Article

Patient-Provider Racial Concordance in Psychedelic-Assisted Therapy: A Call for Research and Action

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Abstract:
Racial concordance between patients and their healthcare providers has been shown to be associated with positive outcomes for individuals in racial minority groups, including in mental healthcare settings. Given the sensitive and vulnerable nature of psychedelic-assisted therapy (PAT), it is plausible that racial concordance may be especially important in the psychedelic space. However, the underrepresentation of racial minorities amongst PAT therapists and clients has precluded research into the hypothesized association between race concordance and PAT outcomes. Given the anticipated expansion of PAT as federal rescheduling efforts progress, there is currently a window of opportunity to increase recruitment of racial minority providers and to better understand the impact of racial dynamics within PAT work prior to its rapid upscaling. We review existing efforts and provide additional recommendations for addressing PAT's recruitment gap.

Keywords:
Psychedelics, psilocybin, MDMA, race, ethnicity, psychotherapy, minority, diversity, equity, inclusion, BIPOC, PAT

INTRODUCTION

Within health disparities research, patient-provider race concordance has been associated with improved clinical outcomes across a range of care settings, including behavioral health [1,2]. For example, a large meta-analysis of studies on race concordance in psychotherapy has suggested a tendency for clients to more positively perceive and prefer treatment by a therapist from the same race, which may be more pronounced for specific minority groups such as African-Americans [3]. The putative mechanisms by which race concordance influences health care outcomes are multiple and complex but may be mediated by improvement in the therapeutic alliance in interaction with an increased likelihood of overlapping cultural and linguistic backgrounds.

Given the evidence supporting the benefits of ethnoracial patient-provider concordance in the traditional psychotherapy model, assessing the impact of race concordance as a variable in the evolving psychedelic-assisted psychotherapy space may prove useful. Psychedelic medicines engender states of increased interpersonal vulnerability and relaxation of ego defenses that may facilitate the emergence of transpersonal and transgenerational perspectives [4], which for racial minorities can often include trauma and chronic stress related to discrimination.

To the extent that race concordance may support the holding and processing of these complex and painful experiences [5], the effect of concordance on variables such as patient preference, patient satisfaction, duration of treatment, and long-term outcomes may be magnified in PAT. Accordingly, we will discuss the promises and limitations of the current PAT literature as it pertains to race concordance and outline potential downstream consequences for health disparities as the availability of PAT rapidly expands in the coming years.

DISCUSSION:

Despite theoretical plausibility, limited empirical data exists regarding the impact of race concordance on PAT outcomes. Modern studies on PAT have enrolled white participants at a disproportionate rate [6]; likewise, the therapist workforce has also been predominantly white, including over 90% of MAPS-trained MDMA therapists in 2018 [7]. As such, while the racial composition of therapist-participant pairings in PAT studies has not been published, the sample of concordant BIPOC pairings is presumably too small for meaningful statistical analysis. Instead, BIPOC participants have largely received treatment in therapeutic triads with white clinicians, suggesting that outcome data on BIPOC participants in existing trials is essentially data on the converse issue of race discordance in PAT. In a post hoc analysis of phase II and III FDA-regulatory trials for MDMA-assisted therapy, Ching et al. found no significant differences in PTSD symptom reduction between BIPOC and white participants, suggesting race discordance does not greatly diminish treatment efficacy in study completers. However, dropout rates in the BIPOC were modestly higher [8]. Instructively, the BIPOC or "non-white" group could not be stratified by more specific racial categories due to low overall minority numbers, obscuring the overrepresentation of Asian participants and underrepresentation of Black/African-American and Hispanic individuals.

Apart from the aforementioned post hoc analysis, qualitative reports from BIPOC participants working with white clinicians comprise the remainder of the empirical literature within clinical trial contexts. Therein, BIPOC clinicians themselves receiving PAT describe the emergence of racial trauma and identity as important themes within their journeys [7,9], as well as the experience of microaggressions and struggle to establish psychological safety with white therapists in nonetheless positive sessions [7]. Outside of clinical research, the growing observational literature on community psychedelic use is also providing insight into use trends, potential benefits, and differences in perception among various ethnoracial groups [10,11], which may translate into unique "set" factors that may be hypothesized to interact with racial concordance or discordance [12].

