**Status of Diversity in Need for and Use of VJLAP Services**

**2021 CLE**

Virginia Judges and Lawyers Assistance Program

Fall Retreat

September 17-18, 2021

**Status of Diversity in Need for and Use of VJLAP Services**

**Summary:**

* “Diversity and Inclusion” efforts recognize the need for equity for all members of the legal profession. In so doing, identifying and addressing the risks, vulnerabilities, and barriers to equity is of primary importance. There are disparities in many racial, ethnic, gender, and sexual minorities in this country in mental health concerns, access to services, and mental health outcomes for multiple factors (e.g., cultural stigma surrounding mental health care, discrimination, a lack of awareness about mental health, structural barriers to accessing mental health treatment, inequities in socioeconomic status).
* Research has identified disparities in regard to risk, prevalence, course and treatment of mental disorders.
* Diverse lawyers have the occupational risks in the practice of law as well as those that are population specific (e.g., history of marginalization, intergenerational historical trauma, lower measures on the social determinants of physical health, discrimination). Data show that additional workplace stressors and the pandemic have added to the stress of practicing law and to diverse lawyers specifically.
* The moderator will start with a discussion on the statistics on (i) addiction and mental health disorders; (ii) impediments to accessing services; and (iii) the proportional rates for accessing services in the general population, in the legal community, and in diverse populations.
* The program will review what panelists have seen within their work communities on the risks for mental health problems and barriers to identifying and addressing mental health needs that are unique to diverse lawyer populations – from the perspective of private firms (large, small, and solo), government, and the judiciary.
* Additionally, the program will briefly explore the intersection of addiction and mental health and the disciplinary system and how delay in accessing services and receipt of mental health services have impacted disciplinary cases.
* This program will also discuss ways to reduce barriers to asking for and accessing help, including working with VJLAP.

**Presenters:**

**Renu Brennan** (Virginia State Bar Counsel)

Renu currently services as Bar Counsel for the Virginia State Bar. She served as Assistant Bar Counsel for the Bar from 2008 to 2016 and has served as Secretary of Lawyers Helping Lawyers and as a member of the ABA Standing Committee on Client Protection. She was a faculty member for the Virginia State Bar Harry L. Carrico Professionalism Course from 2008 to 2011 and has been a member of the Board of Directors of the Asian Pacific American Bar Association of Virginia since 2007. She also served as co-chair of the Judicial Nominations Committee of APABA-VA from 2009 to 2011. Ms. Brennan has participated as an instructor in the Virginia Bar Association’s Rule of Law program.

Prior to coming to the Bar, she was a partner with the firm of Vandeventer Black, LLP, where she handled professional malpractice and commercial litigation. From 1998 to 2004, Ms. Brennan was with the firm of Wright, Robinson, Osthimer & Tatum in Richmond, Virginia. Ms. Brennan is licensed in Virginia, the District of Columbia, and California, where she practiced in Los Angeles. She holds a bachelor’s degree from the University of Virginia and a law degree from Boston University School of Law.

**Stephen Flores** (Flores Law, LLC)

Raised in Roanoke, Virginia, Stephen grew up learning the value of helping others. After graduating from the University of Virginia, he worked as a deputy clerk in the D.C. Court, where he helped pro se individuals with accessing the court. He obtained his law degree from the University of Richmond and has lived in Richmond ever since. After practicing bankruptcy at another firm, Stephen began his bankruptcy with the mission of helping his clients get a fresh start.

**The Honorable Helivi L. Holland** (Suffolk General District Court)

Judge Holland is a district court judge for the 5th Judicial District in Virginia. She previously served as Suffolk's City Attorney and as the Director of the state Department of Juvenile Justice. Judge Holland also previously worked as a deputy city attorney in Suffolk and, prior to being in the Suffolk City Attorney’s office, was a prosecutor in the Portsmouth and Suffolk Commonwealth’s Attorney’s offices, where she prosecuted major juvenile crimes.

