Implicit Bias: Recognizing Its Harmful Impact & Taking Actions to Counter

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About the California Institute for Behavioral Health Solutions (CIBHS) and Our Presenters

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“...racism is a visceral experience, that it dislodges brains, blocks airways, rips muscle, extract organs, cracks bones, breaks teeth. You must always remember that the sociology, the history, the economics, the graphs, the charts, the regression all land, with great violence, upon the body.”

HISTORICAL TRAUMA IN THE U.S.

- Indian Boarding School Policy - The stated purpose of this policy was to “Kill the Indian, save the man.” By 1926, nearly 83% of Indian school-age children were attending boarding schools.
- Mexican Repatriation - Mass deportation to Mexico during the Great Depression of an estimated 2 million Mexican descendants, 60% of whom were citizens, due to U.S. fear of white job loss.
HISTORICAL TRAUMA IN THE U.S.

- Slavery - 400 years, the last slave ship survivor gave an interview in the 1930s. Estimates of 12 million slaves shipped and 1.2 - 2.4 million who died on the journey.
- Japanese Internment Camps - Placement of an estimated 120,000 Japanese Americans into internment camps during World War 2. Taking away land and homes without due process with an estimated economic loss of $810 million - $2 billion in generational wealth.

HISTORICAL TRAUMA IN THE U.S.

- Cumulative psychological and emotional wounding across generations... [emanating] from massive group trauma.
- Collective trauma inflicted on a group of people based on their identity or affiliation related to ethnicity, religious background, and nationality.
**TYPES OF TRAUMA**

- Situational trauma - trauma that occurs as a result of a specific or discrete event, for example: from a car accident, murder or being taken away.

- Cumulative trauma - it is subtle, and the feelings build over time, for example: racism.

- Inter-generational trauma - if trauma is not dealt with adequately in one generation, it often gets passed down unwittingly in our behaviors and in our thought systems. For example, if you want to heal children and youth, you have to heal yourself as well to break the cycle.

**MODEL OF HISTORICAL TRAUMA**

- **Components of Historical Trauma**
  1) Traumatic event.
  2) Shared experience of trauma by a group of people.
  3) Multi-generational impact of the trauma.

- **Levels of Impact**
  Individual   Family   Community
IMPACTS OF HISTORICAL TRAUMA

- Higher levels of chronic disease several generations later
- Unresolved grief
- Weakening of family structures
- Alcoholism
- Suicide
- Depression

While not directly linked to historical trauma, domestic violence and alcohol misuse may be exacerbated by living in communities with unaddressed grief and behavioral health needs.

CONNECTION BETWEEN HISTORICAL TRAUMA (HT) & IMPLICIT BIAS

It’s not just about what happened in the past. It’s about what’s still happening.

HT considers how groups may be targeted on the basis of ethnicity, religious background and nationality, and the ways in which present treatment serves as reminders of historical trauma.
BIAS & STREET CALCULUS

Eliminating Inequities in Behavioral Health Care
5-part webinar series: Implicit Bias

BIAS

Explicit Bias

Reflects the attitude, assumptions, expectation, or beliefs that we endorse at a conscious level.

Implicit/Unconscious Bias

A preference for a group (positive or negative) often operating outside our awareness based on stereotypes, assumptions, beliefs, and attitudes we hold that tend to develop early in life and strengthen over time.
NORMALIZED BIAS/STEREOTYPES OF WOMEN OF COLOR

STEREOTYPES
- Submissive
- Fiery
- Angry
- Invisible

IMPACTS OF BIAS

Racial/ethnic minority youth with behavioral health issues are more readily referred to the juvenile justice system than to specialty primary care, compared with white youth.

Lack of cultural understanding by health care providers may contribute to underdiagnosis and/or misdiagnosis of mental illness in people from racially/ethnically diverse populations.

