CHAPTER 4

Psychiatric Disability and Equity

Many of the disabilities experienced by people with serious mental illness are actually caused or worsened by social determinants of health such as race, ethnicity, gender identity, and sexual orientation. It is by no means identity with diversity per se that leads to disparity but rather the racism, sexism, and other forms of oppression that come from the majority population and limit one's health options. People from these groups often experience greater social disadvantages such as poverty and criminal justice system involvement, which further worsen disabilities and undermine recovery. Equity is a first value of the health care system that reflects fully accessible, available, and culturally relevant interventions that meet individuals' dynamic definition of their health and wellness goals. This chapter begins with a comprehensive definition of social determinants and disadvantages, followed by a summary of research on how these determinants undermine almost every domain that defines needs and goals. The recovery system needs to recognize disparities that result from these determinants and seek to replace the status quo with services that represent the divergent and complex needs of the rainbow of diverse options. This means framing diversity in terms of pride and not victimhood. Equitable services are often grounded in peer-based systems. Community-based participatory research is crucial to including the diverse voice in the actual development and evaluation of recovery-based programs. We end the chapter with an example of how social determinants undermine service engagement and ways to resolve this gap to yield culturally sensitive recovery programs.

SOCIAL DETERMINANTS AND DISPARITIES

Social determinants significantly impact the life goals of people who have psychiatric disabilities separate from disease processes (e.g., psychiatric symptoms and corresponding dysfunctions) that undermine recovery. According to the DHHS, social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Blackburn, Osborn, Walters, Nazareth, & Petersen, 2018; Correll et al., 2017; Misiak et al., 2021; Walker et al., 2015). In trying to make sense of social
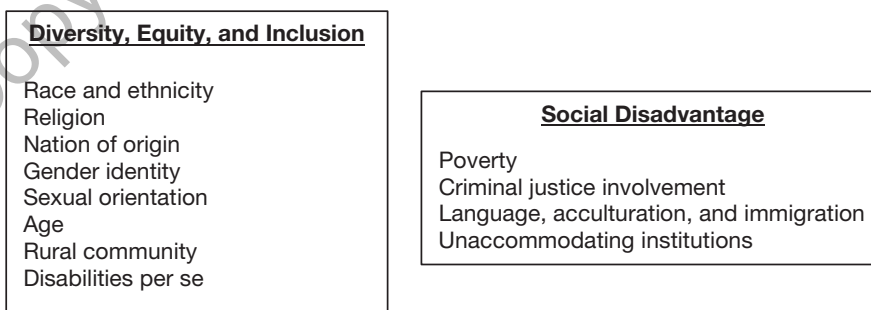
determinants, we distinguish diversity, equity, and inclusion (DEI) groups from resulting social disadvantage. DEI groups are often described as outgroups in social psychology (Brewer, 2007), or as suspect classes in the law (Strasser, 1991), reflecting their minority position. Instead of viewing them through the lens of disadvantage and negativity, however, DEI groups are better viewed in terms of the culturally rich experiences of a collection of people that differs from the majority and suggests unique paths toward recovery. Regrettably, people from DEI groups more often experience social disadvantage (e.g., poverty, criminal justice system involvement, or immigration challenges) that evolves from a pernicious social history reflecting structural discrimination; specific disadvantages are summarized in this chapter.

DEI Groups

Figure 4.1 comprises eight DEI groups that are commonly included in research on social determinants and implicated in disparities among people with psychiatric disabilities.

1. *Race and ethnicity.* Although race and ethnicity are evolving social constructs, the U.S. Office of Personnel Management and the U.S. Census Bureau are widely cited arbiters of race and ethnicity in American health (U.S. Census Bureau, n.d.-a, n.d.-b). The census distinguishes five races—American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White—plus a single ethnic category, Hispanic or Latinx. The evidence is clear; compared to the White majority, for people with psychiatric disability, achieving life goals is significantly worse for people of color, including those who are Black, Native American, Latinx, and Asian American (DHHS, Office of Minority Health, 2022).

