EDITORIAL

Public Health in the Unrest: Baltimore's Preparedness and Response After Freddie Gray's Death

On April 19, 2015, a 25-year-old African American named Freddie Gray died at a Baltimore, Maryland trauma center one week after his fatal injury in police custody. On the day of his funeral, protests began in the city.

CONTEXT

To borrow a term from the medical world, the civil unrest following Freddie Gray's arrest and death was an "acute-on-chronic" situation, an urgent crisis on top of preexisting social and structural disorder.[1] Among the many chronic issues facing Baltimore today are poverty, historical distrust between residents and law enforcement, and neighborhoods blighted by discriminatory housing and financial policies.[2]

Baltimore City has the poorest health outcomes of Maryland's 24 counties.[3] Neighborhoods such as Sandtown-Winchester, where Freddie Gray lived, report disparities in life expectancy of less than 20 years when compared with wealthier areas nearby.[4] Injury deaths in Baltimore City are nearly twice those of greater Maryland. Baltimore City has greater rates of obesity, physical inactivity, sexually transmitted infections, and preventable hospital stays.[3] Differences in unemployment, food insecurity, arrest rates, and educational outcomes further demonstrate the social patterning of Baltimore's unrest.

The intersecting axes of mental health and substance use, longstanding mass incarceration, and a dearth of youth services are of particular importance to the roots of public health problems and to the solutions found in its interventions. Most of the 73 000 arrests made in Baltimore per year are for a drug offense.[5] Of those in prison, eight out of 10 use illegal substances and four out of 10 have been diagnosed with mental illness.[6]

The situation is particularly dire for the city's young people of color, who are both disproportionately detained and arrested when compared with their White peers—particularly for drug-related crimes.[7] The successful diversion of drug-related offenses from incarceration through Baltimore's drug courts is a first step, but the provision of mental health services to residents before incarceration and upon release is a necessary cofactor in improving the city's health outcomes.

This is not just a social issue but an economic one as well. More than half of the frequent emergency department users have mental illnesses, substance addictions, or a combination of the two.[8] Over the past 30 years, Maryland hospitals have seen a rapid increase in uncompensated care from less than one percent to more than nine percent of total gross revenue, with a cost of more than $900 million to the state annually.[9]

PREPAREDNESS AND RESPONSE

As some of the first reports of civil unrest emerged, the Mayor called upon the Baltimore City Health Department as a lead agency along with the Fire and Police Departments to coordinate the response to the riots and demonstrations.

The public health needs were immediate. Many of our nearly 1000 employees work in the field on everything from sexually transmitted disease clinics to animal control. Ensuring their safety as they continued providing services was already an immense challenge. In the media hailstorm, sifting through rumors and reality was chaotic and unpredictable.

Public safety was critical. The Health Department worked with city and state partners to create a security plan for Baltimore hospitals as the night unfolded. We convened hourly phone calls with each of the 12 hospital and six clinic CEOs in our city. Residents called us saying that they did not know whether their hospital or clinic would still be operating. Within an hour, we developed the Baltimore Healthcare Access List and worked with traditional and social media to spread the message.[10]

Daily life went on in the midst of the crisis. Residents were trying to cope without access to food and medications. Seniors dependent on more than a dozen pharmacies destroyed by fire had to ration their medications as the violence continued.[11] While we were focused on providing updates to emergency planners, we saw that readiness and security were not enough. We established a 24/7 line through our city's 311 system to allow individuals to call in if their pharmacies were closed.[12] Amid the chaos, we learned that our plans were moot if our communication strategies failed. One

day after our 311 line launched, we had received only two calls. Instead, we canvassed senior buildings and did outreach at more than 150 churches, hand-delivering medications to 200 seniors across the city.

People told us that they did not just have trouble getting medications—they also did not have food and basic supplies. We worked with local and state partners to establish shuttles and a bus route. Within two days of community requests for services, we established the Mental Health/Trauma Recovery Plan. This consisted of 24/7 crisis response, a free appointment line, and healing circles and group counseling made available to all schools, community groups, and neighborhood associations. This was not work that is routinely done in our health department, but this is the necessary agility of public health: finding effective strategies even under precarious circumstances.

REBUILDING

Though our situation and subsequent solutions were intimately local, none of the challenges facing Baltimore in its rebuilding efforts are unique. Cities across the United States need long-term, multidisciplinary approaches to match the depth of the deep-seated issues that need to be addressed.[13] We need a three-prong, trauma-informed series of interventions to address the roots of the problem through successful reintegration programs, mental health and addiction treatment centers, and youth mental health care.

First, we need to create a team of professionals targeted to the acute psychiatric, primary care, and social service needs of our city's most vulnerable individuals. Small-scale implementation of the Baltimore Crisis Response, including among former inmates, reduced emergency room visits by 24%.

Second, we need to better serve those with mental illnesses and addictions in need of treatment, housing assistance, or other needs with a 24-hour treatment center targeted to such groups. As a part of our Baltimore Citywide Opioid Overdose Prevention and Response Plan, the Health Department recently secured $3.6 million to fund a stabilization center and increase lay access to naloxone, a medication used to counter the effects of opioid overdose.[14] We are looking for funding to build an alternate emergency room for those suffering from drug use, withdrawal, or overdose, which will allow for increased treatment capacity and a greater focus on prevention.

Third, we need to meet the mental health needs of young people in Baltimore's 188 schools across the city and in their homes, and deliver care where people are. Existing home-visiting programs, like those for first-time adolescent mothers and at-risk mothers, need to be expanded to further reduce infant mortality and adolescent pregnancy.[15] The expansion of the Safe Streets program, a public health campaign that employs outreach workers to reduce gun violence, could continue to reduce shooting incidents in Baltimore neighborhoods.[16] We need to implement trauma-informed care for every front-line employee in the city.

LOOKING FORWARD

Our mandate is to help all residents realize their full health potential, *especially* when the challenges seem daunting. It's everyone's job, because health is everywhere—affected by everything and everyone. Public health should never take a back seat. We did not do so in the unrest, and have no intention of doing so now. This is our time to rally local energy and federal resources to catalyze change throughout the city and truly fight for health care equity. ■

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