Judge Holland is a member of First Baptist Church Mahan Street and a Diamond Life Member of Delta Sigma Theta Sorority Inc. in the Suffolk Alumnae Chapter. Ms. Holland was elected to a two-year term as Old Dominion Bar Association President May 30, 2014. She is on the Virginia Judges and Lawyer’s Assistance Program’s Board of Directors and has served on the boards of directors at the Children’s Center, Suffolk Education Foundation, Suffolk chapter of the American Red Cross and the Genieve Shelter. For 12 years, she also served as an adjunct professor at Paul D. Camp Community College, teaching on two campuses as well as at a Virginia Department of Corrections facility.

**Mike Herring** (McGuire Woods)

Mike is a trial lawyer with experience resolving commercial litigation, government investigations, and white-collar criminal defense matters for individuals and corporations. After serving 13 years as Richmond commonwealth’s attorney, winning re-election three times, Mike has earned the respect and admiration of the legal community in Virginia and beyond. Leveraging this experience, he serves clients in a wide array of complex commercial litigation. Herring specializes in commercial litigation, government investigations and white collar criminal defense matters with McGuire Woods.

During his tenure as Richmond commonwealth’s attorney — the city’s top prosecutor — Mike managed an office of 40 lawyers, led high profile criminal prosecutions, and was appointed to head politically sensitive investigations involving alleged conduct of top statewide elected officials. He helped Richmond police develop strategies to reduce homicides and violent crimes dramatically and implemented groundbreaking criminal justice reforms adopted by other Virginia localities.

Prior to Mike’s government service, he was a law firm partner representing clients in medical malpractice, criminal defense and personal injury matters. He is a member of the American College of Trial Lawyers. Mike is active in community and legal organizations and frequently presents at conferences and programs devoted to improving the criminal justice system. Mike also is an adjunct faculty member at the University of Richmond School of Law.

**Agenda:**

**Status of Diversity in Need for and Use of VJLAP Services**

1. Diversity and Inclusion
	1. Equality v. Equity
	2. Barriers to Equity, Diversity, and Inclusion Efforts
	3. Solutions to Equity/Inclusion: PRESS
2. Mental Health Disparities Among Diverse Populations
	1. Women
	2. Racial Disparities – African Americans
	3. Racial Disparities – Asian Americans/Pacific Islanders
	4. Racial Disparities – Hispanic and Latino
	5. Racial Disparities – American Indian/Alaskan Natives
	6. LGBTQ Disparities – Gay/Lesbian Population
	7. LGBTQ Disparities – Bisexual Population
	8. LGBTQ Disparities – Queer/Questioning Population
	9. Other Diverse/Minority Populations (geographic/religious)
3. Diversity and Well-Being in the Legal Community
	1. Diversity Lags Among Lawyers
	2. Well-Being Struggle for Attorneys
	3. Why Well-Being Matters
	4. Why Diversity Matters
4. Recommendations
	1. Acknowledgement
	2. Leadership
	3. Encouragement
	4. Relationship-Building
	5. Professionalism
	6. Diversity and Inclusion Initiatives
	7. Mentorship
	8. Lawyer Sense of Control
	9. Education
	10. Support Lawyer Transition
	11. Deemphasize Alcohol
	12. Support Wellness
	13. Measure Progress

