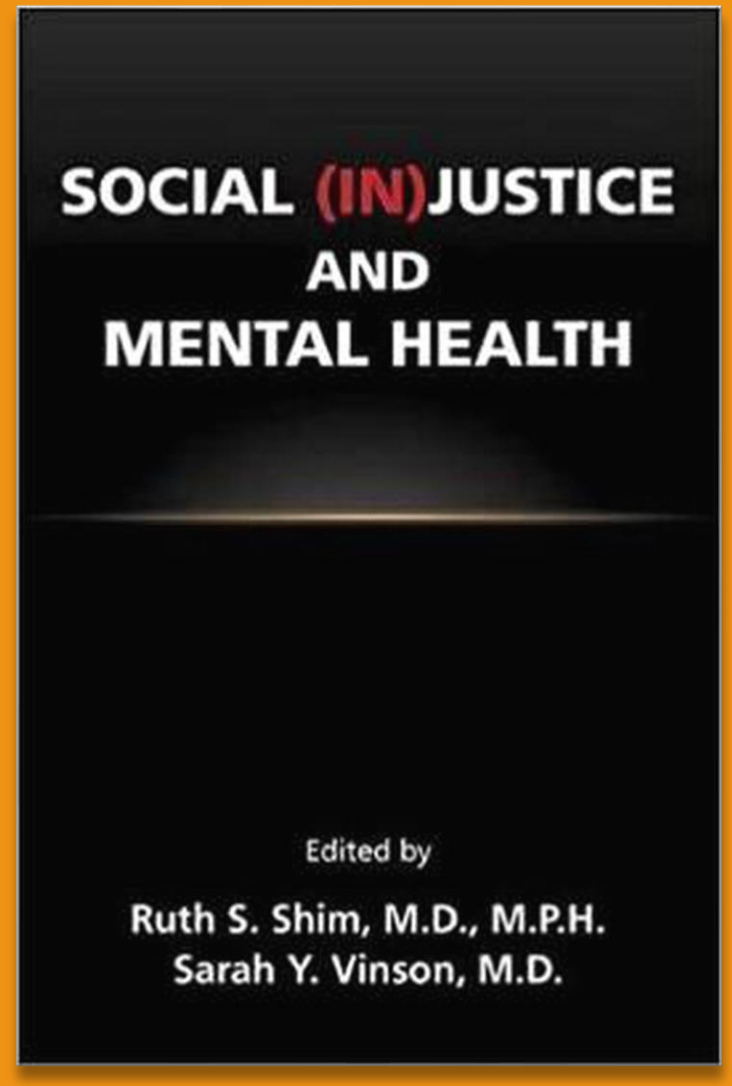
Social (In)Justice and Mental Health



Chapter 9: Healthcare System

Stacey Devenney, Administrator of Behavioral Health and Primary Care at Harborview

Chapter 13: Child Trauma

Ryan Robertson, Director of Behavioral Health and Workplace Violence at Washington State Hospital Association (WSHA)

Chapter 9: Healthcare System

Structural inequities in the healthcare system are re-created in three domains:

1. Hospitals
2. Physicians
3. Health Insurance

Additional layers relative to Mental Health

1. Geographic availability of services
2. Affordability

Chapter 9:

Hospitals

- Hospitals separate / segregated up until 1960's, when government required integration as a condition of Medicaid reimbursement
- Despite integration, hospitals remain unequal based on location and proximity to affluence / poverty, emergence of private hospitals
- Private hospitals / those in affluent communities deliberately market to affluent patients, touting new technologies and best practice care
- Hospitals in poor communities have less resources, are more dependent on government subsidies
- Death spiral for hospitals in low income/rural areas
  - States choose not to participate in ACA expansion
  - Lower cost reimbursements
  - Greater risk of hospital closure

Chapter 9:

