ACU
ASSOCIATION OF CLINICIANS FOR THE UNDERSERVED

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Recommendations for Addressing Hate Crimes in the Primary Care Setting

In 2020, hate crimes in the United States rose to their highest levels in twelve years. In addition to individual reports of hate crimes, mass shootings targeting minoritized groups continue to make headlines. Recent events include the November 2022 shooting in Colorado Springs at an LGBTQ friendly club where five people lost their lives; the March 2022 mass shooting at a grocery store in a predominantly Black neighborhood in Buffalo that resulted in the loss of ten lives; and the March 2021 shooting spree targeting Asian spas in the Atlanta area that claimed eight lives. However, while hate-based verbal abuse, physical assault, and property damage are commonly experienced by minoritized individuals, families, and communities, they are often underreported. Many individuals choose not to report a hate crime because of language barriers, wanting to avoid reliving the traumatic event, beliefs that reporting will not lead to justice, fear that the perpetrator(s) will retaliate, and/or mistrust of law enforcement agencies. As such, the true extent and severity of hate crimes and incidents are largely unknown.

Definitions

Hate crimes are defined across many federal, state, and territorial statutes that are aimed at protecting groups of people. While there isn't a single shared definition, the Department of Justice offers the following federal definitions for a hate crime and hate incident.

Hate Crime: At the federal level, a crime motivated by bias against race, color, religion, national origin, sexual orientation, gender, gender identity, or disability.

Bias or Hate Incident: Acts of prejudice that are not crimes and do not involve violence, threats, or property damage.

A population that is frequently the target of hate crimes that go largely unnoticed are unhoused people. In its report, 20 Years of Hate, The National Coalition for the Homeless cites 1,852 reported acts of violence over a 20-year period towards individuals experiencing homelessness, 515 of which were fatal.

In May 2022, the Department of Justice and Department of Health and Human Services released a special report: Raising Awareness of Hate Crimes and Hate Incidents During the COVID-19 Pandemic. One recommendation in the report is to engage healthcare providers, clinics, and health systems in efforts to address hate crimes and hate incidents. Engaging patients in a primary care setting is encouraged but should be approached with caution and intentionality so that patients feel safe and validated, aren't retraumatized, and receive appropriate guidance and services.

The following recommendations were developed by ACU's Justice, Equity, Diversity, and Inclusion (JEDI) Committee to support administrators and clinicians who are delivering care and providing services to individuals who may have experienced a hate crime or incident.

Bias Motivation Categories for Victims of Single-bias Incidents, 2021

Race/ethnicity (64.8%)
Sexual orientation (15.6%)
Religion (13.3%)
Gender identity (3.6%)
Disability (1.7%)
Gender (1.0%)

In 188 incidents, a total of 271 victims were targeted because of more than one bias.

The U.S. Department of Justice, 2021 Hate Crimes Statistics

Before Implementing a Screening Process for Hate Crimes and Incidents

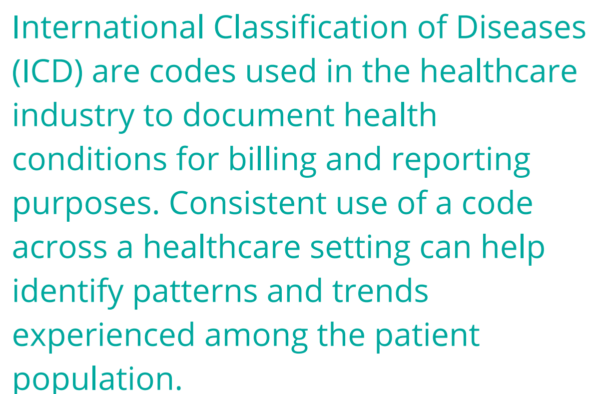
Have a clear purpose for asking patients about hate crimes and incidents. Is your healthcare organization asking about hate crimes and incidents for screening or surveillance purposes? If the question is for screening purposes, resources must be available to address the issue in that moment if one is disclosed.

Determine institutional capacity to support patients. Healthcare organizations should have a process in place for a warm handoff to connect patients to support services such as therapy or assistance with reporting a hate crime to a law enforcement agency, either within the organization or through partner organizations.

