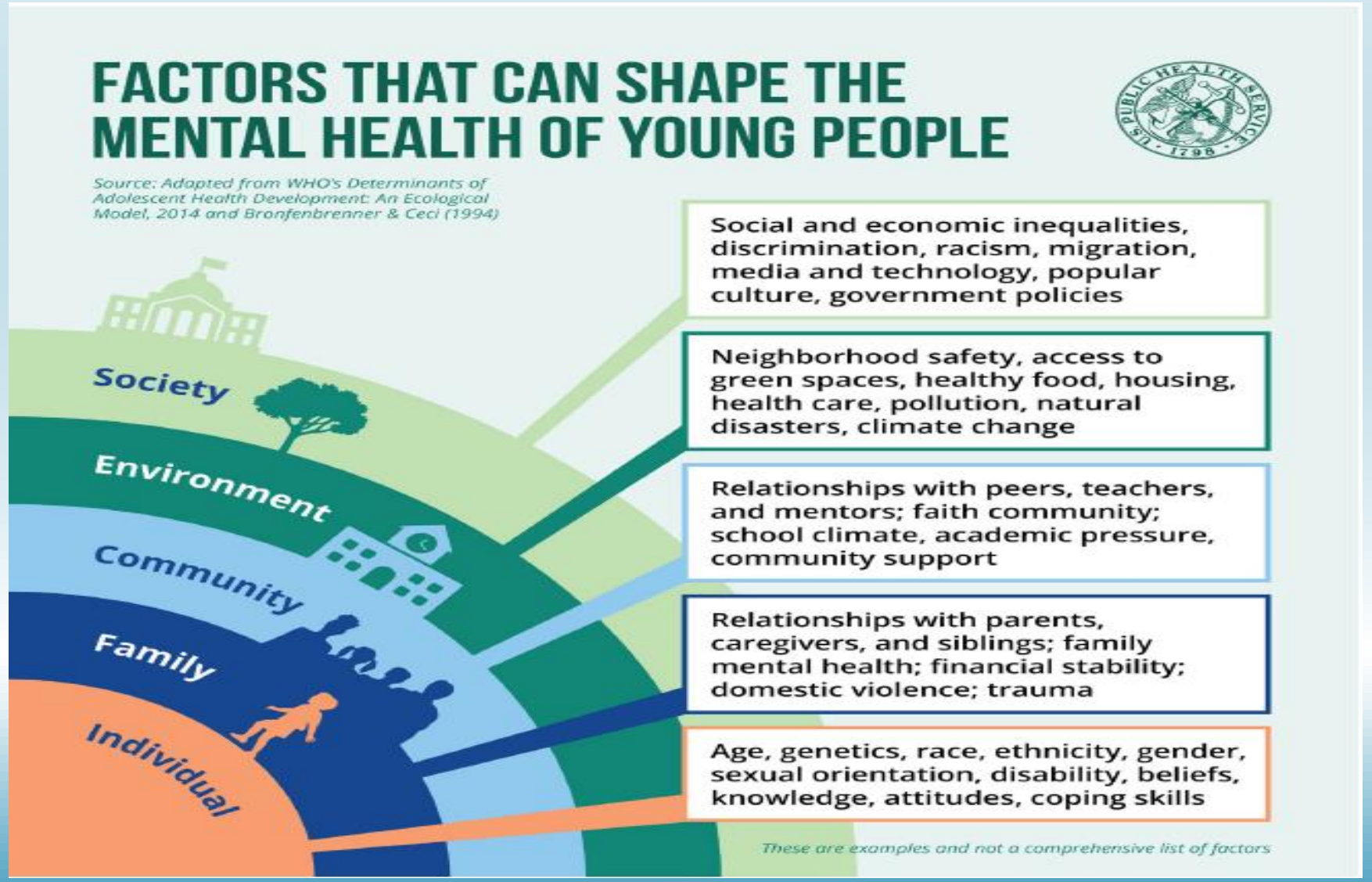
| | General Population | Local Jail | State Prison | Federal Prison |
|---|---|---|---|---|
| Any mental illness | 18.6% | 64.2% | 56.2% | 44.8% |
| Substance use disorder | 9% | 76% | 74% | 64% |
| Severe mental illness | 4.1% | 24% | 15.3% | 10.2% |

James and Glaze, 2006; SAMHSA (2016). Mental and Substance Use Disorders (revised March 2016). http://www.samhsa.gov/disorders

# MENTAL HEALTH DISPARITIES

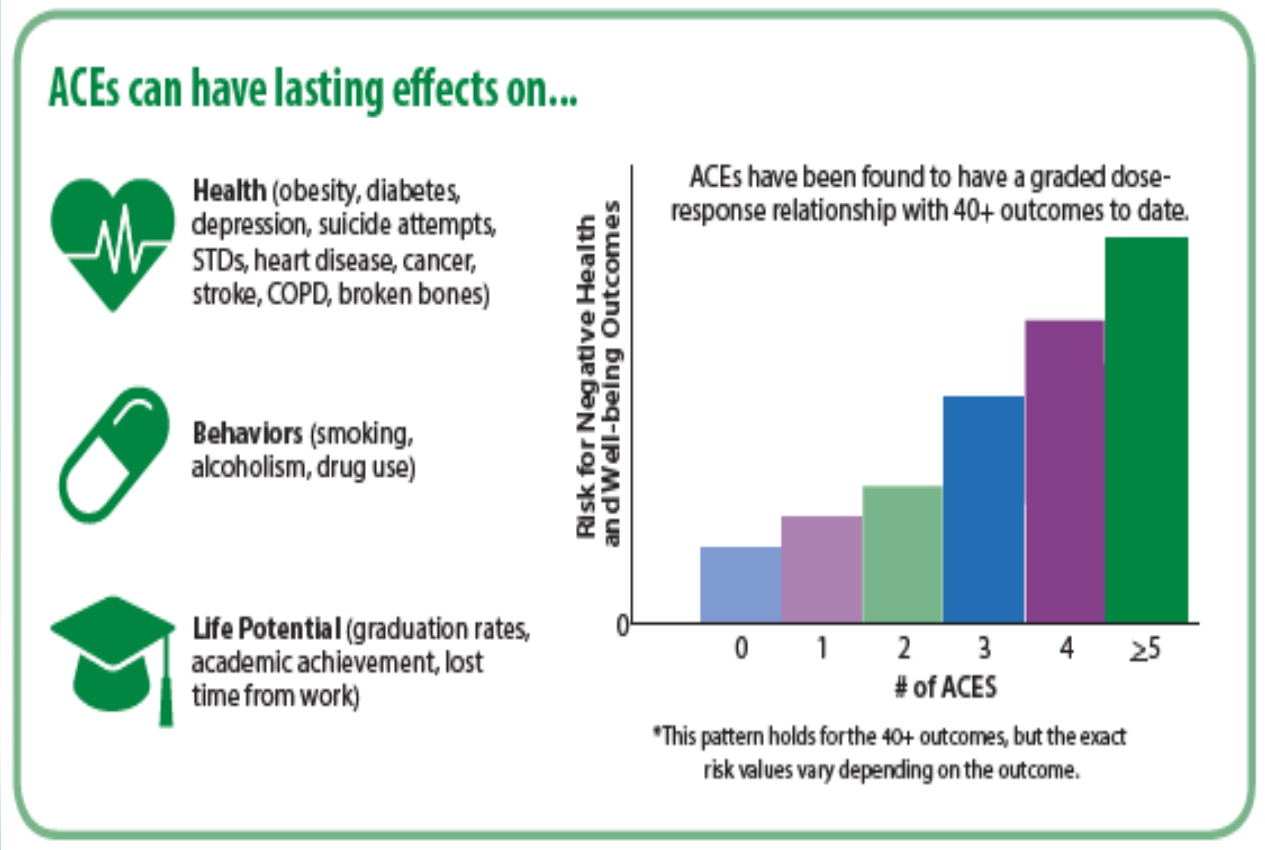
- Stigma associated with mental illness
- Lack of providers from diverse backgrounds
- Health Insurance
- 1 in 3 African Americans who need mental healthcare receives it
- Misdiagnosis
  -More frequently diagnosed with psychotic disorders
- More likely to utilize inpatient services
- Black people with psychotic conditions more likely to be incarcerated than people of other races
- Distrust of the healthcare system
  -Legacies of mistreatment still relevant