Physicians

- Early 1900's: Medicine becomes more research based. Medical schools, tied to academic medical centers, become point of prestige among universities. Closure of most Black and women's medical colleges
- Entry to medical school becomes reliant on college-level coursework, historically available only to white men from affluent families
- Medical schools slow to integrate, waiting until 1968 and Civil Rights Movement to affirm goals to integrate. Enrollment among BIPOC rises until 1996, when 8 states rule schools may not take race into consideration for enrollment, and BIPOC enrollment declines
- Restriction of BIPOC Physicians results in reduced:
  - Physicians committed to serving BIPOC communities
  - Communication and BIPOC patient engagement
  - Understanding of lived experiences, illnesses, stressors among BIPOC communities
  - Mistrust / fear of medical services, willingness to access care and follow treatment recommendations

Chapter 9:

Health Insurance

- Emergence of academic hospitals → professionalization of medicine → 'best practice' healthcare → emergence of private health insurance … accessible to those who are already affluent
- Post-WWII: Employer health insurance grew, but mostly for white collar workers and skilled labor
- Efforts to establish universal healthcare repeatedly blocked in the 40's, 60's, 80's, early 2000's by AMA and other powerful players
- Passage of ACA and Medicaid expansion was a boon for some, but deleterious for others:
  - Intersection of racial resentment → low public support for Medicaid expansion → increased likelihood that a state will oppose Medicaid expansion.
  - Resistance to Medicaid expansion → lower access to healthcare → increased likelihood that local clinics and hospitals will close

Result: persistent racial and ethnic inequalities in insurance coverage

Chapter 13: Childhood Trauma

1. Trauma as an event
2. Trauma as a structural experience
3. ACES: Adverse Childhood Experiences
4. Trauma as a diagnosis in the DSM's

Chapter 13:

Childhood Trauma: Event vs Structural

- Event: Typically experienced in the home (e.g., abuse), or notable occurrence (e.g. fire, natural disaster) that can be attributed to a person, persons, or situation

- Structural: Locked in by systems that are intentionally configured and regularly operate to benefit some while harming others

Chapter 13:

ACES: Adverse Childhood Experiences Studies

ACES study began in 1994

- Explored relationship between child abuse, household dysfunction, later life health experiences and premature death
- Series of questions to "score" occurrence of childhood abuse, neglect and household challenges

BIPOC communities, low-income communities, and communities with less access to education report higher ACES Scores

- While ACES has improved discourse on childhood trauma, it does not take into account community violence, structural trauma or racial trauma. (Urban and poor youth are disproportionately impacted.)
- *Expanded ACES* seeks to account for community experiences: witness to violence, experiencing discrimination, growing up in unsafe neighborhoods, foster care, poverty and childhood social determinants of health.

Chapter 13:

DSM Diagnosis and Interventions

DSM III - 1980

- PTSD Diagnosis included for first time. Event-focused, rather than chronic exposure
- Complex trauma (C-PTSD) addresses long-term trauma with lack of avenues to escape

DSM 5 - 2013

- Certain aspects to diagnosis childhood trauma integrated, while other aspects were removed
- BIPOC children (especially males) more likely to receive stigmatizing diagnoses (e.g., Conduct Disorder) based on perceived individual behaviors, not the structural stressors and racial oppression to which they are exposed

Intervention: Prioritize understanding experiences of BIPOC children. Center care on the whole child and those experiences

Call To Action

Role of MIDD: promote equitable opportunities for health, wellness, connection to community and recovery for King County Residents living with or at risk for behavioral health conditions

AS MIDD and COMMUNITY MEMBERS: Are there opportunities to promote equity within:

- Hospitals – access to facilities and best practice care
- Physicians – entry to the profession and practice standards
- Insurance – access to and equity of insurance coverage
- Recognition and treatment of childhood trauma (including implementation of ACES and DSM diagnoses)

Wrap Up – Chapter 9 & 13

Questions & Comments?

We plan to review both Chapter 8 and 10 in April.

Chapter 8: Social Injustice and the Carceral System

Chapter 10: Social Injustice and Substance Use Disorders

Thank you!!