2. *Religion.* Like race and ethnicity, the United States is rich in religious diversity. A 2021 survey from Pew (Pew Research Center, 2021) described several groups, with Christians (i.e., Protestant, Catholic, Mormon) dominating (65%); Buddhism, Hinduism, Islam, and Judaism at 1% or less; 29% characterizing themselves as unaffiliated, agnostic, or atheist; and 2% as other. Discrimination experienced by non-Christian communities is associated with increased stress (Lewis, Cogburn, & Williams, 2015; Williams, 2018) leading to worse health (Mouzon, Taylor, Keith, Nicklett, & Chatters, 2017; Oh, Yang, Anglin, & DeVylder, 2014).

Diversity, Equity, and Inclusion
Race and ethnicity
Religion
Nation of origin
Gender identity
Sexual orientation
Age
Rural community
Disabilities per se

Social Disadvantage
Poverty
Criminal justice involvement
Language, acculturation, and immigration
Unaccommodating institutions

FIGURE 4.1. Social factors that impact disabilities of people with lived experience.

3. *Nation of origin*. This includes equity and disparity issues for people or their families who have immigrated to the United States or who strongly identify with their countries of origin. Although acculturation (learning and adapting to a new culture; Berry, 2006; Ward, 1996) and enculturation (continuing to identify with one's culture of origin; Kim, 2007) are rich experiences, they may be negatively associated predictors of health, wellness, and disability (Kasirye et al., 2005). This, as well as reduced English fluency, are discussed more in the section "The Worsening Effects of Social Disadvantage," below.

4. *Gender identity*. Much research has examined the effect of binary models of gender (male or female) on health patterns among people with psychiatric disabilities. Research shows, for example, that the course of schizophrenia is worse in males (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012; Li, Ma, Wang, Yang, & Wang, 2016; Rietschel et al., 2015). Far fewer findings exist on the interaction of transgender or nonbinary/nonconforming identity, but studies suggest that corresponding discrimination has harmful relationships with health in general (Downing & Przedworski, 2018; Fredriksen-Goldsen et al., 2014) and with health and recovery among people with serious mental illness (Scheer, Harney, Esposito, & Woulfe, 2020).

5. *Sexual orientation*. Research fairly consistently shows sexual orientation minorities (gay, lesbian, bisexual, asexual, pansexual, and questioning) show worse patterns in health compared to the straight minority (Jackson, Agénor, Johnson, Austin, & Kawachi, 2016; Mayer et al., 2008). Discrimination related to intersection of sexual orientation with mental illness also shows worse health and recovery (Terra et al., 2022; Han, Duncan, Arcila-Mesa, & Palamar, 2020).

6. *Age*. Defined as years from birth, age interacts with mental illness and recovery, especially at the extremes of the continuum. Children and youth with mental illness are more likely to be absent, suspended, or expelled from school (Blackorby & Cameto, 2004). Parental involvement and decision making are especially important for children's health (Hingle, O'Connor, Dave, & Baranowski, 2010; Van Lippevelde et al., 2012). Alternatively, older age (e.g., greater than 60 years old) is associated with health in general (Boersma, 2020; Maresova et al., 2019) and worse health among people with serious mental illness (Bartels, 2004; Bartels & Pratt, 2009). Research here seeks to unpack the physiological impact of old age, with aging representing a social determinant of health (e.g., age discrimination; Baumgartner et al., 2021).

7. *Rural community*. Policies and innovations driving the health and mental health care system seem to be dominated by urban or suburban settings. People living in small towns or other rural areas may have worse outcomes (Li et al., 2011). Causes of this disparity are diverse but may include diminished access and availability to services (Gamm, Hutchinson, Bellamy, & Dabney, 2010) and diminished cultural competence of the provider workforce (Gamm, Castillo, & Pittman, 2010).

8. *Disability per se*. Disability in itself defines a DEI group that is a social determinant of health. As explanations of the psychiatric disabilities and one's mental health career mature, models have developed that frame psychiatric experience and recovery as a culture: not solely a flawed experience, but a group with shared history and experience that defines a positive lore and legacy. Shared history also applies to people with physical, sensory, developmental, and other disabilities. Stigma and discrimination remain, with

PERSONAL EXAMPLE

Recovery on the Streets

Langston Jones, a 32-year-old Black man with serious mental illness, was born and raised on Chicago's South Side. He was a homeless man staying at either the Pacific Gardens shelter or in a slapped together tent city at the entrance to the Dan Ryan Expressway at Roosevelt Road. His psychotic symptoms, including unclear thinking, occurred fairly regularly, worsened by an alcohol-use disorder. He was recently released from Stateville prison after a 2-year sentence for aggravated assault. As a Black man, he was frequently stopped by the Chicago police for loitering or suspicion of robbery. Mr. Jones did not want to enter a residential program for people with mental illness, nor did he want to travel to a city clinic for medication and other case management. He found city clinics to be run by "unaware" White professionals, with police officers providing security at the front desk.