# FACTORS THAT CAN SHAPE THE MENTAL HEALTH OF YOUNG PEOPLE

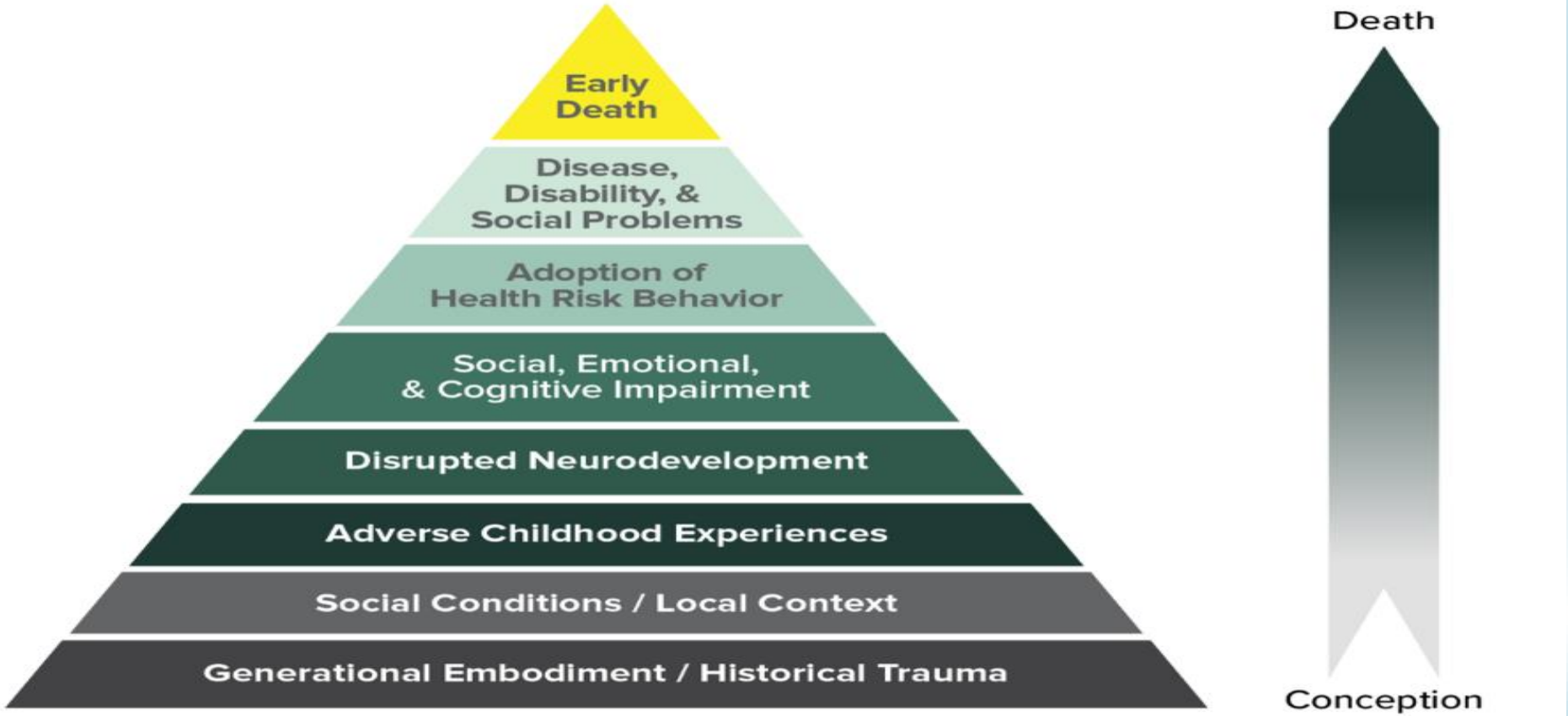


# ADVERSE CHILDHOOD EXPERIENCES

- 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.



# MECHANISM BY WHICH CHILDHOOD EXPERIENCES INFLUENCE HEALTH AND WELL-BEING THROUGHOUT THE LIFESPAN




Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

# ACES IN FAMILIES

- Parents with Multiple ACEs Higher Likelihood in Kids
  - -3 or more likely to have in their kids
- Maternal ACEs Weighed More Heavily
- Can be helped through corrective action and early intervention
- Immigrant Families have less ACEs
  - -Less Financial Resources

