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REVIEW ARTICLE

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Diversity Inclusion and Lifestyle in Behavioral Health Care

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Brief Summary

The movement from a medical model of diagnosis and treatment to a community empowerment and transformation model of resilience and self-determination is revolutionizing the behavioral health field in the United States. As innovative as this model may be, for many practitioners within the helping professions, the approach still needs to expand and be more inclusive of Building Community Capacity, Enhancing Treatment Quality, Changing Administrative Structures, and Diversity, Equity, and Inclusion.

A review of the history of the emergence of the mental health and human services profession informs the reader of professionalized behavioral health practices' political, economic, and sociological influences. Today an integrated model must include the above four approaches for educated professionals who work in partnership with all community members to facilitate a person's healing process.

The Behavioral Health profession has been evolving from the conventional disease-treatment model of care, which emphasizes diagnosis and subsequent treatment, to a more holistic behavioral health approach. This approach addresses the mind/body/spirit and reflects an understanding of the power diversity, equity, and inclusion have in one's personal and communal empowerment in the healing process [1].

From a psychosocial perspective, religion and spiritual practices have helped individuals and their cultures create meaning in their existence and offer explanations for disease, violence, natural disaster, and death. Faith and spiritual leaders in the post-modern era emphasize that humanity has fallen out of harmony with the natural earth and is now living in isolation from family and community. Although technological advances have empowered humans to travel across a continent in a day or communicate via the internet with a business associate on the other side of the globe, the pace of human experience is still rushing, in isolation and dehumanization [2].

The Community Mental Health Movement

In 1955 funds were appropriated for a national mental health study, published in 1961 and titled **Action for Mental Health**. The report called for a shift in the care for psychiatric patients from mental health hospitals to community-based facilities. The Community Mental Health Act of 1963 developed neighborhood centers for psychiatric assistance, consultation, and prevention and provide services to as many people as possible from all diverse cultural perspectives. These new Community Mental Health Centers (CMHCs) attempted to change society and solve various social problems. While this new community psychiatry approach extended an atmosphere of hope and optimism in the community-based psychiatric field of practice, it fell short of its goals [3]. The initial intent was to deinstitutionalize the warehousing of people in long-term care psychiatric hospitals in which most physicians believed that treatment was the exception rather than the rule. Partly based on the ignorance of the medical perspective and the new wave of psychotropic medications in the 1950s and early '60s, people were being released into the community with a *"bag of medicine"* with no integrated aftercare plan. This massive discharge of people from the psychiatric asylums allowed for a decline in hospitalized people despite the upsurge in admissions. The 1963 Action for Mental Health report promised a psychiatric revolution of care and treatment that would shift to the person's home environment. This environmental shift would foster a community where everyone felt respected and welcomed, including members of traditionally underrepresented or marginalized groups [4].

The amounts of money saved because individuals receiving psychiatric care would no longer need in-patient care would allow funds into the community through Community Psychiatry. The medical model of care that put individuals into asylums was primarily responsible for moving the mental health problem out of state hospitals and into the dark ages of community psychiatry. Practitioners in the field changed its name and shifted the place of practice to health care but, overall, continued to ignore issues of diversity, inclusion, and equity concerns. This disregard oppressed and relegated people receiving services to second-class citizenship. Community-based psychiatric services did not address many structural inequalities and barriers. The inability to abandon traditional medical models of care by psychiatrists and, to a lesser degree, psychologists and social workers significantly contributed

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to the failure of the community mental health model. This failure created and fostered an environment where everyone continued to feel disrespected and underrepresented. The minimal success of psychosocial rehabilitation approaches stands in direct contrast to the continuing community health disaster of people living with serious mental health issues. To cure serious mental health challenges, practitioners relied on mental health practices and services without adequate financial support for community care [4,5].

The community mental health movement has failed because it has been nothing more than psychiatry transplanted to an outpatient setting. It has failed to deal with the community, culture, definition of deviance, stress, and support. Furthermore, it has given no more than lip service to preventing mental disease. Psychiatry quickly withdraws from the community and returns to the hospital before the failure becomes too apparent [6].