A local recovery-based agency hired peer community workers to go into the field and meet the needs of people who were homeless on the South Side. As peers, these workers were African Americans in recovery from mental illness. Many also had prior experiences with homelessness, corrections, and/or substance use disorder. LaToya Hampton was a Black woman who, until engaging successfully in her own recovery-based program, bounced back and forth between the state mental hospital and Cook County jail. Ms. Hampton was trained on effective support services to become a peer community worker. She had met Mr. Jones several times at the Dan Ryan camp, where she began to build a relationship with him. Among other things, she introduced Mr. Jones to the team nurse who provided primary care in the camp to interested parties. One time, Hampton accompanied Jones to a Walgreens drugstore for the COVID vaccine. Hampton also went with Jones to check out a local *housing first* program. Housing first providers, described more fully in Chapter 10, eschew rules and regulations (suggest as curfew or daily report) which many people find onerous. Jones checked into his own apartment in the housing first program and, with Hampton's support, was able to stop living on the streets.

research evidence showing that disabilities can be a major source of disadvantage in the health system.

The Worsening Effects of Social Disadvantage

In Chapter 2, we distinguished structural stigma, experienced at societal levels, from better known research on the individual's impact: public and self-stigma (Hatzenbuehler, 2016, 2017; Hatzenbuehler & Link, 2014). Like self-stigma, prejudicial processes evolve from political and economic forces that lead to discriminatory structures that undermine opportunity. Broadly, structural stigma has led to high rates of social disadvantage experienced by people in DEI groups (see Figure 4.1). Four forms of social disadvantage that are prominent in the research literature are summarized here.

1. *Poverty.* People with serious mental illnesses often have incomes below the poverty line (Levinson et al., 2010; Sareen, Afifi, McMillan, & Asmundson, 2011). Absence of sufficient income is significantly associated with health challenges (Ribeiro et al., 2017).

Poverty among DEI groups and for people with psychiatric disability lead to housing instability (Barile, Smith Pruitt, & Parker, 2018) and food insecurity (O'Reilly, Hager, Harrington, & Black, 2020).

2. *Criminal justice involvement*. People with mental illness from DEI groups have higher rates of disabilities at both ends of the crime continuum: victims and arrestees. They are more likely to be victims of violent crime, which worsens health and recovery (Teplin, McClelland, Abram, & Weiner, 2005; Thomas, Nixon, Ogloff, & Daffern, 2019). Trauma related to crime and assault often yields long and enduring effects (Elhai, North, & Frueh, 2005; Sharma, 2003). People with mental illness also are often arrestees (Brame, Bushway, Paternoster, & Turner, 2014; Piquero, 2015) with the corresponding loss of freedom (jail, prison, probation, or parole) interfering with recovery goals (Wennerstrom et al., 2022).

3. *Language and immigration*. The health needs of people with psychiatric disabilities from nations of origin other than the United States are often challenged by language, acculturation, and immigration. Non-English speakers are greatly hampered in navigating the American service system (Timmins, 2002). Difficulties acculturating to a Western approach to health care undermines individual goals (Suarez-Balcazar, Viquez, Miranda, & Early, 2020). Refugees may struggle with trauma from their community of origin as they immigrate to the United States from war-torn or other politically and economically challenged nations (Fino, Mema, & Russo, 2020; Ostergaard et al., 2020). Refugees with mental illness have an especially difficult time with health and wellness goals (Berthold et al., 2014).

