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Margaret Su
3rd Yr medical student, University of Auckland, Auckland

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Essay topic – 'Addressing equity in psychiatric care'

Including but not limited to improving mental health care of culturally and linguistically diverse individuals, and in rural and remote areas.

Acknowledge, Amend and Affirm: Healing the Wounds of Inequity in Mental Health

By Margaret Su

Introduction

A woven kaitaka, from a distance, appears beautifully strong and resilient.
Upon closer inspection, differences between separate flax fibres become evident. Some are strong and tightly woven, while others, frayed from strain, unravel under tension. The stressed areas are often overlooked, for they are unsightly, and easy to ignore… Yet their presence weakens the entire cloak.

Such is the state of psychiatric care.

A contributor to many mental health issues, as well as a barrier to care (Castro-Ramirez, 2021), systemic health inequity acts as a double-edged blade, allowing both the formation and proliferation of preventable issues. This essay will explore the history and impact of inequities on both culturally and linguistically diverse (CALD) and rural communities, along with introducing a framework of 'acknowledge, amend, and uphold' to help improve health equity.

The History and Impact of Inequities

Equity stands as a cornerstone of modern psychiatry, ensuring all service-users receive fair and effective treatment (Health & Disability Commissioner, 2023). The Royal Australian and New Zealand College of Psychiatrists (2023) advocates for culturally appropriate, equitable, accessible, and effective psychiatric care for Māori, Aboriginal, and Torres Strait Islander individuals. Furthermore, RANZCP (2022) has voiced their concern for inadequate staffing of psychiatrists in rural areas, actively promoting the rural psychiatrist position. Despite these ongoing efforts, significant inequities persist, imposing considerable social and economic costs to both individuals and societies (WHO, 2018). Many inequities contribute to a limitation of one of the five 'A's of Access'; accessibility, affordability, availability, accommodation, and acceptability (Penchansky & Thomas, 1981).

Cald Communities

Much of modern psychiatry in Australia and New Zealand is built on Western foundations, whose myopic views often overlook other cultural perspectives. Though it shaped a system that has helped many, it also lies at the root of the mistreatment of communities with whom we have misaligned cultural values (Gopalkrishnan, 2018).

This bias has historically led to pathologisation of normal human behaviours within indigenous and minority communities. For example, ‘drapetomania’, a term coined by Dr. Samuel A Cartwright in the 1860s, pathologised African Americans who sought freedom, an entirely normal human response to enslavement (Willoughby, 2018). Similarly, in New Zealand history, ‘colonialist psychiatry’ pathologised Māori resistance, thus normalising forced colonial rule. (Cohen, 2014).

Māori and Pasifika continue to suffer the lasting effects of intergenerational trauma of colonisation (Moewaka Barnes, 2019), through systemic and individualised racism (Cunningham, 2024), socioeconomic disparities (Ellison-Loschmann, 2006), and inadequate representation (Reid, 2019). Regarding healthcare, Māori suffer from low health literacy (Lambert, 2014), worsened access, and poorer outcomes (Reid, 2022). Today, colonisation remains a basic determinant of health inequities in healthcare (Reid, 2019).

Rural communities

Regional areas in New Zealand often have a severe shortage of psychiatrists (RANZCP, 2022). Rural psychiatrists that we have, often struggle with professional isolation (RANZCP, 2022) along with stress and burnout (RANZCP, 2024), which may result in reduced quality of care in regional areas (Garcìa, 2019). Rural populations also face increased barriers to availability and accessibility, socioeconomic decline (Judd, 2006), reduced mental health literacy, and perceived stigma towards mental health and help-seeking (Wrigley, 2005). This contributes to alarming inequities within rural and remote populations. Rural citizens in Australia or New Zealand are less likely to utilise mental health services, less likely to secure a specialist (RANZCP, 2022), more likely to consume alcohol, tobacco, and illicit drugs (Allan, 2012)(Coomber, 2011), and more likely commit suicide and self harm, than their urban counterparts (Judd, 2006).

For rural Māori, these challenges compound, and create further barriers to equitable health outcomes (Crengle, 2022).

The Future of Health Equity

The framework of ‘Acknowledge, Amend & Uphold’, aims to simplify the theoretical process of achieving health equity by categorising various actions into three distinct steps.

Acknowledge:

A critical step towards achieving health equity is identifying gaps in health experiences and outcomes (Purnell, 2016). The before-mentioned inequities must be acknowledged, along with numerous more, at both a community and individual level (The Institute for Healthcare Improvement, 2020). This process may be difficult, due to inherent biases and schemas that impact physicians’ perspectives (Vela, 2022).

Many healthcare providers hold implicit or explicit biases for marginalised groups. Implicit bias operates in the subconscious, affecting individuals’ behaviours and cognition, and remaining difficult to recognise (Vela, 2022). Despite viewing themselves as objective and unbiased, well-intentioned individuals remain susceptible to biases. (Chapman, 2013). Harvard’s Implicit Associations Test can help psychiatrists and medical students alike identify their subconscious biases (Implicit Project, n.d.).

Buddha ascertains:
“The thought manifests as the word;

The word manifests as the deed;
The deed develops into habit;
And habit hardens into character;
So watch the thought and its ways with care."

