STRUCTURAL COMPETENCY

NEW MEDICINE FOR THE INEQUALITIES THAT ARE MAKING US SICK
OUTLINE OF THIS TALK

- Cultural Competency – What Are We Missing?
- Social Determinants of Mental Health, Structural Violence
- “Structure” as Unit of Intervention
- Structural “Competency” – Putting it into Practice
CULTURAL COMPETENCE

- Institutional History
- Health Disparities and Clinical Miscommunications as Motivation
- Cultural Expertise vs. Cultural Sensitivity
STRUCTURE

- Community organizations
- Health-relevant sectors (schools, housing, law enforcement/corrections, urban planning)
- Public policy
“Cultural” often interpreted as beliefs and behaviors of ethnic group (vs institutional exclusions) that cause inequalities – Cultural Determinism

- Culture interactive, not static – current usage->stereotyping

- Culture is shaped by, and shapes, institutions and political economic conditions – STRUCTURAL factors

- Culture of medicine powerful determinant, but naturalized among clinicians

“Competency” as professional expertise re ethnic groups may defeat goal of making care patient centered

- “Evidence Based Medicine” (as decision trees) vs. collaborative models

- Social Change as Mental Health Promotion
Culture

School + Housing Segregation

Black

White

Media

Mass Incarceration
“Competence” reinforces inequality in Dr-Pt relationship
Instead: “humility” -> patient-centered, equity and community collaboration
CRITICAL THINKING SKILLS

- Technologies and patient populations constantly evolving
- Problem solving and critical thinking are as important as fund of knowledge
- Self-awareness (of culture of medicine) crucial for critical perspective

Education in Psychiatry

*Education in Psychiatry, like Treatment in Psychiatry, begins with a case vignette to illustrate an important problem in clinical psychiatry. However, the goal of Education in Psychiatry is to present and evaluate methods to teach students, trainees, and other psychiatrists how to treat patients with these problems.*

**Teaching Critical Thinking in Psychiatric Training: A Role for the Social Sciences**

Elizabeth Bromley, M.D., Ph.D.

Joel T. Braslow, M.D., Ph.D.

The two patients experienced nearly identical troubles, including failure to live independently, a paucity of social relationships, and persistent psychosis. In the first case, the resident took little interest in the patient’s symptoms.
BUPRENORPHINE PATIENTS IN U.S.:
91% WHITE, 56% COLLEGE EDUCATED
The National Alliance of Advocates for Buprenorphine Treatment

Buprenorphine (Suboxone®, Subutex®) is an opioid medication used to treat opioid addiction in the privacy of a physician’s office. Buprenorphine can be dispensed for take-home use, by prescription. This, in addition to the pharmacological and safety profile of buprenorphine, makes it an attractive treatment for patients addicted to opioids.

Patients: Find a Buprenorphine Physician

Patient/Physician Matching System. Have a certified buprenorphine prescribing physician contact you:

Get Started

Physicians: Help Patients Now

Patient/Physician Matching System. Find patients searching for buprenorphine treatment near you:

Get Started
THEORETICAL FRAMES

- Social Determinants
- Structural Violence and Structural Racism/Oppression
- Individualism of Clinical Mental Health Care
What are Social Determinants?

Elements of social environment, outside of direct clinical care, that cause positive or negative health outcomes.

These are powerful correlates of mental health, visible on population level rather than individual level.
U.S. Health in International Perspective
Shorter Lives, Poorer Health

Why Are Americans So Unhealthy?

The panel’s inquiry found multiple likely explanations for the U.S. health disadvantage:

- **Health systems.** Unlike its peer countries, the United States has a relatively large uninsured population and more limited access to primary care. Americans are more likely to find their health care inaccessible or unaffordable and to report lapses in the quality and safety of care outside of hospitals.

- **Health behaviors.** Although Americans are currently less likely to smoke and may drink alcohol less heavily than people in peer countries, they consume the most calories per person, have higher rates of drug abuse, are less likely to use seat belts, are involved in more traffic accidents that involve alcohol, and are more likely to use firearms in acts of violence.

- **Social and economic conditions.** Although the income of Americans is higher on average than in other countries, the United States also has higher levels of poverty (especially child poverty) and income inequality and lower rates of social mobility. Other countries are outspending the United States in the education of young people, which also affects health. And Americans benefit less from safety net programs that can buffer the negative health effects of poverty and other social disadvantages.

- **Physical environments.** U.S. communities and the built environment are more likely than those in peer countries to be designed around automobiles, and this may discourage physical activity and contribute to obesity.
Inequality: an underacknowledged source of mental illness and distress

Kate E. Pickett and Richard G. Wilkinson

Fig. 1  More people have mental illnesses in more unequal countries.
PHYSIOLOGICAL IMPACT OF RACISM AND POVERTY

- Embodied racism
  Skin color and hypertension, HPA axis: correlate in US, not in West Africa or Brazil
  HPA axis in mental/emotional dysregulation

- Institutional racism
  - Discriminatory public policies (e.g. War on Drugs)
  - Residential Segregation

**Ecosocial Theory (Krieger et al)**
Pathways to embodiment: cumulative and interactive biosocial processes of exposure, susceptibility, resistance
REDLINING (FOLLOWED BY URBAN RENEWAL AND PLANNED SHRINKAGE)
U.S. health care investments are in individual, high technology interventions, while social determinants and institutional/policy reforms are underinvested.

Inequalities by race, ethnicity, and social class are major drivers of poor outcomes.

80% physicians say social causes of disease major, but lack tools to intervene (RWJ). Leave practice because of burnout.

