2022

A CALL TO ACTION FOR PROVIDERS SERVING YOUTH OF COLOR:

Learnings from the Trauma Healing and Learning Series

Funded by the California Mental Health Services Act

TABLE OF CONTENTS

About My Brother's Keeper 3
About the Trauma Healing and Learning Series 3
Letters to Our Readers 4
Introduction 6
  Why Share the THLS Learnings 6
  Experiences of Racism in Health Care: BIPOC youth and young professionals share their experiences 7
Healing Centered Approaches and Solutions 7
  Trauma-Informed and Racially-Informed Care 7
  From Cultural Competency to Antiracist 8
  The Role of Medical Providers 8
How Racism Impacts Health 9
  Modern Institutionalization of Racism 10
Implications of Social Determinants of Health on Providers 12
  Power and Identity 12
  Be Aware of Your Bias 13
Implications of Institutional and Interpersonal Racism on Patient Engagement 14
  Medical mistrust 14
  Mental health stigma 15
Your Call to Action 15
  Individual Practices: It Starts with YOU 15
    Do Your Own Work So You Can Honor Your Commitments as a Health Provider to BIPOC Youth 16
    Do What You Can to Make Each Patient Feel Safe and Seen 18
    Challenge the Status Quo in Your Spheres of Influence 18
  Organizational Practices: Working Together for Change 19
    Change the Institutional Policies and Practices 19
Conclusion 21

Appendix A. Glossary of Terms 22
Appendix B. Health Disparities Data 23
Acknowledgments 26
References 27

ABOUT MY BROTHER'S KEEPER

My Brother's Keeper Alliance (MBK) is a national initiative to increase systemic investments in the health and well-being of boys and young men of color. MBK was started by the Obama White House and is supported by the Obama Foundation.

Managed by the Sierra Health Foundation, the **MBK Sacramento Collaborative** is committed to improving educational, health, social, and economic outcomes for boys and men of color in Sacramento, California. The Collaborative comprises four pillars: education, employment, healthy development, and juvenile justice.

ABOUT THE TRAUMA HEALING AND LEARNING SERIES

In 2019, the Healthy Development Strategic Committee of the MBK Sacramento Collaborative launched the Trauma Healing and Learning Series (THLS). The THLS brings together interdisciplinary scholars, practitioners, students, and community members to discuss and address the ways trauma, mental health, and well-being affect the health of people of color. The THLS meets attendees at the intersection of race, racism, and healthcare, creating safe spaces for growth and understanding of the ways in which these key avenues systematically overlap. As of 2022, the THLS is a project of Public Health Advocates.

LETTERS TO OUR READERS

Dear Reader,

Health equity is important. To achieve it we must address structural racism—the racism embedded within policies, laws, and institutions. It leads to segregated communities and manifests even in communities separated by no more than a street or highway. Despite our best efforts *not* to be racist, we often contribute to racist outcomes because it is so deeply embedded in our societal fabric, and within us. Providers striving to meet patient needs must acknowledge the individual's cultural background, the challenges they might be facing due to this pervasive racism and challenge themselves to unlearn social norms and expectations that perpetuate racism. A public health approach is pivotal to providing the best care for communities and reducing poor health outcomes. Racism - institutional and personally mediated - must be dismantled at all levels if we are to achieve real change.

In the summer of 2021, I interned with the Maternal Child Health Careers/Research Initiatives for Student Engagement–Undergraduate Program (MCHC/RISE-UP) at the University of California, Davis. Through this program, I learned from experts about health inequities and the solutions we must find to overcome them. I also learned that patient care does not end with the appointment: to improve wellness and prevent complications, we must connect patients with services and resources in their own community. My experience with MCHC/RISE-UP solidified my determination to pursue a dual MD/MPH.

My parents speak only Spanish. Many times, their physician interactions have been difficult because of poor or incomplete information delivery. Through focus groups and listening sessions with the community, I have learned that my parents' experience with language barriers is not at all unusual. Healthcare providers, future providers, medical staff, community members, and others must come together to create meaningful and sustainable change. Everyone's effort will be required.

We created *A Call to Action* to support communities of color facing trauma resulting from racism. We must end the cycle of trauma, preventing it by becoming aware of institutional, systemic, spatial, and personal biases and by adopting best practices of care. As you explore this report, we ask that you reflect on the ways we can work together to change our own and society's mindset and the role you can play in achieving our common vision of a world without health inequities.

Sincerely,
Hector Diaz

Dear Reader,

As a young man of color, I struggled through the health stigmas my community was built on. My family never openly talked about mental health or the importance of medical insurance. A trip to the doctor was a rare event, and even more rarely worthwhile. Doctors never comprehended the struggles my family faced. My mother would suggest these visits were a waste of our time and money.

As I grew into an adult, I came to understand the importance of talking about mental and physical health—especially for a young man of color. I understood how crucial it is to speak out about stress, depression, and health stigma.

My work on this toolkit was driven by the vision of helping providers and health institutions to identify the diverse ways they can intervene and help guide families of color—most importantly young men and boys of color—through the health system. We hope you will find it to be a valuable tool for change.

Sincerely,

Johan Cardenas

INTRODUCTION

In recent years, public dialogue about race and racism in the United States has focused a spotlight on disparities in health outcomes[I] and the impact of racism on health and well-being more generally. Responding to heightened attention on the systems and policies that perpetuate disparities, 241 states, counties, cities, and public health departments have joined together in declaring racism a public health crisis[II]. Despite this focus, provider training and resources often fail to discuss the impact of racism on the health of individuals and communities.

The **Trauma Healing and Learning Series (THLS)** was designed to bring together interdisciplinary scholars, practitioners, students, and community members to discuss and address the ways trauma, mental health, and well-being affect the health of people of color.
A Call to Action for Providers Serving Youth of Color: Learnings from the Trauma Healing and Learning Series (A Call to Action) presents insights from the first three years of the THLS and from listening sessions with the youth of color in Sacramento, California. *A Call to Action* is intended to complement existing tools addressing trauma-informed care.[III,IV,V] Specifically, in recent years there have been a number of comprehensive guides on why and how providers can ensure they are serving their patients with trauma-informed care. However, notably absent from many of these guides are discussions of how trauma-informed care must include explicit and intentional efforts to name and address institutional and personally mediated racism and the impacts on health disparities. This report aims to complement those efforts with insights into the why and how of dismantling racism within trauma-informed care.

The THLS was initially developed with a focus on the health and well-being of boys and young men of color. However, all discrimination—whether based on sex, gender, sexual orientation, disability, immigration status, other identity markers, or the intersection of these—harms the health and well-being of individuals and communities. We suggest providers commit to a practice of continuous learning so that they can approach their work with compassion and a willingness to learn about, support, and celebrate the unique cultures and experiences of each patient.

As you read *A Call to Action*, please refer to Appendix A for a glossary of terms.

Why Share the THLS Learnings

Upon reflection, we realized that the THLS had brought together so much rich knowledge and understanding on the extent to which racism impacts the health and well-being of individuals and communities, and the ways in which it is experienced in healthcare. We decided to share these learnings with a broader audience because historical and structural racism and discrimination underlie oppression, silencing, and trauma within Black, Indigenous, and people of color (BIPOC) communities. They are deeply embedded in healthcare system policies, practices, and programming and we as providers and allies must continue to challenge the status quo.

