

UW Psychiatry Residency Program

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 has been factors in bias related to involuntary treatment."

Date: 5/15/2025

Residency Class of 2025

What's The Need?

Residents repeatedly say they want more knowledge and discussion about equity, diversity and inclusion (EDI) in lectures—all lectures. They also evaluate lectures on meaningful incorporation of EDI. This toolkit started as a residents-led initiative to help lecturers include more information about equity, diversity and inclusion into their didactics.

Section 1. Checklist for Incorporating EDI into Didactics

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

Section 2. Goals for Incorporating EDI

Broaden the definition of diversity and focus on intersectionality.			
Diversity exists in terms of gender, sexual orientation, socioeconomics, religion, culture, immigration status, body size, physical or cognitive abilities, and race, and these identities interact with each other.	 Example 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.	 Example Discuss policies that have led to inequitable outcomes or distrust of healthcare systems. Discuss efforts to reduce disparities 		
Embrace cultural humility.			
Believing 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.	 Example 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.	 Example Black Pioneers in Mental Health Celebrating 10 African American Medical Pioneers Celebrating 10 Hispanic Pioneers in Medicine Hispanic Contributions to Psychology Celebrating 10 Women Medical Pioneers 		

Setting the Tone To Help Achieve Your Goals

- 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.
- Use methods to elicit input from everyone rather than just the more vocal contributors (e.g., anonymous polls, small break out groups, etc.).

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

Find your didactic's topic area(s) below for recommended EDI changes and considerations.

Case Examples

- One-liners: 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 in order to avoid reinforcing stereotypes and gender essentialism.
- Case Choices: 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?
- Systems & Structural Factors: 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 a marginalized community hasn't sought out mental health care before, avoid attributing this solely to stigma about mental health in that culture. Instead, consider structural factors such as cost, access to care, and prior negative experiences within the system.
- Use a random name generator to create case example authenticity and avoid perpetuating unconscious biases (e.g., centering Anglophone names).

Diagnosis

- 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 are the structural factors that 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, healthy food, clean water, open spaces, nature? Exposure to noise/air pollution, crime?)
- How do global events, 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

- 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 impact 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

- 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? (e.g. if discussing gender differences, specify whether trans and gender-diverse participants were included, or name this as a limitation)
- Where are participants being recruited (rural/suburban/urban) and 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?
- 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?
- How might the measures used in a study impact its results with different populations? (e.g., questionnaire language)
- What research outcomes were used? Are these outcomes accurate in different populations?

Psychopharmacology

- 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 in how certain groups may perceive medication management? Are there cultural differences? Historical differences?
- Are there different rates in the individuals offered or completing interventional treatments (ECT, TMS, Ketamine)? What factors might be involved in this difference (historical context, implicit bias, patient autonomy)? Has it been studied (why/why not)?

Therapeutic Interventions

- 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

- Are there health inequities in this system? What are their structural causes?
- How might someone from the non-dominant culture experience these systems? For example, how would someone who is undocumented receive care? How might someone with a disability experience this system?
- Who are the individuals creating healthcare policy? (e.g. what is their background, race, prior exposure to patient care?) How does this affect the policies made?)
- What advocacy efforts have been successful in the past, or are currently ongoing? What levels are they intervening on quality improvement, organizational, community, policy, societal? How might residents contribute to these efforts in the future?
- 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 on quality improvement, organizational, community, policy, societal?
- What are effective methods of reducing health equities 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?

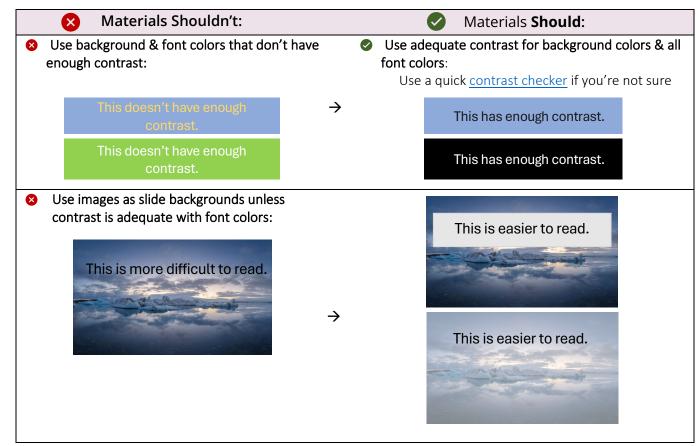
- Thank participants for their input. Remember that it is often hard for residents to speak up about things that make them uncomfortable.
- Avoid getting defensive. Take a deep breath and ask for more detail. Try to understand their position. Be curious.
- Ask how something can be corrected or improved 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.

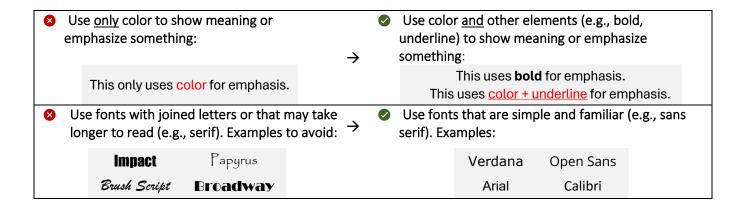
Section 5. Reviewing Learning Material

Are my lecture and learning materials accessible?