4. *Unaccommodating institutions*. Although the ADA proscribes restrictive health practices and prescribes reasonable accommodations, people with psychiatric disabilities continue to lack these entitlements in terms of education and work (Hill, Maestas, & Mullen, 2016). Lack of accommodations also has direct effects on recovery goals (Drainoni et al., 2006; Mason et al., 2019). Specifically, employers and other groups covered by the ADA fail to provide reasonable accommodations when indicated (Sevak & Khan, 2017; Syma, 2019). Similarly, education systems fail to provide necessary on-campus accommodations that help students with disabilities address their goals.

Identity Not Essentialism

There are differing ways of understanding DEI groups. Let's consider essentialism versus constructivism. Essentialism defines DEI groups and their "membership" in presumptions of fundamental endowment or inheritance, often with roots in biology or birth. For example, an essentialist assumption would be that all Latinx share the same body features, religious beliefs, and cultural preferences. These presumptions oversimplify real-life experience by reducing complex groups to neat categories with seemingly well-defined and immutable boundaries: their essences. This is evident in past pseudoscience discussions of race where ethnic phenotypes were linked to genotypes resulting in five supposedly definitive categories: Caucasoid, Capoid, Mongoloid, Australoid, and Negroid (Jackson, 2001). Essentialists presume that evolution and natural development create these DEI groups, which subsequently defines people with corresponding phenotypes. Essentialism has met robust criticism when it mistakes variations of phenotype into categorical differences ("All women are alike"), leading to misattribution of individual choice and behavior in terms of one's group assignment ("Mary decided to become a nurse because she is a woman"), opening the door to stereotypes and discrimination

("Women are not capable of being physicians, so Mary can't do it") (Phillips, 2010). These criticisms have led to a stern rebuke from the American Association of Biological Anthropologists (2019), asserting that essential conceptions of race and ethnicity emerged from Western colonialism, oppression, and discrimination.

Concerns about essentialism have been replaced with insights from social constructivism, the fundamental insight that perceptions and experiences of DEI groups (from both within and outside the group) are created in a *social* world (Berger & Luckman, 1966). For example, a Black person's understanding of being Black is partly built on ways in which Whites engage them. These broad social theories are meaningful to behavior when they explain group and individual *identity* relative to recovery. Tajfel (1974, 1981) argued that humans have intrinsic goals to view themselves in terms of one or more ingroups; they then craft their identity on the basis of membership of that group. Groups influence one's sense of being an individual (Who I am!) (Suarez-Balcazar et al., 2020), self-concept (How I describe myself!), and self-worth (Why I matter!) (Ashmore, Deaux, & McLaughlin-Volpe, 2004). These personally meaningful constructs are fluid, multidimensional, and reflect one's lived world. Social psychologists have shown that individuals who identify with their stigmatized group report less stress arising from prejudice and better self-esteem. This has been demonstrated for Black people (Branscombe, Schmitt, & Harvey, 1999), older adults (Garstka, Schmitt, Branscombe, & Hummert, 2004), women (Schmitt, Branscombe, Kobrynowicz, & Owen, 2002) and the LGBTQ community (Halpin & Allen, 2004).

Pride, Not Victimhood

Another problem with essentialism occurs when defining DEI groups in contrast to the majority (e.g., White, cisgender, straight males), thereby grounding the narrative in terms of downward comparisons. Compared to White men, for example, Black women have fewer opportunities and resources, which accounts for disparities across life goals; this is why their unemployment rate is so high. Although this may be an accurate representation of the social injustices that plague a minority group's history, the downward comparison becomes part of the group's essence, leading to unintentional stories of loss and victimhood that imply inferiority. It frames a group as meek and wounded, suggesting they are unable to thrive on their own. This kind of downward comparison leads to calls for pity. People wrongly think the goal of social justice is for the majority to *bestow* to minorities opportunities they need to achieve their goals. The privileged class should share their privileges with underserved groups. While the overall intent is true, the sentiment is troubling: that the down group should be pitied. This needs to be replaced by parity. Social justice rests on power where people of all groups avail resources and opportunities.

Black civil rights leaders framed power by calling their movement "Black Pride" (Black Power, 2016; Sniderman & Piazza, 2002) with its emphasis on pride and economic power, leading to the creation of appropriate political and cultural institutions. Black Pride can be traced back to Frederick Douglass in the 1850s, and embraced by 1950–60s leaders including Martin Luther King, Jr., Malcolm X, and Roy Wilkins. Similarly, the LGBTQ community embraced Gay Pride to promote narratives of self-affirmation, dignity, and equality (Britt & Heise, 2000; Corbett, 1994). Pride movements accomplish their goals by highlighting rich histories related to cultural and political accomplishments, including the arts and increased visibility of LGBTQ people as a social group.

