

Equity, Diversity, and Inclusion (EDI) Didactic Toolkit

One of my favorite parts of lectures has been the stimulating discussion between lecturers and residents. One lecture that comes to mind was the lecture about the morality of involuntary treatment. We were able to discuss how race, gender, sexuality, and even country of origin have been factors in bias related to involuntary treatment.

-Resident, Class of 2025



? What's The Need?

Residents want more knowledge and discussion about equity, diversity, and inclusion (EDI) in all their lectures. They also evaluate lectures on meaningful incorporation of EDI.

👥 Who is This For?

This guide is for anyone who teaches a didactic to the UW psychiatry residents, including faculty, residents, and guest lecturers. The suggestions range from minor language revisions to more significant inclusion of new topics, so this guide may take anywhere from 15 minutes to several hours to implement changes. Instructors may consider making small, stepwise changes for each iteration of their talk.

Section 1. Checklist for Incorporating EDI into Didactics







To-Do	
<input type="checkbox"/>	Understand the goals for incorporating EDI (see Section 2).
<input type="checkbox"/>	Build up more relevant EDI information related to your didactic topic (see Section 3).
<input type="checkbox"/>	Prepare to facilitate conversations (see Section 4).
<input type="checkbox"/>	Review your materials to make sure they're accessible, inclusive, and intersectional (see Section 5).
<input type="checkbox"/>	Submit your slides for review or ask for a consultation (see Section 6).

Section 2. Goals for Incorporating EDI

Read the goals below and choose 1-2 to focus on for your lecture.

Broaden the definition of diversity and focus on intersectionality.	
Diversity exists in terms of gender, sexual orientation, socioeconomic, religion, culture, immigration status, body size, age, physical or cognitive abilities, race/ethnicity, and other identities that interact with each other.	<p>Examples:</p> <ul style="list-style-type: none"> • Use case examples to discuss how a patient’s many different identities can impact their care. • Add slides throughout the lecture to touch on these different elements of diversity.
Highlight structural inequities.	
Understanding structural barriers helps learners reduce bias and blame on individuals/groups.	<p>Examples:</p> <ul style="list-style-type: none"> • Discuss policies that have led to inequitable outcomes or distrust of healthcare systems. • Discuss efforts to reduce disparities.
Embrace cultural humility.	
Believing that everything about a group can be learned perpetuates the idea that everyone in the group is the same. Instead, encourage learners to reflect on their own identity and foster curiosity about other’s culture.	<p>Examples:</p> <ul style="list-style-type: none"> • When talking about cultural practices and beliefs, present the different ranges that exist. • Role-play different ways to ask open-ended questions.
Celebrate achievements made by diverse people and groups in psychiatry and mental health.	
Psychiatry’s history is often told as a story from Freud to Beck, from Europe to America, but it’s a richer and more diverse story. By celebrating other achievements, we show our trainees, who come from a variety of backgrounds, that they belong and that their contributions matter.	See Celebrating Psychiatry’s Diverse Histories and Achievements in this toolkit for a list of example resources.

Setting the Tone to Help Achieve Your Goals

 Don’t:	 Do:
<ul style="list-style-type: none">  Say you are talking about these issues because it is a requirement.  Call on residents who belong to groups that have been historically, socially, or economically marginalized to educate you or the other participants. 	<p style="text-align: center;">→</p> <ul style="list-style-type: none">  Use methods to elicit input from everyone rather than just the more vocal contributors (e.g., anonymous polls, small break out groups).  Validate both the absence of such content historically and the discomfort that can exist around these discussions.

Section 3. Ways to Build EDI Topics by Didactic Content Area

Find your topic area(s) below to read suggested EDI changes and decide which to incorporate into your didactic. Each section provides a link to the [Appendix](#) of this toolkit for specific PowerPoint examples.



Case Examples

PowerPoint Example: [Appendix 1. Case Example](#)

- Consider leaving race out of the one-liner and discuss it later in a more nuanced way if it is relevant. Consider leaving gender out if it's not relevant to avoid reinforcing stereotypes and gender essentialism.
- Consider using initials for patient names (e.g., D., J.J.) as a trauma-informed approach that helps avoid perpetuating unconscious biases.
- Do you include case examples that reflect patients of diverse identities such as gender, sexual orientation, race/ethnicity, ability, culture, etc.? If discussing gender, do you include case examples with trans and gender-diverse individuals?
- Do you explicitly discuss cultural aspects of your case example?
- Does your case example consider external systems that affect this patient's mental health rather than assigning blame to the individual? Ex: If a patient from an underserved community hasn't sought care, avoid attributing this solely to cultural stigma about mental health. Instead, consider structural factors such as cost, access to care, and prior negative experiences within the system.



