Time to SSTEP Forward

Recommendations to Promote Anti-Racist Clinical Practice

*By Students for Systemic Transformation and Equity in Psychology (SSTEP)**

**SSTEP is comprised of psychology graduate students across Canada who formed a coalition to work towards sustainable, systemic change. Our overarching goal is to transform the field of psychology by making it more equitable at the individual, institutional, and national level. SSTEP is comprised of the following students, listed in alphabetical order: Rita Abdel-Baki, Joanna Collaton, Erin Leigh Courtice, Brianne L. Gayfer, Soeun Lee, Nicolas Narvaez Linares, Joana Mukunzi, Lydia Muyingo, Tatiana Sanchez, Noor Sharif, and Karen T. Y. Tang.*

Racism is prejudice and discrimination targeted at a person or people based on their membership to a racial group that is reinforced by societal structures of power. Unfortunately, the existence and nature of systemic racism has not changed significantly in the past decade,[1,2] and it continues to be present in all facets of society, including psychological practice.[3] Indeed, racism continues to impact the mental health of Black, Indigenous, and People of Colour (BIPOC), via disparities in mental health status and diagnosis; barriers to accessing mental health care; and the lack of cultural competence/sensitivity in therapy.[4-7] In this article, we provide a brief summary of these inequities and provide recommendations, applicable for individuals (e.g., psychologists, supervisors) and organizations/institutions (e.g., Canadian

Psychological Association, universities). While some of the recommendations may already have been implemented or addressed by researchers, clinicians, programs, departments and institutions across the country, we hope that this article will contribute to further self-reflection and change for the discipline and profession.

Racism as a determinant of BIPOC mental health. Racism is an important determinant of health inequities and is associated with poorer mental health in BIPOC individuals.[7-9] For example, the descendants of Indigenous children who were forced to attend Indian Residential Schools in Canada report greater depressive symptoms and suicide behaviour as adults, providing evidence of transgenerational vulnerability of mental health issues from the impact of colonization.[10-13] Further, BIPOC individuals are often underdiagnosed or receive delayed diagnoses; Black adults are less likely to be diagnosed with major depression compared to white adults.[14] and Black children are diagnosed with autism spectrum disorder (ASD) much later in comparison to their white peers.[15] Given that BIPOC individuals report more severe symptoms and impairment when diagnosed compared to white individuals,[5] it is critically important to recognize the impact of racism on our diagnostic systems. On the other hand, BIPOC individuals are also over-represented in stigmatizing diagnoses. For instance, Black children are more likely to be diagnosed with oppositional defiant disorder (ODD) than white children[16] even though the prevalence of ODD is similar across races/ethnicities.[17] Similarly, Black individuals are more likely to be diagnosed with schizophrenia compared to white individuals.[21] Further, there is an overemphasis on substance abuse and suicidality in research involving Indigenous Canadians,[22] and these stigmatizing discourses are used to justify interventions and policies that inflict further harm on Indigenous peoples.[23] Additionally, the assessment tools used to assess mental health in BIPOC individuals are often disproportionately normed on white individuals, and include questions/items that are racist or insensitive.[21] Therefore, it is crucial that psychologists recognize the impact of racism on the assessment and diagnosis of mental health in BIPOC individuals.

Recommendations :

- Provide ongoing, embedded, meaningful education for psychologists and trainees regarding anti-oppressive practice[22] consistently across all programs and sites. This should include training regarding cultural variations in psychological disorders and symptoms.
- Critically evaluate the validity of assessment/diagnostic tools for BIPOC clients. Interpret results with caution and place within an informed, culturally sensitive context. For those who have already implemented this into their clinical practice, we recommend the following next steps:
    - Advocate for re-norming of assessment tools that are drawn from a majority white, middle class population
    - Explicitly note in assessment reports, other clinical documentation, and client feedback, when assessment tools are not drawn from representative populations
    - Place greater consideration on lived experiences in the diagnostic and treatment process, including respect for differing worldviews, collectivistic approaches, family hierarchies, spirituality/religion, and the impact of social oppression.