As system leaders and practitioners, we must continue to ask, *why*?:

- Why do healthcare systems perpetuate a cycle of trauma within marginalized communities?
- Why do we face challenges when trying to connect or work with diverse populations?
- Why do we continue to see significant health disparities and reduced life expectancy in communities of color?

We must also listen to the answers shared by those most impacted:

- Too often, as decisions are made about the health and well-being of those, not in the room, we silence the voices of those who are.
- Too often, practitioners don't look like those they serve and carry unchecked bias and privilege.
- Too often, BIPOC individuals and communities are missed at the margins of care.

If we genuinely want to tackle the root causes of health inequity and trauma, we must acknowledge historical injustices and their role in our system narratives. We must listen to and learn from HIS story, HER story, and THEIR story. We must accept our individual and collective failure to address inequities and heal trauma. We must listen,

engage with our clients, and acknowledge and address our own oppressive beliefs. And, we must challenge the systemic barriers in our sphere of influence. Whether internally or externally, individually or institutionally—to foster healing and system change we must lead with consumer engagement, leverage our power and privilege for advocacy, and create opportunities for learning, redefining, and co-creating systems and services.

Experiences of Racism in Health Care: BIPOC youth and young professionals share their experiences

Ample research suggests health disparities across diverse health indicators are associated with race and ethnicity (see Appendix B). Disparities in health care experience itself are common in Black and Brown communities[VI] and are also evidenced in research.

Prior to diving into the findings of the THLS, we first want to share insights into the experiences of young people who participated in a series of virtual youth listening sessions in 2021. The purpose was to facilitate dialogue and discussion about positive and negative experiences young boys and men of color have within the healthcare system.

Through these listening sessions, youth shared that they often feel...

- uncomfortable or unsafe going to the doctor or talking openly to their provider;
- may be treated as less than or unequal to those having higher quality health insurance (many youth of color are covered by low-income health insurance programs, such as Medi-Cal (California's Medicaid program);
- their practitioner could not connect with them and meet their needs because of a lack of representation, diversity, and cultural competency among healthcare staff; and
- they are poorly understood and disrespected by providers.

The THLS also hosted a panel of young BIPOC professionals to uplift the voices and experiences of youth system change leaders working in health and education and to support young men of color. These young professionals said that they...

- are acutely aware of the lack of diversity and representation among healthcare staff;
- do not feel a strong sense of support and inclusion where they received their care; and
- that they face challenges when trying to address systemic inequities within the workforce (regardless of whether they were working in healthcare).

HEALING CENTERED APPROACHES AND SOLUTIONS

At the heart of the mission of health care systems is healing. Healing comes naturally to us, and provides the most powerful antidote to disease and pain. We measure the efficacy of health care services by their ability to bring about healing. We design treatment interventions to restore a patient to good health. Effective treatment is paramount in the field of health care. All too often, though, we have neglected the methods used to deliver that care. How we provide care is just as important as the care we provide. The experience of the patient with their health care provider can help or hinder the efficacy of treatment[VII].

For young men and boys of color, the examination of how treatment is delivered has come too late. This population experiences the effects of racism and, very often, psychological trauma. Although research to quantify those effects is ongoing, we know that untreated psychological trauma is linked to life-long effects that compromise physical health and life expectancy.[VIII]

Trauma-Informed and Racially-Informed Care

In order to effectively serve young men and boys of color in the healthcare system, it is important to understand the experiences that shape their lives. These experiences provide a context for the ways they seek care and why

traditional treatments have failed to meet their needs. Trauma is a psychological experience that overwhelms one's ability to cope.[IX] Trauma exists in individual and collective experience (community trauma) and can be passed down from parent to child as generational trauma[X]. Racism and its expressions, both covert and overt, also drive trauma for young men and boys of color.[XI]

Young men and boys of color are one of the most vulnerable populations for health care and yet are the most underserved. It is important that our healthcare system be willing to consider alternative ways of providing services.

Doing business differently will require each of us to reflect on the ways health care has failed our young men of color and be willing to take collective and individual responsibility for their healing. We as providers must take on the responsibility of educating ourselves about the unique needs of young boys and men of color that have traditionally hindered their ability to receive quality health care.

From Cultural Competency to Antiracist

Progress has been made in raising provider awareness about persistent disparities in health outcomes. Around 1990, standards for cultural competency were developed and recognized as a factor in the health outcomes of patients. We also learned about the harmful impact of assumptions and ignorance about minority cultures. Culture is a broad term, often used to avoid confrontation about race and power differentials. In the early 2000s, cultural competency evolved into cultural humility. Originating at Children's Hospital in Oakland, California, cultural humility acknowledged the power differential between White doctors and non-White patients. The idea was progressive at the time: no one culture owns the truth. Still, cultural humility failed to address race.

In recent years, a shift in conversations from cultural competency to antiracism have emerged to address this gap. Antiracism, coined by Ibram X. Kendi in his book *How to Be an Antiracist*, is a collection of policies that promote and lead to equity.[XII] To be antiracist, one must be intentional and active. This process is about more than learning, but about taking action to address systems that perpetuate inequity.

The Role of Medical Providers

How did discrimination creep into our health care? Simply put, racism. The American Medical Association has been working to address the harms of racism in the medical field[XIII] and developed a strategic plan addressing the role of racism in medicine.[XIV] Like all of us, providers are socialized long before they enter the medical field and their experiences and attitudes shape how they interact with patients, interpret research findings, and develop treatment plans. Some providers may be conscious of the ways in which they view Black and Brown patients differently from White ones and may overtly discriminate. But focusing solely on conscious and overt racism ignores the pervasive, unconscious, and subtle discrimination Black and Brown communities face every day, including within the health care system.

Research shows that implicit racial biases are pervasive in health care and are associated with poorer provider-patient interactions, treatment decisions, patient satisfaction, patient follow-through, and, ultimately, health outcomes.[XV, XVI, XVII] One study found that resident physicians in an emergency department showed moderate pro-White/anti-Black implicit biases[XVIII]. These biases were more prevalent when the emergency department was overcrowded or they were serving more than 10 patients. Another study showed that resident physician bias against Black patients is not age-specific; they were similarly pro-White/anti-Black whether working with children or adults.[XIX] In a study showing that half of medical students and residents held at least one false belief, those reporting such beliefs rated Black patients' pain as lower than White patients, resulting in poor treatment recommendations.[XX]

The research underscores that being the subject of racial discrimination is associated with poor mental health and self-reported health status, high blood pressure and hypertension, cardiovascular disease, high cortisol levels, obesity, poor glucose regulation, inflammatory response, and a weakened immune system.[XXI] Experiences of racism have also been shown to alter gene expression, contributing to the intergenerational transmission of

trauma. An American Academy of Pediatrics 2019 policy statement named racism a core determinant to child health.[XXII] However, the biases of providers, as with all other individuals, can be unlearned once identified.

The remainder of *A Call to Action* is dedicated to sharing insights from the Trauma Healing and Learning Series that focus on institutional and personally mediated perpetuation of racism, the cascading effects on individual and population health, and tools for health providers to lean into identifying and unlearning their own biases.

