

Health Inequities in Mental Health Care



CMEO Podcast Transcript

Monica Peek, MD:

Hello and welcome to a very special podcast that is part of this series I am leading on diversity, equity, and inclusivity with CME Outfitters. Today's CMEOcast is entitled Health Inequities in Mental Health Care and is supported by an educational grant from Johnson and Johnson. I'm Dr. Monica Peek, and I'm a professor of medicine and the associate director of the Chicago Center for Diabetes Translational Research.

I'm also the Executive Medical Director of Community Health Innovation and the Director of Research at the MacLean Center for Clinical Medical Ethics, all at the University of Chicago Medicine in Chicago, Illinois. I'm honored to be joined today by two colleagues, Dr. Amanda Calhoun and Dr. Jessica Isom. Amanda and Jessica, welcome and please introduce yourself. Amanda, why don't you go first?

Amanda Calhoun, MD:

Thank you so much. My name is Dr. Amanda Calhoun. I'm an adult and child psychiatry resident at Yale School of Medicine and Yale Child Study Center. My research focuses on the mental health effects of anti-Black racism and children, and I very much consider myself a physician activist.

Monica Peek, MD:

Excellent. Jessica?

Jessica Isom, MD:

Yes. Hi, I am Dr. Jessica Isom. I am a clinical instructor in the Yale Department of Psychiatry, focused on workforce development in the social justice and health equity curriculum. I'm also a practicing community psychiatrist who works in FQHC, and I also am an organizational consultant through my company, Vision for Equity LLC, again, working on workforce development around racial equity issues.

Monica Peek, MD:

Thank you so much for joining me today. I love that you both define yourselves as physician advocates and use terms like "social justice" in your work. That is definitely how I describe myself also, and I think that many colleagues shy away from that term, but many students are not.

And so, it's great to see other women leaders embrace that because the people who are coming behind us are watching us in how we move in the world and how we are finding ways to be the most impactful through our clinical work, through our research, through our practice, and through our advocating for social justice for those who are marginalized.

Health Inequities in Mental Health Care



So, very excited to have you ladies here. I want to remind our audience that this CMEO podcast is a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. We're building a comprehensive library of educational activities addressing these very important issues. And today's activity continues this very important discussion in mental health.

On this slide are just some of the titles of activities in this series with links to each of them. To view any of these programs, simply click on the activity title. If you participate in at least three of the programs in our D&I hub, you will also be eligible to receive a digital badge demonstrating your commitment to education on diversity, equity, and inclusivity.

So, let's jump in with our learning objective for today's program, which is to analyze the influence of unconscious bias, health disparities, and health inequities on mental health care. So, as we began to address disparities in mental health, I do want to review some foundational points regarding historical racism that can help us all remember how we got here.

We've done previous programs that cover these topics in depth and those programs can be found in our D&I hub, but I do want to recognize that we'd be doing a disservice if we didn't take a moment to recognize that we have a significant groundwater issue that we have to address and that groundwater issue is racism.

And so, just to make sure that we've all level set and have a key understanding of how racism can cause poor health, how it leads to health disparities amongst marginalized populations, there're several mechanisms. The first two really revolve around what we call "structural racism."

So, structural racism is defined as differential access or decreased access to the goods and services that can promote health and increased access to the negative things that are harmful to your health ultimately. So, those two things might be, for example, access to health care and health-promoting goods and services like healthy food, good schools, hospitals, and health care systems.

And the second might be limited access to healthy environments, things like safe and stable housing where there's no lead paint, decreased crime, physical spaces like parks and recreation, clean air and water where there's... we think about the Flint water crisis where there's none of that. So, again, access to things that can promote your health.

The third is racism itself. That just simply exposure to racism and chronic discrimination, that chronic stress leads to biological changes in our bodies that can cause chronic diseases. It changes our autonomic system, our cardiovascular system, our inflammatory system, so many systems that can be dysregulated that increase our risk for obesity, cardiovascular disease, diabetes, cancer, et cetera.

It also causes changes in our DNA, our epigenetic changes that not only affect our bodies, but the bodies and the lives of our children, and what we now know is our children's children. And then, the last, we are here as health care professionals.