ACA and Triple Aim: population health outcomes and structural change opportunity.
**Johan Galtung**: Violence (the prevention of individuals or populations from reaching their mental and physical potential) without a specific actor committing the violence; when “violence is built into the structure and shows up as unequal power and consequently as unequal life chances.” It may be unintended and indirect. (Journal of Peace Research 1969)

**Paul Farmer**: “suffering...‘structured’ by historically given (and often economically driven) processes and forces that conspire—whether through routine, ritual, or, as is more commonly the case, the hard surfaces of life—to constrain agency.” For example, “choices both large and small are limited by racism, sexism, political violence, and grinding poverty” (Daedalus 1996)
“Structural” focuses on attention on particular institutions and policies (“social” more diffuse)

Leads to examination of institutional decision making and accountability (“determinants” sounds immutable)

“Violence” frames social/institutional/policy change as an urgent health need (rather than an explanatory variable)
New term – “structure” – needed to shift focus above the level of the individual – to institutions (clinical, educational, correctional, etc), communities, policies that determine health

“Competency” to indicate expanded scope of clinical intervention and responsibility: practitioners can bring symbolic, social and cultural capital to bear (in partnerships)
HOW CAN CLINICS CULTIVATE A HEALTH PROMOTING SOCIAL CONTEXT?

- Integrated, community based care
- Inclusion of housing and social conditions in health interventions
- Collaboration with community organizations, schools, law enforcement, parks and recreation
- Addressing chronic trauma/violence in poor neighborhoods
- Advocating for health promoting public policies (drug laws, housing, education, employment as health issues)
- Acting on structural rather than individual level
STRUCTURAL COMPETENCY

New Medicine for the Institutional Inequalities that Make Us Sick

This one-day working conference will assemble multidisciplinary practitioners.

PRELIMINARY PROGRAM—FRIDAY, MARCH 23, 2012

10:00am WELCOME: Mary Louise Pratt, Chair
NYU Department of Social and Cultural Analysis

3:10pm BREAK

3:30pm Roundtable:
Structural competency: Theorizing a new medical engagement with stigma and inequality

Jonathan M. Metz1,*, Helena Hansen1,2,3

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3 Nathan Kline Institute for Psychiatric Research, Orangeburg, NY, United States

ABSTRACT

This paper describes a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. It reviews existing structural...
Recognizing the structures that shape clinical interactions

Rearticulating “cultural” presentations in structural terms

Observing and practicing structural intervention

Developing Structural Humility (e.g. through collaborations)
Heroin dependence -> methadone, then buprenorphine
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Irritability -> mood stabilizers, SSI for Bipolar d/o
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IOP graduation-> skipped doses, street purchases
RUBEN

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SSI-> transitional housing
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Firemarshal raid -> homelessness
Heroin dependence -> methadone, then buprenorphine
Irritability -> mood stabilizers, SSI for Bipolar d/o
IOP graduation -> skipped doses, street purchases

SSI -> transitional housing
Art therapy -> new identity, leadership
Firemarshal raid -> homelessness
Pharmacy policies, insurance authorization -> delayed refills
THE COMPETENCIES

- Recognizing the structures that shape clinical interactions
- Rearticulating “cultural” presentations in structural terms
- Observing and practicing structural intervention
- Developing Structural Humility (Collaborations)
IN-CLINIC STRUCTURAL INTERVENTION

- Electronic Medical Records
- Medical-Legal Partnerships, Health Leads

The Washington Medical-Legal Partnership works towards better health through legal advocacy.
The Brownsville Partnership
A Community Approach to Ending Homelessness before It Begins

It’s an unlikely alliance: the former NBA player working to fix his troubled neighborhood and the young woman wielding flow charts on how to get there. Greg Jackson and Corinne LeTourneau are part of the Brownsville Partnership (BP), a multi-agency collaborative launched in 2008 to prevent families in this Brooklyn public housing neighborhood from losing their homes. Today, the
PSYCHIATRY RESIDENT PROJECTS

- Psychiatric screening, psychoeducation for seniors and those at risk for eviction as part of multidisciplinary home visits

- Community mental health needs assessment used for new Wellness Center (->crisis intervention, youth programs)

- Trauma focused, peer led support groups

- Local health service mapping and referral linkage to promote integration of mental with physical health, continuity of care

- Medicaid data mapping of emergency/inpatient service utilization for street level targeting of prevention
CROSS-SECTOR COLLABORATIONS

Mindy Thompson Fullilove, M.D.

URBAN ALCHEMY

Restoring Joy in America’s Fractured Cities

AUTHOR, ‘URBAN ALCHEMY’ AND ‘ROOT SHOCK’
DRUG WAR DISPARITIES

**Drug Users**
- White: 72%
- Black: 13%
- Other: 15%

**Drug Prisoners**
- White: 25%
- Black: 60%
- Other: 15%
POLICY ADVOCACY

2014 SPRING CONFERENCE

Decarceration: A Public Health Approach to Reentry
First Annual Conference on From Punishment to Public Health (P2PH)

REGISTER HERE

P2PH Academy Conference Outline
Wednesday, April 23rd, 2014
Moot Court Room (Rm. 668) at John Jay College
Identifying key social determinants of health that should be the focus of clinical intervention

Training medical practitioners to implement structural interventions

Clinical partnerships with community organizations and health relevant sectors/agencies to design interventions.

Enhancing the role of medical practitioners in crafting public policy
THOUGHTS FOR STRUCTURAL PRACTICE

- Structural change requires persistence and positive examples
- Structural intervention promises impact and satisfaction
- Collaboration and interdisciplinarity are required
- Hands-on programs and supervision outside of clinic needed