Diversity and Inclusion in Psychiatry: The Pursuit of Health Equity

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The increasing diversity of America requires a workforce that is able to serve the mental health needs of individuals from multiple backgrounds, with a culturally proficient, inclusive, and affirming approach. To accomplish this, clinicians must be mindful of the multiple challenges presented by social determinants of mental health and access to care; the role of culture in wellness protection, mental illness expression, symptom attribution, and help seeking; the impact of provider factors, such as availability and cultural and linguistic congruence and proficiency; and the interaction of clinician and patient, who are with increasing frequency members of differing identity groups. The authors highlight the central role of clinical providers, academic institutions, and service organizations to advance health equity through training and commitment to increase high-quality services that are available, accessible, affordable, and acceptable, improving the care of all individuals.

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In this article, we define and discuss relevant aspects of mental health disparities, diversity and inclusion in medicine and psychiatry, bias and stereotype, and elements of communication as tools to provide equitable care. Our goal is to introduce or reinforce relevant concepts, enhance awareness, foster interest, and offer guidance to providers and service agencies to recognize the urgency of addressing inclusion and equity and to assess and reinforce our commitment to equity-minded policies and practices that may improve our capacity and ability to serve all individuals with excellence.

MENTAL HEALTH CARE DISPARITIES AND HEALTH EQUITY

The Centers for Disease Control and Prevention defines health disparities as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations” (1). Access to and utilization of mental health services are negatively affected in ethnic-racial minority groups, and these negative impacts are often associated with factors such as socioeconomic and insurance status, stigma, cultural beliefs about mental illness that influence help seeking, and lack of patient-physician cultural and linguistic concordance (2). Investigations in minority communities suggest that racial segregation has created disadvantaged environments that exacerbate mental health care disparities in access and service utilization (3). Geographically underserved areas, considered to be mental health professional shortage areas, disproportionately affect socioeconomically disadvantaged individuals from African-American, Latino, and American Indian/Alaska Native communities (2). Other factors contributing to health care disparities in mental health are related to limited diversity among researchers and limited representation of minority groups in research samples. Inclusion of community-congruent minority researchers and participants in all aspects of the translational research continuum may serve as a strategy to address this important limitation (4–6).

In clinical care, disparities exist on the basis of gender, sexual orientation, immigration status, ethnicity, and race among others. Women, who constitute slightly more than half the U.S. population, have higher rates of mental disorders, such as depression, anxiety disorders, eating disorders, and trauma-associated conditions, compared with men. They are also more likely to be victims of trauma or abuse in the form of domestic violence, sexual assault, and human trafficking. Women from ethnic and racial minority groups are less likely to access care, even when it is available (7). A specific focus on women’s mental health in education, clinical, and research settings is essential to build capacity for recognizing and treating women of all ages. Furthermore, recognizing and addressing gender-specific challenges in accessing care, including provision of child care, transportation, and safe settings, need to be considered when developing care programs specific for women. Transgender and gender-nonconforming individuals experience greater prevalence of mental disorders; higher psychiatric morbidity; and reduced access to high-quality, affordable, and gender-affirming care (8). Individuals who identify as lesbian, gay, or bisexual also experience higher rates of mental disorders, suicidal ideation, nonsuicidal self-injury, and substance use (9). When analyses adjusted for level of educational attainment in a lesbian, gay, or bisexual cohort, increased odds of psychiatric morbidity were consistently pronounced among participants from lower educational strata (10). This finding highlights sociodemographic factors as effect modifiers for health care disparities.

Equity in health care has long been a goal of public health and community mental health organizations. Health equity, per the World Health Organization, implies that ideally everyone should have a fair opportunity to attain his or her full health potential and that no one should be disadvantaged from achieving this potential (11). For mental health, this has been an even greater challenge because of disparities between treatment of physical and mental health conditions by insurance companies, including federal and state-run programs. A legislative win for mental health was noted in 2008, with the passage of the Mental Health Parity and Addiction Equity Act (12). Over a decade later, implementation of this federal mandate remains elusive, with differences in coverage for and access to mental health care disproportionately affecting individuals from underrepresented minority groups.

Explanations of health care disparities often note the role of social or minority stress theory. These related theories posit that socially disadvantaged groups are exposed to more social stressors and have lower access to coping resources than more advantaged groups (10). Hostile social environments are seen to negatively influence mental health outcomes for marginalized individuals. Adversities range from low socioeconomic status, reduced access to education, poorer employment opportunities, and lower remuneration to restrictive social and legal policies that engender and sustain disparities. Intersectionality, a legal and sociological theory, is defined as "the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups" (13, 14). Understanding and addressing health care disparities will require a practical appreciation of these complex concepts.

