Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Building a Diverse Psychiatric Workforce for the Future and Helping Them Thrive

Recommendations for Psychiatry Training Directors

Asale Hubbard, PhD[a,b,1], Andrew Sudler, MD, MPH[a,2], Jean-Marie E. Alves-Bradford, MD[c], Nhi-Ha Trinh, MD, MPH[d,3], Anne D. Emmerich, MD[d,4], Christina Mangurian, MD, MAS[a,*]

KEYWORDS

- Workforce diversity • Psychiatry residency training
- Psychiatry residency recruitment • Training directors • Anti-racism
- Structural competency

KEY POINTS

- The development of intentional recruitment pipelines at universities, outreach to minority-serving universities, and examination of selection strategies to reduce bias are essential to increasing underrepresented in medicine (URM) enrollment in psychiatry training programs.
- Retention of URM trainees is strengthened through the creation of affinity group spaces, structured opportunities, and mentorship with URM faculty and consideration of policies and/or potential barriers to the success of URM trainees.
- Training programs must move beyond cultural factors to examine how structural forces impact the experience of health care. Training curriculums should include a focus on structural competency, provide opportunities to engage in advocacy, and the development of research centered on participation of the communities of interest.

[a] University of California, San Francisco Department of Psychiatry and Behavioral Sciences, Weill Institute for Neurosciences; [b] San Francisco VA Health Care System; [c] Columbia University Department of Psychiatry, 1051 Riverside Drive Box 112, New York, NY 10032, USA; [d] Massachusetts General Hospital Department of Psychiatry
[1] Present address: 4150 Clement Street (116B), San Francisco, CA 94121.
[2] Present address: 1001 Potrero Avenue, San Francisco, CA 94110.
[3] Present address: One Bowdoin Square, Boston, MA 02114.
[4] Present address: 15 Parkman Street, Boston, MA 02114.
* Corresponding author. 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110.
E-mail address: christina.mangurian@ucsf.edu
Twitter: @cmangurian (C.M.)

Psychiatr Clin N Am 45 (2022) 283–295
https://doi.org/10.1016/j.psc.2022.03.007
psych.theclinics.com

INTRODUCTION

In 2020, our world irrevocably changed because of the COVID-19 pandemic. Concurrently, in the United States, racial uprisings following the murder of Mr George Floyd and the losses of other innocent Black lives cast a spotlight on the syndemic of COVID-19 and structural racism. This spotlight has galvanized health care institutions to re-examine and renew their commitment to Diversity, Equity, and Inclusion (DEI) with a sharper focus on antiracism efforts.

Demographic shifts in our population over the past few decades also argue for this. Per 2020 census data, only 60% of Americans now identify as White, compared with 80% in 1980.[1] The Pew Center reports that 46.8 million Americans (14% of the population) identified as Black in 2019, an increase of 29% since 2000.[2] More than 50% of young people under the age of 16 years now identify as belonging to one or more racial or ethnic minority groups.[1] Census data estimates predict that by 2043, non-White people will make up more than one-half of the overall US population.[3] A report by Wilson estimates that the shift to a non-White majority working class (defined as people without a college degree, who make up two-third of the workforce) will occur much earlier, in 2032, only 11 years from now.[3]

Despite the shifting demographics in the United States, many Black, Indigenous, People of Color (BIPOC) communities remain marginalized and significant inequities exist in medical and mental health care. Increasing evidence shows that implicit bias by majority clinicians is one of the many reasons why health inequities exist in communities of color.[4] Patients are increasingly requesting access to clinicians from BIPOC communities, and studies support the concept that this can contribute to better treatment outcomes.[5,6] Population demographics are shifting toward a non-White majority, but the demographics of psychiatrists and psychologists are not. We face a diversity crisis in mental health professions. Per an American Psychiatric Association report, the number of psychiatry trainees overall in the United States increased by 20.7% between 2014 and 2018 (to 6247),[7] but "*the racial and ethnic diversity among psychiatric trainees has not changed significantly since 2016*."[8]

In 2018, fewer than 10% of incoming PGY-1 psychiatry residents self-identified as Black/African American and Hispanic/Latino/Spanish Origin. Less than 1% self-identified as American Indian/Alaskan Native or Native Hawaiian/Other Pacific Islander.[8] In 2018, only 7% of US psychiatrists were Black.[9]