In 2015, among adults with any mental illness, 48% of whites received mental health services, compared with 31% of blacks and Hispanics, and 22% of Asians.
MISTRUST OF PROVIDERS

- Mistrust of clinicians by minorities arises, in the broadest sense, from historical persecution and from present-day struggles with racism and discrimination. It also arises from documented abuses and perceived mistreatment, both in the past and more recently, by medical and mental health professionals. *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.*

- Forty-three percent of African Americans and 28% of Latinos, in comparison with 5% of whites, felt that a health care provider treated them badly because of their race or ethnic background. *Commonwealth Fund Minority Health Survey*

CLINICIAN BIAS AND STEREOTYPING

Clinicians often reflect the attitudes and discriminatory practices of their society. Misdiagnosis can arise from clinician bias and stereotyping of ethnic and racial minorities.

Examples include:

- Widely held stereotypes of Asian Americans as "problem-free" may prompt clinicians to overlook their mental health and/or SUD problems.

- African American youth were four times more likely than whites to be physically restrained after acting in similarly aggressive ways, suggesting that racial stereotypes of blacks as violent motivated the professional judgment to have them restrained.
What is Stigma?

- A mark of shame: "Stain"
  - An identifying mark or characteristic; especially, a specific sign that indicates the presence of a disease. [Merriam-Webster]
- In 2017, Dr. Kim Johnson, former Director of CSAT
  - Providers should talk less about stigma and more about discrimination and racism.

Stigma, Discrimination & Racism

- Stigma refers to negative stereotypes. An attribute, behavior or condition that is socially discrediting.
- Discrimination is the behavior that results from the negative stereotype.
- Racism is the belief that different races possess different characteristics, abilities or qualities so to distinguish them as superior or inferior to one another.
Implicit Bias

Unconscious attitudes or stereotypes that affect our understanding, actions and decisions

Poor at seeing bias in ourselves, but good at seeing it in others. In this way, there is real power in groups and teams taking bias on together. Naming them, being transparent and holding each other accountable.

Institutional and Social Stigma

- Structural practices, intended or unintended, that restrict certain individuals or groups from community or governmental opportunities based upon policies, practices and traditions.
- The disapproval of, or discrimination against, a person based on perceivable social characteristics that serve to distinguish them from other members of a society.
- Covid-19 has revealed the sweeping inequity in health care access and outcomes along racial lines. Hugely disproportionate rates of hospitalizations, co-morbidities (rooted in social determinants of health) and mortality rates. This is evidenced in every region and geography of the country, from urban areas on the West Coast and the Mid West, to our least populated and diverse states like Maine. Maine has seen “green light” numbers for gating criteria, is a designated refugee resentment state, works hard and working harder with chambers of commerce to identify and combat racism and inequities, yet, with a 2% African American population, this population bears 25% of all Covid-19 cases.
Stigma and Self-Stigma

Self-stigmatization results in part from public stigmatization in a process leading to the internalization of the negative stereotypes.

Stigmatization of People with Mental Illness, ARTHUR H. CRISP, MICHAEL G. GELDER, SUSANNAH RIX, HOWARD I MELTZER and OLWEN J. ROWLANDS, British Journal of Psychiatry

Stigma and Self-Stigma in Addiction Steve Matthews & Robyn Dwyer & Anke Snoek

Catherine Chichester, APRNBC, CCSHE2019

Stigma, Discrimination and Racism Interact with Systems and Distort Individual Outcomes and Public Health overall

- “I struggle [with] people offering me help, I still think that I’m not worthy of it.”
- “Once we start something good, we feel guilty because we feel like we don’t deserve it.”
- “They don’t care about me, why would I possibly show up there?” “Last time I went there for help, I sat for hours, everyone was rude, and police and security kept asking me why I was there!”
- “All of the groups are during when I work” “No, I can’t tell my boss”
- “Don’t tell white folks your business....” ”rules of survival...keep your hands out of your pockets.” “ask permission to show ID.”
- “You are dressed like you’re in a gang, you can’t look like that here.”
- “She thinks too much of herself and it’s effecting the group. She needs to come down a notch or two.”
Treatment begins with the First Contact

- The first contact SUD programs have with those seeking help sets a tone for patient show rates, engagement, retention, and ultimately, their outcomes.
- Most processes directly dealing with initial engagement are operationally designed to comport with regulatory and financial obligations.
- Often these are not designed with the patient experience as the driver.
- In Behavioral Health Services we often find poor integration of Clinical and Operational front-end processes as a major internal barrier to both clinical and business improvements.
- What front-end processes, policies or traditions exist in your organization that result in unequitable access?