It is widely accepted that the presence of multiple vulnerabilities is the norm for individuals from minority communities, leading to incremental adversity. We often observe a wider mental health disparity for individuals who belong to two or more disadvantaged groups; membership in one group is seen to heighten the baseline risk of psychiatric disorder resulting from membership in the other (10). Research on health care disparities would benefit from findings of effect modification, specifying conditions under which disparities emerge and persist and identifying efficient prevention strategies and improved etiologic theory. Quantitative approaches to intersectionality studies can inform policy in mental health (15). Efforts aimed at reducing disparities must address exposure to stressors and improve cognitive coping strategies at an individual level. Most important, leaders of mental health agencies and individual providers must make health equity an important part of their mission and contribute toward it according to their capacity.

DIVERSITY AND INCLUSION IN PSYCHIATRY

Of the multiple definitions of diversity, one of the most relevant to our field is that offered by the Association of American Medical Colleges (AAMC). AAMC lists diversity and inclusion as one of its four core missions, along with medical education, medical research, and patient care, stating: "Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity." The diversity statement further suggests being mindful of all aspects of human differences, such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability, and age. AAMC similarly promotes inclusion as a core element for achieving diversity, by nurturing an organizational culture of inclusivity through professional development, education, policy, and practice to pursue a climate that fosters belonging, respect, and value for all.

In addition, the American Psychiatric Association (APA) states: "The APA prepares all members to be culturally competent psychiatrists and aids in eradicating mental health disparities by creating programs that align with APA policy by supporting and increasing diversity within APA; serving the needs of evolving, diverse, underrepresented and underserved patient populations; and working to end disparities in mental health care." In 2018, Dr. Altha Stewart became the first African-American APA member chosen to lead the organization after 174 years. In 2019, Dr. Patrice A. Harris, a psychiatrist, became the first African-American woman to lead the American Medical Association (AMA), as its 147th president. Segregationist policies held by AMA and APA and many of its members during the civil rights era led to the creation of independent organizations, such as the National Medical Association and the Black Psychiatrists of America, the latter with a mission "to address the mental health needs of underserved and underrepresented populations with particular emphasis on persons of African descent at a national and global level." APA leadership has shown an increased sensitivity to the need for member and workforce inclusion and community service, especially through the work of the Division of Diversity and Health Equity, which undertakes concrete efforts, such as empowering the various minority and underrepresented group caucuses and hosting diversity support programs to foster engagement, leadership, and career advancement.

Much of the change observed in the national organization reflects grassroots efforts from bottom-up constituencies, heralding individual clinicians as change agents.

The medical education establishment has also made attempts to address health equity and underrepresentation in medicine. The Liaison Committee on Medical Education established requirements for medical school accreditation in 2009 that mandated medical schools to engage in systemic efforts to attract and retain students from diverse backgrounds (current standard 3, element 3.3). In the absence of numerical targets, the impact of these practices has been marginal, according to researchers at Yale School of Medicine who explored data on matriculants from 2002–2017 (16). Despite the modest benefit in diversity composition, the application of diversity standards has supported the creation and a continuum of implementation of diversity and inclusion policies. These include outreach, admissions, institutional climate, curriculum composition, engagement, and student support that promote diversity dimensions specifically defined by each accredited institution.

The Accreditation Council for Graduate Medical Education (ACGME) has recently begun to mandate and monitor implementation of diversity- and equity-specific standards for selection of residents, clinical and intergroup residency program experiences, faculty diversity and trainings, cultural competence trainings, and so forth. Partly on the basis of results from a Clinical Learning Environment Review (17), effective July 2019, residency programs must comply with ACGME common program requirements section IV.B.1.a).(1).(e), which states, "Residents must demonstrate respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation" (18).

In the United States, 26% of the population are members of groups traditionally underrepresented in medicine (African Americans, Hispanics, and American Indian/Alaska Natives), whereas only 6% of practicing physicians come from these groups. The proportion of members of minority racial and ethnic groups is anticipated to expand, contributing to a "turning point" of the U.S. population within a decade, and the country could be minority white by 2045 (19).

The country is also seeing a significant growth in diversity of beliefs, values, languages, and practices that are reflected in the multiple identities shared by many individuals. Most people may not be reduced to a single ethnic or sexual or social label but rather adhere to multiple identities and to some extent may embrace beliefs, values, and behaviors that belong to others and incorporate them into their unique personal experience. These identities are fluid and evolve on the basis of development, migration, environment, and experiences. The current and projected increase in cultural and intersectional diversity highlights the importance of developing a workforce that is increasingly congruent with the composition of the communities we serve and better equipped to appreciate and address the cultural, linguistic, and holistic needs of our patients and those important to them. Academic institutions and physician organizations must continue to expand their commitment to diversity, inclusion, and equity.