Diagnosis

PowerPoint Examples: [Appendix 2. Diagnostic Prevalence Example](#) and [Appendix 3. Diagnostic Bias Example](#)

- Do symptoms present differently in different cultures/groups? Are there judgments or norms from the dominant culture baked into screening and/or diagnosis (e.g., individualism, social expectations)?
- Are there differences in prevalence among different groups? What structural factors contribute to these differences? (e.g., over or underdiagnosis? Racism? Sexism, heterosexism, homophobia, or transphobia? Ableism? Lack of access to healthcare? Lack of access to jobs, nutritious food, clean water, open spaces, nature? Exposure to noise/air pollution, crime?)
- How do global events, the climate crisis, and historical trauma interact with the disorder? (Worsening PTSD, moral injury, anxiety, depression, "eco-anxiety.")
- What structural factors affect prognosis? (e.g., Lack of access to care, stigma preventing care, social connection, racism, ableism, sexism, homophobia, or transphobia?)
- Is there a history of using this diagnosis in a racialized way (e.g., schizophrenia, oppositional defiant disorder)?



Psychiatry & The Law

PowerPoint Example: [Appendix 7. Systems of Care Example](#)

- Are there differences in ITA rates, restraint/seclusion, or incarceration for different populations, different hospitals? Why might this be?
- How might the historical context of the judicial and carceral system affect a patient's experience with ITA, police, and court hearings?
- How are people with mental health disorders treated in the carceral system?
- Are there biases in diagnosis of malingering and judgements of not guilty by reason of insanity (NGBI) for different populations?
- What message is universal ITA firearm restriction sending about serious mental illness and violence? Are there stigmas involved? What is the historical basis for this legislation?



Research & Evidence-Based Information

PowerPoint Example: [Appendix 4. Research & Evidence-Base Example](#)

- Consider the representation of researchers that you cite. Include and highlight research from diverse researchers, who may bring new perspectives.
- Do the studies you cite reflect a homogenous group or do they reflect variations in gender, race/ethnicity, etc.? Can you make this explicit to your audience?

- Can you find studies that reflect a more heterogeneous group or acknowledge the limitations of the research? (Ex: if discussing gender differences, specify whether trans and gender-diverse participants were included or name this as a limitation)
- If research with diverse groups is lacking, why might this be? (e.g., how did they recruit participants?) What sort of research would be useful going forward?
- Where are participants being recruited (rural/suburban/urban)? How applicable is the research protocol when applied to a different setting?
- Does the author have a positionality/reflexivity statement helping readers understand their identity and their relationship to the research?
- How might the measures used in a study affect its results with different populations? (e.g., questionnaire language)
- What research outcomes were used? Are these outcomes accurate in different populations?



Psychopharmacology

PowerPoint Example: [Appendix 5. Psychopharmacology Example](#)

- Are there differences in rates of prescribing in different populations? Why might this be?
- Are there concrete strategies providers can use to mitigate implicit bias when prescribing medications, especially controlled substances? (e.g., identifying root causes of differences, using structure prescribing criteria, finding data that challenges biases, etc.)
- Are there differences between groups in treatment side effects, adherence, or effectiveness? (Was this even studied?) What are the structural factors that might contribute to these differences?
- How do costs affect treatment initiation and adherence in patients of different SES?
- Are there differences (e.g., cultural, historical) in how certain groups may perceive medication management?
- Are there different rates in the individuals offered or completing interventional treatments (ECT, TMS, Ketamine)? What factors could explain this difference (historical context, implicit bias, patient autonomy)? Has it been studied (why/why not)?



Therapeutic Interventions

PowerPoint Example: [Appendix 6. Therapeutic Interventions Example](#)

- Have there been efforts to adapt these interventions cross-culturally?
- What community interventions have been tried? Interventions to increase access in rural or under-resourced areas? Interventions that incorporate cultural/religious liaison?
- Who might not be able to access the intervention and because of what reasons? (e.g., Ableism, socio-economic status, rurality, living situation, insurance, citizenship, education, social support, gender-identity?)
- How might a patient's identities affect their interactions with the therapist?
- How might the therapist's identities affect their interactions with the patient?