Even if the number of BIPOC individuals entering mental health professional training programs increases, it will still take years for the overall availability of licensed BIPOC clinicians in the community to change and training programs are the only mechanism through which this need can be addressed. Lin, Stamm, and Christidis report that although one-third of psychology PhDs were awarded to students who identified as racial/ethnic minorities in 2016, the overall percentage of White psychologists in practice remained 86%.[10] The average medical school graduate takes 4 to 6 years or more to complete psychiatric residency and subspecialty fellowship training and both during and after training, there are geographic inequities in the availability of underrepresented minority (URM) clinicians. A 2019 Association of Medical Colleges Report on Residents shows that 64.5% of psychiatry residents remain in the state in which they trained after completion of residency and across specialties women are more likely to remain in the state in which they trained.[11]

Trainees are not uniformly represented in all parts of the country and psychiatrists, in general, are often scarce in parts of the country with the most significant percentages of non-White residents. The American Psychiatric Association 2019 Resident/Fellow Census[8] stated: "*There are large differences across states in the number of psychiatry*

trainees per capita. The District of Columbia, New York, and Massachusetts have the largest number of per capita trainees. At the same time, parts of the southern and western U.S. tend to have insufficient numbers of per capita trainees." Some states, including Arkansas, Idaho, Montana, and Wyoming had no new trainees enter psychiatry training programs in 2018.[8]

In addition, significant challenges exist for psychiatric training programs attempting to recruit BIPOC candidates. The most challenging is gaps in the pipeline. We must find ways to give young people exposure to STEM careers—particularly mental health—in elementary and high school, supporting them to keep alive their dream of going to medical school throughout college, and providing outstanding mentorship, nurturance, support in medical school, and residency, fellowship, and later.

For the 5% of medical school graduates who do choose to enter psychiatry each year,[7] considerations such as the lower expected income for psychiatrists compared with other specialties can be a barrier. This is a major problem diversifying our field, given that Black medical students owe more on average than students from other groups. Estimates indicate that over 50% of Black medical students graduate with more than $200,000 in debt, and 17% graduate with over $300,000 in debt.[12]

Once recruited, programs also face challenges with retaining trainees who have often become discouraged by bias and microaggressions during the training years.[13] Many BIPOC psychiatrists are also without culturally congruent mentorship. They are vulnerable to being asked to take on more than their share of diversity-related work by their institution, usually with little compensation (often called the minority tax).[14] In addition, given the small numbers of BIPOC trainees, the experience of imposter syndrome is common, again leading to difficulty with later faculty retention and feeling of thriving. In fact, Jordan and colleagues (2020) discuss how failure to retain and promote BIPOC psychiatrists to the highest leadership levels results in lack of role-modeling and belonging.

In parallel, psychiatry training programs face challenges as they attempt to update their curriculums to more effective ones. In the latter half of the 20th century, a focus on cultural competence has transformed into cultural humility and sensitivity, as well as increasing recognition of the importance of structural competence.[15] To understand the many challenges faced by BIPOC trainees, training directors and supervisors must engage in self-education to recognize the impact that structural racism and implicit bias have in their institutions, and simultaneously, how these impact their ability to recruit and retain BIPOC candidates. The Cultural Formulation Interview chapter highlights the importance of focusing on these issues clinically and in the workplace.[16] That said, the field of psychiatry—and the use of the DSM in particular—perpetuates racist narratives about certain communities.[17] This reality is a barrier to recruiting diverse trainees.

Accreditation Council for Graduate Medical Education (ACGME) requirements in psychiatric training reflect this value and place increasing importance on workforce diversity and training of psychiatrists to become capable of caring for patients from diverse backgrounds. These guidelines require that trainees demonstrate competency in the areas of professionalism, patient care, and procedural skills.[18] Programs must also be careful not to blindly assume that pairing trainees with culturally congruent patients will always lead to better clinical outcomes. Rodriguez and colleagues[19] offer a vivid portrayal of the clinical challenges that can occur when a trainee and patient come from the same background and offer useful strategies for supervisors to consider when working with trainees of cultural backgrounds other than their own.

DISCUSSION

Recruitment Strategies

Pipeline within the same university

The Liaison Committee on Medical Education at the American Association of Medical Colleges has encouraged medical schools to become more racially and ethnically diverse throughout the past decade.[20] The encouragement has resulted in a more significant number of URM medical students whom psychiatry residency programs can recruit from their own institutions and beyond. Prior research has shown that connecting with a medical school's diversity office, psychiatry student interest group, and URM affinity groups can help recruit diverse applicants.[21,22]

However, the recruitment pipeline is not limited to the medical school affiliated with a residency program. More attention should be dedicated to students at earlier stages of training who are not yet in medical school, but who have expressed interest in the health sciences. For example, a case study by UCLA's Psychiatry Residency Program found that there is a missed opportunity to connect with premedical students who identify as URM. Psychiatry residency programs should build and leverage relationships with local high schools and community college programs to inspire interest in prospective trainees.[21] This would enable residency programs to showcase opportunities within the field of psychiatry and begin mentoring URM students at an early age.