AWARENESS OF DIFFERENCE, AND BIAS

Humans and other living creatures have benefited evolutionarily by accurately and quickly recognizing ingroup and outgroup membership (20–22). The observed physiological, psychological, emotional, and behavioral responses to difference, which at times resemble threat-based reactions, may be explained by the attachment of preestablished social values and preferences for specific groups (23, 24). Many of these social values underlie implicit associations and stereotypes, which at times are manifested as a preference for ingroup members or dislike of outgroup members. It has been postulated that humans follow two distinct paths of social cognition: a reflexive, unconscious, or unintentional path and a reflective, conscious, or intentional path (25). Unconscious cognition has received much attention, because it may explain the presence of unconscious prejudices that go against the individual's goals or conscious attitudes toward certain groups. An interesting illustration is the work by researchers at Harvard University's "Project Implicit," who have utilized the Implicit Association Test to measure the implicit responses to social constructs, such as race, social class, and sexuality, and individual characteristics, such as sex, age, disability, and weight (26, 27). They describe how first recognizing the existence of these biases from a lifetime of exposure to cultural attitudes can help us align our behaviors to our good intentions (28). The successful alignment of behaviors and intentions is essential for clinicians, because unconscious bias has been reported to result in lower quality of and satisfaction with care in medicine and behavioral health care alike. African-American patients report negative responses to providers who are low in explicit bias and high in implicit bias (29). Providers with higher implicit bias scores talk more and listen less, compared those with lower implicit bias scores (30, 31); they use more first-person plural pronouns, such as "we," "our," and "us," when interacting with African-American patients (32); and their African-American patients reported trusting them less and having less confidence in them and gave them poorer quality ratings (30). Providers with high implicit bias spent less time per patient visit and were less supportive, such that African-American patients picked up on these attitudes, rated them as being less patient centered, and were less likely to remember their communications (33).

Of note, patients and their support networks may themselves hold biases that can be learned from past negative encounters with racism and power differentials in health care, and in some cases, patients may harbor conscious and unconscious biases that complicate care. In a Canadian study of family medicine residents, 35% reported intimidation, harassment, or discrimination from patients. International medical graduates perceived that ethnicity, culture, or language were the basis for microaggressions (34). Psychiatric providers from diverse backgrounds (for example, racial, ethnic, cultural, and religious) are at times recipients of bigoted commentary or behaviors from intoxicated, manic, psychotic, or at times fully aware and minimally symptomatic patients who request a racially or culturally concordant provider. Strategies suggested for medical practitioners to address discrimination from patients and families include assessing illness acuity, cultivating a therapeutic alliance, depersonalizing the event, and ensuring a safe learning environment for trainees (35, 36). Needless to say, the cumulative effect of microaggressions experienced by health care practitioners from minority groups represents a significant source of stress. Therefore, it is very important to recognize, name, and intentionally address them by validating the observed or reported experiences and by promoting values, education, and dialogue in support of a culture of inclusion and affirmation.

Stereotypes and prejudices may bidirectionally influence patients' and providers' ability to connect with, understand, and respond optimally to one another. Recognizing that cultural otherness may be a vehicle for transference and countertransference, it is important to remain in touch with and manage such experience (37, 38) and to work to consciously influence our egalitarian goals to reduce health disparities (39).

OPTIMIZING COMMUNICATION

The U.S. Department of Health and Human Services Office of Minority Health, through its program Think Cultural Health (40), promotes the National Standards for **C**ulturally and **L**inguistically **A**ppropriate **S**ervices (CLAS) to improve health quality and equity by establishing a blueprint for health and health care organizations to provide effective, equitable, understandable, and respectful high-quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Although it may be too ambitions for solo or small practices to consider the implementation strategies offered by the national CLAS standards, CLAS communication principles may offer significant practical value to all providers and service organizations. According to the Office of Minority Health, communication between health care workers and patients can be improved by addressing three key issues: health literacy, cultural competency, limited English proficiency (LEP).

Perhaps in no area of health services is communication as uniquely essential for conducting accurate assessments, coformulating plans, and implementing agreed-upon interventions as it is in psychiatry. It is sometimes said that psychiatrists offer the complex reading of their own conscious experience during a patient interaction as the equivalent of a skilled stethoscope auscultation during a physical examination. This form of therapeutic listening serves as the basis to establish rapport, build trust, generate respect, model genuineness, and express empathy. Although many techniques in psychiatry and psychotherapy have been developed in the service of Western communities, maintaining a patient-centered approach facilitates individualization of the clinical interaction, which can successfully serve the needs of individuals from other groups. In this context, we will discuss the three elements of communication described above.