HOW RACISM IMPACTS HEALTH

Although *A Call to Action* focuses on healthcare specifically, it is important to first understand the context in which healthcare providers and their patients operate and the ways in which that environment impacts well-being. Several models describe the interactive effects of environmental and personal factors on individuals. Urie Bronfenbrenner's *bioecological model* identifies how proximal (e.g., immediate family, neighborhood characteristics) and distal (e.g., social norms, policies, laws) factors interact with an individual's genetic makeup to affect the way we view the world and our health and well-being. Notably, beyond biology and immediate family behaviors, much of how we perceive ourselves and others is rooted in our environment—the built environment as well as media messages and laws governing our lives.

The cascading effects illustrated below mean that providers must take into account individual and community conditions that predate the point at which they meet the patient. Health providers engage patients in treatment within the context of the environments in which they live and work. Providers must understand the patient within the context of factors that shape their health and well-being, including the long-standing conditions created through institutional racism, in order to meet patient needs.

The community conditions affecting health are referred to as social determinants of health.[XXIII] Figures 1 and 2 illustrates the association between social determinants of health, health outcomes, and where providers engage with patients.

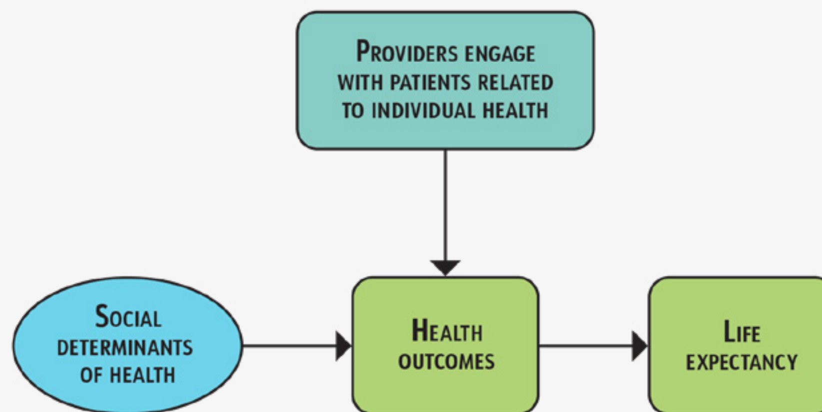

Figure 1. Cascading effects of social determinants of health on patient well-being.
Distal factors associated with health and well-being are represented in blue, measures of health and well-being in green. The teal box represents the meeting of patient and provider.

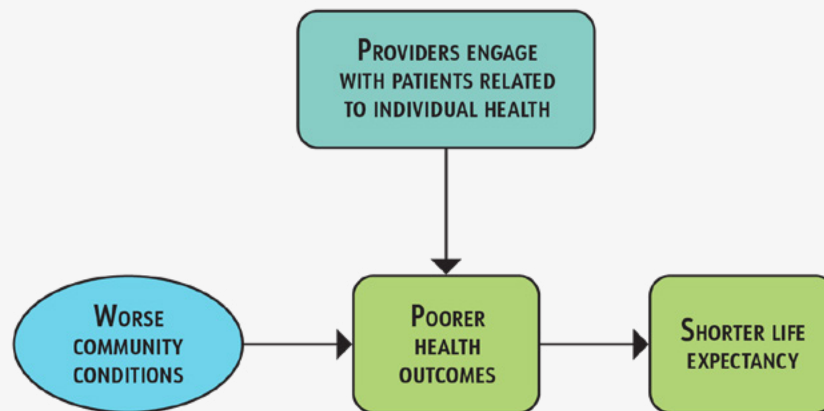

Figure 2. Example of how negative community conditions have cascading effects on patient well-being.
Distal factors associated with health and well-being are represented in blue, measures of health and well-being in green. The teal box represents the meeting of patient and provider.

More specifically, racism is a social determinant of health. Research examining the impact of racism underscores how racism - both interpersonal experiences as well as structural - drives health disparities.[XXIV] Camara Phyllis Jones, M.D., M.P.H., Ph.D., names three levels of racism at play in perpetuating harm: *personally mediated, internalized*, and *institutional* (see Appendix A for definitions of these terms). These three levels of racism operate independently and also interact with one another. For example, even those actively working to dismantle racist and racist practices may cause injury by operating within institutions that perpetuate harm.

Anti-Blackness is deeper than racism.

While all communities of color in the U.S. experience racism, Black individuals and communities face a unique type of discrimination and racism: anti-Blackness. Anti-Blackness is rooted in U.S. history and our dependence on slavery for close to 400 years. It also stems from subsequent policies that perpetuate discrimination specifically against Black communities, such as Jim Crow-era policies, persistent battles for equitable voting rights, and redlining. Exclusionary policies and practices not only grant legal permission for racism, they establish pervasive social norms and biases. Although anti-Blackness may be most evident in White communities, it also exists in communities of color.[XXV] For instance, in Latino/a/x and Hispanic communities, fair skin (*guerrito/a*) is more highly valued than dark skin (*moreno/a*). Families warn children to stay out of the sun to avoid appearing darker, reinforcing the privileges of White and White-passing persons. You don't have to be White to perpetuate anti-Blackness.

Modern Institutionalization of Racism

Federal, state, and even local policies may seem far removed from the health outcomes of individuals, but these distal factors have profound implications on health. Although slavery may have ended, racist laws and policies persist, both in legacy and in current laws and policies, and the impact they have on individuals is deep-seeded. A grasp of the association between community factors shaped by institutional racism and health outcomes is essential to understanding the root causes of population health disparities as well as the ways in which environmental factors influence patients' daily lives, biology, and health.

Examples of modern-day policies rooted in racism include redlining,[XXVI] limits to voting access,[XXVII] and more. Such policies establish legal and social permissions for racism, contributing to disparities with cascading effects on the well-being of individuals and communities. Further how such events are portrayed in the media and talked about among friends, family, and colleagues, shapes the biases individuals hold.

Redlining provides a concrete example of how social determinants of health, in particular racist policies designed to shape communities, have cascading and long-term implications for our health. Instituted by the federal government in the 1930s, redlining identified neighborhoods that were both favorable and unfavorable for investments such as home loans.[XXVIII, XXIX, XXX, XXXI] Neighborhood boundaries fell along the lines of race and ethnicity, deeming neighborhoods with higher proportions of Black and Brown residents as unfavorable. These neighborhoods were coded red on maps, leading to the term redlining. Redlined districts became targets for disinvestment in neighborhood development, healthy foods, and local schools.[XXXII, XXXIII, XXXIV, XXXV] These under-resourced communities are vulnerable to natural and human-created disasters, such as COVID-19 and climate change. In other words, redlined communities are a source of trauma not by accident but by design.

The maps below reported in the National Community Investment Coalition 2020 report, *The lasting impact of historic "redlining" on neighborhood health: Higher prevalence of COVID-19 risk factors*, highlight the associations between redlining in communities with large Black and Brown populations (Figure 3) and reduced life expectancy (Figure 4) for communities where these lines were originally drawn by the federal government as far back as the 1930s.[XXXVI] It is easy to see that the redlined areas have the lowest life expectancy while the areas targeted for investment have the highest.