**Status of Diversity in Need for and Use of VJLAP Services**

Written Materials

1. **Diversity & Inclusion**
	1. Equality vs. Equity[[1]](#footnote-1) –
		1. Equality is giving everyone a house to live in
		2. Equity is giving people in the tropics housing that provides good ventilation, windows with screens to keep mosquitoes out and sufficient shade from the heat; and giving people in artic climates a house with good insulation and a good heat source
	2. Barriers to Equity, Diversity and Inclusion (EDI) efforts[[2]](#footnote-2)
		1. Lack of Budget – can be difficult to prove return on investment (ROI) for EDI investments, must consider all the potential benefits to an organization to accurately calculate ROI
		2. Lack of Support – initiatives often met with skepticism, which requires education of all the potential benefits of EDI (ROI and otherwise set forth in full detail below
		3. Lack of tools – need the tools to measure and track EDI investments, education and support can depend on accurate measurements of progress
	3. Solutions to Equity / Inclusion: PRESS[[3]](#footnote-3)
		1. Problem Awareness –
			1. Research reveals that many white people do not see that racism continues to oppress people of color. 57% of Whites and 66% of working whites believe that there is more racism against them than against Blacks
			2. Assumption is that racism is deliberate action motivated by malice and hatred
		2. Root-Cause Analysis –
			1. Racism can have many psychological sources
			2. Most is the result of structural factors – laws, institutional practices and norms
			3. Many do not involve intent
		3. Empathy –
			1. Once people are aware of problem and its root cause question is whether they care enough to do something about it.
			2. Many experience sympathy, or pity, when they witness racism, but
			3. Empathy is experiencing the same hurt and anger that people of color feel
			4. Empathy provides solidarity and social justice while sympathy quiets the symptoms while perpetuating the disease
		4. Strategy – Once the foundation has been laid, then what to do about it
			1. Need to change personal attitudes, informal cultural norms and institutional policies.
			2. Many strategies for reducing racial bias, but must get people to actually adopt them
			3. Strategy must address all three
		5. Sacrifice – Organizational change requires investment of time, energy, resources and commitment
2. **Mental Health Disparities Among Minorities**
	1. Women[[4]](#footnote-4):
		1. Health Challenges - Depression /PTSD / Anxiety – Women twice as much as men, Eating Disorders – 85-95% of people with anorexia/bulimia are women, and 65% of those with binge eating disorder are women.
		2. Risk Factors for Mental Health – Women earn less than men, 1/3 women experienced sexual violence/physical violence or stalking, 65% of caregivers are women who spend 50% more time in that role than men.
		3. Gender Differences in Seeking/Receiving Mental Health Services – Women more likely to be prescribed psychotropic drugs than men, women more likely to get care from PCP (men seek a specialist), Women less likely to discuss alcohol problem than men
	2. Racial Disparities – African Americans[[5]](#footnote-5) 13.3% of the population:
		1. Health challenges - 27% live below the poverty line (10.8% of non-Hispanic whites), Death rate higher than that of whites for: heart disease, stroke, cancer, asthma, influenza, pneumonia, HIV/AIDS and homicide, 30% of households headed by a woman with no male counterpart
		2. Risk Factors for Mental Health – only1/3 who need mental health care receive it, African Americans with mental illness more likely to use emergency rooms than specialists, and are less likely to receive evidence-based medication therapy or psychotherapy
		3. Barriers to Mental Health: distrust of the health care system, lack of diverse racial/ethnic background of providers, lack of insurance/under insurance
	3. Racial Disparities - Asian Americans/ Pacific Islanders[[6]](#footnote-6)
		1. Health Challenges – 50 subpopulations speaking over 100 languages, fastest growing ethnic group on U.S., highest life expectancy of any group
		2. Risk Factors for Mental Health – 70% from SE Asia diagnosed with PTSD, suicide was a leading cause of death (alone) for those 15-24
		3. Barriers to Mental Health – Myth of Model Minority: group perceived to have higher degree of socioeconomic success creates unreasonable pressure, lack of understanding of mental health leads to denial/neglect of mental health issues.
	4. Racial Disparities – Hispanics and Latinos[[7]](#footnote-7) (Hispanic refers to a language and those whose ancestry comes from Spanish speaking countries. Latino refers to geography and specifically those from Latin America including Caribbean, South America and Central America.
		1. Health Challenges – Youngest ethnic group in US 1/3 under 18, will make up 30% of US population by 2060
		2. Risk Factors for Mental Health – Lower risk of most psychiatric disorders (with US born reporting higher rates than non-US born), 1/10 use PCP for mental health issues and only 1/20 receive help of a specialist, 21.1% uninsured