Culture, Ethnicity, and Assessment

The assessment aims to identify areas of disruption in an individual's life that inhibit positive current behavior and lifestyle. To transform health care delivery, stakeholders in the behavioral health community must re-evaluate how they assess individuals regarding diagnosis and treatment by incorporating diversity, equity, and inclusion into an individual's lifestyle. The danger in a restrictive diagnostic perspective is that the clinician will fail to consider ethnic and other cultural and community factors that influence one's ability to be integrated into a society where thoughts, ideas, and perceptions of all individuals matter. Historically, this cultural insensitivity has led to labeling individuals with inappropriate disorders. When taken out of their ethnic or cultural context, certain behaviors and personality styles could be viewed as deviant or dysfunctional when culturally congruent [2]. There is increasing pressure for practitioners to become more knowledgeable, comfortable, and skilled in working with individuals from diverse cultures, ethnic backgrounds, sexual, gender, religious/spiritual orientations, and other populations bound by contemporary Western standards. This multicultural strength-based concept focuses on what the person is already doing that is successful.

The strength-based perspective of direct multicultural engagement is a change in basic assumptions away from the traditional historical treatment emphasis on psychopathology, disease, and disorder. It attends not too emotional deficits but accents resilience. The strengths perspective is primarily a philosophy or way of interpreting information about our body, mind, and spirit that reinterprets self-defeating behavior, guilt feelings, and dysfunctional relationships. A strength-based approach is a more positive framework in which healthy, intelligent, and emotional responses to life events that might involve unwelcome incarceration, psychiatric hospitalizations, ethnicity/race, cultural differences, etc. All interactions and assessments aim to identify and augment the individual's strengths and resources. Philosophically, there is an expectation that powers exist both in the person and their larger environment, and most individuals know best how to utilize these resources [7,8].

Many social scientists believe that ethnic identity is a significant cultural variable that affects a person's s concept of belonging with other members of a subgroup and defines the individual's relationship to the dominant culture. These shared influences can affect a person's willingness to seek help concerning a behavioral health challenge. Additionally, a person's cultural perspective affects how he may describe his problems to a professional worker [9].

Culture, Ethnicity, and Standards of Cultural Competence

Culture is a learned system of values, beliefs, and attitudes that shapes and influences perception and behavior. A person's culture is understood and accepted through traditions, customs, art, folklore, history, norms, and institutions. Ethnicity (often referred to as minority membership) is integral to one's culture and must become essential to behavioral health recovery. Currently, there is insufficient research on the relationship between ethnic and cultural differences and their effect on the assessment, diagnosis, and treatment of dysfunctional behavior. Sometimes members of minority groups may view and react to the world as the dominant group culturally reacts. Other times they may feel differently, believing their problems result from exposure to racism and poverty. Research on personality and maladaptive behavior has increased similarities and differences and the impact these differences have on individuals living in different communities [10,11]. A client's difference becomes relevant because helpers must be knowledgeable about the world views of the people receiving services and attempt to understand these views without making negative judgments [12,13]. Unless helpers consider an individual's social, cultural, racial, ethnic, and community context, it is almost impossible to understand that person's struggle [14]. For example, research on cross-cultural comparisons of emotional disturbance and its expression has shown that depression often has different meanings and forms of expression in different societies. Most cases of depression worldwide are experienced and expressed in bodily terms of aching backs, headaches, fatigue, and a wide assortment of other somatic symptoms that lead individuals to regard this condition as a physical problem. Only in contemporary Western societies is depression seen principally as an intrapsychic experience [15]. Clinicians need to take account of cultural factors regarding cultural variations in emotional expression, body language, and religious/spiritual beliefs and rituals within societies such as the United States [16].

It is not necessarily important that the helper is in recovery or a survivor of trauma to help an individual. What is more important is that the helper possesses and or is receptive to a similar set of feelings and struggles. Sometimes our differences are as significant as our similarities. Culture affects the evaluation process, but no unmistakable evidence exists that cultural or religious difference necessarily impairs the outcome [17,18]. If an evaluator is oblivious, apathetic, and unskilled regarding a person's values, beliefs, and customs, their culture, ethnicity, or recovery has a negligible impact on the individual's competence. Insensitive Euro-Americans (Whites) are just as problematic as cold African Americans, Asian Americans, Latinos, or Native Americans.