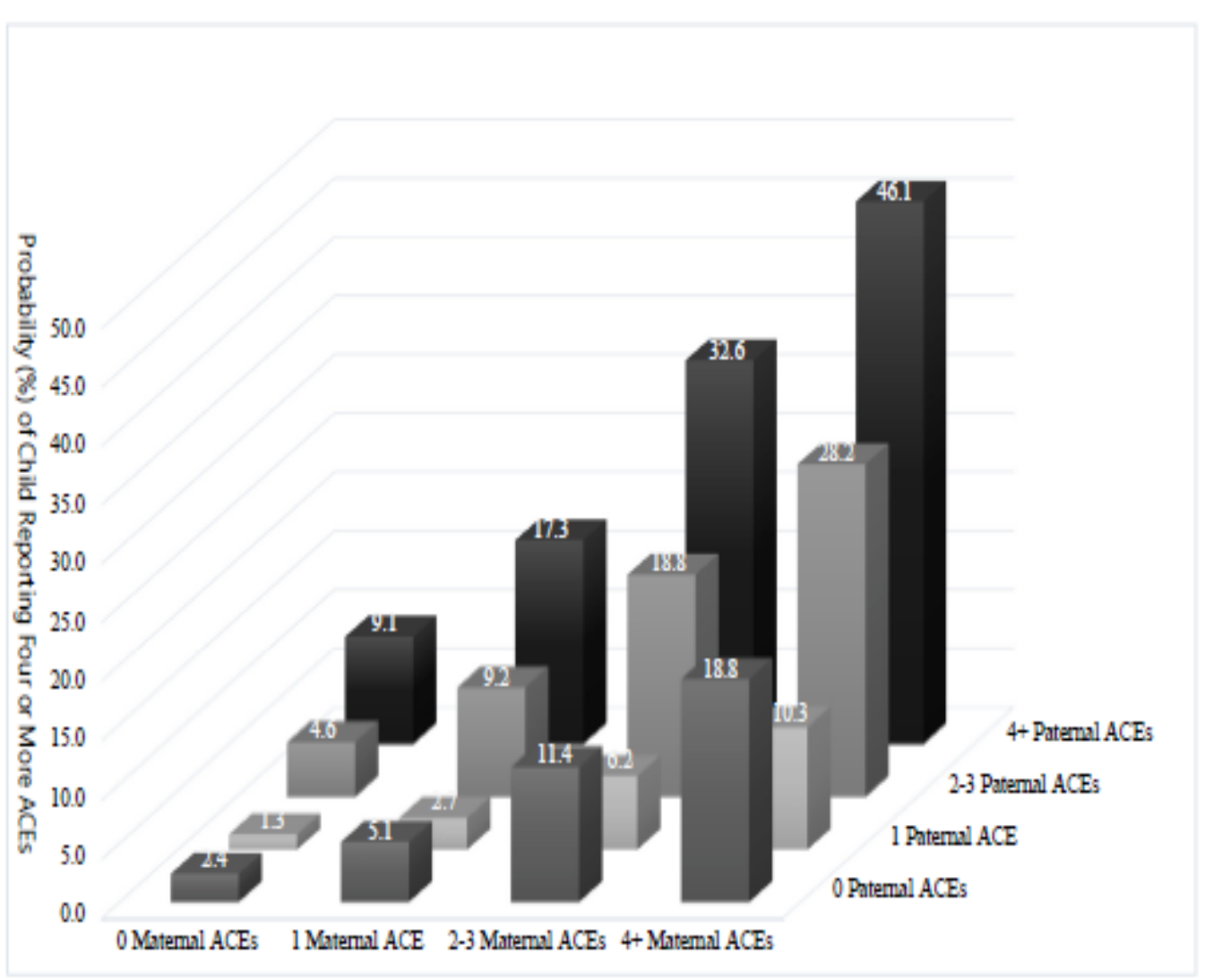



**Figure 1.** Risk of Four or More Child ACEs by Paternal and Maternal ACE Complement.

# STRATEGIES FOR PREVENTING ADVERSE CHILDHOOD EXPERIENCES

## Preventing ACEs

| Strategy | Approach |
|---|---|
| **Strengthen economic supports to families** | • Strengthening household financial security<br>• Family-friendly work policies |
| **Promote social norms that protect against violence and adversity** | • Public education campaigns<br>• Legislative approaches to reduce corporal punishment<br>• Bystander approaches<br>• Men and boys as allies in prevention |
| **Ensure a strong start for children** | • Early childhood home visitation<br>• High-quality child care<br>• Preschool enrichment with family engagement |
| **Teach skills** | • Social-emotional learning<br>• Safe dating and healthy relationship skill programs<br>• Parenting skills and family relationship approaches |
| **Connect youth to caring adults and activities** | • Mentoring programs<br>• After-school programs |
| **Intervene to lessen immediate and long-term harms** | • Enhanced primary care<br>• Victim-centered services<br>• Treatment to lessen the harms of ACEs<br>• Treatment to prevent problem behavior and future involvement in violence<br>• Family-centered treatment for substance use disorders |

# CULTURAL COMPETENCE

## "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."**

# CULTURAL FEATURES: RELATIONSHIP BETWEEN INDIVIDUAL AND CLINICIAN

## 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 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**."

# INCREASE UNDERSTANDING OF CULTURAL IDENTITY

## 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

To be avoided, however, is the false sense of security in one's training evidenced by the following actual case from 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-proclaims cultural expertise.

# CULTURAL HUMILITY

- Lifelong Process
- Self Reflection and Self Critique
- Checks Power Imbalances
- Minimizes Stereotyping
- Institution Must Be Consistent

# ON RACISM: A NEW STANDARD FOR PUBLISHING ON RACIAL HEALTH INEQUITIES

"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:

-Institutionalized

-Personally-mediated (i.e., interpersonal)

-Internalized

Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8): 1212-1215.

# INSTITUTIONALIZED RACISM

Differential access to the goods, services, and opportunities of society, by "race"

Examples

–*Reduced access to housing for African Americans due to racial covenants and redlining policies*

–*Over-representation of African Americans in the penal system due to inequities within various parts of the criminal justice system*

Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8): 1212-1215.

# PERSONALLY MEDIATED (I.E., INTERPERSONAL, RACISM)

Differential assumptions about the abilities, motives, and intentions of others, by "race"

Examples

-*Lack of respect [African American woman who volunteers to medically assist a fellow air passenger is asked, "Are you really a doctor?"]*

–*Suspicion [African American man entering a luxury apartment building is asked, "Do you live here?"]*

–*Devaluation [Degrading political speech about African Americans and other racial minorities: "The inner cities are a disaster."]*

*Jones CP. Levels of racism: a theoretic framework and a gardener's tale. Am J Public Health. 2000;90(8): 1212-1215*

# INTERNALIZED RACISM

Acceptance by members of the stigmatized "race" of negative messages about their own abilities and intrinsic worth

Examples

–*Self-devaluation ["I do not belong."]*

–*Resignation ["I cannot succeed."]*

–*Hopelessness ["My future is already decided."]*

Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8): 1212-1215.

# STRUCTURAL RACISM

The totality of ways in which societies foster racism through mutually reinforcing institutions, which then energize the racism which occurs institutionally, interpersonally, and internally – making racism a self propelling system.

**Note: "Structural" and "institutional" racism are often used interchangeably – please note that institutional racism is an ELEMENT of structural racism in this definition.*

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*, *389*(10077), 1453–1463.

# 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.

From David Williams, PhD, MPH. (2016, April). *The House that Racism Built*. Keynote Speech presented at the Johns Hopkins Urban Health Institute's Fifth Annual Symposium on the Social Determinants of Health, Baltimore