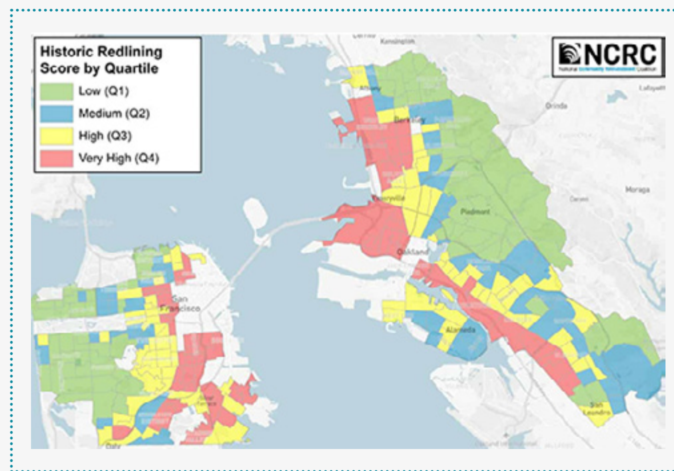

Figure 3. Historic redlining score by quartile.
Original HOLC grading of the historic redlining scores for census tracts.
Red indicates "very high risk" and green indicating "low risk." [XXXVII]

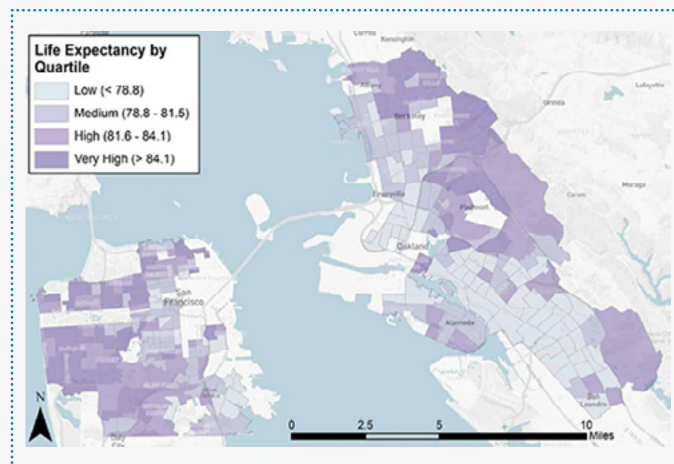

Figure 4. Life expectancy in redlined areas.
Areas in gray have the lowest life expectancy, areas in dark purple the highest.[XXXVIII]

Figure 5 further illustrates the pathways by which institutional racism shapes health outcomes and life expectancy in Black communities.

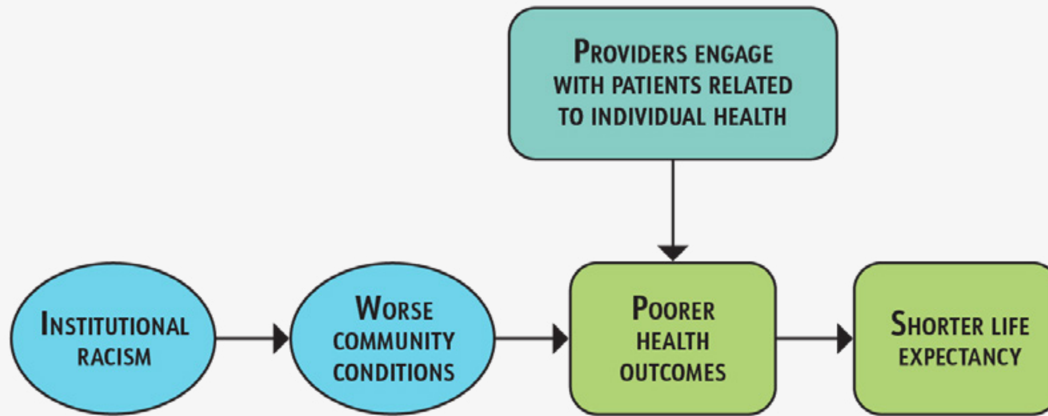

Figure 5. Cascading effects of institutional racism on patient well-being.
Distal factors associated with health and well-being are represented in blue, measures of health and well-being in green. The teal box represents the meeting of patient and provider.

Of course, redlining is just but one example of institutional laws and policies with race-based impacts and contributing to health disparities. Additional examples include, but are not limited to, the war on drugs[XXXIX, XL, XLI] and child welfare laws.[XLII, XLIII]

IMPLICATIONS OF SOCIAL DETERMINANTS OF HEALTH ON PROVIDERS

Social determinants of health have profound effects on patients and providers alike. In addition to influencing our health, they influence opportunities available to people, and their perspectives. Although the field of medicine is diversifying, all providers, regardless of your own identities have work to do to explore your own identity, the way you perceive your power, and your biases.

Power and Identity

To accept responsibility for changes that must be made we must first understand and make explicit where we have and where we have or lack power and privilege. Indeed, most people have aspects of both privilege and subjugation, which are dependent on our context.[XLIV] As Johnson notes in “Privilege as Paradox” (p. 104), “when it comes to privilege, it doesn’t matter who we really are. What matters is who other people think we are.”[XLV] Yet, our ability to understand and acknowledge where we have power is often overridden by the salience of and our focus on our subjugated selves.[XLVI] Therefore, it is crucial that we interrogate the privileged parts of our identity to see our responsibility in relationships.

Race is one of the most powerful and earliest learned organizing constructs of power and it shapes how we see and treat each other. One way to think about the power you hold - and therefore your privilege - is if in a given context you are acutely aware of your positionality. For example, many people of color learn they have a subjugated identity (i.e., a piece of their identity is without power) very early in life. In contrast, White people, having a privileged racial identity, most often learn they are White much later in life. The acute awareness of who has power in a relationship is a good indicator that one is in a subjugated position. A feature of privilege is the lack of awareness of power.

Assessing one's power and privilege, however, is not simple as every person has multiple identities and the identities that feel most salient to us at any given time are dependent on the context. Kimberle Crenshaw introduced the term "intersectionality," and with it a new way to think about our identities and our power within those identities.[XLVII] Intersectionality involves understanding the hierarchy of power in our society and where our identities fit within that power. Parts of us may be privileged and other parts subjugated (i.e., without power) at the same time. Privilege and subjugation can, however, be understood only within the context of our relationship to others.

For practitioners, this self examination is even critical, as your patients' lives depend on you understanding that regardless of your many identities, when in a room with a patient, you have the ultimate power and privilege. Please see Box 1 in the "Your Call to Action" section for an activity to reflect on your privileged and subjugated selves.

Be Aware of Your Bias

Social determinants of health and the environments in which we live and grow also shape the lens through which we perceive the world and those around us. As we grow up, we all develop biases towards food, relationships, and people. These biases develop based on our experiences, media exposure, and other sources. Biases shape what information we attend to, how we process it, what we remember of it, and how we respond. As startling as it may be, race- and gender-based biases begin to develop in *early childhood*.[XLVIII]

Of course, we all have explicit biases, those that we can easily identify and often easily admit to. However, our implicit biases, those which are subconscious, are especially harmful because they occur without us realizing it. Research has found implicit biases have potential harmful effects on how people perceive young men of color. For example, studies have shown that Black boys were viewed as older and less innocent than White boys of the same age[XLIX] and that young black men were seen as bigger and more physically threatening than White boys.[L] Implicit biases can even contradict our stated beliefs. For example, a 2019 study found that even those who said they supported racial equity endorsed racist attitudes.[LI]

As healthcare providers, in addition to reflecting on your own power and privilege, it's important to also examine and challenge your biases. Biases lead to disparities in the treatment of African American patients and in worse health outcomes.[LII] A 2007 study found that biases made physicians less likely to recommend appropriate treatment for Black patients.[LIII]

However, despite the sneakiness with which implicit biases shape our experiences and interactions with others, it is possible to unlearn them. A study conducted by Devine, Forscher, Austin, and Cox (2012) attempted to discover how a longitudinal, multi-faceted intervention program could support individuals to decrease their implicit bias.[LIV]

Their intervention included the following practices:

1. **Stereotype replacement:** Replace a stereotypical response with a non-stereotypical response.
   - Helps understand why your response was stereotypical and trains you to avoid stereotypical responses.
2. **Counter-stereotypic imaging:** Imagine counter-stereotypes of others in great detail.
   - Example: Imagine a smart Black person or a famous Black person to challenge your current bias.
3. **Individuation:** Obtain specific information from an individual to avoid generalizing about a group.
   - Form judgments of others based on their personal qualities rather than their group stereotypic identities.
4. **Perspective-taking:** Take the first-person perspective of someone from a stereotyped group.
   - This can help you to connect psychologically with others.
5. **Increasing opportunities for contact:** Seek out positive exposure through contact with individuals from a stereotyped group,
   - Helps change and improve the representation you've formed in your mind about the group.