And it's that differential treatment within health care systems specifically where we talk about implicit and explicit bias that has a particularly pernicious impact on what happens to people's medical care when they're really in a

Health Inequities in Mental Health Care



crisis and come in vulnerable with disease, and need that treated, and are differently treated and received substandard inferior care.

So, those are multiple mechanisms in which racism can each cause poor health. So, with that as a level set, I'm going to turn it to you, Amanda, and let me start and ask how bias and stigma has been connected to outcomes for patients of color with mental health disorders?

Amanda Calhoun, MD:

Thank you so much, Monica. And to be honest, in my practice and in my work, I don't use the words "bias" or "stigma." And I'll talk a little bit about why. They can be helpful terms, and I know different people use them and I respect it. But for me, I don't use the terms "implicit and explicit bias" because I like to focus on the person who's targeted and less on the aggressor.

And so, in my mind, for me to talk about the differences between explicit and implicit racism or racist treatment, it's all explicit to the person who's targeted. And while I think it's important to talk about different levels of racism, so we can talk about structural racism, we can talk about "everyday racism," which is what I use instead of actually the term "microaggression."

So, the daily slights and cuts that Black patients, other minoritized patients experience. I really like to talk about how racism affects mental health care and you mentioned a lot of the things in the health care system at large. And I think the mental health care system is no different. Frankly, I see very often, differential treatment of Black patients versus White patients, frankly, is what I see the most commonly.

And as an example, you can even look at the way that patients are described in charts. So, I work with children, these are little kids, and not that it makes it better with an adult, but I work in an inpatient hospital setting. So, parents of these children are trusting us as physicians, nurses, health care staff to be taking care of their children in a locked unit.

So, a lot of what goes on is confidential. The parents aren't aware of it. And I consistently see Black patients described in very demeaning, with very violent terminology for the same behaviors as White patients. Just as a brief example, let's say there's a White patient who punches a wall and a Black patient who punches a wall, pretty common when kids get upset and dysregulated.

The White child will often be described as "struggling, in need of help," will receive a lot more compassion and empathy, especially for predominantly White health care providers. The Black child will be labeled as "violent, manipulative, problematic." And so, that has been something that's been very upsetting for me personally.

And the other big thing is also, and you mentioned in the slide, prescribing habits. We see, there's a long history that is very deep that we don't have time to go into, but results in basically Black children and adults more likely to be prescribed antipsychotics versus antidepressants. And so, when we think about that, we're talking about a Black and a White patient who come in with comparable symptoms.

So, low mood, lack of motivation, maybe some anger, some irritability, and the White patient will be more likely to be viewed as depressed, started on an antidepressant, whereas the Black patient is more likely to be viewed

Health Inequities in Mental Health Care



again as problematic, violent, let's tame this behavior. And I say tame in a very degrading way on purpose with an anti-psychotic.

Anti-psychotics are important, I use them, but I have a big problem with the fact that I am consistently seeing this differential treatment. And so, those are some examples I think of how they play out. And another big thing you do mention in the slide is just this thing we do in health care, in mental health care where we're still equating race with biology.

And if you look at a lot of research papers, you can easily see this. You'll see a paper that describes differences in the way that patients respond to medications. And when you look at it, they'll compare Black and White patients when that's very problematic because you're essentially taking the way that someone identifies or the way you identify them, frankly.

Because sometimes, researchers aren't even asking patients how they identify. So, for example, looking at a person like me, depending on the person who looks at me, I could be from many different places in the world. I'm a light-Brown woman. So, I may be 50% European descent, 50% African descent, but if you look at me and call me Black, I'm going in the path of this is how Black people respond to medication.

Race does not track to ancestry, but this idea that race and ancestry are equivalent, race is biological, is very much a racist mindset. So, those are some of the things in which I think that are important to bring up, but there's so much more to delve into.

Monica Peek, MD:

Yes, there is. And you said so much. And one of the things that I want to make sure that our audience understands on your last point is that race is not biological, but racism causes biological changes. And so, race is a social construct, but it's the exposure to racism because of race that can change your biology and can result in health outcomes that are different.

And so, that is the message that we want to be consistent with, and have people understand that there's nothing about my brown skin that should put me at increase for heart disease. It is the fact that people react to my brown skin in such a way that I have life experiences that then put me at increased risk for heart disease.

Amanda Calhoun, MD:

Yes, very nice.