Systems of Care, Advocacy, & Policy

PowerPoint Example: [Appendix 7. Systems of Care Example](#)

- Are there health inequities in this system? What are their structural causes?
- How might someone from non-dominant culture experience these systems? Ex: How would someone who is undocumented receive care? How might someone with a disability experience this system?
- Who are the individuals who create healthcare policy? (e.g., what is their background, race, prior exposure to patient care?) How does this affect the policies made?
- How can bias affect patient care and how can we mitigate this?
- What advocacy efforts have been successful in the past, or are currently ongoing? What levels are they intervening in: Quality improvement, organizational, community, policy, societal?
- What are effective methods of reducing health inequities and what ecological level do they intervene on (individual, community, policy, societal)?
- How does publicly funded vs privately insured care affect outcome, navigation, or satisfaction? How does our current health insurance system impact accessing the care or treating the illness you're presenting on?
- What are some local provider or patient-facing resources that residents should be aware of in accessing the care or treating the illness you're presenting on?

Section 4. Prepare to Facilitate Conversations



How do I facilitate a challenging conversation about EDI? What should I do if someone calls me out during my didactic?

- Thank participants for their input. Remember that it is often hard for residents to speak up about things that make them uncomfortable.
- Avoid getting defensive. Take a deep breath and ask for more detail. Try to understand their position. Be curious.
- Ask how something can be corrected or improved if it's not clear.
- If you agree with a correction, simply apologize and move on.
- If you don't know the answer, acknowledge this. It's okay not to have expertise. Residents may have done their own research about an EDI topic. You can thank someone for their question/comment and let them know you will look up the answer later.
- If there is debate amongst participants around a contentious topic, take some time to allow participants to feel heard, even if it derails your timeline.

Additional resources on this topic are available in [Navigating Difficult Conversations: Resources](#).

Section 5. Review Learning Materials



Are my lecture and learning materials accessible?

Accessibility

Accessible learning materials increase equity for learners, including those with “hidden” diagnoses. Disability and ableism are defined and discussed separately in a later section, “[Addressing Disability](#).” Digital accessibility neutralizes barriers to people with mobility and hearing disabilities, but also to those with vision, learning, and cognition disabilities.


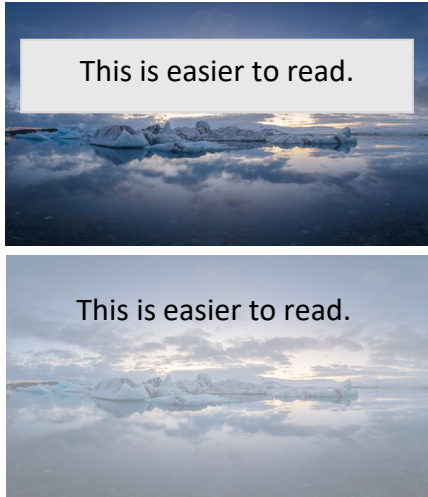
Important Note: On April 24, 2024, the Department of Justice (DOJ) published a [new rule](#) on digital accessibility under Title II of the Americans with Disabilities Act (ADA). This rule requires the University of Washington’s web content, including academic content, to be accessible starting on April 24, 2026, meeting WCAG 2.1 Level AA conformance standards.

The following section highlights some common pitfalls that make slides and documents inaccessible, paired with strategies to address them. Although it can feel overwhelming at first, focusing on one error type and then building step by step helps you gain confidence and momentum.

Note: Word and PowerPoint’s built-in accessibility review tool is helpful for identifying and resolving some issues but may not readily identify all common accessibility issues.

Additional resources on this topic are available in [Accessibility: Resources](#).