These strategies helped study participants to reduce their implicit bias over the long term, which is promising because previous studies have focused on short-term changes. Based on the study, in order to effectively engage with the strategies and reduce your implicit bias, you must become aware of your biases, demonstrate concern over the consequences of implicit biases, and practice the strategies you believe will help you reduce your bias. The study did not determine whether one strategy was significantly better than another. Rather, overall, participants benefited from the multi-faceted intervention program.

Although we do not intentionally develop biases and cannot always shape our environments, they affect our behavior, and it is our responsibility to become self aware so that we can consciously engage with others. As providers, it is critical to ensure your biases do not impact patient and community well-being.

IMPLICATIONS OF INSTITUTIONAL AND INTERPERSONAL RACISM ON PATIENT ENGAGEMENT

As a result of experiences with personally mediated and institutional racism, social determinants of health, subjugated identities, and factors related to power, privilege, and biases that shape patient-provider relationships, it is no wonder that patients of color, and in particular BIPOC youth, may be reticent to trust practitioners and medical institutions. Two common ways, among many, in which reticence shows up in the patient-provider relationship is mistrust of the systems and the providers within them, and avoidance of care as a result of stigma associated with seeking care.

Medical mistrust

Medical mistrust is the result of a system that has repeatedly failed communities of color. Medicine has a long history of abuse and exploitation of patients of color. Abuses are well documented and in recent years have been more frequently discussed publicly. However, a continued lack of transparency and accountability for the mistreatment of patients of color perpetuates their long standing mistrust, impairing the provider-patient relationship.

An infamous example is the U.S. Public Health Service's Tuskegee study examining the natural history of untreated syphilis. In 1932, the study recruited 600 Black males—399 with syphilis and 201 without—from a vulnerable low-income community. Participants were not informed of their diagnosis and were given sham treatments to falsely reassure them they were receiving care for an unspecified blood condition. Informed consent was not collected. By 1943, syphilis was widely treated with penicillin, yet study researchers offered neither information about it nor treatment to participants. It was not until 1972 that the study was shut down as unethical after a whistleblower leaked information about it to the New York Times. Apologies were issued and attempts were made to compensate families, but the death of 28 study participants from syphilis and 100 more from complications, infection of 40 wives, and transmission of the disease to 19 newborns during childbirth led to immense and enduring mistrust. Even today, many Black individuals are wary about participating in medical research and accepting recommended treatments, as has been recently reflected in documented Coronavirus vaccine hesitancy.

It is important to note that medical mistrust is not specific to Black communities, and that communities of color face different challenges. For example, undocumented individuals are dehumanized by anti-immigrant rhetoric and depending on where they live, their access to health care and risk of deportation varies. However, regardless of location they live in fear of deportation, which creates barriers to seeking care and following through with treatment. It is essential to understand their unique experiences and fears to provide the care that will best meet their needs.

Research tells us that the patient's relationship with their provider contributes to their health outcomes.[LV] Although an individual provider may not have harmed patients through their actions, the provider remains responsible for understanding, owning, and working to build trust in service of promoting health equity. To be effective, providers must take responsibility for their interactions with all of their patients, including understanding the

context in which they live and the impact of that context on the ways they show up for care. Their ability to trust you and see you as a partner in their well-being. It is your responsibility to build that trust. This may be most easily accomplished when patients can physically see themselves in you (e.g., your are both BIPOC and/or female), that trust is also dependent on patients feeling like *equal* partners with their providers. Each patient will have their own ways of defining equal partnership, but speakers from the THLS events identified that being seen as experts of their *own* bodies, with providers as experts on the physicality of the human body and medical treatments, was critical for trust.

Mental health stigma

In recent years, mental health providers have advocated for both mental health and physical health to be taken equally seriously as one affects the other. Mental health advocates suggest effective health care and efforts to promote wellness are best achieved when care includes addressing the patient as a whole person, attending to both their physical and mental health, as well as considering potential factors outside of the reason for their visit that may impact their health.

Talking about mental health has become more normalized in recent decades. Celebrities, athletes, and other public figures have begun to publicly disclose their own struggles with mental health challenges. Having more frequent conversations about our inner lives leads us to change the way we think about ourselves and others.

That being said, mental health care is highly stigmatized among communities of color, who commonly avoid speaking about and seeking help for their mental health concerns out of fear for the opinions of community members. *Machismo* is common in Latinx families, where boys and men are expected to hide their emotions to avoid the perception that they are not "masculine enough." It is important for providers to understand the ways in which this may interfere with optimal self or provider care, and to understand the best ways to support patients in their cultural context.

YOUR CALL TO ACTION

Health disparities will persist unless we commit to addressing racism and discrimination as the root cause of harmful, even if unintentional, healthcare policies and practices. This is our **call to action** for you! Some of the work is personal and some of it is institutional. It is easy to say, "*I can only change me*," but institutions are designed and upheld by individuals. Therefore, it is critical that each person works to identify where in your spheres of influence you can leverage your own power and privilege - no matter how small - and contribute to systems change. The ideas that follow are not an exhaustive list of opportunities to create change, but emerge from the conversations of the THLS.

Individual Practices: It Starts with YOU

If done with intention, unlearning your biases, reconceptualizing your power and privilege in different spaces, and doing the work of an active ally for BIPOC youth (your patients and those who are not), will make you uncomfortable. The work is not easy and it requires you actively work to change the lens you have which has developed over decades.

The following practices that emerged from our THLS events. They focus on ways in which you can begin this work and are broken into three categories: doing your own work, making patients feel safe and seen, and challenging the status quo. We encourage you to watch all of the events on the *Sacramento My Brothers Keeper YouTube channel*, however, below we summarize ideas presented.