		3. Barriers to Mental Health – Lack of insurance, cultural stigma associated with mental health issues, shortage of bilingual or linguistically trained health professionals, lack of awareness of mental health problems
	5. Racial Disparities – American Indians / Alaskan Natives[[8]](#footnote-8)
		1. Health Challenges – 567 federally recognized AI/AN with more than 200 languages, 2/3 live off the reservations, life expectancy is 4.4 years lower than the nation, highest poverty rate of any ethnicity
		2. Risk Factors for Mental Health – High rates of Substance Use Disorders (SUD), PTSD suicide and intergenerational historical trauma, Highest reported rates of depression
		3. Barriers to Mental Health – significantly more likely to seek help from traditional healer than other sources, lack insurance and financial resources, mistrust health care providers, lack of awareness of mental health issues and available services
	6. LGBTQ Disparities – Gay/Lesbian Population[[9]](#footnote-9)
		1. Health challenges – Increased rates of mood/anxiety disorders, discrimination affects access to jobs, insurance and financial stability, internalized homonegativity results in devaluation of the self
		2. Risk Factors for Mental Health - 1/6 attempt suicide in their lifetime, higher rates of substance abuse, couples have increased stress due to disclosing relationships to family, being safe in public, feeling judged and having unequal legal rights.
		3. Barriers to Mental Health – more likely to report dissatisfaction with health care system, social discrimination linked to decreased service use, social isolation and worsening psychological symptoms
	7. LGBTQ Disparities – Bisexual Populations[[10]](#footnote-10) –
		1. Health Challenges – largest self-identified group with lowest research, variations within the group in terms of sexual attraction and sexual behavior
		2. Risk Factors for Mental Health – Regularly experience hostility from other members of the LGBTQ community (bi-negativity), more likely to hide their identity that gay or lesbian increasing stress/anxiety, increased risk of suicide over gay/lesbian or hetero community
		3. Barriers to Mental Health – underrepresented in research, more likely to have experienced sexual trauma as a child, seek mental health services for concerns about their sexuality less than gay/lesbian peers, minority stress and social isolation due to marginalization of their identity
	8. LGBTQ Disparities – Questioning/Queer Population[[11]](#footnote-11) – Questioning: process of determining sexual orientation/gender identity, Asexual: people who do not experience sexual attraction, Genderqueer: umbrella term for individuals who describe their gender identity that does not conform to the male/female gender binary
		1. Health Challenges – identifying spectrum of same-sex attraction / same-sex behavior, feelings of identity and attraction are complicated, do not fit into traditional categories and/or change over time.
		2. Risk Factors for Mental Health – misunderstood, overlooked and underrepresented in the health care system, worsening mental health from resulting prejudice, bias and discrimination within society
		3. Barriers to Mental Health – limited access to and use of health care services, internalized homonegativity and lack of health care expertise
	9. Other Minority Populations – Appalachian People[[12]](#footnote-12) – Appalachian Region defined by the federal government as extending over 1000 miles from Mississippi in the south to New York state in the north,
		1. Health Challenges – 87% of the region has more than 150% of the US poverty rate, Cancer diagnoses 10% higher, COPD 27% higher, stroke 14% higher and diabetes is 11% higher than national rate,
		2. Risk Factors for Mental Health - suicide rate 17% higher than national average, Eastern KY has a poisoning mortality (including drug overdose) of 35.9/100,000 highest rate in Appalachia and double the national average, deliberate targeting of Appalachia by pharmaceutical companies
		3. Barriers to Mental Health – isolated/mountainous terrain limit access to care, lingering skepticism of outsiders extends to medical and mental health care, Appalachia has 35-50% fewer mental health care providers than the national average
	10. Other Minority Populations – Muslim Americans[[13]](#footnote-13) – about 3.45 million living in the US
		1. Health Challenges – limited data on prevalence of psychiatric disorders, high rates of adjustment disorder within those seeking mental health services
		2. Risk Factors for Mental Health – more likely than any other faith group to report low household income (<$30,000.00), Negative factors include: mental illness can be perceived as will of God or an opportunity to remedy disconnection from God, Positive Factors include: emphasis on personal hygiene and personal reflection, strong sense of community
		3. Barriers to Mental Health – Islamophobia – 60% report some level of religious discrimination, nearly 1/3 of Muslim Americans experienced discrimination in a health care setting, need for more research
3. **Diversity and Well-Being in the Legal Community**
	1. Diversity Lags Among Lawyers[[14]](#footnote-14) -
