BACKGROUND

THE WESTERN MEDICAL MODEL
When we talk about the Western medical model (referred to as the medical model from this point on), we are referring to the model of understanding and treating health conditions, both mental and physical, that most of the Western health care industry has adopted, especially within the U.S., in which clear and accurate diagnoses, evidence-based treatments, measurable data and outcomes, and a reliance on systematic research and analysis are emphasized. In the past, this model has been referred to as “allopathic medicine,” to distinguish it from more holistic approaches to care and treatment. The model focuses on diagnosis and the management of symptoms presented in the disease, while more holistic methods take into account an individual’s lifestyle in their treatment.

This model has been helpful for a number of reasons, including establishing mental health parity legislation, developing many evidence-based treatments and therapies for mental health conditions, and reducing stigma surrounding mental illness in Western cultures.

However, the model’s domination in the mental health field in the U.S. has become a major issue for BIPOC and other marginalized communities. This model struggles to be culturally relevant and inclusive for marginalized communities. It neglects the unique needs, experiences, perspectives, and cultural and community-based practices of BIPOC and other marginalized identities.
DIAGNOSIS IS A PRIVILEGE
The key to effective treatment within the medical model is often a complete and accurate diagnosis, but medical model diagnosis procedures are not always culturally competent and therefore cannot provide a complete and accurate diagnosis.

Additionally, not all mental health concerns should have to require a diagnosis to receive support. A diagnosis is not always attainable for many people who are struggling with their mental health.

MISDIAGNOSIS/UNDERDIAGNOSIS OF SYMPTOMS
Poor cultural competency of health care providers can contribute to underdiagnosis and/or misdiagnosis of mental illness in BIPOC in part due to the medical model's reliance on the DSM-V for diagnosis in the mental health care system. Language differences between patient and provider, stigma of mental illness among BIPOC, and cultural presentation of symptoms are some of the many barriers to care that explain these errors in the diagnostic process.

For example, when treating Black and African American clients, clinicians tend to overemphasize the relevance of psychotic symptoms and overlook symptoms of major depression compared to treating clients with other racial or ethnic backgrounds. For this reason, Black men, in particular, are greatly over-diagnosed with schizophrenia.

BIPOC youth with mental health conditions are especially vulnerable as they are more likely to be directed to the juvenile justice system than to specialty care compared to non-Latinx white youth. Their symptoms may present differently than their white peers and are therefore treated as character flaws rather than struggles needing support and compassion.

LIMITED ACCEPTABLE TREATMENTS
Even if someone is able to receive a complete and accurate diagnosis, the medical model tends to have a narrow view of what practices are acceptable to treat these diagnoses, with particular therapies and medication management being the dominant treatment practices within the model. While these practices work for some people, they may not work for everyone, especially those in marginalized communities. This can lead to disillusionment with treatment, leading to dropping treatment altogether.

“Evidence-based” practices are also often designed and studied in specific communities and not always transportable or relevant to others. Because emphasis is then put on these specific evidence-based practices, many community and culturally-based treatments and mental health supports that are used by members of marginalized communities are dismissed or not treated as legitimate by the mainstream healthcare system.

EVIDENCE-BASED PRACTICES CAN EXCLUDE MARGINALIZED IDENTITIES
Evidence-based practice (EBP) is defined by Duke University Medical Center as “the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care.”

Implicit racism and bias and lack of diversity in the health care industry can strain the doctor-patient relationship between the majority white healthcare workforce and BIPOC and other patients of marginalized identities, which can often mean that the “patient values” piece of evidence-based practices is lost or neglected for patients with marginalized identities. Furthermore, many practices and mental health supports utilized by marginalized communities have not been evaluated at all or have not been evaluated with a medical model-supported research design, which means that these practices are not recognized as “evidence-based” by those trained under the medical model. However, a lack of evidence does not mean a lack of effectiveness. These practices will not appear on lists of evidence-based practices due to the rigorous research required to establish effectiveness under the Western medical model.
INSURANCE COVERAGE REINFORCES THE WESTERN MEDICAL MODEL

As mentioned above, many community and cultural supports utilized by marginalized communities to address mental health concerns will not appear on lists of evidence-based treatments based on the Western medical model. This is also problematic because most insurance companies have lists of approved treatments for particular conditions (both mental and physical) and it is unlikely to find a treatment on an insurance company’s list that is not subject to the rigorous studying involved in creating an evidence base.

For a treatment to get sufficiently studied, two things are needed. Someone working in the recognized scientific community must decide to study that treatment, and someone else has to provide the dollars needed to carry out the study. But because the medical model frequently dismisses “non-medical” community and cultural practices, the lack of evidence for these practices perpetuates. Additionally, studies have shown that BIPOC receive different and worse treatment from doctors compared to white patients.6

One study found that physicians were 23 percent more verbally dominant and engaged in 33 percent less patient-centered communication with Black patients than with white patients.7 These adverse experiences leave many marginalized folks with a deep distrust of healthcare systems, which translates into serious barriers to care.

DISTRUST OF THE HEALTH CARE SYSTEM

In addition to the inferior quality of health care treatment received by marginalized folks6, centuries of nonconsensual medical research on minorities at the hands of white doctors,9 language barriers and lack of representation in the field, and dangerous law enforcement responses to crisis calls contribute to the fear and mistrust of the health care system that often prevents BIPOC and other marginalized identities from seeking care from western medical providers.

It is necessary to provide legitimate, culturally relevant alternatives to the medical model to improve the existing mainstream systems and to provide sufficient care to all people -- not just those who benefit from the systems that are already in place.

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6 https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/
7 https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts
8 https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/
9 https://www.webmd.com/diabetes/minority-health-20/minority-medical-distrust