Monica Peek, MD:

Yes. And another thing that when you're talking about how even children were described in such a violent way, I had co-authored a paper that came out last year and just made this huge splash. And for us it was like, of course, but we looked at the medical charts of adult patients who were coming into our hospital.

Health Inequities in Mental Health Care



And it turns out that people who were Black were two and a half more times to have negative descriptors, like aggressive or whatever than White patients. And that is something that we have noticed as individual physicians. But I was shocked actually by how much press that got, by how amazed people were by that finding.

And these were people who were coming into the general internal medicine service for medical problems. So, if you imagine that they're going into a psychiatric facility for things that are much more subjective, where it's their behavior specifically that's being analyzed, that this tendency to rely on your subjective assumptions and impressions of people, that that difference, that two and a half times would be much, much higher.

Amanda Calhoun, MD:

Very good point. I think I read that study actually. I think I cited it. It was an amazing study.

Monica Peek, MD:

Thank you. All right. So, Jessica, I'm going to bring you into the conversation and ask you, what do you think about all of this and how it impacts patient engagement in prescribing habits? And what should providers be considering to do to address some of these barriers?

Jessica Isom, MD:

Yeah. I appreciate the mention of subjectivity because one of the ways that I conceptualize the consequences of how we're socialized into making meaning of our racial category and also of others is distortion. That's one of the outcomes. So, there's a distortion of our subjective, and experiences, and the lens through which we view the environment around us.

And one of the challenges with health care professionals specifically is this felt sense that we're egalitarian, that we are immune from being impacted by the socializations that we've been exposed to. And that's a part of that surprise, that shock, which really represents denial about our racial reality. The same thing comes up in interactions with patients.

There's a really good paper from Zestcott that has a complex image that distills this conversation into checkpoints. And I'll walk through the image. Essentially, when a patient enters into a health care professional space, the health care professional is looking at that patient and drawing conclusions both at a conscious and unconscious level.

And they're using those conclusions, using that data, again, determined by their subjectivity to say, "This is how I'm going to present myself in this encounter with this patient." I'll give an example of this in real life. So, I have a patient who comes into the office, I'm looking at them, what they're wearing, I might be looking at how their hair is styled, I might be looking at their manner of speech.

There might be clues that come up in the chart that prime me to have an expectation, and I might prepare myself to tailor my interaction based on conclusions or assumptions I draw about that data, which means I might be prepared to speak more or speak less. I might prepare myself to have a defensive posture because there might be some really stigmatizing language in the chart about how aggressive they might be, all these sorts of things.

Health Inequities in Mental Health Care



And then, from there, there's a relationship. There's a dance between me and the patient in that clinical encounter. And there's things happening for both of us. So, I'm eliciting data, I'm formulating it, I'm coming up with a treatment plan. The patient is experiencing me in this encounter, and they're making use of the data they observe to decide how they're going to show up and interact with me.

So, one of the downsides or one of the consequences downstream of how I show up for patients is they may show up for me in ways that hamper their participation in the encounter. So, if they're concerned about me in a stereotype threat sense, thinking that they're not intelligent, if they're concerned about me being the paternalistic person that they're used to, they may be less likely to ask questions.

They may be less likely to double check things that are said, et cetera. So, I really think it's important in that patient engagement conversation to consider the dance, and how much we as health care professionals are responsible for leading in a way that acknowledges that there is a power dynamic, but also that it should be a dance where two people tango together to ensure that good data is collected.

We generate a formulation that's at least as accurate as possible, and then a treatment plan that honors that we're sitting across from a human being. So, those are some things that come to mind for me in working with patients.

Monica Peek, MD:

So, I'm going to jump in before you move to the next thing. This is so exciting for me because this idea of shared decision-making, this dance between patients and providers around power is one of my core areas of research, and how that dance differs for people who have been marginalized, particularly by race than for those who have not.

And so, part of what I do is to develop interventions to help teach Black people how to do this dance, and help health care providers understand the lived experience, and the challenges and the barriers that we may have to participating in that dance. What we may be asking our patients to do, who have, for generations, may have learned, and are still teaching our young boys, for example, how to interact with the police to survive.

And so, some of our survival strategies may be ones of deference to power. And so, then they come into another health care system, which may not have always treated us correctly, and we know that to be true. And then, we're saying, "No, no, no, no. Here, you're supposed to ask questions and do all these things." And this may not naturally be how our community in vulnerable spaces interacts with power in order to get out alive.