		1. 86% of lawyers are non-Hispanic white people, compared to 60% of the US population
		2. Percentage of female lawyers has increased from 31% to 37% (2010 – 2020), Female equity partners @ 21% in 2019, up from 15% in 2012.
		3. Gains among people of color and other minorities are minimal:
			1. 5% are black (same as 10 years ago), while 13.4% of US population is black.
			2. 5% are Hispanic (up from 4% 10 years ago), while 18.5% of US population is Hispanic
			3. 2% of all lawyers are Asian (up from 0.4% 10 years ago), while 6% of US population is Asian
			4. Native Americans are represented proportionally to their presence in the general population: 0.4% of lawyers are Native American compared to 0.7% 10 years ago
			5. LGBT lawyers represent 3% up from 2.5% three years earlier
			6. Physically Disabled lawyers represent 0.5% of the profession (twice the representation 10 years ago)
	2. Well-Being Struggle for Attorneys[[15]](#footnote-15)
		1. Well-Being: continuous process whereby lawyers seek to thrive in these areas: emotional health, occupational pursuits, creative or intellectual endeavors, sense of spirituality or greater purpose in life, physical health and social connection with others.
		2. Stats – Between 21 and 36% of lawyers qualify as problem drinkers, 28% struggle with depression, 19% with anxiety and 23% with stress. Younger lawyers in private firms experience the highest rates of problem drinking and depression. In young lawyers, 17% experienced depression, 14% severe anxiety, 23% mild or moderate anxiety and 6% suicidal thoughts; 43% report binge drinking in previous two weeks, 22% reported 2 or more times in that period and 25% fell into a category at risk for alcoholism.
		3. Pandemic Effect on Well-Being
			1. COVID-19 has a significant effect on all segments of legal profession: age, gender, race/ethnicity, seniority and practice setting
			2. Lawyers, especially those with children, are overwhelmed – much higher levels of stress, disengagement with social aspects of work, frequently questioning whether employment as a lawyer is worth it.
			3. Greater impact upon minorities: higher levels of stress at work, greater difficulty in taking time off from work, harder to keep work and home life separate.
			4. Greater Impact Among Women: greater disruption in work than men, greater proportion feel overwhelmed, greater pressure to care for children,
			5. Regardless of increased obligations because of COVID, levels of work have not decreased: 80% continued to have full-time workload
	3. Why Well-Being Matters:
		1. Good for Business: well-being linked to many organizational successes – lower turnover, higher client satisfaction, higher productivity and profitability
		2. Good for Clients – well-being influences ethics and professionalism, troubled lawyers can struggle with minimal competence 40-70% of disciplinary/malpractice proceedings involve substance abuse, depression, or both.
		3. The Right Thing to Do – untreated mental health and substance use disorders ruin lives and careers, well-being is part of the ethical duty to practice with competence, it includes the ability to make healthy/positive work/life choices, it is not solely the absence of illness, but also a positive state of wellness
	4. Why Diversity Matters[[16]](#footnote-16)
		1. Diversity is a key driver of innovation – multiple and varied employees have a wide range of experiences helping to generate new ideas and provide valuable insight into the markets they reflect
		2. Diverse Workforce Attracts Top Talent: to attract the best talent, a company needs to be reflective of that talent in the market, ability to attract best talent also depends upon solid job advancement opportunities for that talent
		3. Diversity/Inclusion is not just about gender and race: many contemporary companies are seeking/maintaining diversity in areas of disability/sexual orientation/and age
4. **Recommendations[[17]](#footnote-17)**
	1. Acknowledge the Problems and Take Responsibility:
		1. Every sector of the legal profession must support lawyer well-being
		2. Each lawyer should strive to change the profession’s mindset from passive denial to active support for change.
		3. All need to prioritize lawyer health to change the legal culture
	2. Leaders Must Demonstrate a Personal Commitment to Well-Being –
		1. Broad-scale change requires buy-in and role-modeling from the top down.
		2. Leaders in the courts, law firms, law schools and bar associations are watched by others for signals as to what is expected
		3. Leaders can create and support change through their own demonstrated commitment to well-being in their personal and professional lives
	3. Facilitate, Destigmatize and Encourage Help-Seeking Behavior
		1. Factors hindering seeking help for mental health include: failure to know symptoms, not knowing how to access treatment, a culture’s negative attitude about such conditions, fear of adverse reactions by others, feeling ashamed, viewing help-seeking as a sign of weakness, fear of career repercussions, concerns about confidentiality, uncertainty about effectiveness of treatment, and lack of time
		2. Rather than seeking help early many wait until symptoms are so severe they interfere with work