# INTERVENTIONS: THE FRAMEWORK FOR AN ANTI-RACISM ACTION PLAN

- Interpersonal
  -Implicit bias education
  -Cultural competency

- Institutional
  -Policy

- Internal
  -Treatment encounter

- Transitioning toward Anti Racism

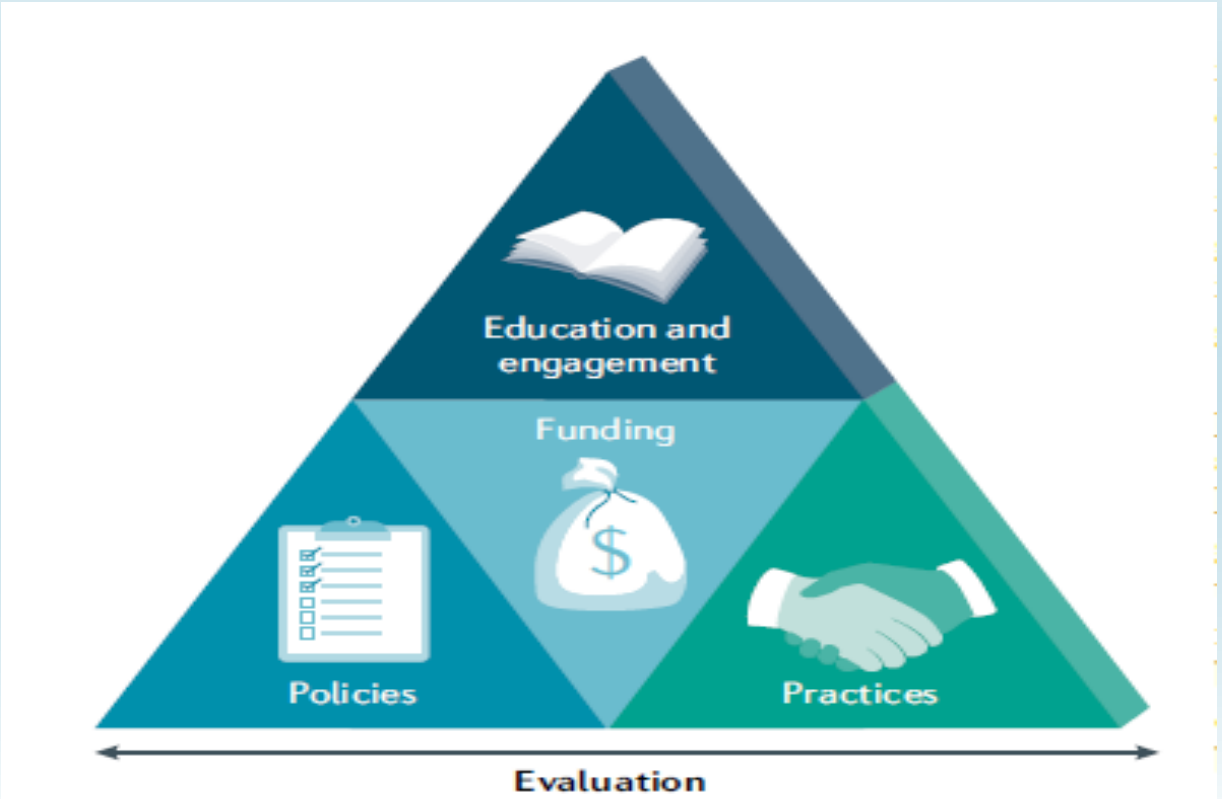



Fig. 1 | **The framework for an anti-racism action plan.** Academic medical centres committed to being anti-racist must critically examine and reform the education and engagement of their students, trainees, faculty, staff and community as well as institutional policies and practices. Funding and evaluation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

# 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

# EDUCATION AND ENGAGEMENT

COMMENT

Check for updates

## How academia should respond to racism

*Darrell M. Gray II[1,2], Joshua J. Joseph[3], Autumn R. Glover[4] and J. Nwando Olayiwola[5]*

Structural racism in academia and academic medicine is destructive to science and society. To deny its existence is to fertilize the soil in which it thrives. Uprooting it demands, at the very least, a fundamental transformation in institutional education, policies, practices and resource allocation with sustained anti-racist actions.

Structural racism is a social determinant of health. It extends well beyond the scope of institutional and learners to be effective allies to those who are subject to racism, to disrupt the downstream effects of racism.

Type here to search

Check for updates

comment

## The not-so-silent killer missing in medical-training curricula: racism

Racism is a social determinant of health and negatively affects health outcomes. This Comment describes steps to take toward achieving equity and racial justice in medical training and addressing racism in clinical settings.

Frinny Polanco Walters, Adjoa Anyane-Yeboa and Alden M. Landry

George Floyd. Breonna Taylor. Ahmaud Arbery. Atatiana Jefferson. Stephon Clark. Botham Jean. Aiyana Jones. Keith Scott. Eric Garner. Freddie Gray. These are just a few names of Black people who have been brutally murdered because of racism in the USA. The loss of these precious lives has proven that Black people cannot go



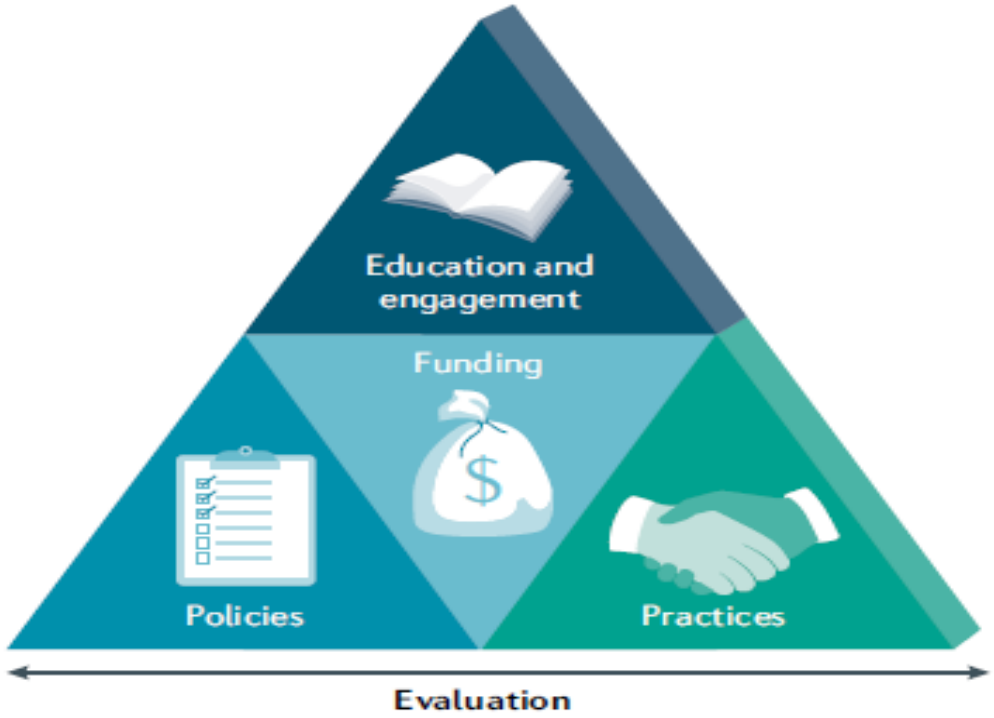




Fig. 1 | **The framework for an anti-racism action plan.** Academic medical centres committed to being anti-racist must critically examine and reform the education and engagement of their students, trainees, faculty, staff and community as well as institutional policies and practices. Funding and evaluation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

# CLOSING THE GAP IN RACIAL HEALTH OUTCOMES

"Closing the gap in racial health outcomes in the United States will only be accomplished by identifying, confronting, and abolishing racism as an American tradition and root of inequity."

# VIGNETTE FOR AN ADOLESCENT

16-year-old Nicholas has just woken up to prepare for the day. He lives with his mother, grandmother, younger brother, and younger sister in a one-bedroom apartment. Every morning, he helps his younger siblings wake up and get ready, walks them to school, administers his grandmother's morning medications, and catches public transportation to his school across town. His family had to move during the school year and has not yet registered him in the new district. His family is currently on public assistance, and his mother works two jobs, not getting home until 7 A.M. He drops off his siblings at school and heads toward the nearest bus stop. Some guys who attend his school approach, and he hurriedly ducks behind some bushes to avoid being seen. Nicholas gets verbally bullied because his clothes are old and he has no name-brand shoes. Nicholas hopes to be able to afford to buy some new clothes soon with his new job. Currently, he is wearing a shirt that he wore earlier in the week.