And so, we have to enter into that paradigm, the space to understand that racism has altered that dance for us and that we are making a calculus on what we say, how we say, what we do based on so many factors, all the ones that you just mentioned. And so, thank you for bringing that up, and how important it is not just for me as a primary care physician, but how doubly important that is in mental health where there's not an EKG or a lot of these evidence that we can look at together, but it really is all about a relationship.

Health Inequities in Mental Health Care



Jessica Isom, MD:

And I'll say I've worked with majority Black patients across the diaspora in my clinical practice. So, there're lots of different kinds of dances. I was just talking to a patient last week who dances quite well and I love it. They're asking questions, they're challenging information, they're forcing me to divulge my rationale in a way that I love.

And I actually gave them positive feedback that they should consider writing a book to help others who actually are struggling with that dance to know that these are things that you can do. But I'll say a large part of my dance with patients is being explicit about what they should expect, not only for me, but also from other health care professionals.

And it is a part of psychoeducation letting people know transparently, this is what you can do in this dance with me. This is what you should do. And anyone who's discouraging you from doing that is problematic.

Monica Peek, MD:

Yes, yes, exactly. All right. I had interrupted you, anything else that you want to add?

Jessica Isom, MD:

Yeah. I think a stance of humility is really important for patient engagement. They're always teaching me things. And of course, there's my lived experience that informs what I do, but a lot of what I do now has integrated what I've learned. So, for example, in conversations around prescribing medication or even suggesting a next step as an intervention, there's how I experience it and there's how they experience it. So, things like, we're going to "try" Prozac. Even the word try-

Monica Peek, MD:

Try.

Jessica Isom, MD:

... loaded.

Monica Peek, MD:

Have you done this before?

Jessica Isom, MD:

Right. And then, also people's experience of shared decision-making will vary. So, I've learned to be transparent about why I am doing what I'm doing. Some people will say, "Dr. Isom, I mean you're the expert. Why are you asking me what I want?" And then, other-

Health Inequities in Mental Health Care



Monica Peek, MD:

Didn't you go to medical school? Did you graduate?

Jessica Isom, MD:

I'm like, "Okay, okay, I get it." And then, other people will say, "You know what? I think I want to tweak my surgery, my Zoloft this week. I've noticed this, this and that." And on the inside I'm like, "Oh my God, this is so great," that you feel engaged enough in the shared decision-making enough that you can suggest a change on your own. So, I've learned a lot just from working with patients and integrating that along the way.

Monica Peek, MD:

Absolutely, absolutely. And I would say I do the same thing. Amanda, I'll just ask if that's part of your practice too, that learned behavior of having to the preamble as we introduce new therapies or new medications to patients?

Amanda Calhoun, MD:

Yeah. I'm often dealing with the child as well as the parents. So, there are multiple people in this dance for me because it's my first interaction is usually with the child. And then, we are developing a therapeutic relationship, and then I may call the parents, and there's a whole another dynamic of the parents and how they play into it.

And so, I definitely agree with Jessica in that I really try my best to let the patients and their parents know that this is a shared decision-making process. We're partners in this, this is your health. And I usually like to describe myself as a guide. However, I want them to know that they can ask me questions, they can question things, and if something doesn't feel right, we can talk about it.

Some of my favorite, actually, child patients are what people will call the "difficult" patients. And these would be the kids who are very externalizing. They're the ones, like I said, punching the wall, screaming, maybe calm in the hospital, but at home, out of control. So, especially, I find for kids like these who often are trying to find a sense of control because their life feels out of control.

Giving them some control is very helpful to say, "Hey, what do you think? We have this as needed medicine that you're supposed to take. You can take it twice a day. Do you want to take it now? Do you want to take it later?" Even small things like that, allowing the child to make the decision about when they take their medicines, if it's an as-needed medicine.

Or, "Hey, you're taking this medicine in the morning, but you're telling me you're feeling really tired, what do you think about taking it at night? What do you want to do?" And I often do find someone, like Jessica said, some patients are like they're on it, and they very much like that, and are very advanced in share decision making.

And some patients are like, "Well, what do you mean? What I want me to do?" And I then go back to explaining, "Yeah, I could give you my recommendation, but what you want and what you feel is also important in this." And I find that's really, really helpful, not only the children, but also parents.