Disparities in Access to Medications for Opioid Use Disorder in the Veterans Health Administration

- Among the 53,568 veterans at VHA facilities diagnosed with opioid use disorder in Fiscal Year 2017, vulnerable populations – including women, older, Black, rural, homeless, and justice-involved veterans – had lower odds of receiving medications for opioid use disorder than their nonvulnerable counterparts.

Finlay, Andrea K. PhD; Harris, Alex H. S. PhD; Timko, Christine PhD; Yu, Mengfei MS; Smelson, David PsyD; Stimmel, Matthew PhD; Binswanger, Ingrid A. MD Journal of Addiction Medicine: August 18, 2020 - Volume Publish Ahead of Print
Access: Front-End Processes and Pt. Impact
Universal Truths

- The steps we take from first contact through the end of the 1st clinical encounter make or break a prospective pts. resolve to attend and return.
- No one aspires to attend a SUD evaluation or treatment.
- The many steps in the road to recovery are not palatable in the first contact or appointment.
- Rules and lists at initial points of contact are distracting from the intent of the contact.
- We rarely remember what we are asked in services access. We always remember how long we wait, and if the people are nice.

Foundation: Access to Treatment

- According to SAMHSA, only 11.6% of the people who need addiction treatment actually get it. Within this 11.6% are a much smaller proportion of Black and Latino populations whose access to SUD treatment and completion rates are significantly lower than whites.
- Front-end or Access processes contribute heavily to Engagement or Show Rates
  - The processes are defined by either High Demand or Low Demand Characteristics.
  - What are some examples of High or Low Demand Characteristics in pt. access that you can think of?
  - What are some examples of Demand Characteristics that are rooted in bias, discrimination or racism?
Access Characteristics

High Demand

- Leave a Message
- Long Hold Time
- Cultural incompetence, insensitivity
- Bring ID/Proof of Income
- Call weekly while on wait list
- Reviewing rules for participation (initial contact)
- Multiple contacts prior to disposition
- Administrative process delays care
- Stigma and Discrimination

Low Demand

- Real time, human answers 1st call for help, accepts walk-ins
- Multi-Cultural Competence, multi-lingual
- Clinical triage vs. financial
- Low (less than 3 days) or no wait times
- Providing what is tolerable
- Availability to troubleshoot barriers—Transportation, childcare, tx., or medication assistance and Technology
- MAT and Medication 1st processes

American Academy of Family Physicians Aug. 2019

Addressing one’s professional biases

- Introspection: Explore and identify your own prejudices by taking implicit association tests or through other means of self-analysis.
- Mindfulness: Since you’re more likely to give in to your biases when you’re under pressure, practice ways to reduce stress and increase mindfulness, such as focused breathing.
- Perspective-taking: Consider experiences from the point of view of the person being stereotyped. You can do this by reading or watching content that discusses those experiences or directly interacting with people from those groups.
- Learn to slow down: Before interacting with people from certain groups, pause and reflect to reduce reflexive actions. Consider positive examples of people from that stereotyped group, such as public figures or personal friends.
- Individuation: Evaluate people based on their personal characteristics rather than those affiliated with their group. This could include connecting over shared interests.
- Check your messaging: As opposed to saying things like “we don’t see color,” use statements that welcome and embrace multiculturalism or other differences.
- Institutionalize fairness: Support a culture of diversity and inclusion at the organizational level. This could include using an “equity lens” tool (mulco.us) to identify your group’s blind spots or reviewing the images in your office to see if they further or undercut stereotypes.
- Take two: Resisting implicit bias is lifelong work. You have to constantly restart the process and look for new ways to improve.
Tools to Assess, Address and Change Implicit Bias, Discrimination And Racism

What Is The Equity and Empowerment Lens?