Color, Contrast, & Fonts

✘ Materials Shouldn't :	✔ Materials Should :
<p>✘ Use background and font colors that don't have enough contrast:</p> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 10px;"> <div style="background-color: #00a0e3; color: white; padding: 10px; border: 1px solid white; text-align: center;"> This doesn't have enough contrast. </div> <div style="font-size: 2em;">→</div> <div style="background-color: #00a0e3; color: white; padding: 10px; border: 1px solid white; text-align: center;"> This has enough contrast. </div> </div> <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 10px;"> <div style="background-color: #92d050; color: white; padding: 10px; border: 1px solid white; text-align: center;"> This doesn't have enough contrast. </div> <div style="font-size: 2em;">→</div> <div style="background-color: black; color: white; padding: 10px; border: 1px solid white; text-align: center;"> This has enough contrast. </div> </div>	<p>✔ Use adequate contrast for background colors and all font colors.</p> <p>✔ Use a quick contrast checker if you're not sure.</p>
<p>✘ Use images as slide backgrounds unless contrast is adequate with font colors:</p> <div style="text-align: center; margin-top: 20px;">  </div>	<p>✔ Use a simple background with solid colors.</p> <p>✔ If using an image or design as a slide background, increase its transparency level or add a text box to increase visibility.</p> <div style="text-align: center; margin-top: 20px;">  </div>
<p>✘ Use only color to show meaning or emphasize something:</p> <div style="text-align: center; margin-top: 10px;"> <div style="background-color: #f0f0f0; padding: 10px; border: 1px solid #ccc;"> This only uses color for emphasis. </div> </div>	<p>✔ Use color and other elements (e.g., bold, underline) to show meaning or emphasize something:</p> <div style="text-align: center; margin-top: 10px;"> <div style="background-color: #f0f0f0; padding: 10px; border: 1px solid #ccc;"> This uses bold for emphasis. This uses <u>color + underline</u> for emphasis. </div> </div>
<p>✘ Use fonts with joined letters or that may take longer to read (e.g., serif). Examples to avoid:</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"> <p>Impact</p> <p><i>Brush Script</i></p> </div> <div style="text-align: center;"> <p>Papyrus</p> <p>Georgia</p> </div> </div>	<p>✔ Use fonts that are simple and familiar (e.g., sans serif). Examples:</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;"> <p>Verdana</p> <p>Arial</p> </div> <div style="text-align: center;"> <p>Open Sans</p> <p>Calibri</p> </div> </div>

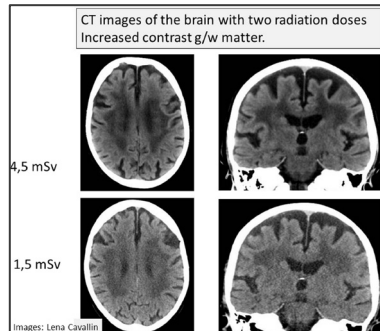
Images & Videos

✓ Do:

- ✓ Add alt text if image contains information important for understanding content, activity, etc.

PPT: Right-click image, “view alt text,” add quick description of image

Example:



Alt text:

“2 CT scans of the brain, frontal view, showing increased contrast between grey and white matter across 2 radiation doses.”

- ✓ Turn on closed captions and/or provide transcripts when playing any audio or video.



Can I improve inclusivity and intersectionality?

Person-Centered Language

- Default to person-centered language, but respect that some communities, like Deaf and Autistic groups, may prefer identity-first terms. Ask patients what they prefer. See “[Addressing Disability](#)” for more information.
- Avoid words with a negative value judgment (see examples below).
- Include patient narratives that humanize the individual and help the audience develop empathy.

Additional resources on this topic are available in [Equitable Language: Resources](#).

✗ Don't:

✓ Do:

- ✗ Use diagnoses as nouns or adjectives:

*Schizophrenics, schizophrenic patient,
Alcoholics, addicts, abusers*



- ✓ Center the person with a disorder:

*Patient with schizophrenia
Patient with alcohol use disorder*

- ✗ Use language that blames or dehumanizes the patient:

*Substance abuse
Clean or dirty urine toxicology results
Commit suicide
Illegal
Inner-city or ghetto
Third-world countries*










- ✓ Address conditions as treatable and use language that doesn't blame or racially code:

*Substance use
Testing positive or negative
Die by suicide
Undocumented
City-dwellers or low-income
Low- and middle-income countries (LMICs)*









Gender Equity

- Avoid gender essentialism (the presumption that all people of a certain gender have the same genetics, physiology, anatomy, sexuality, or social roles). For example, if the possibility of pregnancy is relevant to a case or intervention, it is more inclusive to refer to “people with the capacity for pregnancy” rather than “women” since not all women can become pregnant, and not all people who can become pregnant are women.
- Include/acknowledge trans and gender-diverse people in discussions about gender.
- Avoid describing trans and gender-diverse people with terms that misgender them or reinforce gender essentialism.