Health Inequities in Mental Health Care



Monica Peek, MD:

Yeah, absolutely. So, this is great conversation. Thank you, ladies, because so much of your experience mirrors my own. And I think partially because as an internist, a lot of what we do is very basic psychiatry. We do a lot of the primary stuff before it really becomes complicated, particularly for racialized minorities who still have a lot of reservation about seeking mental health professionally.

I want to talk a bit about the cost of medications. Many medications are expensive, including ones for mental health. And so, how do we get the medications to our patients that they need? How do we bring up issues of cost? Jessica, I'm going to toss this to you first.

Jessica Isom, MD:

Yeah, it's interesting. So, I'll say I come from a lived experience of not having a lot. So, a part of what informs my approach to any conversation about something associated with cost is sometimes people just don't have it. I've experienced that. So, I want to be transparent about that as a part of why I just... from that basis, approach the conversation that way.

But also, statistically, we know folks are differently insured in a racialized way. How you're insured can determine what access you have as far as what's on formulary, and what's not, and how much a fight it might take to get you access to something that's, for example, not on a formulary, it requires a prior authorization. There're also differences in life.

So, I have patients who I know if I prescribe something on January 1st, they may not get it until January 29th because they couldn't get a ride, or their check has not come in yet, or they forgot because they have multiple responsibilities, multiple jobs, and it just wasn't on their list. So, all this goes into a conversation with them that's casual, informal, relational.

For example, do you think you'll be able to go pick up your medication today or when do you think you'll be able to go pick it up? Have you had any trouble recently with picking up your medication from the pharmacy? What's the copay like? Or even have you had trouble coming to these appointments? I've heard patients say copays are like \$150 depending on insurance.

So, just in a really casual normalizing way, also is validating way, acknowledging that there are social determinants that may infect your ability to enact the treatment plan and cost as well. And I hand out lots of coupons for folks too. So, like goodrx.com. So, again, just position us together as trying to get you access to this intervention as opposed to you go out there and figure it for yourself.

So, a lot of this is around collaboration or centered on collaboration because of the way the health care system is structured. So, I can write that prescription, but then the pharmacist has responsibility for one part and the insurance company has responsibility for another part, and we're often not supporting that patient and figuring out even what their next steps are.

So, I often say in a very maternalistic way, "If you have trouble, let me know. Don't rely on the insurance company, let me know. Don't rely on the pharmacist or the pharmacy to let me know. You got to keep me in the

Health Inequities in Mental Health Care



loop." The last thing I'll say with that is technology allows some folks to be able to navigate those situations better than others.

So, my patients that have MyChart and are engaged in MyChart are much more successful at advocating for themselves and navigating those barriers than those who do not who relying on phone calls to call centers with delays and things of that nature. So, one practical suggestion would be is supporting patients that have technology access and helping them with that process, but paying attention to those who have to rely on other needs to get in contact with the health center or their pharmacy.

Monica Peek, MD:

Yeah, exactly. Excellent points. Amanda, do you have any other tips that you use when you're talking to patients about cost and how you bring that up? I love Jessica that you had said that you normalize things.

And so, for me, I think I manage a lot of patients with diabetes, so I'm always normalizing a lot of things that people may otherwise not want to tell me about, what they're eating, what they're doing, what they're not doing, their medication adherence, all of these things like, this is hard. Every day, you've got to think about 15 things that are related to your diabetes, and most days, something is going to drop. So, what's going on? So, any other tips you have, Amanda?

Amanda Calhoun, MD:

Yeah. It's interesting because hearing the outpatient perspective is really interesting because mostly, like I said, I'm on the inpatient side. And so, I think what I try to do is be very mindful again of how I'm describing patients in the chart. And to go back to the chart, I think there's a real lack of thinking about the patient as a person in the world.

So, if a patient comes in and they haven't been on medicine and they decompensate, let's say, I often will see in the chart the patient is "noncompliant with medicine." And just this idea of noncompliance, which we know that is a negative label, is more likely to be thrown at Black patients. And also it just frankly clashes because it's like just saying the patient isn't following the plan, I'll change it.