Understand and assess clinician capacity to discuss hate crimes with patients. Healthcare organizations should think about the capacity of their clinicians to support patients who have experienced hate crimes and discuss these topics with them. Some providers are not comfortable having these conversations. Others may have experienced similar trauma and may not have the emotional capacity or space available to support another person without their own trauma coming up. Regular assessment of clinician ability and capacity paired with opportunities for skill development may help develop increased capacity among staff.

Determine institutional capacity to support providers. Patients may prefer to see providers who share their identities. These providers may need additional support to protect their mental and emotional wellbeing as they engage in conversations that reflect their own lived experiences with identity-related stressors. Supervisors should regularly check in with clinicians who identify with minoritized groups and ensure that they have access to resources to support their mental health.

Determine how hate crimes and incidents will be documented. Since hate crimes and incidents are underreported, data available from your healthcare organization may provide a better understanding of the extent to which community members are experiencing hate crimes and/or incidents and the health-related impacts. Communicate these protocols with staff and the privacy of and rationale for any documentation to patients.



International Classification of Diseases (ICD) are codes used in the healthcare industry to document health conditions for billing and reporting purposes. Consistent use of a code across a healthcare setting can help identify patterns and trends experienced among the patient population.

ICD-10-CM Diagnosis Code **Z60.5**: Target of (perceived) adverse discrimination and persecution

Screening Patients

Screening questions can be included in a patient's intake paperwork. Responses can be a prompt for clinicians to broach the topic during the patient's clinical visit. Example screening questions:

- Have you been experiencing any sort of negative impact because of different aspects of your identity?
- Are you experiencing stress, marginalization, or oppression based on your identity (for example race or ethnicity, gender or gender expression, sexual identity, disability status, faith, etc.)?
- Do you avoid going places because of how you are treated?

Consider patient educational, literacy, and language needs to ensure patients understand questions (written or verbal). This may involve asking questions in different ways and in different languages.

Supporting Patients

Practice trauma-informed care. Clinicians should be trained in trauma-informed care prior to asking a patient about hate crimes and incidents. Trauma-informed care principles (safety, trust, choice, empowerment, and collaboration) are incorporated in the recommendations below.

Provide resources for non-English speaking patients. Some patients may choose not to report hate crimes or incidents because of language barriers. Having information and resources in languages spoken by your patient population can help address language barriers and create a more welcoming environment.

Prioritize patient trust and safety. Asking about hate crimes can cause someone to relive a traumatic experience. Patients may not feel safe talking about their experience with someone they haven't already developed a trusting relationship with.

Let patients know why you are asking. For example, are you offering resources and assessing your patient's interest in accessing those? Are you asking to better understand any physical or mental health needs that might be considered in a patient's care plan?

Support patient choice and empowerment. Support patient decision making by letting them know up front that they can disclose as little or as much as they want.

Give the patient options for addressing a hate crime. An empowerment approach offers patients options for addressing a hate crime both in terms of whether to report it to a law enforcement agency and what, if any, therapeutic approaches they may wish to access. Patient decisions should then be fully supported by their clinicians.

> *When you share with me, I can hold space for you in this moment – just as a safe space to talk where this conversation doesn't leave the room – or I can share resources with you and provide next steps if you want to do anything about it.*
>
> ~Dr. Rosandra Daywalker

Supporting Patients, *continued*

Consider the frequency of screening/following up with patients. When tensions are high and hate crimes and incidents appear to be increasing, consider more frequent screenings of your patient population such as every 90-days. If a patient responds that they have experienced a hate crime, clinicians should consider following up at every visit. This sends a message that the clinician cares enough about the patient to acknowledge the potential impact of this experience and check on their well-being.

Assess for hate crimes and incidents experienced by the pediatric population. Clinicians/pediatricians can benefit from training to better understand and address pediatric experiences of discrimination and hate, including how these experiences might manifest (e.g., changes in behavior). When asking the pediatric population about their experiences, it is helpful to have specific examples, such as bullying over one's cultural foods, appearance, or language.

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For additional information and resources, visit ACU's JEDI Initiative webpage.