Barriers to Accessing Psychological Services. Psychological care provided for BIPOC individuals can also be compromised by racism (either overtly or via unconscious biases and prejudices). Racialized groups report greater unmet mental health care needs compared to white people[23] and have noted several barriers to accessing mental health care, including financial barriers, language barriers, discrimination, distrust of healthcare systems/ professionals, and preference for non-Western approaches to medicine/ therapy.[6,8,22-24] Additionally, BIPOC clients report a preference for a clinician of their own race/ethnicity,[25] though there is a significant underrepresentation of BIPOC clinicians in psychological practice.[26] Racism also often intersects with gender, class, and other identities, which can further compound these barriers. For example, the high cost of accessing psychological services, which are rarely covered by government funding in Canada (e.g., provincial insurance coverage), may disproportionately impact BIPOC individuals who are significantly more likely than white individuals to be of low socio-economic status.[27] Reducing barriers to accessing psychological services is an important step towards providing equitable care.

Recommendations:

- Psychologists and private psychological practices should dedicate a proportion of their caseload to sliding scale or pro bono services for underserved individuals.
- Advocate for the continued use and implementation of telepsychology across psychological practices, beyond the COVID-19 pandemic. Because the technologies required to implement telepsychology services can be costly, we also recommend that overseeing bodies (such as the Canadian Psychological Association) provide funding opportunities for psychologists whose clients rely on telepsychology services.
- Actively reach out to and engage with underserved communities to extend the reach of psychological services, rather than waiting for individuals to seek us out.
- Engage in active mentorship of BIPOC clinicians-in-training, for example through practicums and paid supervised practice or internships.
- Provide funding for clinicians to practice within organizations and settings that serve historically underserved communities (i.e., BIPOC communities).

The Role of Culture in Therapy. Once able to access therapy, BIPOC individuals have shown higher rates of dropping out of treatment,[28] which may be attributable to many factors. The therapeutic alliance is a robust predictor of treatment outcomes.[29]

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However, cultural miscommunications and misunderstandings and differences in cultural norms and values can make this more challenging for BIPOC clients to establish.[28] Indeed, having a therapist low in client-perceived cultural competence has been found to be a risk factor for premature termination of treatment.[30] In order to address these concerns, there is a growing call to expand education in cultural competence for psychologists and psychology trainees.[31,32] While this is a positive step, education alone is not sufficient, and evidence suggests that direct clinical experiences and supervision related to working with diverse clients is more helpful for facilitating clinician-perceived cultural competence.[33] Further, a clinician's self-rating of their own cultural competence was not found to be enough to predict effectiveness of treatment - instead, this was predicted by client ratings of their clinician's cultural competence.[34] Therefore, the ways that we evaluate "cultural competence" in psychology are also important to consider. Taken together, these findings suggest a pressing need to integrate cultural competency and awareness into training and supervision models.

Recommendations:

- Implement ongoing anti-oppression training for all clinicians/staff/students; this training should be provided by BIPOC individuals who are appropriately compensated.
- Provide financial stipends or professional days to support didactic and experiential training related to diversity and equity.
- Ensure regular discussion of diversity issues in supervision and consultation groups.

A note for students: The authors of this article are students in psychology PhD programs across Canada. Thus, these recommendations come from the perspective of the student authors and members of STEPP. As students, we recognize that graduate training in psychology does not necessarily prepare us for advocacy work within the many institutional hierarchies where we work and train.[35] While many of our recommendations are directed toward these institutions, we do provide the following recommendation to students specifically:

- Advocate for changes that you believe institutions must make to help you serve diverse clients and to create a more inclusive field. Some psychologists may believe that advocacy should be reserved for those outside of academia or established senior psychologists, although students have shown great potential to usher meaningful change through advocacy work.[35,36] As the decision makers of tomorrow, we encourage students to seek out and engage with other students and trainees on important issues, start conversations with those in positions of power with the ability to make institutional changes, and model transparency and accountability for advocacy.

For a complete list of references, please go to www.cpa.ca/psynopsis