 Don't:	 Do:
<p> Assume a patient's gender based on name or appearance. Case example: Max is a 25-year-old patient presenting with low mood and anhedonia. He is complaining of trouble sleeping.</p>	<p> Ask for and use correct pronouns.  Provide pronouns in case examples. Case example: Max (she/her) is a 25-year-old patient presenting with low mood and anhedonia. She is complaining of trouble sleeping.</p>
<p> Use terms that enforce gender essentialism: <i>Biologically male, genetically female, male-to-female</i></p>	<p> Use more gender-affirming terms: <i>Trans-man, trans-woman, nonbinary person</i> +/- <i>assigned male at birth (AMAB) or assigned female at birth (AFAB)</i> if this information is clinically relevant</p>

Health Equity

- When talking about health inequities, provide context to avoid unintentionally assigning blame to a group of people.

 Don't:	 Do:
<p> Omit context, which can lead to assigning blame to a group of people: <i>Low-income people have higher rates of XX.</i></p>	<p> Provide contributing factors or further context for statistics: <i>People who are forced into poverty due to XX have higher rates of XX.</i></p>
<p> Use blanket labels for groups that have historically experienced oppression, marginalization, and discrimination: <i>The marginalized or vulnerable</i></p>	<p> Be specific and contextual about the community or population: <i>Groups that have been historically and intentionally excluded; People who are underserved or under-resourced by medical services.</i></p>
<p> Use passive voice to describe traumas on groups or populations: <i>Black, Indigenous, and people of color were economically marginalized by the use of redlining.</i></p>	<p> Use active voice or add context to avoid erasure of responsibility, when possible: <i>The government used redlining to economically marginalize Black, Indigenous, and people of color.</i></p>

Addressing Disability

- Disability is a broad category that encompasses physical disabilities (e.g., mobility, hearing, and vision disabilities) such as developmental and learning disabilities, chronic illnesses, and mental health disabilities.
- Consider how a person’s disability intersects with their other identities.
- Consider whether a person’s disability is visible or invisible and how this affects their interaction with their communities.
- Consider a person’s disability from both a medical model (i.e., how their disability affects them individually) and a social model (i.e., how their disability emerges from barriers in the person’s physical and social environments)
- Some people and/or communities with disabilities may prefer Identity-First Language because it acknowledges that the disability is a part of their identity (e.g., Autistic person, Deaf person, blind person, disabled person). A good principle to follow is to default to person-centered language unless you know that someone prefers Identity-First Language.

Additional resources on this topic are available in [Disability: Resources](#).

❌ Don't:	➡	✅ Do:
<p>❌ Use terms that convey negativity, pity, blame, or judgment: <i>Suffers from...</i> <i>Afflicted by...</i> <i>Confined to a wheelchair</i> <i>Wheelchair-bound</i></p>	➡	<p>✅ Use neutral, descriptive language: <i>Person with [condition]</i> <i>Person who has experienced a stroke</i> <i>Person who uses a wheelchair</i> <i>Wheelchair user</i></p>
<p>❌ Use binary “functioning” labels: <i>High- or low-functioning</i></p>	➡	<p>✅ Be specific about the type and level of support needed: <i>High-, medium-, or low-support needs</i> <i>Needs help with daily care tasks</i></p>
<p>❌ Use language that implies disability is inherently negative: <i>Normal</i> <i>Healthy person</i> <i>Able-bodied person</i></p>	➡	<p>✅ Use neutral, person-first language: <i>Neurotypical</i> <i>Nondisabled person</i> <i>Person without disabilities</i></p>

Section 6. Resources



What if I still have questions or am unsure about my slides?

Consultation Service

You are welcome to ask for a consultation and/or submit your slides for review! Email the residency office (psychres@uw.edu) to ask for a consultation, and they will help arrange this. Please submit this request at least 2 weeks in advance of your lecture.



Where can I learn more?