DO YOUR OWN WORK SO YOU CAN HONOR YOUR COMMITMENTS AS A HEALTH PROVIDER TO BIPOC YOUTH	
Allocate time for learning	*Seek educational opportunities as part of your responsibility to your patients. Having experiences in places that center people of color that are important for widening our perception to include the experiences of the patients we treat. Being willing to do things that are unfamiliar to you in order to understand your patients' lives is the best kind of practice improvement.*
Education is more than knowing facts, it's about exposing yourself to experiences	*For many of us, educational training takes years before we can practice with patients. Many of the interactions we have with patients are dictated by the experiences we expose ourselves to. Understanding relationships and power dynamics are an important part of facilitating healing. Just as our education and training as a provider informs us in our practice, so do our experiences. This means that if you want to be an ally for young men and boys of color then you must expose yourself to some elements of their world. An ally can not live a segregated life.*
Do the work to recognize unlearn your biases	*Learn about your own biases with personal reflection and/or by taking the Race Implicit Association Test,[LVI] an online assessment that captures race-based biases. Reflect on the steps identified by Devine, Forscher, Austin, and Cox (2012) in their research on interventions to address implicit bias.[LVII] Talk to others about your biases and theirs and how you can actively practice retraining your conscious and unconscious thoughts, perceptions, and actions.*
Confront and accept which parts of your identity are privileged	*There is an inherent privilege providers carry as a result of the patient-provider dynamic. Our work as providers is to acknowledge that and use our privilege responsibly. See Box 1, below, for an activity that you can do to understand how your power and privilege relate to your intersectional identities. Become more familiar with the tasks of the privileged and subjugated individuals developed by Dr. Kenneth Hardy.[LVIII, LIX]*
Read medical research with a discerning eye	*Medical study results often cannot be generalized because they were conducted with a homogenous population, with few if any people of color, for example. Yet these studies are used to design effective treatments. Use evidence-based treatments wherever possible, especially in mental health. Application of treatments for young men of color when they were not represented in studies used to develop those treatments should be discussed transparently with the patient.*

Box 1. Understanding Your Power and Privilege within Your Intersectional Identities

Our identities are complex and nuanced and reflecting on which of our identities confer privilege and which are subjugated helps us to understand how they shape our interactions with others.

The following activity, *One-Up One-Down*,* is designed to help people examine which aspects of their identities have privilege or subjugation.

A one-up identity means you are holding power in a given identity. One-up identities come with privilege, power, and the opportunity to make choices. One-down identities are marked by a sense of voicelessness, deference, and compliance. It is important to acknowledge that as providers, you often have a one-up identity in the context of patient relationships, even if you possess other One-down identities. Reflection and awareness of the power you have in a given interaction is key to understanding how to use the privilege you may have and not abuse it.

Identify your One-up and One-down identities in the table below. Please note, this is not an exhaustive list of identities, please feel free to add your own.

*This activity is broadly used in social justice work and the original source is not known. Examples of this activity can be found https://www.csun.edu/sites/default/files/One%20Up%20One%20Down%20Assessment.pdf and http://tmlink.org/files/2019/01/Complex-Identities-with-Questions.pdf

Types of Oppression	Variable	One-Up	One-Down
Racism	Race/ethnicity/color	White	Black, Indigenous and People of Color
Sexism	Gender	Men	Women, non-binary, transgender
Heterosexism	Sexual orientation	Heterosexual	LGBTQIA
Religious Oppression	Religion	Protestant	Muslim, Jewish, Not-religious
Classism	Socioeconomic status	Owning, upper/middle class, managerial	Poverty, working class, low hourly wage workers
Elitism	Educational level/place in hierarchy	College-educated; top 20-40 schools	Not college education; less prestigious schools
Xenophobia	Immigration status	U.S. born	Immigrants (especially from non-White countries)
Linguistic Oppression	Language	English speakers	Non-English speakers
Ableism	Physical or mental ability	Able-bodied person (body/mind)	People with disabilities

Table 1. Historically One-up and One-down groups in the United States

Reflecting on your One-Up identities:

1. How many One-Up identities do you have?
2. How has your One-Up identity shaped your experiences?
3. Are there policies that govern your One-Up identity or that you benefit from?

Reflecting on your One-Down identities:

1. How many One-Down identities do you have?
2. How has your One-Down identity shaped your experiences?
3. Are there policies that govern your One-Down identity or disproportionately impact you be cause of it?

DO WHAT YOU CAN TO MAKE EACH PATIENT FEEL SAFE AND SEEN	
Create a physically and psychologically safe space for your patients	*Provide access to free resources in their preferred language. Health care treatment should exist separate from but coordinated with law enforcement. Confidentiality is an important principle practiced by providers, in short because providers need the most information they can get to treat the patient effectively. The threat of punitive action leaves patients less likely to give accurate information that could be crucial to providing health care.*
Focus on empathy and transparency	*Patients are likely to have questions or concerns about medical advice that is standard practice to you. Remember that information you share may be new to them or a new way of thinking about their own health. Be sure to be honest about known and unknown risks.*
Be open to difficult conversations	*Practice difficult conversations with colleagues you trust. Remaining open to topics that make you feel defensive is key to communicating with populations that traditionally have not had power in the provider relationship.*
Maximize your learning from each patient	*To better support the mental health of patients, and particularly young BIPOC patients, maximize your time with patients and consider the following questions:* ▪ *Have you given your patient the opportunity to ask questions about their health?* ▪ *How is your patient's outlook on life? What stressors could be contributing to their poor health?* ▪ *Does your patient have access to the resources that will keep them well? For example, do they have safe spaces for physical activity, a grocery store nearby with healthy foods, or a supportive adult to talk to?*

CHALLENGE THE STATUS QUO IN YOUR SPHERES OF INFLUENCE	
Become an Active Ally	*As an ally, failing to challenge oppression leaves you complicit in fueling systems of oppression. Acting in partnership with and finding opportunities to lead this work helps alleviate the burden placed on marginalized groups. It can also sometimes expedite change because their voices are not always valued equally to that of someone with privilege.*
Insist on inclusivity	*Leverage your privilege to address inequities. Name, question, and address inequities that may exist in representation. For example, be intentional about fostering representation, participation, true belonging, and power-sharing in spaces you occupy. This could be a meeting, coalition, or within your department. Consider how you can "pass the mic." Use your privilege to make space for BIPOC participants and leaders to step up.*
Uplift the work and voices of marginalized groups	*When BIPOC are not in the room, invite them, but also amplify unheard voices, stories, and narratives of diverse communities and figure out what is needed to engage them the next time. Consider establishing opportunities to gather input from those most marginalized or least represented in your spaces.*

Acknowledge historical root causes and identify how they have manifested within our systems	*Share your knowledge with colleagues, friends, and family. Help others to understand the current and pervasive impact of institutional racism. Consider facilitating racial equity dialogues to give others a chance to discuss these issues and identify solutions to existing inequities.*

ORGANIZATIONAL PRACTICES: WORKING TOGETHER FOR CHANGE

Some practitioners have organizational power and positionality to create institutional change from the top down. Below are practices that can be instituted in collaboration with staff from all levels of an organization in service of better meeting the needs of BIPOC youth.