Health literacy is the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health care decisions (41). It is determined by the continuum of skills that includes reading, writing, listening, speaking, numeracy, and critical analysis, as well as communication and interaction skills (42). According to the World Health Organization, health literacy is the most important component of the social determinants of health, being "a stronger predictor of an individual's health status than income, employment status, education and racial or ethnic group" (43). Mental health literacy has been recently defined as "understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy (knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities) (44). The elements listed here vary dramatically among cultures, highlighting the need to develop a patient level of appraisal that will empower successful communication and engagement. Those working in broader public health policy and programming are encouraged to address mental health literacy for differing communities and cultures as a strategy to reduce inequities in mental health and health care.

CULTURAL COMPETENCE

As people change throughout their lives, so do their cultures and the way that their culture influences them. Similarly, an individual's personality, gender, age, sexual orientation, religion, ethnicity, and socioeconomic status make the person part of multiple, ever-changing cultures at once. Culture is particularly important in psychiatry, because it influences how health information is received, what is considered to be a health problem, how symptoms of a problem are expressed, what types of treatment should be given, and who should provide the treatment. In response to growing national diversity and global connection, there has been a move from cultural competence and sensitivity to the concept of cultural humility. A seminal paper by Tervalon and Murray-Garciá (45) summarized that "cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician- patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations." Multiple publications in the current issue of this journal are dedicated to addressing approaches to best serve the clinical psychiatric needs of culturally diverse patient populations and offer practical strategies for their application, including the use of the cultural formulation interview (46), affirmative care across cultures (47), trauma-informed care (in the context of cultural humility) in mental health treatment of minoritized communities (48), and challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States (49).

LEP is defined as a limited ability to read, write, or understand English (50). Over 350 languages are spoken in the United States, and there are over 50 million individuals in this country who speak a language other than English. In the absence of language assistance, LEP has adverse outcomes on patient care, such as less access to primary, preventive, and specialty care. Psychiatry in particular is an area of medicine in which oral communication is essential for adequate care. Individuals with LEP who have mental disorders are significantly less likely to identify a need for mental health services, and they experience longer duration of untreated disorders and use fewer health care services for mental disorders, particularly specialty mental health care (51). Solutions that help address disparities related to LEP include a targeted increase in workforce representation of individuals who are fluent in languages of largely underserved groups (i.e., holistic recruitment and selection of Spanish-speaking candidates for psychiatry residency, providers, administrators in U.S.–Mexico border region) and use of certified interpreters who not only interpret language but can assist as cultural brokers and interpret subtle contextually implied messaging (52).

Use of professional interpreters is particularly important in psychiatry, given the delicate nature of behavioral health symptoms, the shame experienced by survivors of trauma, and the relational impact of being perceived as dangerous to themselves or others or being vulnerable. For these reasons, care should be taken to avoid the assistance of relatives or visitors (especially minors) as interpreters. When working with interpreters, start by introducing yourself and other members of the team (including the interpreter) to the individual, explain that you will be speaking directly to each other and that the interpreter will serve to facilitate your communications. It is important to follow general best-interviewing practices: position yourself facing the individual, leaning forward with an open and relaxed posture and establishing respectful eye contact unless avoided by the individual. Remember to listen actively and attentively to both verbal and nonverbal content and process and to communicate your openness, interest, connection, and comfort. Allow the individual (not the interpreter) to take control of some aspects of the interview. Recognize that extra time will be necessary when working with an interpreter; care must be taken to avoid appearing rushed or annoyed. In the care of individuals with LEP, it is important to take time to adhere to one's usual routine when using interpreters and to avoid sacrificing rapport building, thorough assessment, and informed treatment planning and to avoid delegating excessively to junior members of the clinical team because they are bilingual.

CONCLUSIONS

This article is not meant as a comprehensive review but rather as an opportunity to reinforce awareness of the many differences we will likely encounter with increased frequency in our interactions with patients, and their impact. Our differences at times represent a source of creative innovation, cultural richness, and diversity of cognitive strategies that facilitate solutions to complex challenges. However, differences in identity and preferences may sometimes support division due to "otherness," limiting trust and understanding and complicating care. This issue of *Focus* is a call to sensitivity, humility, commitment, and action to support advocacy and service for the individuals for whom we care, especially the most disadvantaged.

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