Resources & Additional Reading

Cultural Humility: Resources

- [Reflections on Cultural Humility](#) (Waters & Asbill, 2013)

Navigating Difficult Conversations: Resources

- [Diversity, Equity & Inclusion Toolkit: Getting Started with Difficult Conversations](#) (AAUW)

Celebrating Psychiatry's Diverse Histories and Achievements: Resources

- [Black Pioneers in Mental Health](#) (Mental Health America)
- [Celebrating 10 African American Medical Pioneers](#) (AAMC, 2019)
- [Celebrating 10 Hispanic Pioneers in Medicine](#) (AAMC, 2020)
- [Hispanic Contributions in Psychology](#) (Oklahoma State University)
- [Celebrating 10 Women Medical Pioneers](#) (AAMC, 2020)
- [Celebrating the Legacy of LGBTQIA+ Pioneers in Medicine](#) (The Oregon Clinic, 2022)
- [5 Historical LGBTQ Contributors to Medicine](#) (Touchcare, 2021)
- [Native American Heritage Month: Pioneers for Mental Health](#) (Compass Health)

Disability: Resources

- "Demystifying Disability: What to Know, What to Say, and How to Be an Ally," by Emily Ladau
Ladau, E. (2021). *Demystifying Disability: What to know, what to say, and how to be an ally*. Ten Speed Press.
- "Disability Visibility: First-Person Stories from the Twenty-First Century," edited by Alice Wong
Wong, A. (Ed.). (2020). *Disability visibility: First-person stories from the twenty-first century*. Knopf Doubleday Publishing Group.

Accessibility: Resources

- [Digital Accessibility](#) (UW)
- Accessibility Quick Cards (MN.gov): [Word](#), [PowerPoint](#)

Equitable Language: Resources

- [Equitable Language Guide](#) (UW)
- [Health Equity Guiding Principles for Inclusive Communication](#) (Archived from CDC via RestoredCDC.org)

Authorship & Acknowledgments

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Appendix: PowerPoint Examples

Appendix 1. Case Example

This slide example (Figure 1) shows how language choices can either reinforce bias or promote equity and inclusion. The side-by-side comparison highlights common missteps in clinical documentation and communication, alongside more respectful, person-centered alternatives.

Case Examples

DON'T:

- 31-year-old **African American schizophrenic** man with a **dirty** Utox admitted voluntarily after trying to **commit** suicide.
- You are paged on nightfloat because he is **demanding** to leave AMA
- The RN says he is paranoid that another patient on the unit is "targeting him," and he became "agitated and threatening."
- What do you do?

DO:

- 31-year-old **man with schizophrenia and a substance use disorder** was admitted voluntarily following a suicide attempt.
- You are paged on nightfloat because he is **asking** to leave AMA.
- The RN says he is paranoid that another patient on the unit is "targeting him," and he became "agitated and threatening."
- What do you do?
 - The patient is **African American**. How might this be affecting how other patients interact with him? How staff interpret his actions?

Don't include race in the one-liner without addressing it

Avoid blaming language like "dirty," "commit," and "demanding"

Avoid labels that center the diagnosis like "schizophrenic"

Use person-center language to describe diagnoses

Discuss race in a more nuanced way

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Figure 1: Example of presenting a patient case vignette

Appendix 2. Diagnostic Prevalence Example

This slide example (Figure 2) demonstrates how data presentation can unintentionally reinforce bias—or instead promote equity and inclusion. The side-by-side comparison highlights how racial disparities in diagnostic prevalence are often framed without context and offers a more thoughtful approach that centers systemic drivers and community-informed interventions.

Diagnostic Prevalence Example

DON'T:

Alcohol dependence by race:

- American Indian and Alaska Native: 14.9%
- Native Hawaiian and Other Pacific Islander: 11.3%
- Hispanic: 8.6%
- White: 8.4%
- Black : 7.4%
- Asian: 4.6%

Avoid presenting racial disparity alone, which can unintentionally assign blame

→

DO:

Drivers of alcohol use:

- Intergenerational trauma and the effects of colonialization have led to disparity in alcohol dependence in certain communities.

Present systemic factors that drive disparities

Interventions for alcohol use:

- Interventions currently being tried in indigenous communities
- Raising self-esteem
- Emphasizing traditional values
- Advocacy by indigenous youths

Address potential interventions to reduce disparities

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Figure 2: Discussing diagnostic prevalences of alcohol use

Appendix 3. Diagnostic Bias Example

This slide example (Figure 3) explores how diagnostic bias can contribute to disparities in mental health care. It highlights contributing factors, such as clinician bias and structural barriers, and offers practical strategies lecturers can model to reduce misdiagnosis and promote culturally responsive care.

