Examining Why Racialized Women are Underdiagnosed with ADHD

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Abstract

Despite increasing research that identifies race and gender as independent determinants of health, there is still a significant gap in research considering the relationship between one's intersectional identity and health. This lack of research has contributed to a poor understanding of why racialized women are less likely to receive a medical diagnosis. To address this gap, I explore the question: what factors contribute to the underdiagnosis of cognitive disabilities like ADHD for racialized women in Canada? I conduct a review of qualitative data including journal articles in public health, political science, and feminist and gender studies in order to determine existing knowledge gaps in my area of research and guide my research. I use an intersectional feminist approach to examine if the persisting inequities in healthcare are a result of institutionalized racism and sexism. Following my review of existing literature, I suggest increasing health research of women's experiences, the creation of a health equities toolkit, and partnerships with community-based organizations that support women with ADHD to gradually improve access to receiving diagnoses for illness and other healthcare services for racialized women. Exploring this research question contributes to existing Canadian literature on health inequities and clearly demonstrates that sexism and racism have been institutionalized in Canadian healthcare systems. The findings of this project will be beneficial to Canadian health practitioners and policymakers to ensure that there are accessible and helpful healthcare services and support for racialized women seeking diagnosis for cognitive disabilities.

Key Words: Canadian healthcare, Health inequities, Racialized women, Institutionalized racism, Cognitive disabilities, Public Health

Introduction

Research shows that up to 75 percent of girls with ADHD are undiagnosed and 46% women were misdiagnosed with another disorder prior to being diagnosed with ADHD (CADDAC, 2023). Although these statistics do not reference one's ethnicity and race, an American study found that Asian, Black, and Hispanic children are significantly less likely to be diagnosed with ADHD compared with White children (Shi et. al, 2021). This led me to question the effect of women's intersectional identities on their likelihood of receiving an ADHD diagnosis. Throughout my project, I identify factors that contribute to the underdiagnosis of cognitive disabilities of racialized women in Canada. The demographic of women as a group include anyone who identifies as a female, while racialized individuals will consist of those from backgrounds that are non-Caucasian. Exploring this research question will contribute to the existing Canadian literature on health inequities and highlight factors that affect the treatment of racialized women. My work fits into existing work by progressing the conversation about sexism and racism in public health by naming them as factors that result in underdiagnosed illnesses of cognitive disabilities for racialized women in Canada

I conduct a review of research in the areas of public health, feminist, and gender studies in order to determine existing knowledge gaps in my area of research and guide my research. Before my literature review, I highlight existing policies meant to encourage equality amongst people of various identities and current diagnostic measures used by Canadian practitioners. My literature review is organized by three main groupings; gender and race as a social determinant to health, intersectional feminist lens, and connecting institutionalized racism to healthcare. In my analysis of these groups, I identify institutionalized racism and sexism as factors that contribute to undiagnosed cognitive disabilities for racialized women. Following my analysis of existing literature, I suggest increasing health research of women's experiences, the creation of a health equities toolkit, partnerships with community-based organizations that support women with ADHD to gradually improve access to receiving diagnoses for illness and other healthcare services for racialized women.

Background knowledge

Although healthcare provisions are specific to each province in Canada, there are federal policies and initiatives that encourage equitable treatment between individuals from various backgrounds and gender identities. For instance, the Canadian Charter of Rights and Freedoms highlights that each individual, regardless of their, racial, ethnic, religious, sex, age, physical or mental disability are entitled to equal treatment consideration in Canadian institutions (“Government of Canada”, 2022). Similarly, there are healthcare policies that are enforceable in all Canadian provinces. For instance, the Government of Canada's Health Portfolio Sex and Gender-based Analysis (SGBA) Policy encourages the equal conduction of health research of both men and women in order to ensure the inclusion of the experiences of women (Government of Canada, 2012). This policy made revisions to the previous Health Canada document “Inclusion of Women in Clinical Trials” issued in 1997 (Government of Canada, 2012). Despite the encouragement of equality within these policies, there are still issues of poor access to healthcare services and quality of care for racialized women in various Canadian healthcare institutions.

In order to examine factors that result in underdiagnosis of cognitive disabilities like ADHD, it is crucial to note the current methods to diagnosement. Although there are multiple methods to diagnosis in Canada, many practitioners use a combination of objective and subjective data. For instance, a virtual diagnosis platform for women across Canada use the Adult ADHD Self-Report Scale, the Weiss Functional Impairment Rating Scale, DSM5 Criteria, various forms of patient health questionnaires and personal interviews with the patient in order to reach a diagnosis (Frida, 2023; American Academy of Family Physicians, 2013). I argue that these policies and approaches have gaps that allow for the underdiagnosis of cognitive disabilities for women.