Collectively, healthcare workers and members of society must watch their implicit biases carefully, and not harden habits of racism and inequity into the character of society.

Additionally, effective advocacy remains empirical. In order for issues to be addressed, they must be *acknowledged* by a wider collection of people (Klugman, B., 2023). Thus, raising awareness engages the wider community to allow amendment of health inequity issues through individual changes, collective action, and policy reform (Farrer, 2015).

Amend:

After acknowledging issues that exist within the system, there must be action to amend them.

Firstly, to amend individual shortcomings, psychiatrists and medical students alike may partake in extensive bias training, including bias literacy, emotional regulation, and allyship training (Vela, 2022).

As conscientious clinicians, psychiatrists should be able to apply cultural humility to their work with minority populations. Currently, all New Zealand healthcare professionals must meet cultural safety standards, as coined by the Medical Council of New Zealand (2019). It presents criteria with a focus on 'cultural competency', however, this may not be sufficient. Sudak, et al. (2020) coined 'Cultural Humility', which is the recognition that culture is unique to each individual, and that clinicians must identify their own cultural beliefs, which influence patient experiences. A contrast to its predecessor 'Cultural Competency', the idea of 'Cultural Humility' that the more patients one encounters, the more one realises the challenges of knowing a particular patient's cultural alignment and identification (Sudak, 2020).

On a more structural level, implementations can take place for the betterment of the psychiatric system. Lacking representation of Māori as providers occurs concurrently with the overrepresentation of Māori as patients (Johnstone, 2000). The 'Māori and Pacific Admission Scheme' at the University of Auckland currently stands as a unique student pathway to facilitate the entrance of indigenous students into clinical programmes (Watkins, 2022). However, internationally, psychiatry is relatively unpopular, compared to the vast number of other specialties, thus it is uncertain that the field of psychiatry will benefit directly from such schemes (Feifel, 1999). Additionally, the 'Kia Ora Hauora' or 'Māori Health as a Career Programme' encourages the entrance of Māori students into the health and disability sector, strengthening the volume of Māori in such workforces, and thus cultural influence in healthcare (Kia Ora Hauora, 2025). This may contribute to the diversification of the multi-disciplinary teams of psychiatry.

Regarding regional communities, Telepsychiatry consults can be expanded on, not only for patient provider connection, but also for connections between providers (RANCZP, 2022). Telepsychiatry consultations have been shown to be as effective as face-to-face (García-Lizana, 2010), providing a promising solution for patients with geographical barriers. For providers, Virtual Multidisciplinary Teams can be used for supervision, training, and collaborating on complex diagnoses (RANZCP, 2022). Telepsychiatry however, may emphasise the inequities experienced due to the digital divide, and worsen outcomes for select minorities (OECD, n.d.).

Increasing the volume of the rural psychiatric workforce is another potential solution to be explored. New Zealand is currently recruiting overseas medical professionals to improve access. This, however, faces challenges, as these professionals may not be culturally adapted to serve the New Zealand population. There may be misalignment of cultural beliefs and values (RANZCP, 2022). Additionally, rural admissions schemes facilitate the entrance of students with rural backgrounds into clinical pathways, however, the increasing sub-specialisation of medical professionals reduces their abilities to return to their rural backgrounds after their training (RANZCP, 2022).

Furthermore, the lack of utilisation of services by regional individuals may indicate a lack of realised access (Penchansky & Thomas, 1981). Community programmes could improve mental health awareness and literacy. Approaches such as workshops, community awareness days, rural school programmes, and house visits can spread the message without paternalising the rural population (Reeves, 2021). Discussions at events like these can help raise awareness on the dangers of drugs and alcohol, types of services available, and stigmatised issues such as men's mental health (Isaacs, 2012).

Uphold:

Deeply ingrained discrimination and stigmatisation cannot be erased with non-racism; providers must be anti-racist (Ahuriri-Driscoll, 2022). Non-racism involves merely refraining from racism, and passive tolerance, while anti-racism refers to opposing racism, promoting respect for CALD groups (Essed, 1991), and actively advocating for the confrontation and eradication of racism (Bonnet, 2000). Seeing as racism is deeply embedded individually, systemically and institutionally, anti-racism rhetoric must be adopted in all areas (Ahuriri-Driscoll, 2022).

Furthermore, we must maintain our values and commitment to the cause of health equity. Despite progress, inequities may persist. Upholding equity requires continual advocacy, vigilance, and dedication (Betancourt, 2002).

Conclusion

Health inequity is a multi-faceted and deeply complex issue that requires careful, nuanced consideration. Improving these disparities requires collective action, and can be guided by the principles of 'acknowledge, amend and uphold'. While this essay focuses on CALD and remote & rural populations, it acknowledges the extensive impact of health inequities endured by other marginalised communities, along with the inability to explore each aspect of health inequity in entirety. Such is what characterises the complexity of these inequities.

Psychiatry, like the kaitaka, is woven with many threads. By mending the frayed fibres, we can strengthen them individually, but also as a whole.

Key:
CALD = Culturally and Linguistically Diverse
Kaitaka = Traditional Māori Cloak

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