What about *pride* and psychiatric disabilities? Some might think that the defining

qualities of mental illness are fundamentally negative, based on symptoms and dysfunction. Hence, the primary goal of mental health treatment, of being in the mental health group, is to get out of it. Hence, one might think people with mental illness should not identify with their illness. Research is mixed here. Some findings support the benefits of avoiding a mental illness identity. Research, for example, has found correlations between assuming a sick patient role and subsequent pessimism (Lally, 1989). People who believe identifying with mental illness threatens their broader well-being are likely to suppress that identity (Rüsch, Corrigan, Wassel, Michaels, Larson, et al., 2009; Rüsch, Corrigan, Wassel, Michaels, Olschewski, et al. 2009). This would seem to imply that identity as a person with mental illness should be avoided.

However, relationships between identity and self-stigma are more complex. Research has shown that effects of illness identity are influenced by perceived legitimacy of mental illness stigma (Lysaker, Davis, Warman, Strasburger, & Beattie, 2007). Those who identify with mental illness but also agree with the stigma of their disorder ("I guess that's right; people with mental illness choose their illness because they are weak") report less hope and self-esteem. Conversely, persons whose sense of self prominently includes their mental illness, and who reject the stigma of mental illness, showed not only more hope and better self-esteem but also enhanced social functioning. Hence, identifying with mental illness does not automatically lead to more stress; it is the perceived legitimacy of the stigma that threatens identity and harms emotional health. The evolution from patienthood to personhood is not necessarily a rejection of mental illness but rather an integration of its central experiences into a total self-image (Roe, 2001). People with lived experience of recovery have Mad Pride, which is a similar effort to change the dialogue about mental illness from harm and failure to identity and accomplishment (Farber, 2012; Rowland, 2015).

Intersectionality

The effects of DEI, social disadvantage, and psychiatric disability on health and wellness are additionally complex when considering the multiple intersections of identities that occur within the individual. The idea of intersectionality emerged from feminist psychology to describe the oppression experienced by Black women; that is, DEI identity is sometimes similar to the experience of Black men or White women, sometimes the combination of both, and sometimes unique to the interaction (Cole, 2009). The life choices and opportunities of individuals with psychiatric disability are also influenced by multiple DEI identities and social disadvantages that combine in unique, integrated patterns. Oexle and Corrigan (2018) unpacked the effects of intersectionality on psychiatric disability by differentiating two perspectives using an example from the life experiences of Terrell Washington, a Black man with serious mental illness. The first view is *double disadvantage*. The harmful effects of stereotypes accumulate as the person is identified with multiple DEI groups (Grollman, 2014). As Terrell is associated with multiple identities including disability, he is viewed as more different and less worthy of opportunities, including those related to health and wellness (Corrigan, Talluri, & Qin, 2021; Shah, Nieweglowski, & Corrigan, 2022). The other perspective is *prominence*. One perceptually salient DEI group in an intersection may inhibit another and dominate negative reaction (Kang & Bodenhausen, 2014). Prominence is not solely influenced by perception (i.e., Terrell's black skin) but also context. A minority racial group, for example, becomes more prominent in primarily White settings. Hence, Terrell may experience worse opportunities in service systems dominated by Whites. Ideas of intersectionality are relatively

new, with calls for both research methods and practice applications as recovery-based interventions continue to evolve.

