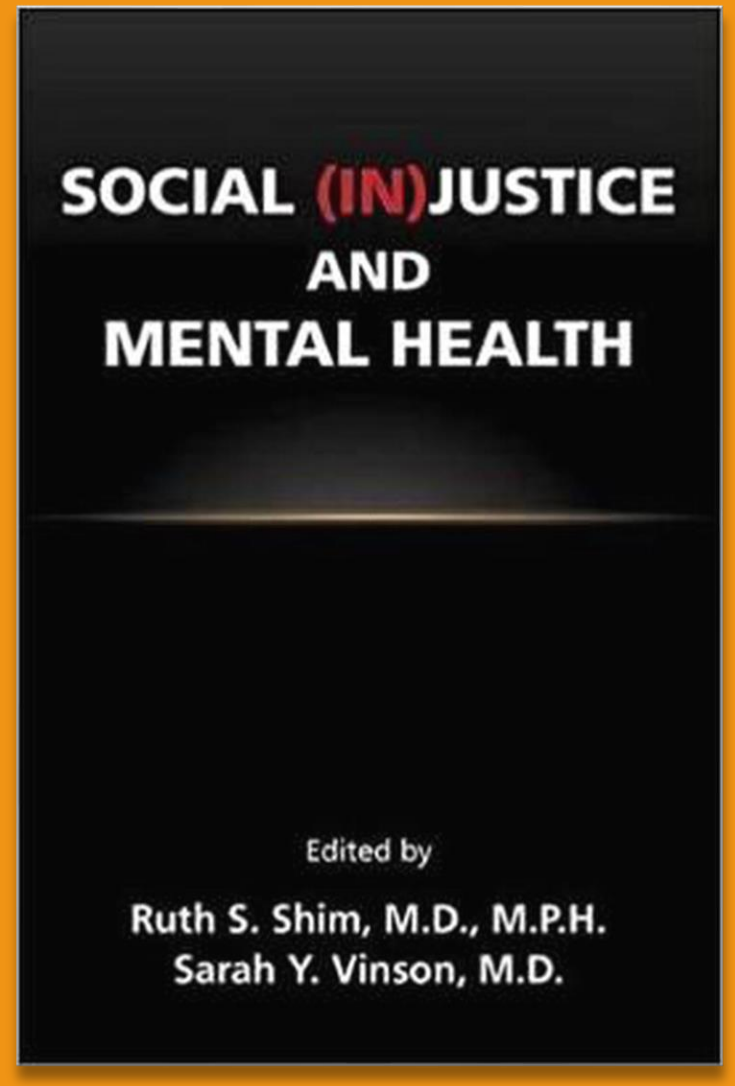
Social (In)Justice and Mental Health

Chapter 3: Social Injustice and Mental Health Inequities



Health Inequities

- Inequality = uneven distribution or outcome
- Inequity = avoidable and unjust inequality

- Health inequalities are differences in health or determinants of health between various population groups
- Health inequities are uneven distributions or outcomes that can be avoided and are unjust

Focus on the Hows of inequity rather than the What

- Health professionals must elevate the precision of discourse on mental health inequities
- There is no moral distance between the forms of inequity from our past and those that persist today

Essentialism

- Essentialism represents the misbelief that there are distinct, unchanging, and natural characteristics that define social groups and facilitate their categorization.
- Essentialist thinking has rooted itself in our paradigms of thought about identity, illness and health

Biological Determinism – the misbelief that certain ethnicities are biologically prone to certain diseases and medical outcomes

- Inequity patterns require us to remember that the What of inequity is usually less pertinent thant the How – that the vectors of inequity shapeshift throughout time and space and continue to inform our diagnostic tools, treatment systems, research frameworks, and even our initiatives to promote health equity

- When further exploring structural drivers of inequity, we should ask questions like:
  - Who has access to healthy food and why?
  - Who has a work schedule that permits time for exercise and why?
  - Who is poor and why?