Cory, discussing culture in clinical practice, established some practical guidelines for working effectively with people from diverse populations:

1. Learn more about your culture and how it has influenced your behavior and thoughts about others.
2. Identify basic assumptions about culture, race, ethnicity, gender, etc.
3. Expand your knowledge and experience with other cultural groups.
4. Learn to find common ground with people of diverse backgrounds.
5. Recognize the importance of flexibility in applying techniques that benefit diverse cultures [19].

From the above guidelines, it is clear that:
Too many Euro-Americans (Whites) have limited experiences with minority communities, cultures, and concerns. Americans continue to go to different schools, live in non-integrated neighborhoods, attend segregated churches, and socialize in various parts of the community. Social scientists and many others believe that groups who live separately neither know nor understand each other, have difficulty trusting one another, and know extraordinarily little about the social and cultural realities of individuals different from their worldview. Book knowledge about culture is different from living with and experiencing diverse cultures. Too often, helpers enter the healing professions with no meaningful contact or exposure to other cultures.

The interpersonal relationship or the development of effective therapeutic relationships fosters respect, professional courtesy, and competence that helps experienced; skilled practitioners work effectively with culturally dissimilar people. Expertise in assessment and treatment requires that the counselor have sufficient breadth and depth in [1] cultural awareness and sensitivity, [2] a body of multicultural knowledge and experience, as well as [3] a specific set of practice skills [16].

Different Approaches to Diagnosis

Since diagnostic categories represent the medical model, clinicians should know that symptoms do not necessarily mean the same thing or dictate the same type of intervention. They are only a guide and provide acceptable boundaries of discourse. Many recovering individuals cannot understand why the treatment of behavioral health challenges and spirituality are not integrated, along with other aspects of culture, into one unified, comprehensive approach [21]. It took almost ninety years and the evolution of modern Psychiatry to produce the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952. The DSM-II in 1968, the DSM-III in 1974, with the more detailed manual, and the DSM III-R in 1987. The DSM-IV in 1994 (Reid and Wise, 1995), the DSM IV-TR in 2000, and the DSM-V in 2013. The DSM-5-TR update in 2022 addresses an individual's cultural background and how it impacts their healthcare. An individual's experience is significantly associated with social determinants of health and mental health [22].

Structures perpetuate racial discrimination, diversity, and equity and influence the risk of early adverse experiences and trauma across all social strata. The APA (American Psychiatric Association) Ethno-racial Equity and Inclusion Work Group and the Cross-Cutting Culture Review Group provided an update and review of the impact of culture, race, and racism on the diagnosis [23]. The DSM-5 TR workgroups looked closely at the research literature supporting DSM diagnoses to ensure that higher rates of mental health disorders were within specific communities. The studies had adequate sample sizes and accounted for social determinants of health, including racial and racial determinants of bias and discrimination [24].

Awareness of the many social and cultural factors influencing the assessment process should help clinicians evaluate data and make valid diagnoses. According to the DSM-5 TR workgroups, people of color are incorrectly diagnosed with schizophrenia because people do not follow [DSM-5] but let their biases and projections influence diagnosis. If one follows the manual, one comes to a proper diagnosis that early life adversity and trauma are more than triple the risks for psychiatric disorders across all social strata [25].

Labeling individual behaviors into symptom complexes known as diagnostic groups (the Multiaxial classification system) reflects two of the three explanatory paradigms: [1] the Biomedical and [2] the Psychosocial. The Biomedical model emphasizes the physical body and the connections and communications between nerves, bones, muscles, etc. Much of Western medicine and, to a considerable extent, American Psychiatry is in this model.

The second exploratory paradigm, the psychosocial, includes much behavioral health counseling. Historically, the Freud/Jung schism had more to do with identifying psychiatry as a branch of modern medicine with little or no association with historical religious or spiritual traditions. Jung's constant references to theological and cultural explanations of psychic phenomena threatened the new marriage between psychoanalytic thought and modern medicine [26].