COMMUNITY-BASED PARTICIPATORY RESEARCH

Disability, recovery, and rehabilitation are ever-evolving constructs requiring effective research to identify what works for individual groups; one dominant agenda of the past decade is representing lived-priorities of the wonderful variety of DEI groups and corresponding social disadvantages. CBPR has emerged as one way to do this; it is all about *partnership*. Traditional sciences framed people with lived experience as *objects* of research. Both qualitative and quantitative methods were then used to obtain meaningful information *from them* so scientists can, through their methods, determine answers to what they hypothesize to be research questions. CBPR reworks the research enterprise so key stakeholders *join* a team with shared authority over all segments of development and evaluation. CBPR is defined by 10 principles: (1) recognize community as the unit of identity, (2) build on strengths of community, (3) facilitate collaborative and equitable partnerships in all research phases through power-sharing processes, (4) promote co-learning and capacity building among partners, (5) achieve balance between research and action, (6) emphasize public health problems of local relevance, (7) involve systems development, (8) disseminate findings to all partners and constituencies, (9) require long-term process and commitment, and (10) address issues of race, ethnicity, racism, and social class through the lens of cultural humility (Minkler & Wallerstein, 2011). CBPR has been described as a *moral imperative* for people with disabilities—to borrow a term from the disability rights movement, "nothing about us without us" (Collins et al., 2018; Hancock, Bundy, Tamsett, & McMahon, 2012)

CBPR in rehabilitation research is especially compelling at two times in the process:

1. *Going into the project.* At start-up, the CBPR team members come together around a central, loosely defined concern (e.g., how might we: address health and well-ness needs in the existing health care system, or implement supported education in community colleges, or link with faith-based communities to address individual spiritual priorities?) This opening definition focuses the CBPR team; members with psychiatric disability from DEI groups already have years of experience reacting to the focus in the real world that leads to meaningful research questions and hypotheses. None of the team members with lived experience *dictate* hypotheses, because the goal of CBPR is research. Hence, the team as a whole uses start-up hypotheses to collect information that confirms or further revises questions and the methods meant to answer them. This typically includes qualitative research, where people from the focal community group are interviewed about their perceptions of the problem and solutions, and quantitative research, where these perceptions are tested in rigorous study.

2. *Coming out of the project.* CBPR is action research; its first goal is to use findings to actually change policy and practice so people with psychiatric disabilities from DEI groups receive services that better meet their needs and goals. The demands of different types of stakeholders at project completion on the team yield different actions coming out of CBPR. Researchers are often driven by academic demands to write up the study, put it on the library shelf, and go on to the next grant-funded project often in different areas. It is the CBPR team member with lived experience who has historical interest in project foci

with the promise that it will lead to better services. They are the advocates on the team; they are most likely to turn research into action. This is where power and CBPR become most obvious; agendas from the grassroots have emerging and significant credibility in the current U.S. *zeitgeist*.

As alluded to earlier, CBPR is conducted by *teams* that vary in stakeholder representation defined by and built around people with lived experience of psychiatric rehabilitation and DEI group. This lived experience group is defined by a community-of-interest (e.g., Black people with serious mental illness who are homeless). Hence, the team for this kind of CBPR would comprise Black people with serious mental illness who are homeless. They come together in a group of four to five and partner with other stakeholders, including scientists who are in some way technicians of the group, posing methods or analyses for the study, and then guiding the discussion about interpretations of findings. The team also includes family members, friends, others from the community, service providers, administrators, and policymakers. The entire team consists of about 10 people. Team processes may require months to accomplish; team members hope they can commit to this kind of timeline over the course of a study.

BARRIERS TO ENGAGEMENT

One of the broadest effects of disparities due to DEI and social disadvantage occurs as a barrier to engagement in recovery-based interventions, reducing the degree to which individuals regularly interact with a recovery team to attain their goals. As discussed in Chapter 3, engagement does not mean compliance or adherence; opting to not engage does not mean failing to understand one's problem or to join in services prescribed by health professionals. Engagement reflects the health system and the degree to which it is welcoming, whether health care providers and the services they provide reflect an individual's sense of personal goals and priorities. Engagement is broadly defined with contributions from the provider team; these include mental health professionals, vocational and educational counselors, housing specialists, criminal justice transition teams, and support providers, both peers and nonpeers. People who engage well in services achieve more of their recovery goals. Figure 4.2 summarizes three sets of barriers to engagement that especially represent the effects of DEI and social disadvantage. They are framed in terms of three questions. Where: In what settings and with what services are evidence-based recovery services available? Who: Who are the providers of these services? What: What are the specific services provided?