Cultural Determinism and Culture Talk

The Cultural competency model in practice today serves as a toolkit of racial stereotypes that are presented as scientifically based, and medically relevant for doctors treating diverse populations

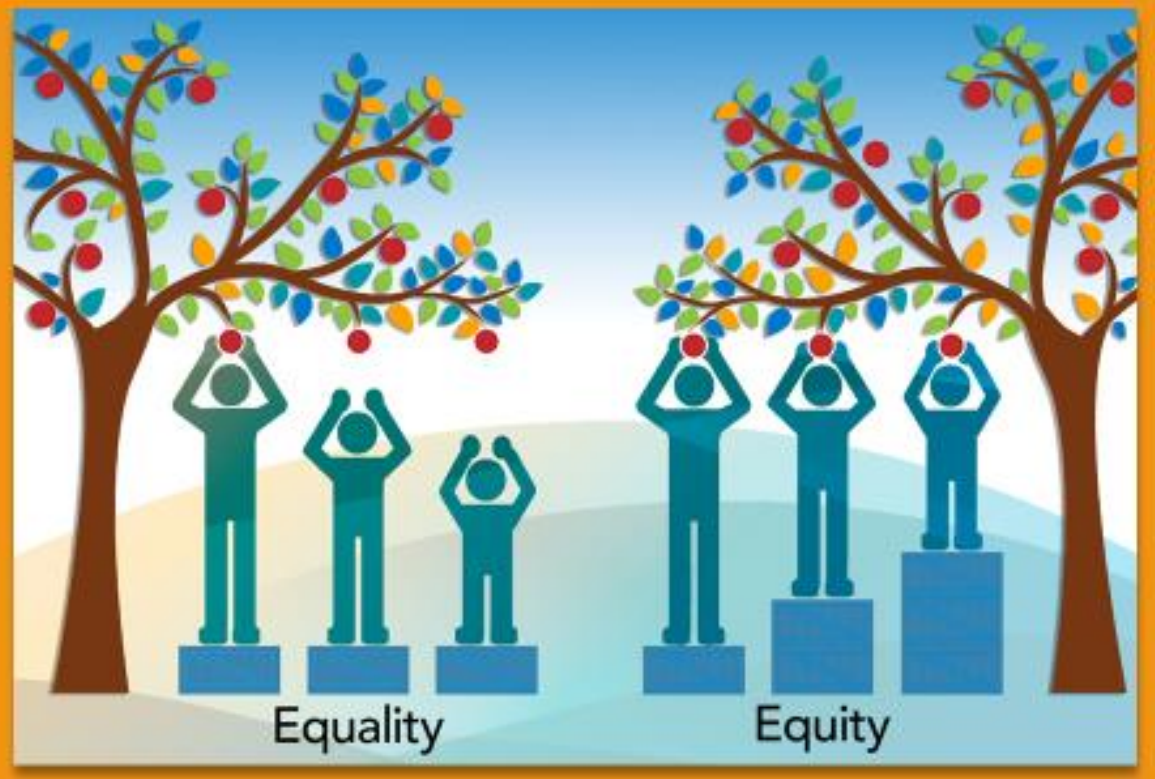
If we truly internalize the understanding that humans do not have any intrinsically differing or hierachized traits by group, then when we begin to see differences in outcomes, then we begin to comprehend that oppressive forces have treated these groups differentially and are really the cause of such differences.

We must relinquish our myopic view of risk factors and seek out what structural and historical factors have caused disparate outcomes in a given socially constructed group.

Privilege and the Positionality of Medicine Made Invisible

- There is often an invisible norm to which other groups are compared, or deemed diverse populations (white, male, insured, heterosexual, cisgender, English-speaking, able-bodied). It is presumed that only training and education on all other essentialized groups are needed.
- Inequity involves hoarding of resources/overserved as much as it involves the removal or deficit of such privilege from others.
- Deficit approach – diagnosing trust issues through the medical model.
  - Leads to providers misattributing behaviors as fixed cultural attitudes of individual groups rather than questioning the culture of medicine.
- Lack of humility and presumption of fairness, despite evidence to the contrary, allow the practices of our field to perpetuate injustice while remaining off limits for critical evaluation or transformation.

Equality vs. Equity



How we think about differences shapes the quality of our understanding and the accountability of our interventions.

We can't keep societal/structural norms invisible or immune from critique. Oppression continues when unchallenged.

Break Out Session

Discussion Questions:

1. What are the times in my professional education or continuing education when equity issues were presented as cultural ones?
2. How can I be more intentional in my acknowledgment of privilege and positionality in medicine?
3. How can I transition to focusing on the *how* and *why* of mental health inequitities rather than the *what*?

Wrap Up – Chapter 3

Questions & Comments?

Chapter Four will be discussed at the October 26th Advisory Committee Meeting:

Social Injustice and Structural Racism

Thank you!!