- The Equity and Empowerment Lens (with a racial justice focus) is a transformative quality improvement tool used to improve planning, decision-making and resource allocation leading to more racially equitable policies and programs. At its core, it is a set of principles, reflective questions and processes that focuses at the individual, institutional and systemic levels by:
  - deconstructing what is not working around racial equity;
  - reconstructing and supporting what is working;
  - shifting the way we make decisions and think about this work; and,
  - healing and transforming our structures, our environments and ourselves.

[Diagram of the Equity and Empowerment Lens]

Equity and Empowerment Lens

- **People**: Who is specifically and negatively affected (by this issue) and how? How are people differently affected in terms of the barriers they experience? Are people systematically excluded (by your local decision area)? Consider physical, emotional, mental health and contextual effects.

- **Place**: How are you/the issue or decisions affecting the people, emotional and physical safety, and their need to be productive and feel whole? How are you considering environmental impacts as well as environmental justice? How are public resources and investments distributed geographically?

- **Process**: How are we intentionally excluding or including people, communities or places who are affected? What policies, processes and structural barriers contribute to the exclusion of communities most affected by inequities? Are there empowering processes at every level? What processes are transactional and how do we improve them?

- **Power**: What are the dynamics of power within the system? How are we having the decision-making power (in this system)? What is accountable? What is your decision-making structure? How do the current laws, policies, or programs setting power dynamics create barriers to the equitable values and support of communities of color?
Defining An Individual’s Purpose:

- What is my purpose towards achieving racial equity?
- What gets in the way of maintaining my purpose towards racial equity?
- What do I need to maintain my purpose?
- Purpose towards racial equity is also further clarified by our positions in the hierarchy.

1. If you are a manager or other type of leader with positional authority, how can you further clarify your purpose so that you are leveraging the power you have?
2. If you are at a lower level in the organization, what do you need from leadership in order to feel valued and a key contributor to the organizational purpose?
3. How does your role and your purpose influence and align with?

Defining An Institution’s Purpose:

- What is our institution’s purpose towards racial equity?
- How are we clearly defining that purpose, and where and how do we communicate that?
- How can we ensure that our purpose is integrated into our policies, procedures and practices?
- How can we give our employees a greater sense of meaning in what they do around racial equity, so they feel more enthusiastic and hopeful about their work?
- In what practical ways can our institution add more value around racial equity and do less harm?
- Is racial equity the central theme in your recruitment and retention efforts?
- Do you have the right people around you to achieve your purpose? If not, how can you move towards this reality?
- How do you ensure individuals work together with leaders to align to the institution’s purpose towards racial equity?
Define Purpose Toward Racial Equity

In a purpose-driven system, all partners at all levels align around transformative values, relationships and goals moving towards racial equity, integrating an emphasis on doing less harm and supporting actions that heal and transform.

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<tr>
<th>Six Outcome Areas</th>
<th>What steps can we take to create the conditions to better understand equity, and apply this lens to our work?</th>
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<tbody>
<tr>
<td>1 Shift in social norms (values, beliefs and behavior)</td>
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<td>2 Strengthened Organizational Capacity (diversity in staffing, leadership, structure, finance, &amp; planning)</td>
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<td>3 Strengthened Alliances (improve access, coordination and collaboration among traditional &amp; nontraditional system partners)</td>
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<td>4 Strengthened Base of Support (diversity in breadth, depth and influence of support)</td>
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<td>5 Improved Policies (any or all stages of policy change)</td>
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<tr>
<td>6 Changes in Impact (improved social, emotional, physical, and environmental conditions for affected populations)</td>
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To Obtain More Resources, Logic Model, Tools, Strategies and Examples Visit:

Call to Action: Addressing Implicit Bias

Instructions:
During a staff meeting, choose a racial equity outcome you would like to work toward.

Discuss:
What steps can your team or organization take to work toward the outcome?
How would you test the steps?

Questions
Contact Information

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