Where: Barriers to Services and Settings

Evidence-based services practices are often not *available* or not accessible in low-income communities where people from many DEI groups with psychiatric disabilities live (Buzza et al., 2011; Chan, Hart, & Goodman, 2006). In addition, services are often difficult to *access* because of long urban commutes with public transportation (Hall, Kurth, Gimm, & Smith, 2019; Syed, Gerber, & Sharp, 2013), and programs frequently located in relatively high crime areas (Tung, Boyd, Lindau, & Peek, 2018). Rural communities have additional hurdles to availability (Buzza et al., 2011; Chan et al., 2006) and accessibility (Dassah, Aldersey, McColl, & Davison, 2018; Iezzoni, Killeen, & O'Day, 2006). Administrative steps central to guiding appointments and follow through also
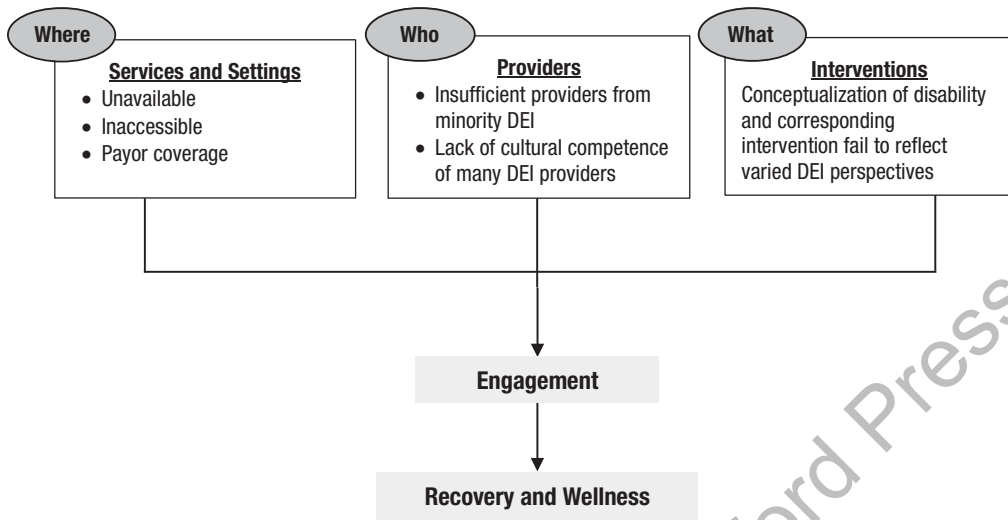
FIGURE 4.2. Barriers to engaging in recovery-oriented services. DEI, diversity, equity, and inclusion.

interfere with service engagement (Hwang et al., 2008; Langheim, 2014). Facilities are often unfriendly to DEI groups, especially to people with physical disabilities (Drainoni et al., 2006; Pharr, James, & Yeung, 2019).

Access to third party payers that support these interventions is hampered by whether the individual is certified to receive different levels of government and entitlements (Artiga, Damico, & Garfield, 2015) and whether providers assist in accessing those entitlements (Bowers, Owen, & Heller, 2017). Insurance is more than a binary construct: "Yes or no, do people have benefits they might avail for health care costs?" Description of the role of third-party payment includes type and breadth of insurance, place in a larger service system (e.g., does an individual provider accept an insurance plan?), and administration and logistics to avail third-party payment.

Who: Barriers by Providers

The *by whom* of most health care services may be reduced to the individual provider–person or provider team–person relationship. Providers are professionals or paraprofessionals offering direct services across the range of recovery goals. They also include reception and administrative support and entitlement personnel. DEI match between provider and person has been shown to influence subsequent engagement with the care plan (Ziguras, Klimidis, Lewis, & Stuart, 2003). Research, for example, shows matching race and/or ethnicity of persons with psychiatric disabilities and providers enhance engagement and outcome (Hill, Jones, & Woodworth, 2020; Nguyen et al., 2020; Takeshita et al., 2020), as do matches that reflect gender identity (Sacks, 2013; Zhao, Dowzicky, Colbert, Roberts, & Kelz, 2019) and sexual orientation (Bishop, Crisp, & Scholz, 2022; Lisy, Peters, Schofield, & Jefford, 2018). Corresponding policies have called for professional training and education of students from DEI groups, leading to increased hiring and support of paraprofessionals and professionals.