Diagnostic Bias Example

Black patients with affective disorders are more likely to be misdiagnosed with psychotic disorders than white patients

- **Contributing factors:**
 - **Clinician bias**, including **less thorough interviews of Black patients** and **misinterpreting appropriate distrust** as paranoia
 - Black patients may present later to care (**due to access barriers**) with more severe symptoms
- **Ways to mitigate this:**
 - Use standardized screening checklists for psychosis and affective disorders in interviews
 - Use anti-bias strategies (e.g. perspective taking) and adopt a stance of cultural humility
 - Build rapport and check in with the patient about the therapeutic alliance

Identify contributing factors for any diagnostic disparities mentioned.

Name structural factors for any differences in behaviors between groups to avoid inadvertent blame.

Provide strategies to reduce disparities to avoid demoralizing learners.

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Figure 3: Discussing diagnostic biases and misdiagnosis of Black patients

Appendix 4. Research & Evidence-Base Example

This slide example (Figure 4) highlights how research framing can either perpetuate exclusion or promote equity in evidence-based practice. It contrasts common oversights in neurobiological research, such as underrepresentation and unexamined bias, with inclusive strategies that acknowledge limitations and center diverse populations.

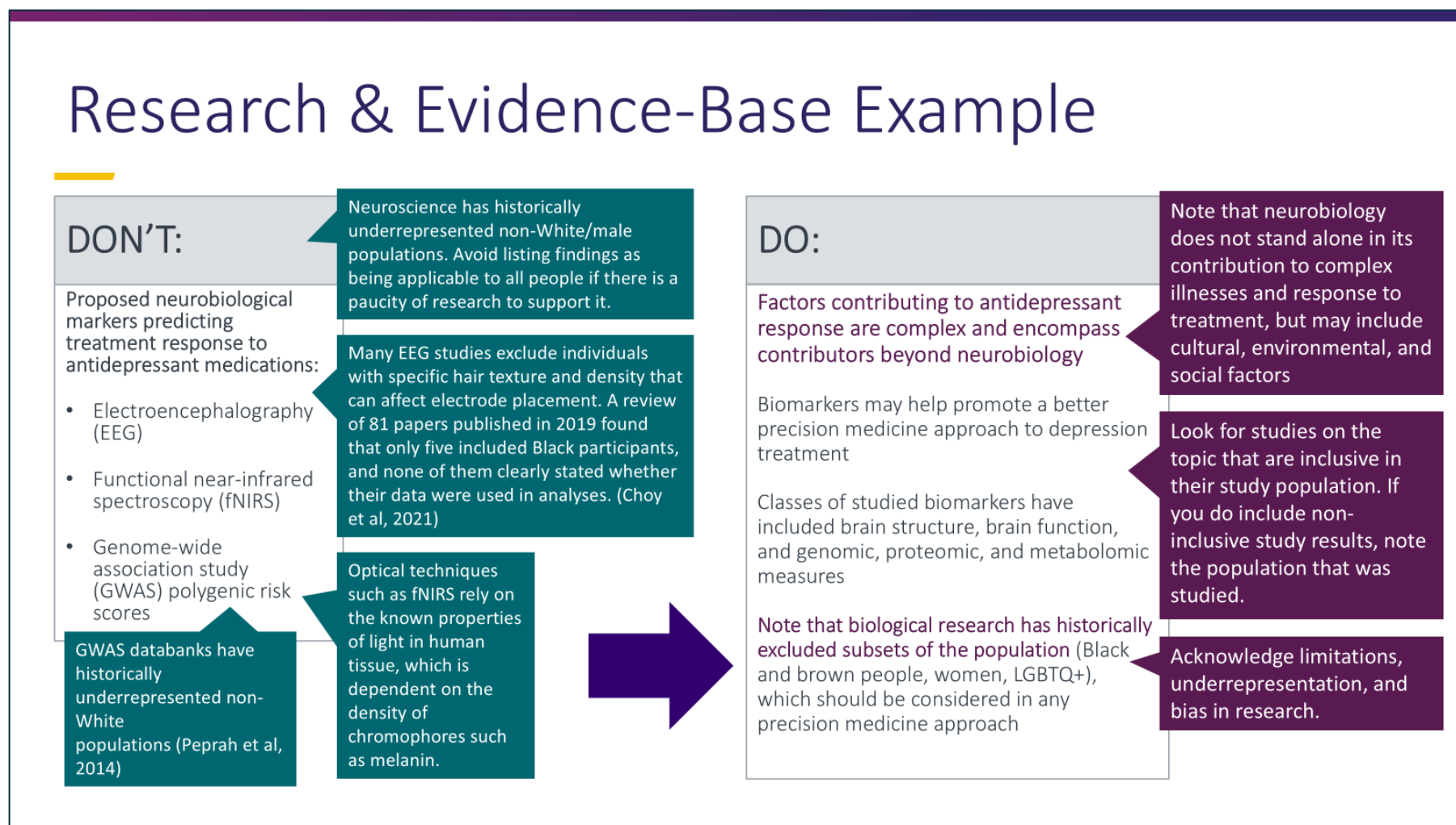


Figure 4: Discussing research & evidence base for neurobiological biomarkers and response to antidepressant medications.

Appendix 5. Psychopharmacology Example

This slide example (Figure 5) addresses how implicit bias can shape prescribing practices. It highlights disproportionate benzodiazepine prescribing patterns and offers practical strategies faculty can model to promote equitable, reflective decision-making in clinical care.

Psychopharmacology Example

Benzodiazepines are disproportionately prescribed to **older white women due to implicit bias.**

Ways to mitigate implicit bias when prescribing:

1. Ask yourself, "Would my decision to prescribe or not prescribe this medication change if the patient were of a different age, gender, race, etc.?"
2. Use structured criteria to decide when to prescribe a medication in order to be consistent.
3. Seek consultation from colleagues.
4. Challenge implicit bias: There's no difference in terms of race when comparing people who used benzo as prescribed vs misusing it.

Point out differences in prescribing trends & their causes

Provide ways for learners to combat these inequities in their own clinical care

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Figure 5: Discussing bias in prescribing benzodiazepines