Outreach to Historically Black Colleges and Universities and other universities

In addition to internal pipeline programs, strategic recruitment at Historically Black Colleges and Universities (HBCUs) can help increase diversity in graduate medical education.[23] For example, HBCUs only account for 2.6% of all medical students[24]; however, 15% of Black medical students attend HBCUs. The sizable Black population at these institutions represents a valuable opportunity to recruit individuals who are underrepresented in medicine.

In addition, HBCUs have set a high standard for diversifying academic medicine at all stages of training. A phenomenon known as the "*HBCU Medical School Effect*" describes how the number of Black medical students is positively related to the number of Black faculty and department chairs at an institution.[25] Although this piece is focused on diversifying the psychiatric workforce through training; to achieve that goal, we must diversify all levels of academic psychiatry. HBCUs have developed a successful model for increasing representation in academic medicine.[25] Psychiatry residency programs at other institutions would benefit from collaborating with and learning from HBCUs, and specifically recruiting medical students from these rich medical schools.

Selection: holistic review

A holistic review of residency applications is a method that residency programs can use to diversify their selection process.[23,26] This approach considers the totality of an individual's lived experiences in concert with their academic achievements.[23,27] This approach is also used to reduce reliance on measures tainted with bias, such as the USMLE Step 1.[28]

Regarding psychiatry, a recent study comparing holistic and traditional reviews found that individuals identifying as URM were greater than twice as likely to receive an interview under holistic criteria than conventional criteria.[28] One downside to conducting a holistic review is that it is typically more time-consuming than traditional methods, especially with more applications.[28,29] Therefore, successful implementation of holistic review will require that programs have more support.

Outreach to promising candidates

Programs can also increase the diversity of psychiatry trainees by actively and transparently conveying an interest in having a particular URM applicant train with them. The case study from UCLA recommended that having program directors and residents reach out to applicants after being interviewed can help establish connections.[21]

However, tailored outreach to URM applicants does not have to wait until an applicant has interviewed at a program. Programs can also conduct outreach throughout the application season, as evidenced by the Visiting Elective Scholarship Program (VESP) at UCSF. The VESP is a GME-wide initiative where URM students interested in particular specialties can participate in electives in the department of their choice.[30] Given the COVID-19 pandemic, the VESP program operated virtually in 2020, with the psychiatry department hosting multiple information sessions and recruitment events dedicated to URM students. In addition to VESP, many programs also host "Second Look" events that are specifically dedicated to giving URM applicants another opportunity to learn about a residency program.[31] These events typically focus on DEI-related initiatives and are meant to create a supportive community among prospective URM trainees.

Another strategy is to partner with community affinity groups. In 2020, the American Psychiatric Association's (APA) Black Caucus hosted a virtual event about DEI initiatives at 36 psychiatry residency programs for URM students. Seventy percent of the students reported that the event inspired them to learn more about a particular program.[32] Data have shown that applicants often find this type of outreach to be helpful. Residency programs might consider partnering with the APA Hispanic Caucus to hold a similar recruitment program early in the recruitment process.

Continuous quality improvement to measure the impact

As URM recruitment strategies are implemented, evaluating the programs' success in matching, and retaining URM applicants. We must identify measurable goals and metrics and be transparent about processes and progress. Evaluation measures are standard in residencies, but they are typically used to assess trainees' progress. For example, a 2007 study proposed a tripart paradigm of evaluation that focuses on the skills residents brought into the program ("before"), the experiences they had while training ("during"), and their achievements postgraduation ("after").[33] Training programs should measure dimensions including diversity, inclusion, and belonging and monitor performance from all residents, including those from minoritized identities. Metrics such as resident feedback from rotations, the ACGME survey, and the retention of faculty are ways to measure and monitor performance over time. We suggest taking an intersectional approach—specifically reviewing the intersection of gender identity and race/ethnicity—in evaluating trainees and faculty across their career trajectory. A similar framework could evaluate the success of a residency program's URM recruitment. By comparing a program's initial URM diversity, feedback from applicants who experience DEI programming, and the URM representation in a program's matriculating class, programs can identify what strategies helped them achieve their DEI metrics and which methods fell short. Ultimately, the qualitative and quantitative data collected,[33] can help continuously improve URM recruitment throughout the life of the residency program.