# VIGNETTE CONT'D

The guys keep walking by, narrowly avoiding Nicholas. The bus approaches moments later, and Nicholas gets on. He realizes that he does not have any more money on his bus card and will need to figure out a plan to catch the bus home, or he will end up walking 5 miles, which he hates. Exhausted, Nicholas dozes off on the bus and ends up missing his stop. He wakes up an hour later and is frantic when he sees on the bus's clock that it is 9 A.M. School began 90 minutes ago, and his school has a "zero tolerance" policy for consecutive tardiness. Nicholas has been late several times over the past month, and after the last instance, Principal Shelby told him that he would be suspended if he were late again. Unfortunately, Principal Shelby is in the hallway when he arrives and tells him to go to the office to call his mother to pick him up because he is suspended for tardiness.

# POLL - REFLECTION QUESTIONS

**What are some of the key social determinants in Nicholas's case? (vote for one determinant)**

- Poverty, lack of a stable income and insufficient housing
- Lack of funds for appropriate transportation
- Increase responsibility for younger siblings and grandmother

# POLL - REFLECTION QUESTIONS

Do you agree with the Principal's decision to suspend Nicolas?

- Yes
- No

# POLL - REFLECTION QUESTIONS

**What are some ways to help Nicholas' situation?**

- Referred to school social worker to investigate why Nicolas is so often late to class
- Explore the possibility of obtaining a bus card for Nicolas since his family is currently on public assistance.
- Referred to counselor who may be able to assist him in terms of the current bullying.

# HISTORY OF EMERGENCY MEDICINE

- Wasn't defined academic specialty until 1960s
- Previously whichever physician was available
- Staffing patterns used resident, intern, other hospital staff physicians, or rotating on-call duty of all specialties including those such as psychiatry and even pathology.
- There was neither coordination of hospital care nor organized pre-hospital care.
- At least half of all ambulance services run by morticians or funeral directors because they had vehicles that could transport people horizontally, often using untrained staff

# BECOMING A SPECIALTY

- 1961 four physicians started to staff emergency departments (ED)

  -Independently realized the need for a specialist in emergencies who would be available to patients at all times or day or night.

- Other developments influenced the establishment of emergency medicine in the U.S. were the introduction of

  -CPR as a resuscitation measure, the

  -Federal government began paying for in-hospital services through Medicare and Medicaid

  -Overall increased public demand and better quality of all types of healthcare services.

- Definition focuses on the ability to take care of all types of acute illness and injury in patients of all age groups in all settings, both pre-hospital and in-hospital.

  -Variation does exist between countries including physicians practicing extensively in the pre-hospital setting, or in the critical care unit of the hospital.

# PATIENT DUMPING

- 1980s Cook County Hospital
- "the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere"
  - -Majority were minorities and unemployed
  - -Lack of Insurance (87%)
  - -Minimal Informed Consent (6%)
- Poor Outcomes
  - -Twice as likely to die
  - -1/4 Transferred in Unstable Condition
- Guidelines existed but not enforced

# EMERGENCY MEDICAL TREATMENT & LABOR ACT (EMTALA)

- Passed by the US Congress in 1986 as part of the Consolidated Omnibus Reconciliation Act (COBRA)
- *In the case of a hospital that has a hospital emergency department, if any individual… comes to the emergency department and a request is made… for examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department to determine if an emergency medical condition exists*

# DUTIES OF HOSPITALS

- According to the statute, only facilities that participate in Medicare are included (almost 98% of all US hospitals)
- First, hospitals must perform a medical screening examination (MSE) on any person who comes to the hospital and requests care to determine whether an emergency medical condition (EMC) exists.
- Second, if an EMC exists, hospital staff must either **stabilize** that condition to the extent of their ability or transfer the patient to another hospital with the appropriate capabilities.
- Third, hospitals with specialized capabilities or facilities (e.g., burn units) are required to accept transfers of patients in need of such specialized services if they have the capacity to treat them.