		3. Leaders can remove these obstacles with education, skill building and stigma-reducing strategies
		4. Most effective way to reduce stigma is through direct contact with someone who has personally experienced a relevant disorder (ideally practicing lawyer/law student) to create a personal connection
	4. Build Relationships with Lawyer Well-Being Experts
		1. Partner with Lawyer Assistance Programs - All should partner with and insure sufficient and stable funding for Lawyer Assistance Programs
		2. Consult Lawyer Well-Being Committees and Other Types of Well-Being Experts – similar to Lawyer Assistance Programs many bar associations have quality of life/well-being committees or initiatives and there are many high-quality consultants available on the topic
	5. Foster Congeniality and Respectful Engagement Throughout the Profession:
		1. Judges, practitioners, regulators students and professors regularly interact with each other, clients, opposing parties and clerks, staff and many others, that contact can be foment a toxic culture or foster a respectful culture.
		2. Civility is in decline: 72% describe incivility as a serious/moderately serious problem with the profession compared with 42% 15 years ago
		3. Judges, law firms should adopt rules of professionalism including the expectation that all leaders in the profession should be role models for such rules/standards
		4. Exemplary standards of professionalism are inclusive: organizational diversity and inclusion initiatives are associated with employee well-being, general mental and physical health, lower perceived stress levels, increased job satisfaction, increased organizational commitment, increased trust, increased work engagement,
	6. Promote Diversity and Inclusivity – Scholarships, bar exam grants for qualified applicants, law school orientation programs to highlight importance of diversity and inclusion, CLE programs on diversity, business development and symposia for women and minority owned law firms, diversity clerkships and law firm initiatives
	7. Create Meaningful Mentoring and Sponsorship Programs – can aid well-being and career progression for women and diverse professionals
	8. Enhance Lawyers’ Sense of Control
		1. High job demands coupled with lack of control over schedule/lives breeds depression, elevates risk of alcohol abuse
		2. Long-standing structures of the legal profession, organizational norms and embedded expectations can be modified to allow increased sense of control and support healthier lifestyle
	9. Provide High-Quality Educational Programs About Lawyer Distress and Well-Being-
		1. Legal professionals should receive training in identifying addressing and supporting fellow professionals with mental health and substance use disorders
		2. Training should include: warning signs, how and where to get help, relationship between substance use, depression anxiety and suicide, freedom from substance use and mental health disorders as an indispensable predicate to fitness to practice
		3. enlist help of recovering lawyers who are successful members of their community
	10. Guide and Support the Transition of Older Lawyers:
		1. Legal community is aging and practicing longer.
		2. Create system to detect and address cognitive decline in oneself and others
		3. Leaders should develop succession plans to guide the transition of the aging legal professional
		4. Legal professionals, judges, courts, law schools should develop programs to aid in the transition of retiring legal professionals.
	11. De-Emphasize Alcohol at Social Events –
		1. Workplace cultures that support alcohol consumption are among the most consistent predictors of employee drinking.
		2. Can reinforce tendencies towards problem drinking and stigmatize4 seeking help
	12. Utilize Monitoring to Support Recovery from Substance Use Disorders
		1. Random drug/alcohol testing is effective way to support recovery
		2. 96% of medical professionals subject to random drug tests remained drug free vs. 64% not so subject
		3. 95% were still working in the healthcare field at a five year follow up
	13. Begin a Dialogue About Suicide Prevention –
		1. Lawyers have a high rate of suicide related to reluctance to ask for help, high levels of depression and stressful nature of the job
		2. Members of the profession need to provide education and take action
		3. Share stories of those affected by suicide
		4. Provide education about signs of depression/suicidal thinking
		5. Learn non-verbal signs of distress
		6. Collect and publicize available resources.
	14. Support a Lawyer Well-Being Index to Measure the Profession’s Progress – Bar associations need to create a well-being index for legal professionals including metrics related to lawyers, staff, clients, the legal profession and the broader community. Success should not be measured in purely economic terms
1. Schindler, Janine, MCC, *Equity And Accessibility in the Workplace*, November 11, 2020. <https://forbes.com/sites/forbescoachescouncil/2020> [↑](#footnote-ref-1)
2. Watson, Holly, *Webrecruit 3 Common Barriers to Equality, Diversity & Inclusion Initiatives*, March 17, 2021