Retention Strategies to Promote Inclusion and Belonging

Create a supportive and inclusive environment

To increase diversity in residency programs, training directors need to implement strategies to retain our underrepresented trainees. Training directors need to consider the

climate of the residency training program and create supporting inclusive environments where trainees can thrive. Inclusion and belonging are critical for career satisfaction. Diversity without inclusion or belonging may lead to decreased well-being, increased burnout, and attrition.[34] Community building is one way to increase inclusion and belonging. Group activities, gatherings, and wellness events can build community. Community affinity groups began as race-based employee forums in corporate environments in response to the social conflict in the 1960s.[35] Today, community affinity groups go beyond race, they are meetings in which participants gather based on a particular social identity to discuss related personal experiences.[35] Community affinity groups can be centered around a shared identity or interest—and can create a community and mutual support for URM trainees.[36] In programs where there are small numbers of URM trainees, consider starting a joint community affinity group for URM trainees across all trainees in the institution. For example, Columbia University Medical School has formed a GME diversity council for resident members from any department.

In addition, trainee development programs through national organizations can provide additional support, mentorship, sponsorship, and belonging. The APA Minority Fellowship Programs are one such example. Regional and national meetings provide an opportunity to share experiences with other URM peers, get to know and spend time with URM faculty mentors. Such models may be limited in the trainees' home institution.

Increase role models

BIPOC trainees need to see URM role models at all aspects of the academic hierarchy, including in senior leadership roles. In addition to role models, ongoing mentorship, career development, and sponsorship are essential. Mentoring does not have to be from URM faculty only; mentoring from both URM faculty and non-URM faculty is valuable. All faculty should have required training in microaggressions, upstander skills, and mentoring people from backgrounds other than their own.[37,38] Mentors give advice and feedback while sponsors are in positions of power and use their influence and networks to create opportunities for others. Sponsorship—where people of power talk about a trainee and provide opportunities—is often missing in URM trainees' careers. Training programs should intentionally match URM trainees with sponsors or provide sponsoring opportunities by connecting the trainees to local, regional, and national leaders who can help to provide additional career guidance and recommend opportunities.[39] Notably, to reduce minority tax (see the following section), these URM role models should be compensated in some form (eg, relief from clinical duties, financially).

Decrease the minority tax

Several prominent underrepresented physicians have written about leaving academic medicine and organized psychiatry.[40,41] Problems such as structural and interpersonal racism and discrimination lead to URM faculty feeling they have to constantly prove their value and ability, distracting them from more meaningful activities. The "minority tax" of increased expectations for work that is not compensated or rewarded, including committee work, diversity-related institutional efforts, extra clinical assignments, voluntary community assignments, and mentoring, is commonly seen in URM trainees and faculty in academia. This tax contributes to burnout and poor retention of our diverse workforce.[42]

Faculty training in interpersonal and structural racism and response to bias

URM trainees experience microaggression frequently, up to 75% in some samples.[43] Microaggressions and other forms of racism and bias may lead to feelings of

isolation, decreased self-esteem, poor mental and physical health, and burnout.[43] Recent data from ACGME reveal that Black, Asian, and Latinx trainees get dismissed from training programs at higher rates than White trainees.[44] Although the reasons for dismissal are unknown, bias is likely one of the drivers. In addition, in a recent review of over 30,000 medical students responding to the Association of American Medical Colleges (AAMC) Graduation Questionnaire, administered to graduating students at all 140 medical schools, URM student's disproportionality reporting perceiving a lack of respect for diversity among faculty.[45] Training directors need to be aware of the "hidden curriculum (knowledge not explicitly stated)," which trainees learn by watching the faculty and the institution. Separate care systems and under-resourced care for patients from community populations in contract to the faculty practice send a message to trainees. In addition, trainees are overhearing disparaging comments toward patients and trainees of color and are experiencing and often witnessing bias toward patients and trainees of color. Faculty development in structural and interpersonal racism to help faculty recognize bias is essential. Skill development such as upstander skills can help to change the culture. Senior leadership involvement and support of such faculty development are vital to model the necessary culture change.

The Training Itself: Opportunities for Intervention and Innovation

Structural competency built into the organization

Psychiatry training programs are at a critical juncture to respond to both the response to the COVID-19 and racism pandemics. Through crises emerges opportunities to meet the needs of our current cultural landscape. In recent decades, psychiatry training has shifted from focusing on cultural competence and characteristics of different social groups/identities toward a holistic frame through structural competency. Structural competency serves as a paradigm shift in understanding health and health disparities by critically examining the structural factors that impede well-being.[15] The approach guides providers to look beyond patient symptomatology and explore the social determinants of health also influencing the clinical encounter.[15] Competency, understood through the lens of cultural humility—an openness to continued self-reflection and learning.