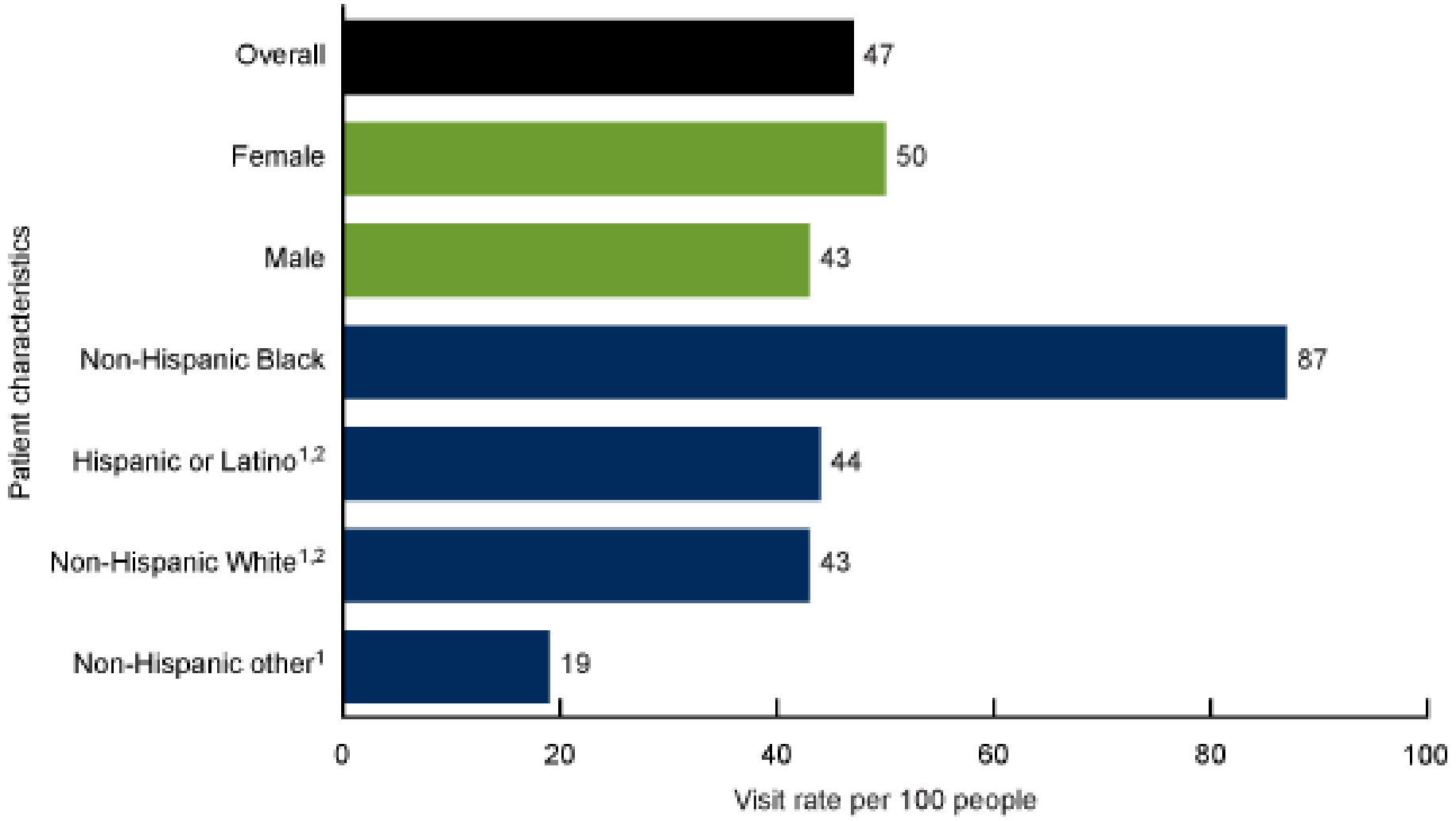
# PRINCIPLES FOR FUTURE SYSTEM

- Improved overall medical system development
- Rapid urbanization causing transition from infections to trauma and ardio-respiratory disease
- Increasing demand for outpatient medical visits
- Demonstrated success of EM in other high profile countries increasing expectations
- International travel
- Terrorist and other mass casualty events
- Public expectations/meeting the need of the people

# REASONS TO SEEK EMERGENCY CARE

- Access to services
- Insurance Status
- Challenge of determining the urgency of symptoms such as chest or abdomen pain without further diagnostics
  - -Primary Care Referrals
  - -Hours of operation

# RATES OF EMERGENCY DEPARTMENT VISITS BY RACE



# INCREASED SERVICE UTILIZATION

- Superusers" (individuals with frequent, recurrent visits to the ED)
  - -Complex and ongoing health needs, (i.e. chronic conditions or mental health/SUD conditions)
  - -Attempts to connect to preventive and ongoing care to prevent them from needing to utilize the ED.
- Social determinants of health may play a role in where people seek care (particularly for mental health/SUD treatment)
- Homelessness
  - -Overrepresented in mental health conditions and substance use disorders

# VISITS TO THE ED: MENTAL HEALTH/SUD PRIMARY

- Alcohol-related (~25%)
- Anxiety/fear-related disorders
- Depressive disorders
- Suicidal ideation
- Schizophrenia

# VISITS TO THE ED: MENTAL HEALTH/SUD SECONDARY

- Mix of common diagnoses from other categories
- Nonspecific chest pain
- Septicemia
- Abdominal/digestive issues
- Urinary tract infections
- Skin and subcutaneous tissue infections.

# TYPES OF CRISIS PROGRAMS (*NON HOSPITAL*)

- Hotlines
  - -National Suicide Hotline
  - -988
- ACCESS Programs
  - -System Navigation
  - -Crisis Services
- Mobile Crisis Teams
  - -Onsite Assessments
  - -Can be partnered with police
  - -Can vary by insurance
- Mental Health Urgent Care
  - -Drop in Facility
  - -Can still need transfer to ED setting

# TYPES OF CRISIS PROGRAMS (HOSPITAL BASED)

- Psychiatric Emergency Programs
  - -Voluntary and Involuntary
  - -Most have to be discharged by a clinician
  - -May have a regional focus
- Psychiatric Hospitals
  - -Can have intake hours for admission
  - -Limited in dealing with medical emergencies
- Hospital Medical Emergency Departments

# CHALLENGES OF CLINICAL PRACTICE IN EMERGENCY PSYCHIATRY

**TABLE 1. Challenges of clinical practice in emergency psychiatry**

| |
|---|
| Undifferentiated patient presentations |
| • Substance-induced, delirium, and primary psychiatric illnesses are all common |
| High morbidity and mortality |
| • 21% of patients in the ED with suicidal ideation will self-harm within a year[21]<br>• Missed diagnosis of delirium is associated with 31% mortality at 6 months[6] |
| Diversity of patient presentations—medication refills to severe psychosis |
| Fast pace and high volume |
| Significant collaboration with community providers and external partners |
| Significant collaboration with non-psychiatric providers |
| Diversity of practice environments |

- Only 16.9% of Emergency Departments have psychiatrists available
- 11% do not have any mental health professionals on call

# LIMITS OF THE SYSTEM

- Longer stays for psychiatric patients
- Increased hospitalizations for suicidal ideation
- Disposition for patients is a challenge
  - -Limited inpatient beds
  - -Divestment from mental health services
  - -Difficulty coordinating community resources

# POLL - REFLECTION QUESTION

**How often do you have clients go to the emergency department?**

- 1-5 Times per year
- Monthly
- Multiple times per month

# POLL - REFLECTION QUESTION

**How do your clients end up in the emergency department?**

- They decide to go themselves
- We make the decision together
- Family members/friends are responsible for their presentation
- Staff sends them

# POLL - REFLECTION QUESTION

**What are the predominate reasons for seeking emergency services?**

- Danger to self or others
- Requiring Hospitalization
- Not taking medications
- Needing treatment adjustments

# ED MENTAL HEALTH PROCESS

- Source of referral
  - -Voluntary vs Involuntary
  - -Outside agencies
- Triage
  - -Columbia Suicide Severity Rating Scale (CSSRS)
  - -Differences in Acuity
- Medical Screening
  - -Variable Standards
- Mental Health Interview
  - -Mental Health professional
- Disposition
  - -Outpatient
  - -Hospitalization
    - Voluntary vs Involuntary

# INCREASED WAIT TIMES

- Crowding can lead to longer wait times, and higher mortality for patients
- Not just a function of volume, but also speed of assessment and disposition
- Behavioral health emergencies can be slower and more difficult to process because of a shortage of behavioral health beds
- Limited continuity of care or preventive care could affect the overall quality of care they receive.

# PSYCHIATRIC BOARDING

The adverse effects of “psychiatric boarding,” that is the holding of a behavioral health patient in the ED, while an inpatient bed or other appropriate placement is sought, on patient health and hospital finances and staff resources have long been acknowledged, yet the problem persists, fueled by the past decrease in in-patient psychiatric beds, the increase in opioid use disorder cases and inadequate community-based alternatives.

# POLL - REFLECTION QUESTION

Have your clients had positive experiences with interventions for psychiatric emergencies? (Please provide additional comments in the chat)

- YES
- NO

# POLL - REFLECTION QUESTION

**Have emergency visits impacted the treatment relationship?**

- It remains unchanged
- The client drops out of treatment
- The client no longer trusts us
- The client feels more comfortable in treatment

https://www.youtube.com/watch?v=yQYLiFllErc

# INVOLUNTARY HOSPITALIZATION IMPACT (YOUTH AND YOUNG ADULTS)

- 40 in depth interviews (ages 16 – 27)
- 75% reported negative impact on trust
  -Selective non-disclosure of suicidal feelings
- Factors contributing to distrust
  -Perceiving hospitalization as punitive
  -Not meeting therapeutic needs
  -Perceiving staff to be judgmental
- Indirect Benefits
  -Greater access to care
  -Greater family support
  -Less judgment from family members

# INVOLUNTARY HOSPITALIZATION IMPACT(WORKING ALLIANCE WITH OUTPATIENT PROVIDERS)

- 60 Surveys
- Majority from outpatient environments
- 15% of respondents had decreased trust
  -Decreased likelihood of reporting symptoms
- Women and blacks more likely to experience loss of trust
- Increased trust if outpatient provider is involved

# INVOLUNTARY COMMITMENT LAWS

O'Connor v. Donaldson, 422 U.S. 563 (1975). Mentally ill plaintiff was confined without treatment for 15 years. Held: states cannot constitutionally confine, "without more," a person who is not a danger to others or to himself. The latter category includes the suicidal and the "gravely disabled," who are unable to "avoid the hazards of freedom" either alone or with the aid of willing family or friends. 422 U.S. at 575 and n.9. As the plaintiff received no treatment, the Court expressly reserved the question "whether the provision of treatment, standing alone, can ever constitutionally justify involuntary confinement or, if it can, how much and what kind of treatment would suffice. . . . " Id. at n.10. The Court has never revisited this issue.