Taken as a whole, the current empirical literature on race in PAT is largely limited to MDMA-assisted therapy (MAT) for PTSD and suggests that while BIPOC clients do derive significant benefits in race-discordant pairings with white therapists, there is little information on whether additional positive effects occur in concordant BIPOC pairings due to underrepresentation of racial minorities among PAT clients and clinicians generally. For similar reasons, it is even more difficult to assess different BIPOC groups individually, given that the recruitment gap appears especially marked for Black, Hispanic, and Indigenous people [8], an unfortunate irony given the historical origins of psychedelic plant medicine use. Recent randomized-controlled trials for psilocybin appear to reflect similar trends to the MDMA literature, with 88% and 79% of participants identifying as Non-Hispanic white in studies for depression and alcohol use disorder respectively [13,14].

While post hoc analyses of pooled trial data may extend the statistical exploration of race in PAT despite low minority recruitment, prospective studies comparing BIPOC participants in race-matched and non-matched pairings remain ideal for studying the impact of race concordance, particularly for expanded indications such as race-based trauma and PTSD [7]. In addition, naturalistic studies are also needed to understand how race concordance affects PAT outcomes once psychedelic medicines become federally

deregulated, and settings of care evolve rapidly outside of protocol-driven clinical trials. Once established, PAT programs with specialization or at least ample experience in working with BIPOC communities may be useful settings for research, given evidence supporting advantages for mental health services dedicated to specific ethnoracial groups [15]. Lastly, given the tendency of biomedical culture to prioritize quantitative data, it will be important to continue support for qualitative research on the unique experiences of BIPOC individuals in PAT, both as a source of valuable insight and an affirmation of BIPOC voices in the psychedelic space.

At the same time, while one can imagine various research approaches to understanding race concordance in PAT, the recurrent and fundamental barrier remains the recruitment gap for minority participants in the psychedelic medicine space, particularly among Black, Hispanic, and Indigenous people [16]. Fortunately, efforts are underway to increase the recruitment of racial minorities as participants and, to some extent, clinicians in PAT clinical trials. These have included establishing minimum requirements for the racial composition of study samples, inclusion of DEI advocates into trial planning and decision-making processes in national organizations like MAPS, as well as prioritizing outreach to potential referring providers who work in diverse and affordable community care settings. In addition, there is a need to acknowledge and redress historical wrongs that occurred during the first wave of psychedelic research [17] as well as provide education and reassurance around confidentiality and protection of use in the clinical trial context, given the fraught history of Black, Indigenous, and Latinx communities and law enforcement around controlled substances [5].

However, looming events in the regulatory landscape around psychedelic medicines suggest that there is an especially urgent need to focus on the recruitment and retention of BIPOC clinicians and researchers in addition to clinical trial participants. On the federal level, the anticipated rescheduling of MDMA for PTSD, possibly followed by psilocybin-assisted therapy for depression, will likely lead to a rapid expansion of PAT in research and clinical settings. Therefore, FDA decision-making and default protocols for PAT will be based on research that is occurring now, largely involving white participants and white therapists. While preliminary data supporting the efficacy of MAT for aggregated BIPOC participants is reassuring, the downstream effects of racial inequities in current research are hard to predict and cannot be assumed to be benign, given that the standards of care defined by these landmark studies will likely have particular inertia considering foreseeable concerns from insurers, health systems, and clinicians around working with controlled substances. Moreover, if the most well-reproduced findings from the race concordance literature are to be extrapolated to PAT, patient preference for and perceived satisfaction with race-matched therapists will also entail an increase in demand, particularly if successful early implementation begins to decrease stigma and aid acceptance of PAT as a legitimate and legal modality in the public sphere as a whole.