CHANGE THE INSTITUTIONAL POLICIES AND PRACTICES	
Diversify staff and opportunities for inclusion	*Be intentional about creating opportunities that promote equity and diversity among your staff. Create training programs and professional development opportunities to ensure you can recruit and retain staff with identities that are underrepresented in your field. Allocate sustainable funding for such efforts. Identify opportunities where you can curate opportunities for collective healing within and across affinity groups.*
Establish participatory processes to dismantle racist systems	*Address the policies and practices that support or create barriers to developing a diverse staff. Actively engage diverse communities (e.g., levels of staff, demographics of staff, patient groups) in program planning and decision making. Create measurable ways to address conflicts in policies, practices, and programming.*
Increase mandatory training on the impact of racism on the health and wellbeing of BIPOC patients and how to practice anti-racism	*Continuous education is critical for providers. This is true for reinforcing the impact of social determinants of health - and in particular racism - on patients' health and wellbeing. It take repetition, many years, and intentional efforts for each of us to unlearn, relearn, and reimagine how we do our work with an anti-racist lens. Help make that possible for staff by requiring participation in related trainings. See Box 2, below, for more information anti-racism curriculum.*

Box 2. The Importance of an Anti-Racist Curriculum

Medical schools are entrusted with training and educating future physicians to provide the best care. However, medical schools are not immune to institutional racism. National organizations such as the American Medical Association and Association of American Medical Colleges (AAMC) have historically excluded Black physicians and established racist policies. In 1948, the AAMC offered scholarships to Black medical students, but only to attend one of two predominantly Black universities. This was a legal way to segregate medical students. Other similar policies have been documented from these organizations, and it's important to understand this because they are key stakeholders in determining medical school curriculum. They have recently declared their stance against racism and acknowledged their past wrongdoings. Yet their current curriculum is focused on **race-based medicine**, teaching students to believe that biological differences exist based on race/ethnicity. This explicitly and implicitly influences students to believe that Black patients have thicker skin, or communities of color have more disease. An antiracist curriculum should instead focus on **race-conscious medicine**, teaching students the ways in which *racism*, not race, leads to health disparities.

Medical school can play an important role in changing students' implicit bias about Black people. A longitudinal study[LX] found that the "hidden" curriculum (faculty behavior and institutional culture) and negative comments from faculty increased racial bias in 3546 medical students from 49 U.S. medical schools; African American students were excluded. The study also found that favorable contact with Black faculty, completing the White-Black IAT during medical training, and self-efficacy regarding care for Black patients decreased racial bias.

Researchers at Tufts University[LXI] initiated a pilot anti-racist curriculum in their medical school to understand how students responded to it. Through medical student experiences and focus group discussions, three main themes emerged:

1. There are differential needs and experiences between medical students of color and those who are White.
    a. Underrepresented medical students also expressed that they had different needs compared to their White peers.
    b. Students of color feel an emotional burden when talking about racism, and still, experience racism in medical school from fellow classmates, faculty, and the institution.
2. Racism must be addressed within medical education as well as in medical care.
3. Accountability is important: challenging institutions and their beliefs is not easy but is necessary.

The history and prevalence of racism in medicine cannot be taught in one year. It was suggested to ensure that pre-med students, residents, and attending physicians also receive antiracist medical training. Identify ways in which you can contribute to this trajectory of continuing education.

CONCLUSION

Most health care providers have chosen their profession out of a desire to help people. Being in the business of healing requires us to have knowledge of our patients bodies and their lives, and ourselves. Being a part of a patient's healing can be an incredibly rewarding experience. The privilege of that facilitation requires us to reflect, understand, and give of ourselves. We must ask ourselves what we are willing to do to help people; the reason we got into this profession in the first place; how might we be contributing unintentionally to their harm; and how might we approach our humanity and theirs differently. When providers are willing to do that work, healthcare becomes wellness. We believe every young boy and every young man of color deserves to be well. As providers you have been called to this work, and we would like to extend this *Call to Action* to you in service of your hearts' work.

In her book, *Caste*, Isabel Wilkerson shares a metaphor that crystalizes the action antiracism requires:

> ***"America is an old house. We can never declare the work over....We in the developed world are like homeowners who inherited a house on a piece of land that is beautiful on the outside, but whose soil is unstable loam and rock, heaving and contracting over generations, cracks patched but the deeper ruptures waved away for decades, centuries even....And any further deterioration is, in fact, on our hands."***[LXII]

APPENDIX A. GLOSSARY OF TERMS

Community Trauma: Trauma produced by structural violence, which prevents people and communities from meeting their basic needs.[LXIII]

Consumer engagement: Actions individuals can take to become better informed and more directly and proactively involved in decisions and behaviors that affect their health, insurance coverage and health care.[LXIV]

Discrimination: In the healthcare setting, discrimination can be defined as negative actions or lack of consideration given to an individual or group because of a preconceived and unjustified opinion.[LXV]

Diversity: Any dimension that can be used to differentiate groups and people. Respect for and appreciation of differences. We all bring with us diverse perspectives, work experiences, lifestyles, and cultures.[LXVI]

Disparities: a lack of equality or similarity, especially in a way that is not fair.[LXVII]

Equity: Defined by the World Health Organization as "the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation)."[LXVIII]

Inclusion: The act or practice of including and accommodating people who have historically been excluded.[LXIX]

Implicit bias: Acting based on prejudice and stereotypes without intending to do so.[LXX]

Institutional racism: Policies, laws, and regulations that perpetuate disparities.[LXXI]

Justice: The state of being just, impartial, or fair.[LXXII]

Racism: A system of structuring opportunities and assigning value based on the social interpretation of how one looks that unfairly disadvantages some individuals and communities; unfairly advantages other individuals and communities; saps the strength of the whole society through the waste of human resources.[LXXIII]

Trauma: A psychological, emotional response to an event or an experience that is deeply distressing or disturbing.[LXXIV]

APPENDIX B. HEALTH DISPARITIES DATA

The data presented are a snapshot of disparate health outcomes and are not a comprehensive representation of health disparities.

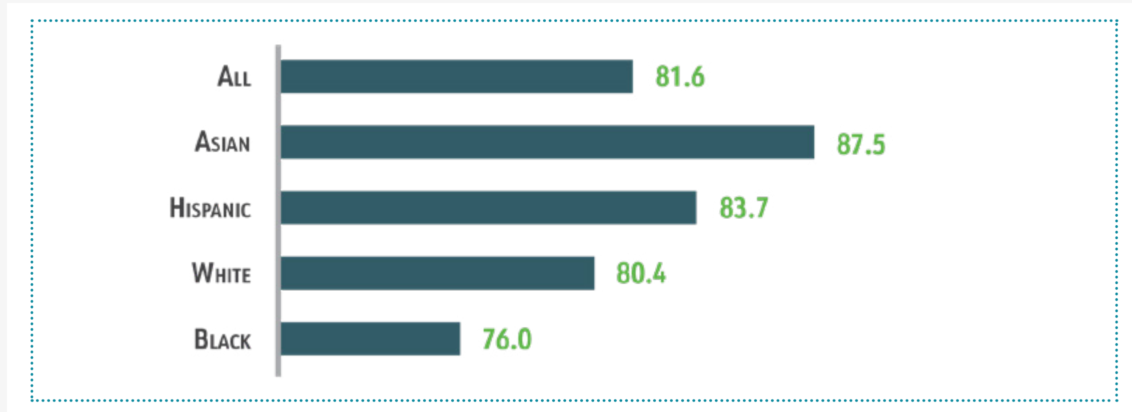

Figure 6. Years of life expectancy in California by race and ethnicity[LXXV]