Metzl and Hansen[15] describe structural competency training as composed of 5 skill sets: (1) recognizing the structures that shape clinical interactions (eg, economic, sociopolitical, and physical forces); (2) developing an extraclinical language of structure (eg, intersection of social structures and biology); (3) rearticulating "cultural" presentations in structural terms (eg, inclusion of structural forces and impacting care); (4) observing and imagining structural intervention (eg, consideration of methods to address structural health concerns); and (5) developing structural humility (eg, commitment to continued growth and awareness of limitations in examination of structural forces). Structural competency training moves providers from a purely diagnostic focus to more sophisticated conceptualizations that expand the clinical picture in the clinical environment. Considerations may include other relevant factors in care, such as the ability to afford medications, transportation to and from the appointment, and access to safe housing, to name a few. Our ability to see patients beyond individual characteristics to the larger social and societal structures they inhabit increases our ability to provide high-quality, patient-centered care. There is a robust Web site created by leaders in the field available for readers.[46]

In planning psychiatry training program curricula, training directors should consider an approach to building structural competency that provides continued exposure and increased complexity of experience over time. There is great benefit in repeated

exposures to content regarding diversity and social inequities rather than singular or stand-alone training.[47] An ideal training model includes introspective awareness through cultural competency (eg, implicit bias, patient/provider communication) and a broader societal understanding by examining political, social, institutional, and economic factors.[15]

A developmental model allows for the inclusion of lower to higher experiences appropriate for the current level of training.[48] For instance, a developmental model may start with a focus on cultural self-awareness (implicit bias) and eventually move toward advocacy and action (participation in policy development). Like the structural competency training described earlier, such training is more effective when focusing on both awareness and skills.[47] One such example of a relevant tool for this is the "Structural Vulnerability Assessment," a screening instrument used to identify structural obstacles and inform resources and advocacy required to prevent poor health outcomes.[49] The answer to the screening question "*Do the places where you spend your time each day feel safe and healthy?*" can lead to the immediate consideration of needed resources or advocacy needed to obtain resources for vulnerable trainees.[49] The structural competency approach has also been described in relation to lesbian, gay, bisexual, transgender, gender nonconforming, and those with differences in sex development.[50] Although much of the initial training in structural competency may be didactic through understanding systemic forces, integrating opportunities for modeling action-oriented interventions expands this work from merely academic to transformative through advocacy.[51] As more psychiatry training programs seek to adopt structural competency training as part of their programs, psychiatry and national training organizations (e.g., AADPRT) must also provide continuing education and support for training directors to be sucessful in change managment. Many training directors are finding their trainees are more knowledgable on topics related to experiences of racism, discrimination, and health disparities. Psychiatry would benefit from a critical examination of training to move toward adopting a national diversity, equity, and inclusion curriculum setting standards and competiences for psychiatry.

Advocacy to promote antiracism

In adopting a structural competency model, we would be remiss not to consider how psychiatrists can effectively be advocates, particularly in addressing racism both within and outside of their organization. Kirmayer, Kronick, and Rousseau[51] posit that advocacy is, in fact, a core competency in psychiatry. For instance, a key competency in the University of California San Francisco (UCSF) Psychiatry HEAL Fellowship in Global Mental Health is engagement in the health system by way of evaluating health programs, engagement with local leaders/groups, and developing interventions with local partners.[52] The training program provides an ideal environment in which training faculty can model skills in advocacy and provide opportunities to put learning into action. Understandably many psychiatry faculty and residents are concerned that getting involved in advocacy means getting engaged in politics or working outside of one's scope. The reality is that the structural competency lens puts psychiatrists in an ideal position to understand the forces impacting those they serve and represent those interests on their behalf.

In developing advocacy skills, it is essential to model the different ways and levels one may advocate.[51] Kirmayer and colleagues outline 3 levels of advocacy: (1) recognizing and understanding the structural determinants of health and incorporating this knowledge into professional education, clinical practice, and community intervention; (2) supporting coalitions and collective action that aim to change policy and practice;

and (3) initiating, mobilizing, and organizing, action to challenge social injustices. Putting this into context, we want to understand the systemic factors compounding one's experience of depression, such as racism and discrimination. Still, we also seek to create more resources to reduce those factors that impact this individual and the broader community.

There is precedence for advocacy to be part of clinical training through community treatment teams identifying how systemic factors impact mental illness or developing a policy advocacy program where residents learned to draft bills enacted into law.[53] Although many URM residents may find themselves drawn to this work, White-identified faculty and residents must be encouraged to stretch the boundaries of their comfort zone toward incorporating advocacy as part of their psychiatry professional identity.