Indeed, there are behavioral health challenges that require diagnosis and medical and psychosocial interventions. Indeed, to survive in the behavioral health field, one must know and contribute to the diagnostically driven healthcare payment system. However, service providers must never lose sight of their primary mission, which is physical, psychosocial, and spiritual; ignoring these three perspectives splinters an individual's reality.

The DSM IV and V do accomplish their objective of providing an understanding of the complex bio-psychosocial concepts of psychiatric diagnosis. It falls short of its mission by ignoring the spiritual aspects of *"mental disorders."* M. Scott Peck, M.D., in his address to the American Psychiatric Association in May of 1992, noted that:

The failure of American psychiatry to deal with the issue of spirituality is itself a profoundly over-determined symptom rooted in multiple historical forces and other factors. American psychiatry's neglect of spirituality is the profound influence of Freud. Freud has had a more profound impact on American psychiatry than upon psychiatry anywhere else on the globe

[Freud] was deeply threatened by the issues of spirituality to terminate his relationship with his most beloved disciple, Jung [27].

The degree to which psychosocial and environmental factors play a role in an individual's overall health has long been a concern of healthcare providers. What is incontrovertible is that the evolution or deterioration of a whole community is a predictive factor in an individual's chances for recovery from addiction, trauma, and other behavioral health issues. If a society is dysfunctional and lacks the necessary support for economic and social sustainability for its members, the individual's chances for resilience and recovery decline. When we refer to the individual in this comprehensive approach to healing, we are not only referring to the individual or the family but the community. As a matter of course, the community's health must factor in spiritual health and spirituality as a part of the healing process [16].

Factors that impact one's quality of health depend on a person's lifestyle choices, as you can observe that 70% of an individual's health quality relates to lifestyle and environmental issues. Logic would dictate a need to build a community capacity to address various health inequities that directly impact a person's background so that individuals would enhance their lifestyles [28].

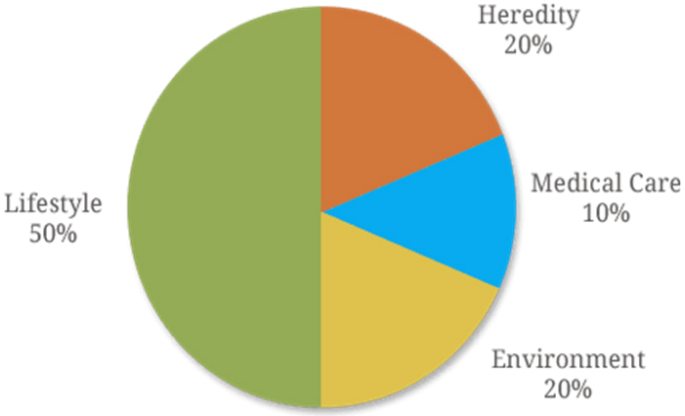

Figure 1:

Over twenty years ago, JL Geller indicated that the great challenge for community mental health in the 21st century was our continued concerns about the locus of care and our confusion with humaneness, effectiveness and quality of care. Geller, as well as Sharfstein, felt that success needs to reflect in a public health response that addresses issues of people who are not in treatment, who resist treatment, and who become marginalized and impoverished. Geller concluded that even after fifty years of moving patients out of state hospitals and putting them elsewhere, behavioral health policymakers and practitioners remain too myopic in their ability to create a comprehensive care system [4,5].

Creating an administrative system of care for children and adults with behavioral health challenges must consist of as least three primary strategies: 1) Building community capacity, 2) Enhancing treatment quality, and 3) Changing administrative structures [29-31].

Building Community Capacity

Refers to a macro approach to improving social conditions by promoting comprehensive strategies to reduce crime and revitalize communities. Building community capacity means encouraging communities to help themselves by empowering them to a) reduce violence and drug crime, b) strengthen community resources to increase the quality of life, and c) promote long-term community health and resilience through education.

Enhancing Treatment Quality

Success can be measured through a broad range of improvements for people receiving services, increased length of stay, a better-educated workforce, and clear expectations of performance measurements. The above measures are best practices, and best practices are the most efficient and practical way of accomplishing a task.