I'll say, "Patient was struggling to get medications due to cost." And I feel like that's a small thing I can do, but then when I go to discuss it with the team, that's a very different conversation of, "Oh, the patient just keeps coming into the hospital," not because they just decided to stop their medicines because they wanted to, which that would be a separate discussion.

But because they were not able to access them or the patient knew they were in crisis, was trying to see an outpatient therapist or psychiatrist, and they told me, "It was a six-month wait, my depression worsened. Then I became suicidal and started to think about ways to end my life." And so, I try to be very specific and mindful. And when I talk to patients, even in my brief interaction in inpatient, try to basically normalize it, similar to what Jessica said.

But then also, carry that into the chart into my communications with the team. "Hey, let's not label this patient as just a patient that doesn't want to take their medicine," which by the way, they're an adult or they're a person

Health Inequities in Mental Health Care



and they can decide to take their medicine. We should also delve into why they decided not to take it, but also some patients want to take their medicines.

It's just they don't have the ability to because of lack of funding, or lack of transportation, or lack of being able to find an outpatient psychiatrist or therapist. I think I just try to be very mindful of that and very pushback against just the patient is noncompliant. We see the end results, and that's what goes into the chart, and not all of the factors that led to the result.

Monica Peek, MD:

Yes. So, can you talk to us about some of the resources that are there for patients to address some of these things along the way so that they don't get to the end result of not being able to take their medications or not being able to get in to see a provider? What resources are available for mental health care for patients in the community?

Amanda Calhoun, MD:

So, it's difficult because, like I said, the system is so clunky and difficult to navigate. But some of the resources that I really like, so NIMH, so I should say I also really resources that empower patients like what we were talking about to advocate for themselves. And that's not to say that the racism in the mental health system is the patient's fault.

No, it's the fault of the health care providers, and racism, and the history of racism in this country. However, we do know that being able to advocate for yourself, ask for help will help with patient outcomes. And just knowing when something doesn't feel right, your ability to say, "I don't like this psychiatrist or this therapist, I don't feel like they're treating me well."

And I think the elephant in the room is we say Black people and Black children are less likely to access mental health care. But I see all of the Black children and adults who do access mental health care, and are alienated by a racist system, and racist therapists and psychiatrists, they'll tell me all the time. I was looking on this resource. I was trying to find a therapist.

And when I started talking to them, I had a Black patient specifically who told me he was depressed. He went in and talked to a therapist, and the therapist upon first meeting asked him, "Did you grow up in the hood?"

Monica Peek, MD:

No.

Amanda Calhoun, MD:

Right. So, these are very disturbing interactions that Black patients are having with therapists, and psychiatrists, and they don't really know who to talk to about it and they just fall out of care. So, that's just an example. So, some of the resources that I like to offer are for Black girls, obviously, because I work with kids, there's Therapy for Black Girls.

Health Inequities in Mental Health Care



It does have resources of providers, and also just tips and things to look out for. It also helps talk about the importance of being a Black girl and your identity as a Black girl in therapy. I also really actually like, CDC has some really good health equity resources for, even just communication between patient and provider.

And then, also SAMHSA has actually come out with a lot of really, really good tools actually, not just for patients, but also for providers to be able to look at their own practice and have resources of how do I talk to patients in a way that is going to work towards achieving equity rather than perpetuating racism. So, those are some examples and I really, really like those resources.

SAMHSA also has a lot of really important resources on the rising rates of Black youth suicide, which is a crisis that has really been minimized and not talked about as much as it should. So, SAMHSA, NIMH, CDC, those are some really, really good resources that both patients actually and providers can access for getting tips about how to navigate this health care system.

Monica Peek, MD:

Excellent, excellent. So, if you both could think about a personal experience that was particularly moving to you with a patient, maybe one that had a positive outcome, maybe.

Amanda Calhoun, MD:

I'm going to say a good moving or bad moving experience?

Monica Peek, MD:

On a light note, but either, one that was illuminating or relevant to the conversation that we're having right now that you could share with the audience to help them understand these issues as a take home. I think that the stories are always important and I am so grateful to the both of you because I think that this conversation has been filled with information, and things to do and tips, but also the stories that we've been telling I think will be really helpful for practicing clinicians and those who are listening.

So, I'm going to ask each of you to think of a patient or a family that really just stands out to you as they have been trying to navigate their way in the mental health care system. And maybe, Jessica, I'll bounce to you first.