Promoting equal access to research

Despite many clinical programs focus on improving recruitment and retention of URM applicants, research training programs are another key area for growth. A structural competency approach to psychiatry training also requires a shift in the training and focus beyond predominately disease-focused research in White populations. Research is a critical component in developing needed interventions from science to practice and can help inform policy changes. Unfortunately, because of several factors, including mistreatment in health care and research, many marginalized communities are often not included or included in such small samples as to limit interpretation. There is a need to develop research programs that can address factors limiting participation, and that are able to effectively link outcomes to practice.[54]

One such approach to consider toward this effort is community-based participatory research (CBPR), which centers on the experience of the community studied at every facet of the research design.[54] CBPR builds on traditional approaches to soliciting research participants by going directly to the community studied to invite them into the process of creating the study rather than eliciting research participation without such investment.[55] The power of providing training opportunities in CBPR is that residents become more knowledgeable about the communities they serve (thus impacting clinical care outcomes), and through research, are better equipped to ask the right questions—questions that speak to the experience of the community. Moore and colleagues[54] proposed a model for equitable analysis including the following steps: (1) identify population or community of focus, (2) build relationships with community or patient leaders, (3) community engagement, (4) develop research questions and design, (5) data analysis and interpretation, (6) implementation and scaling of interventions, and (7) accountability. Training directors should seek to provide explicit training on this model in all psychiatry research training programs.

In addition, training directors should be mindful of the implicit bias that can lie in the types of research projects that are funded by large organizations, including NIH.[56] Institutions should consider building internal funding sources to support trainees interested in research on antiracism, health inequities, and structural determinants of health.

SUMMARY

The COVID-19 pandemic and murder of Mr George Floyd served as catalysts for examining antiracism efforts in psychiatry training programs and health care systems. Our recruitment and retention of Black, Indigenous, and other racial/ethnic minority psychiatry trainees has not met the demand for care and does not represent the communities served. Training directors at a critical juncture in creating systemic changes

to recruitment, retention, policies, and curricular competencies to address ongoing inequities and disparities in health care. In this piece, we describe several strategies and considerations for training directors in supporting a diverse psychiatric workforce. Specifically, we describe strategies to improve recruitment including the development of intentional recruitment pipelines at universities, outreach to minority-serving universities, and examination of selection strategies to reduce bias are essential to increasing URM enrollment in psychiatry training programs. We also describe methods to retain trainees is through the creation of community affinity group spaces, and structured opportunities and mentorship with URM faculty. In general, we recommend that training programs move beyond cultural factors to examine how structural forces impact the experience of health care. Training curriculums should include a focus on structural competency, provide opportunities to engage in advocacy, and the development of research centered on participation of the communities of interest.

CLINICS CARE POINTS

Recommendation for Psychiatry Training Programs

- Recruitment
  - Bolster pipeline within your university (premedical students), local community colleges, and high schools
  - Create opportunities for interested BIPOC students to visit (eg, second visit, elective rotations)
  - Outreach to HBCUs and other institutions with high BIPOC enrollment
  - Partner with affinity groups within the APA for outreach
  - Holistic Review and ensure adequate support for successful implementation
  - Direct outreach to promising candidates
  - Continuous quality improvement to distill essential elements for successful recruitment
- Retention
  - Promote a supportive and inclusive environment, including implementation of community affinity groups.
  - Increase number of BIPOC role models for mentorship and sponsorship, but provide funding for this to decrease minority tax
  - Ensure that all faculty receive regular training in bias and allyship, and upstander behavior
  - Institute feedback mechanisms (quantitative and qualitative) and develop metrics to track progress over time
- Training
  - Include training in cultural competence, cultural humility, and structural competency
  - Provide opportunities for trainees to engage in advocacy as part of their curriculum, through modeling, and incorporation in training rotations
  - Develop trainee skills in conducting research centered on participation of the communities of interest.
  - Build internal funding structures to support research in antiracism, health inequities, and social determinants of health

DISCLOSURE

The authors have nothing to disclose.

REFERENCES

1. Frey WH. The nation is diversifying even faster than predicted, according to new census data. Brookings Institute; 2020. https://www.brookings.edu/research/new-census-data-shows-the-nation-is-diversifying-even-faster-than-predicted/.