Changing Administrative Structures

Agency employees are the heart of an institutional environment. They are a significant factor in social system change. Staff and administrators are critical to organizational operations, vision, and purpose in the organization's interdependent environment.

Diversity, Equity, and Inclusion

A lifestyle passion for building community capacity enhancing treatment capacity and changing administrative structures must be a part of a community's ability to be diverse, equitable, and inclusive.

Long-term healthcare is attainable to those willing to work for it regardless of class, race, sex, gender, religion, or sexual orientation. **Diversity** in healthcare not only reminds us that one's recovery depends on our morals and values. When we dislike or hate people for being whom or what they are, we put a barrier not just between ourselves and the rest of the world. Still, we also inhibit or restrict our recovery process. Diversity may also include differences in political perspective, learning preferences, personality, and communications preferences. While diversity is essential, variety does not make us unique. We must learn from others rather than attempt to differentiate ourselves from them. If we do not follow this diversity process, individuals may never recover since we believe that our uniqueness, "our diversity," sets us apart. One diversity, experience, and personality are essential in deciding the best way to care for them. That diversity may influence a person's recovery course, but it should never separate one from our standard process of being drug-free [32]. Our ability to meet today's challenges and thrive in the future is related to an inclusive culture, a diverse workforce, a strong presence in various communities, and the provision of culturally responsive care [33]. Diversity embraces our differences across all facets of life and lived experiences.

In recovery, as in life, diversity assumes equity and inclusion. **Equity** establishes and ensures accountability to marginalized and underrepresented policies and practices that restrict access, opportunity, and advancement. It promotes justice, impartiality, fairness, and equal access

to opportunities, improvement, and participation. It also addresses many structural inequalities and barriers through rights in procedures, processes, practices, and the distribution of resources.

Inclusion intentionally fosters an environment where any individual or group is and feels welcomed, respected, supported, and valued. Inclusion fosters an environment where everyone feels respected and accepted, including members of traditionally underrepresented or marginalized groups [33-35].

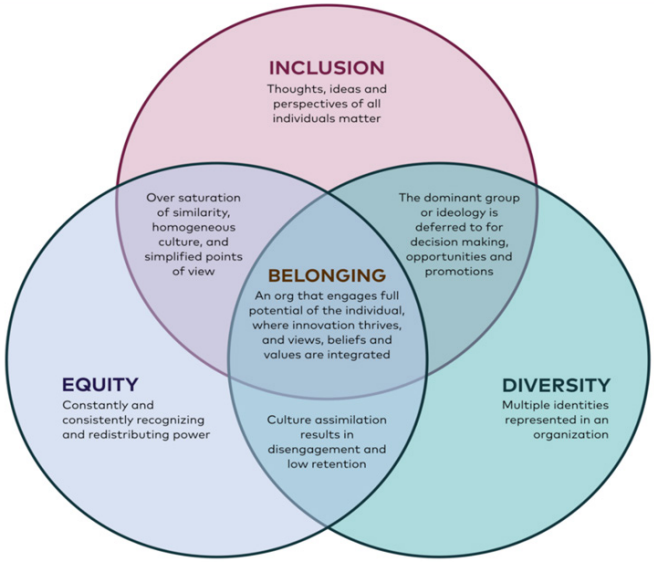

Figure 2:

In conclusion, a behavioral health professional must be sensitive to building community capacity, enhancing treatment quality, changing administrative structures, and focusing on diversity, equity, and inclusion. A healing community of individuals and families will produce a healthier environment supporting positive mental and physical health for all its citizens.