Considering the training period for initial certification in PAT and additional experience needed to develop expertise in its delivery, changes in the enrollment of BIPOC training candidates now will be slow to impact the clinical landscape for some time. Encouragingly, researchers have begun to discuss barriers to the recruitment of minority clinicians, such as cost, awareness, concerns about professional vulnerability, as well as ethnoracial and cultural discordance between majority white trainers and BIPOC trainees. In addition, efforts have been made to pilot specialized training pathways to increase racial diversity among therapists in the MAT space, including a MAPS MAT training for

minority cohorts, as well as establishing scholarship programs to help defray costs and encourage networking among BIPOC therapists. However, despite these important effects, a bottleneck in the training of MAT therapists has developed due to the limited availability of therapist roles in FDA-approved trials to obtain the required clinical experience and supervision. Therefore, even if BIPOC enrollment has improved for later cohorts of MAPS trainees, the completion of certification among BIPOC candidates may not have meaningfully increased (and should be the subject of data collection and potential intervention).

CONCLUSION:

In both research and clinical settings, BIPOC PAT clinicians will be needed both ahead of and during the early expansion of psychedelic medicine following state and federal deregulation. Given the limited recruitment of BIPOC providers, particularly among underrepresented minorities (URM), the mental health system in the United States is not prepared to meet the demand, which may further delay the acceptance of PAT among URM and thereby impede research into race concordance as well as race in general in PAT. Moreover, even if BIPOC individuals present less frequently to PAT services, clinical demand will still dramatically increase in all quarters upon the liberalization of psychedelic regulation in medical spaces. Considering the 2-8 years of postgraduate education required for therapist qualifications in most states, as well as the additional year or more of specialized training required to obtain certification and develop experience in each form of PAT, recruitment efforts for BIPOC providers will need to anticipate clinical and research demands by at least a decade. Even facilitators in states with less restrictive educational requirements, such as Oregon, will need a substantial amount of time to develop requisite skills, and academic medical centers will still likely prefer more traditionally certified therapists to provide PAT. Given the time horizon for legalization being discussed in several states, the time to act on recruitment is now.

While increasing BIPOC training in general psychotherapy programs may eventually translate into increased representation in PAT certification and should remain an overarching goal, recruiting already qualified BIPOC therapists into PAT training programs will be the most cost-effective and efficient approach in the short term. Accordingly, it will be imperative to recruit BIPOC therapists through dedicated training pathways that include clinical experience, robust needs-based scholarships, tuition subsidization for URM candidates, investment in culturally-competent curricular development, as well as opportunities for BIPOC mentorship at institutional and national levels with support for academic publishing and involvement in teaching the next generation of providers. Given that issues surrounding race have received even less attention in the psilocybin as opposed to MDMA therapy space [18], it will be likewise important to advocate for support for BIPOC therapist training from organizations outside of MAPS, such as non-profit entities like the Usona Institute. as well as for-profit corporations like Compass Pathways.

PAT-training programs could also go further in establishing a specialization in the treatment of specific BIPOC groups or racial trauma; creating educational tracks with primarily BIPOC instructors intended for BIPOC candidates; recruiting for PAT training programs at historically Black colleges and universities (HBCUs); admitting a BIPOC therapist for each white therapist entering a PAT training program until the cohort quota is met (rather than admitting on a first-come, first serve basis or prioritizing those not requesting scholarships); and increasing representation of BIPOC authors in the program's

required or recommended texts. Following up with BIPOC research trial participants to offer information on PAT training programs to their community therapists may also be helpful for both reducing clinician stigma around PAT and increasing outreach to individuals who may have more experience working with BIPOC clients. More general changes, such as encouraging PAT training programs to offer remote and asynchronous learning, may also be helpful, not only to increase geographical access but also to allow those with unique circumstances to attend (new parents, shift work schedules, etc.), while potentially decreasing cost of certification for both the trainee and the program.

From a broader perspective, our limited knowledge on race concordance in PAT reflects underlying racial disparities in psychedelic medicine, emphasizing the need for dedicated efforts to increase BIPOC therapist training to meet growing clinical and research demands. While preliminary evidence suggests that psychedelic medicines are likely to be effective for many BIPOC participants regardless of therapist race, the potential added benefits of concordance, especially for URM and in the treatment of race-based trauma, are yet to be explored. Given the fraught history of biomedical research and psychoactive substance use among BIPOC communities in the United States, increased research about BIPOC clients and particular needs within these minority communities, as well as an increased presence of BIPOC clinicians within the culture of the field, will be important for engendering trust that the modality is safe and effective for them as well. However, considering that actions taken now will take years to manifest in the availability of BIPOC providers, the window for early intervention remains open, but not for long.

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