2. Tamir C, Budiman A, Noe-Bustamante L, et al. Facts about the U.S. Black population. 2021. Available at;. https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population/. Accessed August 2, 2021.
3. Wilson V. People of color will be a majority of the American working class in 2032. Economic Policy Institute 2016;9:1–27. https://www.epi.org/publication/the-changing-demographics-of-americas-working-class/#epi-toc-2.
4. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics 2017;18(1):1–18.
5. Alsan M, Garrick O, Graziani G. Does diversity matter for health? Experimental evidence from Oakland. Am Econ Rev 2019;109(12):4071–111.
6. Huerto R, Lindo E. Minority patients benefit from having minority doctors, but that's a hard match to make. University of Michagan Health 2020;. https://labblog.uofmhealth.org/rounds/minority-patients-benefit-from-having-minority-doctors-but-thats-a-hard-match-to-make-0.
7. Moran M. Psychiatry residency match numbers climb again after unprecedented year in medical education. 2021. Available at: https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.5.27. Accessed August 2, 2021.
8. American Psychiatric Association. 2019 Resident/Fellow Census. 2020. Available at: https://www.psychiatry.org/File%20Library/Residents-MedicalStudents/Residents/APA-Resident-Census-2019.pdf. Accessed August 2, 2021.
9. Lee S. Racial disparities lead to poor mental health care for Black Americans. 2020. Available at: https://www.verywellmind.com/racial-disparities-mental-health-5072490. Accessed August 2, 2021.
10. Lin L, Stamm K, Christidis P. How diverse is the psychology workforce? Monitor Psychol 2018;49(2):19.
11. American Association of Medical Colleges. 2019 report on residents executive summary. 2019. Available at: https://www.aamc.org/data-reports/students-residents/interactive-data/report-residents/2019/executive-summary. Accessed August 2, 2021.
12. Hanson M. Average medical school debt. 2021. Available at: https://educationdata.org/average-medical-school-debt. Accessed August 2, 2021.
13. Molina MF, Landry AI, Chary AN, et al. Addressing the elephant in the room: microaggressions in medicine. Ann Emerg Med 2020;76(4):387–91.
14. Jordan A, Shim RS, Rodriguez CI, et al. Psychiatry Diversity Leadership in Academic Medicine: Guidelines for Success. Am J Psychiatry 2021;178(3):224–8.
15. Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Social Sci Med 2014;103:126–33.
16. Lewis-Fernandez R, Aggarwal NK, Hinton L, et al. DSM-5® handbook on the cultural formulation interview. Arlington, VA: American Psychiatric Pub; 2016.
17. Medlock MM, Shtasel D, Trinh N-HT, et al. Racism and psychiatry: contemporary issues and interventions. Cham, Switzerland: Humana Press; 2019.
18. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2020. Available at: https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2020.pdf]
19. Rodriguez CI, Cabaniss DL, Arbuckle MR, et al. The role of culture in psychodynamic psychotherapy: parallel process resulting from cultural similarities between patient and therapist. Am J Psychiatry 2008;165(11):1402–6.
20. Richman EE, Ku BS, Cole AG. Advocating for underrepresented applicants to psychiatry: perspectives on recruitment. Am J Psychiatry Residents' J 2019;14(2):2–4.

21. Pierre JM, Mahr F, Carter A, et al. Underrepresented in medicine recruitment: rationale, challenges, and strategies for increasing diversity in psychiatry residency programs. Acad Psychiatry 2017;41(2):226–32.
22. Brenner AM, Balon R, Coverdale JH, et al. Psychiatry workforce and psychiatry recruitment: two intertwined challenges41. Academic Psychiatry; 2017. p. 202–6.
23. Rohrbaugh RM, DeJong SM. The role of the program director in supporting diversity, equity, and inclusion. Academic Psychiatry; 2022. p. 264–8.
24. Yancy CW, Bauchner H. Diversity in medical schools—need for a new bold approach. JAMA 2021;325(1):31–2.
25. Rodríguez JE, López IA, Campbell KM, et al. The role of historically black college and university medical schools in academic medicine. J Health Care Poor Underserved 2017;28(1):266–78.
26. Aibana O, Swails JL, Flores RJ, et al. Bridging the gap: holistic review to increase diversity in graduate medical education. Acad Med 2019;94(8):1137–41.
27. Ross DA. The match: magic versus machines. J Graduate Med Edu 2019;11(3): 274–6.
28. Barceló NE, Shadravan S, Wells CR, et al. Reimagining merit and representation: promoting equity and reducing bias in GME through holistic review. Acad Psychiatry 2021;45(1):34–42.
29. Walaszek A. Keep calm and recruit on: residency recruitment in an era of increased anxiety about the future of psychiatry. Acad Psychiatry 2017;41(2): 213–20.
30. University of California San Francisco Medical Education. Visiting elective scholarship. 2021. Available at: https://meded.ucsf.edu/residents-clinical-fellows/gme-resident-and-fellow-resources/diversity-gme/visiting-elective-scholarship#WHO-CAN-APPLY. Accessed August 6, 2021.
31. University of California San Francisco Graduate Medical Education. UCSF GME Handbook for Holistic Review and Best Practices for Enhancing Diversity in Residency and Fellowship Programs. 2021. Available at: https://medschool.ucsf.edu/about/diversity/differences-matter/action-groups/focus-area-2-climate-recruitment.
32. Ojo E, Hairston D. Recruiting underrepresented minority students into psychiatry residency: a virtual diversity initiative45. Academic Psychiatry; 2021. p. 440–4.
33. Durning SJ, Hemmer P, Pangaro LN. The structure of program evaluation: an approach for evaluating a course, clerkship, or components of a residency or fellowship training program. Teach Learn Med 2007;19(3):308–18.
34. Gonzaga AMR, Appiah-Pippim J, Onumah CM, et al. A framework for inclusive graduate medical education recruitment strategies: meeting the ACGME standard for a diverse and inclusive workforce. Acad Med 2020;95(5):710–6.
35. Douglas PH. Affinity groups: Catalyst for inclusive organizations. Employment Relations Today 2008;34(4):11–8.
36. Tauriac JJ, Kim GS, Lambe Sariñana S, et al. Utilizing affinity groups to enhance intergroup dialogue workshops for racially and ethnically diverse students. J Specialists Group Work 2013;38(3):241–60.
37. Plews-Ogan ML, Bell TD, Townsend G, et al. Acting Wisely: Eliminating Negative Bias in Medical Education—Part 2: How Can We Do Better? Acad Med 2020; 95(12S):S16–22.
38. Haynes-Baratz MC, Metinyurt T, Li YL, et al. Bystander training for faculty: a promising approach to tackling microaggressions in the academy. N Ideas Psychol 2021;63:100882.