<https://webrecruit.co/blog/recruitment-insights/3-common-barriers-to-equality-diversity-inclusion-initiatives> [↑](#footnote-ref-2)
3. Livingston, Robert, “How to Promote Racial Equity in the Workplace,” *Harvard Business Review*, September – October 2020. <https://hbr.org/2020/09/how-to-promote-racial-equity-in-the-workplace> [↑](#footnote-ref-3)
4. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Women’s Mental Health*, Updated and Reviewed by Misty Richards, M.D., Maureen Sayres Van Neil, M.D., and the Council on Minority Mental Health and Health Disparities, 2017. <https://psychiatry.org> [↑](#footnote-ref-4)
5. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: African Americans*, Updated by Phillip Murray, M.D., and Reviewed by Danielle Hairstrom, M.D. and the Council on Minority Mental Health and Health Disparities, 2017. <https://psychiarty.org> [↑](#footnote-ref-5)
6. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Asian Americans/Pacific Islanders*, Authored by Raissa Tanqueco, M.D. and Sejal Patel, M.P.H. and Reviewed by Vabren Watts, Ph. D., 2017. <https://psychiatry.org> [↑](#footnote-ref-6)
7. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Hispanics and Latinos*, Updated and Reviewed Respectively by Maria Jose Lisotto, M.D. and the Council on Minority Mental Health and Health Disparities, 2017. <https://psychiatry.org> [↑](#footnote-ref-7)
8. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: American Indians and Alaskan Natives*, Updated by Mira Zein, M.D., M.P.H., and Reviewed by Mary Roessel, M.D. and the Council on Minority Mental Health and Health Disparities, 2017. <https://psychiatry.org> [↑](#footnote-ref-8)
9. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Gay Populations*, Authored by Mark Messih, M.D., M.S.C. and Reviewed by Eric Yarbrough, M.D., 2017. <https://psychiatry.org> [↑](#footnote-ref-9)
10. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Bisexual Populations*, Authored by Sarah Noble, M.D., and Reviewed by Eric Yarbrough, M.D., and Sejal Patel, M.P.H., 2017. <https://psychiatry.org> [↑](#footnote-ref-10)
11. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Questioning/Queer Population*, Authored by Dr. Kali Cyrus and Catherine Morrison and Reviewed by Drs. Eric Yarbrough, Andrew Tompkins, Jeremy Kidd and Daena Petersen, 2017. <https://psychiatry.org> [↑](#footnote-ref-11)
12. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Appalachian People*, Authored by Myra Elder, Ph.D. and Diana Robinson, M.D. and Reviewed by Richard L. Merkel, Jr., M.D., Ph.D. and James Griffith, M.D., 2017. <https://psychiatry.org> [↑](#footnote-ref-12)
13. American Psychiatric Association, Division of Diversity and Health Equity, *Mental Health Disparities: Muslim Americans*, Authored by Drs. Awais Aftab and Chandan Khandai, and Reviewed by Drs. Balkozar Adam and Rania Awaad, 2017. <https://psychiatry.org> [↑](#footnote-ref-13)
14. ABA Profile of the Legal Profession: Diversity and Well-Being, 2020

[https://www.2civility.org/aba-profile-of-the-legal-profession-diversity-and-well-being/#](https://www.2civility.org/aba-profile-of-the-legal-profession-diversity-and-well-being/) [↑](#footnote-ref-14)
15. The Report of the National Task Force on Lawyer Well-Being, “The Path to Lawyer Well-Being: Practical Recommendations for Positive Change” Task Force Chairs: Bree Buchanan and James C. Coyle, August 2017.

<https://www.americanbar.org/groups/professional_responsibility/task_force_lawyer_wellbeing> [↑](#footnote-ref-15)
16. Hunt, Vivian, Layton, Dennis, and Prince, Sara, Why Diversity Matters, McKinsey & Company, January, 2015.

<https://www.mckinsey.com/business-functions/organization> [↑](#footnote-ref-16)
17. The Report of the National Task Force on Lawyer Well-Being, “The Path to Lawyer Well-Being: Practical Recommendations for Positive Change” Task Force Chairs: Bree Buchanan and James C. Coyle, August 2017.

<https://www.americanbar.org/groups/professional_responsibility/task_force_lawyer_wellbeing> (provides source data for IV (a) through IV (n)) [↑](#footnote-ref-17)