References

1. Pullen Sara. Cultural Awareness and Implicit Bias in Healthcare. ContinuED. 2021.
2. Scoles P. Recovery Communities, the Insanity of Addiction and Spiritual Consciousness. Journal of Addiction and Recovery. 2021; 4(1): 1026.
3. https://chicagopolicyreview.org/2021/03/12/community-mental-health-care-lessons-from-history/
4. Geller JL. The Last Half-Century of Psychiatric Services as Reflected in Psychiatric Services. Psychiatric Services. 2000; 51(1): 41-67.
5. Sharfstein Steven. Whatever Happened to Community Mental Health?. 2000.
6. Murray JE. Failure of the Community Mental Health Movement. The American Journal of Nursing. 1975; 75(11): 2034-2036.
7. Saleeby D. The Strengths Perspective in Social Work. Boston: Allyn & Bacon. 1997.
8. Cooper M, McCleod J. Pluralistic counseling and psychotherapy. Los Angeles, CA: Sage. 2011.
9. Olandi M. Defining Cultural Competence: An organizing framework. In: M. Olandi (Ed) Cultural Competence for Evaluators: A guide for alcohol and other drug abuse prevention practitioners are working with ethnic/racial communities. Rockville, MD: U.S. Department of HHS. 1992.
10. Jackson J. Life in Black America. Newbury Park, CA: Sage. 1991.
11. Uba L. Asian Americans: Personality Patterns, Identity, and Mental Health. New York: Guilford Press. 1994.
12. Jeff M. Afrocentrism and Afro-American Male Youths. In R. Mincy (Ed). Nurturing Young Black Males. Washington, DC: Urban Institute Press. 1994; 99-118.
13. Moore Q. The Whole New World of Diversity. Journal of Intergroup Relations. 1994; 20(4): 28-40.
14. Scoles P. Cultural Competence, Race, and Ethnicity in Community Based Recovery Treatment Programs. International Journal of Addiction Research and Therapy. 2020; 3: 22.
15. Jenkins J. Cross-cultural Studies in Depression. In J. Becker & A. Kleinman (Ed). Psychosocial Aspects of Depression. Hillsdale, NJ: Lawrence Erlbaum. 1991; 67-99.
16. Scoles P. Spirituality, Culture, and the Process of Assessment in Recovery. Journal of Addictive Behaviors, Therapy & Rehabilitation. 2020; 9: 2.
17. Davis L, Proctor E. Race, Gender, and Class: Guidelines for Practice. New Jersey: Prentice-Hall. 1989. Social Work. 1992; 37(3): 275-276.
18. https://www.td.org/talent-development-glossary-terms/what-is-dei-training.
19. Cory G. Theory and Practice of Counseling and Psychotherapy. New York: Brooks/Cole Publishing Co. 2000.
20. Leong FT, Kim HW. Going beyond cultural sensitivity on the road to multiculturalism: Using the intercultural sensitizer as a counselor-training tool. Journal of Counseling and Development. 1991; 70: 112-118.
21. Scoles P. Faith and Spirituality in Human Services. Kindle Publication. 2021.
22. Scoles P. Public Health, Population Health, and the Self-Help Movement in Recovery. Journal of Behavioral Health. 2021; 10(4): 1-5.
23. Moran M. Impact of Culture, Race, Social Determinants Reflected Throughout New DSM5-TR. 2022.
24. https://footprintstorecovery.com/anxiety-disorders/generalized-anxiety/.
25. DSM-5 TR Steering Committee and the Ethno-racial Equity and Inclusion Work Group. 2022.
26. Scoles P. Jung, Addiction, and Recovery. Erudition Books. M.A. 2001.
27. Peck MS. Further along the road, less traveled. New York: Simon & Schuster. 1993.
28. Carrell Robyn MPH. How Environmental Health Impacts Our Quality of Life and Health. Public Health. 2020.

29. www.dbhmrs.org/transformation-tools-2/

30. www.dbhmrs.org/technical-papers-on-recovery-transformation

31. www.dbhmrs.org/conceptual-framework

32. Snyder C, Bianca K Frogner, Susan M Skillman. Facilitating Racial and Ethnic Diversity in the Health Workforce. J Allied Health. 2018; 47(1): 58-65.

33. https://www.td.org/talent-development-glossary-terms/what-is-dei-training?cm_mmc=bing-_-https://www.td.org/talent-development-glossary-terms/what-is-dei-training.

34. paid-_-undefined-_-BRAND-Awareness2022-Paid-BingSearch-DEI).

35. https://unitedwaynca.org/blog/what-is-diversity-equity-and-inclusion/