39. Alves-Bradford J-M, Trinh N-H, Bath E, et al. Mental health equity in the twenty-first century: setting the stage. Psychiatr Clin 2020;43(3):415–28.
40. Blackstock U. Why Black doctors like me are leaving faculty positions in academic medical centers. 2020. Available at: https://www.statnews.com/2020/01/16/black-doctors-leaving-faculty-positions-academic-medical-centers/. Accessed August 12, 2021.
41. Shim RS. Structural racism is why I'm leaving organized psychiatry. 2020. Available at: https://www.statnews.com/2020/07/01/structural-racism-is-why-im-leaving-organized-psychiatry/. Accessed August 12, 2021.
42. Rodríguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: what of the minority tax? BMC Med Educ 2015;15(1):6.
43. Sandoval RS, Afolabi T, Said J, et al. Building a tool kit for medical and dental students: addressing microaggressions and discrimination on the wards. MedEdPORTAL 2020;16:1–12.
44. Vela MB, Chin MH, Peek ME. Keeping our promise—supporting trainees from groups that are underrepresented in medicine. N Engl J Med 2021;385(6):487–9.
45. Weiss J, Balasuriya L, Cramer LD, et al. Medical students' demographic characteristics and their perceptions of faculty role modeling of respect for diversity. JAMA Netw Open 2021;4(6):e2112795.
46. Structural competency. Structural competency: new medicine for inequalities that are making us sick. structuralcompetency.org.
47. Bezrukova K, Spell CS, Perry JL, et al. A meta-analytical integration of over 40 years of research on diversity training evaluation. Psychol Bull 2016;142(11):1227.
48. Jones JM, Sander JB, Booker KW. Multicultural competency building: Practical solutions for training and evaluating student progress. Train Edu Prof Psychol 2013;7(1):12.
49. Bourgois P, Holmes SM, Sue K, et al. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. Acad Med 2017;92(3):299.
50. Donald CA, DasGupta S, Metzl JM, et al. Queer frontiers in medicine: a structural competency approach. Acad Med 2017;92(3):345–50.
51. Kirmayer LJ, Kronick R, Rousseau C. Advocacy as key to structural competency in psychiatry. JAMA psychiatry 2018;75(2):119–20.
52. Buzza C, Fiskin A, Campbell J, et al. Competencies for global mental health: developing training objectives for a post-graduate fellowship for psychiatrists. Ann Glob Health 2018;84(4):717.
53. Hansen H, Braslow J, Rohrbaugh RM. From cultural to structural competency—training psychiatry residents to act on social determinants of health and institutional racism. JAMA Psychiatry 2018;75(2):117–8.
54. Moore Q, Tennant PS, Fortuna LR. Improving research quality to achieve mental health equity. Psychiatr Clin 2020;43(3):569–82.
55. Collins SE, Clifasefi SL, Stanton J, et al. Community-based participatory research (CBPR): towards equitable involvement of community in psychology research. Am Psychol 2018;73(7):884.
56. Hoppe TA, Litovitz A, Willis KA, et al. Topic choice contributes to the lower rate of NIH awards to African-American/black scientists. Sci Adv 2019;5(10):eaaw7238.