Appendix 6. Therapeutic Interventions Example

This slide example (Figure 6) models how to broach identity-related concerns in therapy. It presents a clinical scenario and prompts learners to reflect on how race, gender, and provider–patient differences might shape the therapeutic encounter, and how to address them with cultural humility and psychological safety.

Therapeutic Interventions Example

You are seeing a patient 29-year-old Black woman who works as a lawyer in a prestigious law firm. She tells you that she is continuously overlooked for promotions and her work goes uncredited. She is becoming increasingly burnt out and thinking about quitting.

- Would you ask her if she thinks that her race and/or gender are affecting how she is treated at work? If so, how would you ask?
- If your identity is different from the patient's, would you bring that up and ask her if she feels comfortable talking about this topic with you? What would you say?

Teach learners when and how to broach issues of identity and difference within the therapy encounter.

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Figure 6: Discussing identity and difference in therapeutic encounters

Appendix 7. Systems of Care Example


This slide example (Figure 7) demonstrates how systems-level disparities can be framed in ways that either overwhelm or empower learners. It contrasts deficit-focused presentations with approaches that name structural causes and offer actionable interventions for clinical and advocacy contexts.

Systems of Care Example

DON'T:



Impact of Disproportionate Incarceration of and Violence Against Black People with Mental Health Conditions In the World's Largest Jail System

A Supplementary Submission for the August 2014 CERD Committee Review of the United States



Avoid describing inequity without discussing potential interventions. This demoralizes trainees.


DO:



How Psychiatrists Can Talk with Patients and Their Families About Race and Racism


Approved by the Joint Reference Committee, November 2020

Include possible interventions that trainees can participate in, considering both clinical and advocacy avenues



According to NAMI, only ~46% of patients with mental illness received *any* treatment in 2020.

Using a single statistic for shock value can oftentimes distort the fuller picture and places emphasis away from pertinent DEI details.



Only 46% of patients with mental illness received treatment in 2020, **due to a combination of financial barriers, language barriers, and lack of trust with medical/psychiatric providers**

Flesh out reasons for why unequal care occurs using DEI lenses.

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Figure 7: Discussing disparities and interventions in systems of care