Jessica Isom, MD:

Yeah. There're lots of stories. I'll say first, another resource would be from the Joint Commission. It's called Speak Up. Specifically, it's tailored to users of health services to help them know their rights and specifically know what they should expect in health care environments. So, JCO with Speak Up.

There's a patient who I met who is in his early 30s, Black man, who'd been working with therapist at my clinic, and then had begun to establish a relationship with psychiatrist. And is an example of someone who was not served in their youth because they've gone through their life with diagnoses of depression, PTSD, but not been diagnosed with ADHD.

Health Inequities in Mental Health Care



So, I walk into my clinical practice, not just knowing what disparities exist diagnostically, but incorporating that knowledge into what I do. So, for my patients who are mostly, again Black, I'm thinking about what everything could be. So, not just schizophrenia, but OCD and ADHD, we got them all. So, I diagnose him with ADHD, prescribed a stimulant.

Transformative, improved his relationship with his children, his relationship with his partner, helped him to better understand himself and some of his shortcomings in a way that was more compassionate. But the interesting part about this is, is I was going at the time pre-pandemic to this restaurant down the street from the clinic to get one of my favorite meals before the restaurant closed, which was catfish and potato salad.

And I'm standing in this lobby area, and this woman is like, "Hey, hey, are you Dr. Isom?" And I was like, "Yes, I'm Dr. Isom." And she's like, "Oh, you've been taking care of my son." And she expressed thank you to me for doing that. And what I knew from her son was that she'd actually discouraged him from coming to see psychiatry because she was worried about how he would be treated and worried that that mistreatment could result in consequences for him and his health.

So, that for me was this community psychiatry moment of it's not just me or just the patient that I'm treating, it's also their family. They're observing the experience this patient has with me. Maybe it will shape how she navigates in the future, her relationship with services. But it was just a beautiful moment of connecting with different pieces of the puzzle.

Monica Peek, MD:

Yes. That is a beautiful ending because as his mother, she's going to have so much influence over so many other members of the family. So, not just what she does, but what her other kids do. And she's got that restaurant, how many people are coming into that restaurant for food that she's going to be giving out free medical advice to? Do you know what I'm saying? So, she is like a node in the community. And so, you changing her mind has potentially changed an entire community.

Jessica Isom, MD:

So important, one patient.

Monica Peek, MD:

It really is. It really is. You just never know. All right, Amanda, can you top that?

Amanda Calhoun, MD:

Yeah. So, mine is a little bit of a spin because it's negative at the beginning, but it gets better.

Monica Peek, MD:

Okay.

Health Inequities in Mental Health Care



Amanda Calhoun, MD:

So, I was in the hospital and was approached by... so I was there doing admissions to help the on-call physician that was there. So, I wasn't technically the psychiatrist on call that was fielding all the calls, but I was just there to help out with admissions because we had a lot of admissions. So, a White nurse called me over, and first of all, she was quite rude in the way that she called me over.

And so, I already was like, "Okay, this is going to be an interesting conversation," because she just walked up to me and started talking and I said, "Oh, hello, I'm Dr. Calhoun. I'm Amanda. I'm the resident on tonight. What's your name?" And she screamed her name. And I was like, "Okay." She's like, "Can you go see this patient? She's been complaining all day and I'm just really tired of hearing it.

And she's just been complaining, you just go see her." And that's just the way she talked. Mind you, this is a child. So, I said, "Sure, I'll go see the patient." So, I went in to see this child. This was a little Black child, curled up in a ball, under blanket, shivering. And I walked up to the child and I recognized them because I had seen them before at the hospital.

And I said, "What's going on?" And the child told me that they were in a lot of pain. I also knew that this... and the nurse knew as well, this child had sickle cell. And I said, "Is your pain really high right now? Because I know that you live at a high level of pain, but where are you... where's your pain?" And she said, "Probably an eight or nine." And I said, "That sounds too high."

She said, "Well, I've been trying to take a hot shower, do everything I can." But I really don't want to go to the emergency department because we have to transfer them out of the inpatient psychiatric unit. So, I said, I think you probably do need to go. So, I went and talked to my colleague who happened to be a White woman and was the person on call.