# INITIATING HOLDS

- Police can detain people in each state
- Police can initiate the hold in 38 states
- Mental health practitioners can initiate holds in 31 states
- Medical personnel can initiate holds in 22 states
- "Any interested person" can initiate holds in 22 states
  -Can require a hearing/acceptance by a legal authority

# STATE VARIATIONS FOR EMERGENCY HOLDS

FIGURE 1. State variation in requiring judicial approval before emergency holds

Judicial approval required (N=22)
AR, CO, DC, FL, IA, ID, IN, KS, KY, MD, ME, MS, ND, NH, NV, NY, SC, TN, TX, VA, VT, WY

Predetention ex parte hearing (N=9)
AR, CO, FL, KY, MD, MS, NY, VA, VT

Postdetention adversarial hearing (N=13)
DC, IA, ID, IN, KS, ME, ND, NH, NV, SC, TN, TX, WY

https://lawatlas.org/datasets/involuntary-outpatient-commitment-1442865639

# APPLYING INVOLUNTARY CRITERIA

- Imminent risk is the prevailing standard
- Law's application can depend on clinical setting
- Standards for "grave disability"
- Substance use does not usually qualify on its own
- Needing treatment does not automatically necessitate involuntary hold
  - "Is what's going on serious enough for me to take away someone's civil rights?"

# CLINICAL VIGNETTE FOR AN ADULT

65 year old male lawyer with a history of bipolar disorder is working on a high profile class action suit in Wisconsin. He has been logging long hours and having difficulty with the time change. He has been having more energy and his thoughts are not easy to follow. During an important deposition, he starts taking off his clothes and articulating obsessive thoughts about one of the main plaintiffs. He is taken to a local hospital, but representatives from the law firm get him released on the condition that he enters treatment and follows strict guidelines and check ins established by the firm.

# CLINICAL VIGNETTE CONTINUED

He is back in New York two weeks later, but is no longer answering his phone. He has not attended his follow up appointments, has checked out of the hotel he was staying in and the firm has learned that he has been contacting the plaintiff that he was previously focused on. They have learned that he is becoming more paranoid, and his thoughts are making less sense.

# POLL - REFLECTION QUESTION

**What do you do next?**

- Continue to monitor the situation
- Try and find a way to talk to him
- Pursue involuntary hold

# POLL - REFLECTION QUESTION

**Do you think he meets criteria for an involuntary hold?**

- Yes
- No

https://www.youtube.com/watch?v=_RcnRSmNh3g

# INVOLUNTARY HOLDS

"Optimal use of involuntary hold laws involves the balance of competing concerns: the welfare of adults with incapacitating mental health conditions, the civil rights of such adults, the public's concern with safety, the high direct cost of acute inpatient psychiatric services, and the (perhaps even higher) indirect, deferred cost of not providing such services in a timely way to the people who need them."

# PREDICTORS OF PSYCHIATRIC BOARDING

- Differences in Insurance Status
  - -Unfunded
  - -Medicare/Medicaid
  - -Private Insurance
- Public vs Private Institutions
- Medicare/Medicaid and return to ED

# RESTRAINT USE IN EMERGENCY DEPARTMENT

- Male Sex
- African American Race
- Hispanic Ethnicity
- Medicaid
- Bipolar/or Psychotic Disorder

# RESTRAINT USE CONT'D

- Less likely if PCP involved in network
- No associations between:

  -Language

  -Alcohol or substance abuse

  -Homelessness

# INVOLUNTARY HOSPITALIZATIONS

- Previous Involuntary Hospitalization
- Psychotic Disorder
  -Bipolar disorder to a lesser degree
- Male
- Single
- Unemployed
- Receiving Welfare Benefits

# CLINICAL VIGNETTE AFRICAN AMERICAN MALE ADULT

Emergency Tele psychiatry consult for a 34yo African American Man brought in police custody expressing SI. Patient was arrested for shooting at a check cashing establishment. He did not harm anyone during the exchange. Per arrest report patient quoted as saying "I'm about to air this b***h out." Once in police custody he started saying he was suicidal. He has been in good behavioral control in the ED. He does not remember details about diagnoses but references being labeled bipolar at some point. He reports a prior history of limited prescriptions for Seroquel, but has not been regularly in care. He currently denies manic or psychotic symptoms. He reports difficulty with irritability and frustration. He has a history of witnessing violence during his childhood and reports multiple financial stressors, and states he had difficulty with staff at check cashing establishment leading to frustration. His urine drug screen is normal.

# POLL - REFLECTION QUESTION

**What factors increase his risk for involuntary hospitalization?**

- Male Sex
- Being African American
- Clients' previous diagnosis of bipolar
- Arriving With Police

# POLL - REFLECTION QUESTIONS

**What are some potential negative outcomes from his emergency department presentation?**

- Client has previous history with the justice system may be returned to jail
- Increase possibility of medication that may be inappropriate.
- Failure to review the clients previous trauma history

# CLINICAL VIGNETTE (CONT'D)

He currently denies SI, HI, AH, VH. He states he said he was suicidal because he was worried he would die in police custody. He is certain he will harm someone if he goes to lock up tonight. He has been calm and cooperative throughout the interview. Examine his automatic assumption that he will harm someone this evening. Start to discuss stress management and emotion regulation techniques. Patient interrupts "Oh, I can tell you've never been to jail before!" While exploring some of the patient's prior experiences in the jail environment, he is able to explain why he has his current his thought process.