Lack of cultural competence and humility by the *existing* provider workforce staff is an additional barrier to service engagement. Several systematic literature reviews (Betancourt, Green, Carrillo, & Park, 2005; Henderson, Horne, Hills, & Kendall, 2018; Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2011) have defined cultural competence or the lack thereof, including antecedents such as cultural openness, awareness, desire, and knowledge; these reviews have also defined attributes such as respecting and tailoring care aligned with personal values, and provision of equitable and ethical care with sensitivity. Documented consequences of culturally competent and humble providers include satisfaction with care, perception of quality, effective interaction, and improved health outcomes (Lie et al., 2011). Especially important here is replacing essentialist with constructivist views of DEI (Garneau & Pepin, 2015). As said earlier, essentialism was the status quo perspective (i.e., DEI groups are defined by common values, beliefs, and practices that are objectively observable and stable over time; Garran & Werkmeister Rozas, 2013). This leads to providers working with someone from specific DEI groups with prior presumptions of their values and goals. Proponents of constructivist models frame cultural competence as dynamic processes within a DEI group, as well as the changing identities of individuals in that group (Carpenter-Song, Schwallie, & Longhofer, 2007).

What: Interventions

The "what" of services is defined by evidence-based interventions described by practice guidelines specifying provider behaviors meant to help people with disabilities achieve their health goals. These guidelines are typically grounded in conceptualizations of the disabling condition; for example, the phenomenology of the disability itself, the way it undermines life goals, its causes, and factors that mitigate its ongoing experience. The task becomes even more complex when considering the description of DEI and social disadvantage intersections. American approaches to psychiatric rehabilitation have been grounded in Western models (Suarez-Balcazar et al., 2020) that often ignore other perspectives to understanding health and wellness (Hogan, 2019; Dodge, Daly, Huyton, & Sanders, 2012). Corresponding guidelines then lead to a menu of interventions that may assist people in addressing their health concerns. These too have been dominated by the West in the United States, though emergence of alternative and complementary approaches to care have begun to open service options to broader DEI perspectives (Attena, 2016; Kisling & Stiegmann, 2022).

Consider a prominent example. SDM is a Western-centered approach to rehabilitation that dominates psychiatric rehabilitation (Agency for Healthcare Research and Quality, 2016; Edwards & Elwyn, 2016) and includes three components: (1) Providers share information regarding specific concerns (e.g., related to work, education, or housing goals) and corresponding interventions with costs and benefits of each; (2) people explore their preferences with the provider regarding costs and benefits of each intervention; and (3) interactive discussion between person and provider yields mutual decisions about subsequent treatment and testing. Despite its promise, concern has been expressed about *self*-decision-making models, especially when considering people from DEI groups where the broader social network may be keenly involved in treatment decisions (Corrigan & Lee, 2021). SDM reflects self-determination theory, which identifies autonomy as essential for psychological growth and well-being (Attena, 2016; Kisling & Stiegmann, 2022). Autonomy, however, seems to reflect Western, individualist perspectives that may be less valued in more Eastern or collectivist societies (Oishi & Diener, 2001). Miller

(1997) suggested that directive feedback from family members may yield more satisfaction than autonomy in some DEI groups.

SUMMARY AND CONCLUSIONS

Discussion like these have changed from a focus on disparity to promotion of equity. While the goal is to erase *disparities* so people, regardless of DEI group and social disadvantage, can fully avail services to meet personal goals, *equity* is meant to celebrate the process. The discussion has evolved from "What should we stop doing?"—how have majority cultures failed underserved groups—to "What should we craft in an affirmative manner?" Equity is celebratory; acknowledging diversity across all groups recognizes the strengths and resources of each. This is not a rehash of *color blindness,* a 1960s idea that prejudice and discrimination can be erased by ignoring differences between groups. Pride shouts out difference, followed by strategies to honor it. While equity needs to broadly be the goal across the world, goals of equity become a bit more focused when looking within a community. We need to recognize that communities are often described by shared values related to culture, religion, gender identity, sexual orientation, and disability. Recovery-based programs that reflect the generic world—the cross-diversity approach—ignore the need to frame goals and actions specific to the community. Going forward in this book, readers should ask themselves how specific principles and practices would be experienced by different DEI groups.