And so, I said, "You can do whatever you want to do. You're the person on call, but there's a child up there who I really think you need to see. And if I were you, I would send that child to the emergency department." And so, my White colleague goes up, talks to this white nurse who again rolls her eyes, says, "I think the child is faking her pain. I don't think this is real."

And then, I'm laughing because my White colleague comes back downstairs and she goes, "Amanda, this is exactly what you've been talking about with Black patients and White providers saying they're faking their pain. This is it." And I said, "Yeah, this is what we're talking about." So, she sent that child to the emergency department. That child ended up being admitted.

She was in a sickle cell crisis, and we reported that nurse. But to me, that was a win because my colleague was able to listen, learn, and incorporate what I had been talking about, and what so many other people have been talking about who are experts in this, and make a change in a child's life, right?

Monica Peek, MD:

Right.

Health Inequities in Mental Health Care



Amanda Calhoun, MD:

And so, it was one child, one instance, she called the child's mom who was so happy that she had someone looking out for her. And so, for me, it was a huge win because it's like, "Wow, people are listening to these things that we're saying and they are helping." And something that we may think we're saying over and over again, we're reaching different people.

And to me, that was a win that we got the child the care that she needed because had she just gone by what the nurse said, the child would've just stayed there in a sickle cell crisis without further intervention. And so, I like telling that story because it lets people know how real racism is currently and how common it is, but also, the fact that you as a White person, as a Black person, however you identify, can be part of the change.

You don't have to continue perpetuating that. You can take the conservative safe approach and say, "I'm going to send this child to the emergency department. They're telling me they're in pain, we're going to check them out." And so, that's my story that I really like to share.

Monica Peek, MD:

Well, you did equal Jessica's story because basically, you converted someone else. And so-

Amanda Calhoun, MD:

Exactly.

Monica Peek, MD:

... for her to be like, "Girl-

Jessica Isom, MD:

Yes,

Monica Peek, MD:

... all that stuff you've been talking about, that really does happen." And for her to see it with her own eyes, made a believer out of her. So, now she is not only changing her practice, but I bet you, because White people who are listening, you have access to see and hear things that we will not. And you have the ability to do something about it right then and there to be upstanders, where persons of color aren't even in the room.

And so, the ability to act, to do the right thing for your patients, your reach potentially is much faster than ours because we only see a fraction of what is happening that's bad that we can potentially try and address right then. And so, when you have people who see it, and then understand it, and then start talking to their colleagues about it, that's real change right there.

Health Inequities in Mental Health Care



So those are both excellent stories. Yay, thank you both for sharing. I'm so excited. This has been a wonderful, wonderful conversation. Thank you. Thank you. Thank you, Amanda and Jessica, for that discussion. I learned a lot. I always do, and I'm sure our audience did as well. So, I'm going to try and summarize our discussion into action items that we could all do to provide more equitable mental health care.

So, they are to discuss potential barriers to accessing follow-up care and treatments with every patient before the treatment planning begins. Try and normalize those things so that people don't feel ashamed to talk about them, so they understand that those are real barriers that real people have that they may be having as well.

To assess and address inequities experienced by each patient during the assessment and treatment planning processes, including unconscious bias, prior health care experience, social determinants of health, age of onset of mental health difficulties, occupation, comorbidities, and health literacy, all of these things that can impact someone's mental health.

Try and really be thorough and not just thinking about comorbid diseases, but comorbid life experiences that can impact how they present and their treatment arc. Educate patients on their condition and their available treatment options. We want patients to be activated as well, asking questions, and learning about their disease, and so they can be partners with us.

And we want to have cultural humility and language congruency to minimize the disparities in mental health care and to promote health literacy. And then, last, you share decision making practices with patients so we can develop holistic, individualized treatment plans with relevant community resources for each patient.

So, I would like to thank again, Dr. Calhoun and Dr. Isom, for joining me here, and to remind our audience that you can join me here for additional CMEO podcast, live webinars, case discussions, and more. We have another upcoming CMEO briefcase for you. You can find out all about these upcoming live events and view previous ones at the D&I hub at the link shown here.

So, here are just some of the topics we've covered so far, and we'll be adding new content every month. Please remember to collect credit for this activity by using the "Apply for Credit" button on your screen. Again, thank you all for participating. Thank you to our faculty presenters for your input today. And just thank you everyone for providing equitable and holistic care to patients around the globe. Have a wonderful day.