# POLL - REFLECTION QUESTION

**What would be the potential diagnosis?**

- Bipolar
- PTSD
- Schizophrenia
- Delusional Disorder

# POLL - REFLECTION QUESTIONS

**What would be your disposition?**

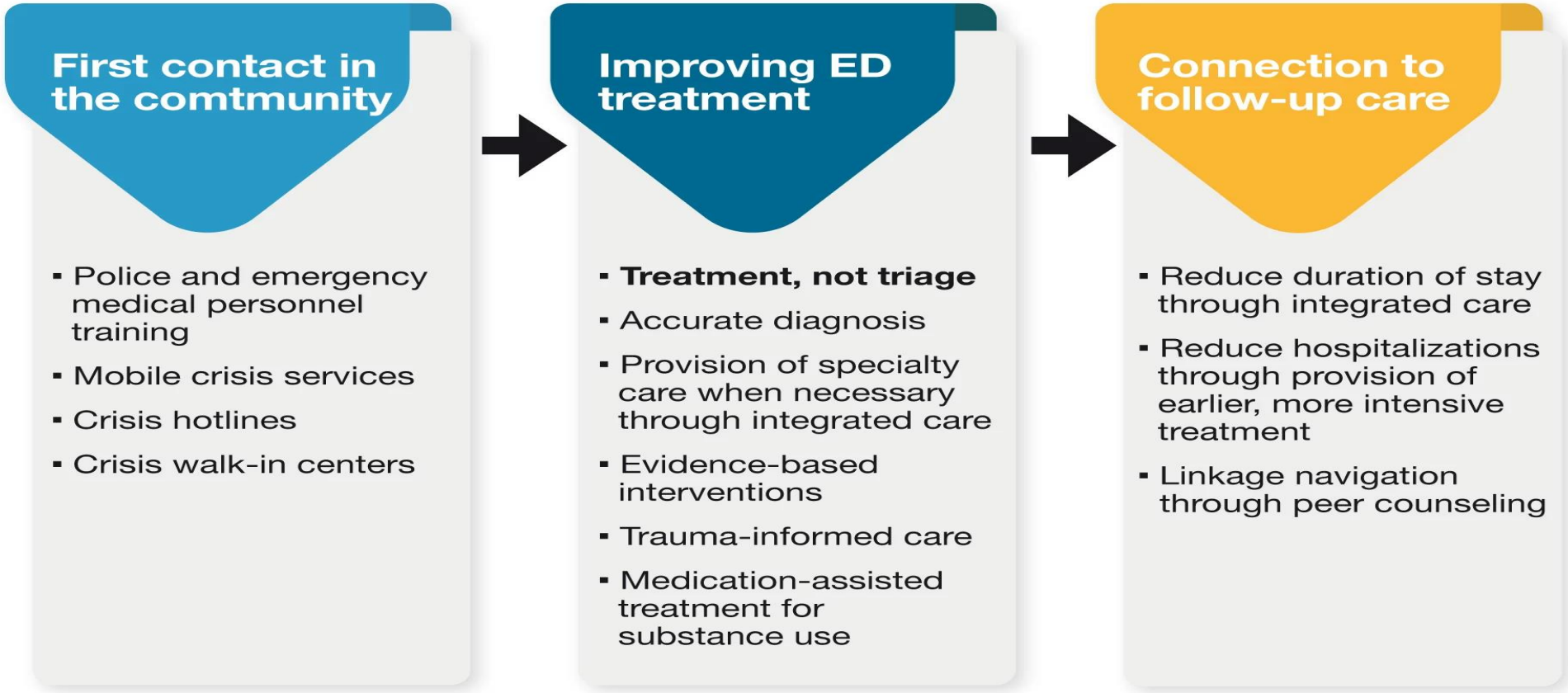
- Admit him to the hospital
- Discharge him to the jail
- Start medications in the emergency room

# CASE RESOLUTION

- Determined patient does not represent an imminent risk to himself or others and does not require inpatient hospitalization
- Recommend patient have a solitary cell until he can complete booking process in the morning

# INNOVATION TO IMPROVE EACH STEP OF EMERGENCY PSYCHIATRIC CARE

**FIGURE. Innovations to improve each step of emergency psychiatry care**



# NEW WAYS OF DELIVERING EMERGENCY PSYCHIATRIC CARE

**TABLE 2. New ways of delivering emergency psychiatric care**

| |
|---|
| Pre-hospital care initiatives to improve care by police and ambulance crews |
| Telepsychiatry |
| Integrated care in the ED |
| Regional collaborations to support psychiatric emergency services |
| Enhanced psychiatric training among non-mental health providers |

# PRE HOSPITAL CARE

- Management of behavioral emergencies begins in the community-well before ED arrival
- Partnerships with police departments and other first responders
- Provide training in the recognition and initial management of psychiatric emergencies
- Increasing awareness of the prevalence of psychiatric illness in the community and teaching verbal de-escalation to help patients in crisis.
- Crisis Intervention Training (CIT) is a national model for police departments to use for working with mentally ill patients in the community
- Ambulance crews can use medications for treating agitation quickly and safely prior to arrival in the ED
- Education among pre-hospital providers also encourages use of diversion facilities (eg, crisis centers) over EDs or jails.

# TELE PSYCHIATRY

- Can help address rural and low volume EDs
- Large health systems and academic medical centers may utilize tele psychiatry to extend specialty consultation expertise to other clinical sites
  - -EDs
  - -Urgent care centers
  - -Partnership hospitals.
- More limited for providing verbal de-escalation or management of disruptive behaviors and acute agitation

# EMPATH UNITS – (EMERGENCY PSYCHIATRIC ASSESSMENT, TREATMENT, AND HEALING)

- Operates in concert with the ED and under the same hospital license
- Patients referred after a medical screening exam in the general ED
- More therapeutic setting
  - -Individuals are treated concurrently in a large common milieu room
  - -Staff always interspersed for constant and safe observation and reevaluation
- Overall focus on avoiding coercion and causes of frustration
- Results in lower incidence of physical restraints, aggression, and assaults

# TRAUMA INFORMED CARE

- Treatment approach that recognizes harmful consequences of trauma on the well-being of individuals
- Improves patient satisfaction and encourages collaborative, healing partnerships among patients and providers.
- Includes the use of patient-centered de-escalation techniques
- Availability of non-pharmacologic tools
- Dedicated training to familiarize staff with TIC principles

# PEER SUPPORT

- Health care workers who use their lived experience with illness to facilitate treatment
- Increasingly utilized in emergency service for engagement
- Ambivalent about mental health treatment
- Uncertain as to positive behavioral change
- In need of linkage to care
- Some programs include follow up with patients after ED discharge

# PROVIDER LEVEL INTERVENTIONS

- Be familiar with legal statues and community resources

- Minimize consequences through being involved in the process
  -Make decision with patient
  -Process after discharge

- Communicate with emergency departments
  -Contact information for emergency departments
  -Help with coordinating care after discharge from ED

# SUMMARY

- The current mental health system is still shaped by deinstitutionalization
  - -Divestment in mental health services
  - -Limited social safety net
  - -ED is logical site of care
- Limitations of emergency room settings for mental health emergencies
  - -Reflection of limitations of larger health system
  - -Focus on stabilization
  - -Limitations of overall mental health system
- Unintended Consequences from Emergency Department Visits
  - -Distrust
  - -Disparities in restraints
  - -Non clinical factors can impact presentation and adverse outcomes

# CONCLUSION

- It is our responsibility to be mindful of social determinants of health and their potential impacts in all clinical settings
  - -Mindfulness of personal bias
  - -Each case is unique
  - -Cultural Competence vs Cultural Humility
- Despite limitations emergency services still serve a purpose
  - -Be clear on reasons for presentation
- Alternatives to current emergency system
  - -Pre Hospital Interventions
- Systems improvements can require a multifaceted approach
  - -Advocacy at multiple levels
  - -Collaboration across disciplines

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