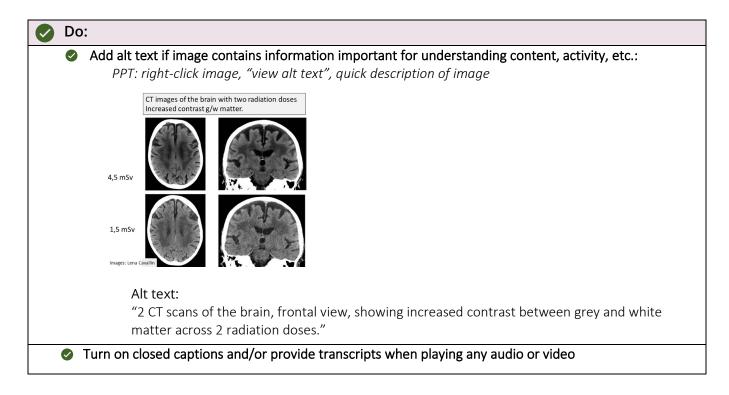
Accessibility

Accessible learning materials increase equity for learners, including those with "hidden" diagnoses (Fleming et al., 2022). Accessibility neutralizes barriers to people with mobility and hearing disabilities, but also to those with vision, learning, & cognition disabilities. Disability and ableism are defined and discussed separately in a later section, "Addressing Disability." Review your didactic materials for some common ways to increase a learner's ability to understand and perceive learning content:





Images & Videos



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

Can I improve inclusivity and intersectionality?

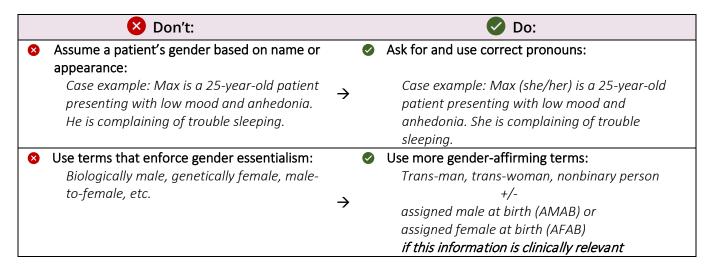
Person-Centered Language

- 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.

	🔀 Don't:			Oo:
8	Use diagnoses as nouns or adjectives: Schizophrenics, schizophrenic patient, Alcoholics, addicts, abusers	\rightarrow	•	Center the person with a disorder: Patient with schizophrenia Patient with alcohol use disorder
8	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 & 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.



Health Equity

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

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

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 default to person-centered language unless you know that someone prefers Identity-First Language.

	🗴 Don't:			Oo:
8	Use terms that convey negativity, pity, blame, or judgment: Suffers from Afflicted by Confined to a wheelchair Wheelchair-bound	→	•	Use neutral, descriptive language: Person with [condition] Person who has experienced a stroke Person who uses a wheelchair Wheelchair user
8	Use binary "functioning" labels: High- or low-functioning	\rightarrow	•	Be specific about the type and level of support needed: High-, medium-, or low-support needs Needs help with daily care tasks

8	Use language that implies disability is inherently negative:		Ø	Use neutral, person-first language:
	Normal	\rightarrow		Neurotypical
	Healthy person			Nondisabled person
	Able-bodied person			Person without disabilities

Section 6. More Questions & Didactic Consultations

What does equity, diversity and inclusion mean?

- Equity refers to fairness and justice, recognizing that we do not all start from the same place because of systemic marginalization. Address equity by discussing how these systems of oppression came to be, continue to exist, and the ways we can help our patients overcome them.
- **Diversity** refers to representing the different identities that we encounter including race, ethnicity, gender identity, sexual orientation, socioeconomic status, age, education, religion, culture, immigration status, body size, physical or cognitive abilities. Address diversity by making sure our data and examples accurately represent different identities. Call out communities that are included, excluded, or lumped together.
- Inclusion refers to creating an environment that allows us to express our authentic identities. An inclusive didactic not only talks about the ways we can allow our patients to be their authentic selves but also allows participants to do the same.

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

• You are welcome to ask for a consultation and/or submit your slides for review! Please submit this request at least 2 weeks in advance of your lecture. You can let the residency office know that you'd like a consultation, and they will help arrange this.

Where can I learn more?

- Equitable Language Guide (University of Washington)
- Advancing Health Equity: A Guide to Language, Narrative and Concepts (AAMC and AAMA, 2021)
- Health Equity Guiding Principles for Inclusive Communication (Archived from CDC via RestoredCDC.org)
- Reflections on Cultural Humility (APA, 2013)
- "Demystifying Disability: What to Know, What to Say, and How to Be an Ally" by Emily Ladau
- "Disability Visibility: First-Person Stories from the Twenty-First Century" edited by Alice Wong

Authorship/Acknowledgments

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References

Fleming, J. I., Wilson, S. E., Hart, S. A., Therrien, W. J., & Cook, B. G. (2021). Open Accessibility in Education Research: Enhancing the Credibility, Equity, Impact, and Efficiency of Research. *Educational psychologist*, *56*(2), 110–121. https://doi.org/10.1080/00461520.2021.1897593