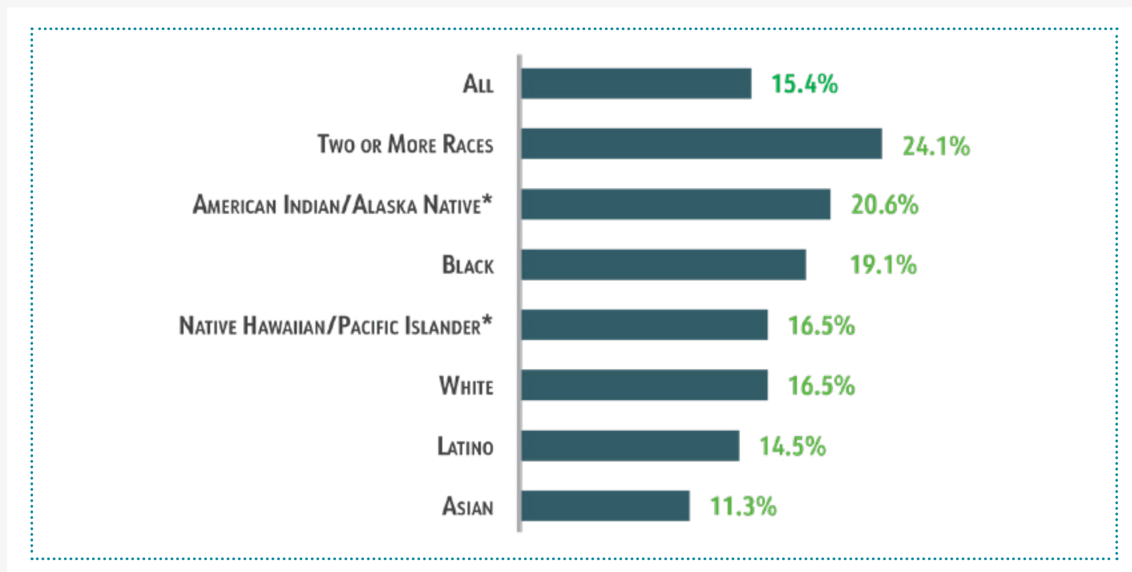

Figure 7. Rates of adults ever diagnosed with asthma in California by race and ethnicity.[LXXVI]
*Note. *Data pooled for 5 years (2016-2020) to ensure statistically stable estimates*

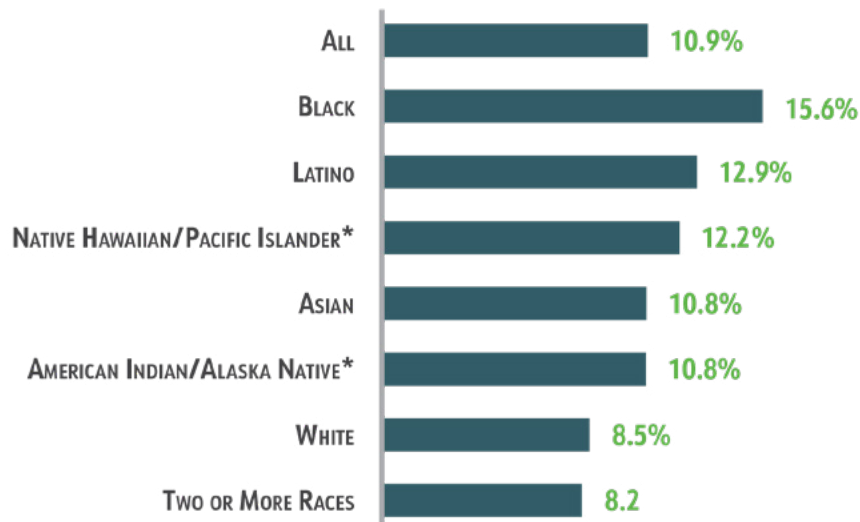

Figure 8. Rates of adults ever diagnosed with diabetes in California by race and ethnicity.[LXXVII]
*Note. *Data pooled for 5 years (2016-2020) to ensure statistically stable estimates*

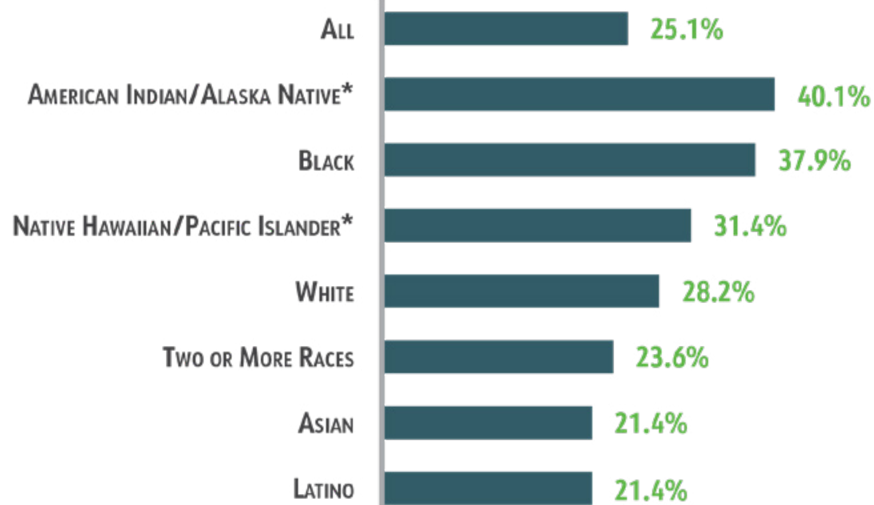

Figure 9. Rates of adults ever diagnosed with high blood pressure (including borderline) in California by race and ethnicity.[LXXVIII]
*Note. *Data pooled for 5 years (2016-2020) to ensure statistically stable estimates*

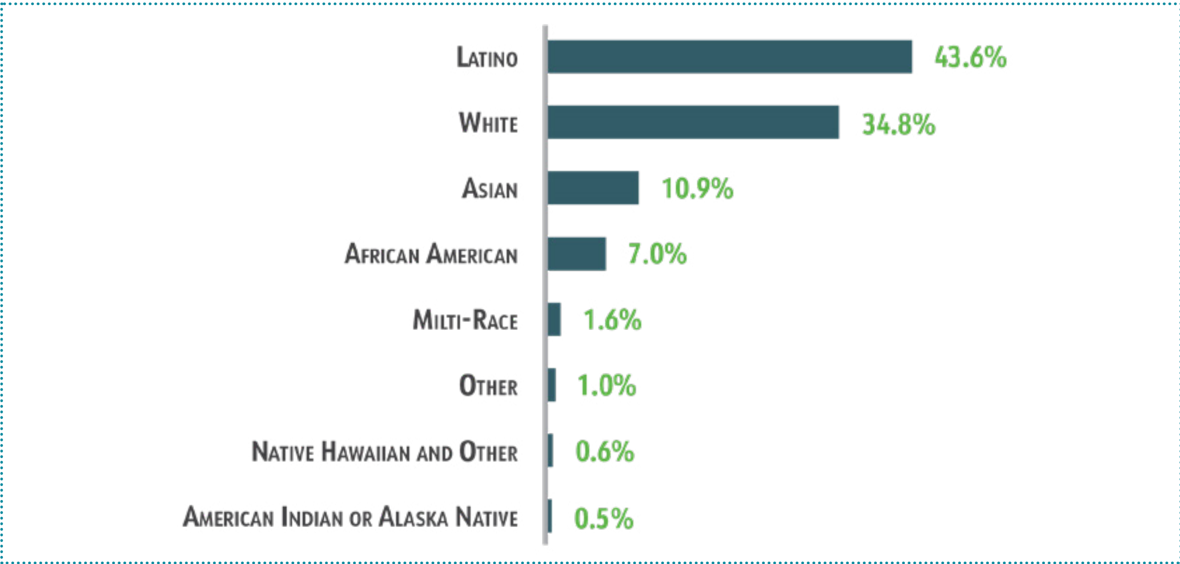

Figure 10. COVID-19 deaths.[LXXIX]

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