Methodology

This project uses an intersectional feminist lens where I engage in empirical research on the policies that are meant to protect the equality rights of individuals from various backgrounds, systematically review literature in public health and feminist studies that focus on understanding the experiences of racialized women, and examine alternative forms of support that women navigate towards after being left out by the healthcare system. Since there is no singular methodology associated with feminist research, I draw upon aspects of historical institutionalism in my recommendations and grounded theory for my review of qualitative data in order to give my methodology more clarity.

Feminist research brings women to the center of analysis, gives weight to women's subjective experiences and experiential knowledge, and rejects the idea of 'objective' reality (Gilbert, 1994). This shift from focusing on an 'objective reality' as followed in other areas of research to appreciating a ' subjective reality' that values the lived experiences of women is one of the key benefits of engaging in feminist research (Tripp, 2018). As a result, I adopted this approach for this project to build trust with those affected by my research. Another benefit in using an intersectional feminist research lens is that it keeps me grounded as I am aware that my research is a part of a larger social movement, advocating for equality of racialized women (Ackerly & True, 2020). My work focuses on looking at the importance of structural factors as opposed to individual factors to try and create a single conceptualization of a social reality. Although each health-care professional may have their own approaches to healthcare and treatment they provide, I believe that the institutionalization of ideas can influence the way they provide care. Through my analysis, I identify the institutionalization of sexism and racism as factors that result in poor quality of life for disabled women. Although each racialized woman will have their own unique experience with healthcare providers and accessing healthcare services, my research relies on the ontological assumption that the institutionalization of racism and sexism construct a view of reality that applies to many individuals. My qualitative review of journals through a feminist lens includes analyzing studies and academic journals that discuss the experiences of racialized women with empathy and understanding. A way that I ensured that I was critically analyzing literature and creating inclusive policy suggestions through an intersectional feminist approach was by completing a Gender Based Analysis Plus certificate (Government of Canada, 2023). The certificate content provided me with a framework on how to address the needs of a marginalized group. For instance, it notes that the notion that inclusive research and policy development is an ongoing process where researchers are constantly reflecting on what they know (Government of Canada, 2023). My feminist approach was operationalized for this project by focusing on how gender inequities have resulted in a discrepancy between the diagnoses that women receive for cognitive disabilities in comparison to men. I ensure that the experiences of women are highlighted throughout my work and draw upon work that equally values the knowledge of womens’ lived experiences. Lastly, my approach is demonstrated my analysis and discussions, where I suggest the implementation of recommendations that will truly benefit racialized women. My recommendations connect to the historical institutionalist idea of layering policy solutions in order to make gradual change (Mahoney & Thelen, 2009).

Literature Review

In this literature review, I contextualize the presence of health inequities for racialized women and examine the gaps in current research that investigates gender and race as social determinants to health. I then highlight key contributions to the development of intersectional feminist analysis and explain why this method is helpful for my research. Lastly, I examine factors that apply to the discrimination of women in other institutions and question whether the factors that apply to the systemic discrimination of Indigenous women, who were colonized by the Canadian government, apply to other racialized women.

A need for further research on how gender and race as social determinants of health

Vohra-Gupta et. al (2022) identify gender and intersectional aspects of one's identity as social determinants of health. This is supported by Miani et. al (2021) who state that the socialization of one's gender can contribute to their quality of treatment. Heise et. al (2019) takes this acknowledgement a step further by stating that unconscious gender biases and sexism in patient care results in differential health outcomes for women and gender minorities. The acknowledgement that one's gender and race plays a role into one's treatment in healthcare supports my discussion of whether the gender and racial identities of racialized women contribute to why they are diagnosed less often with cognitive disabilities. Although the arguments that Vohra-Gupta et. al (2022) Miani et. al (2021) highlight are primarily based on the experiences of American women, their conclusions are applicable to the investigation of Canadian racialized women's experiences as the socialization of one's identity is still present regardless of the different physical location of American and Canadian women. I add to the discussion of gender and race as determinants by connecting them to cognitive disabilities and changing the perception that these disabilities do not affect racialized women in a different way.

Williams & Mohammed (2009) express that there is a need for further research on the relation between one's race and their treatment from Canadian healthcare practitioners. Bassily et. al (2020) adds to this statement by suggesting that gender-based and racial based stereotypes contribute to the underdiagnosis of illnesses for racialized women. They proceed to argue that the lack of research conducted on how illnesses affect women may also play a role in the significantly lower numbers of women who receive a diagnosis from a healthcare practitioner (Bassily et. al, 2020). Despite this source being Canadian, the authors rely on a lot of research conducted by American scholars and statistics based on the American racialized women, pointing out a significant gap in the literature; that there is limited Canadian research on the underdiagnosis of illnesses for racialized women in Canada. Moreover, the limited amount of health research conducted on women's experiences with certain pharmaceutical drugs has been cited as a reason for strained relationships between patients and their practitioners (Yakerson, 2021). This demonstrates the impact of this research gap it can affect the way that patients and practitioners interact with one another which can have numerous problematic implications like patients not getting access to treatment options or being recommended to take pharmaceutical drugs that will not positively react with their body. Gaps in empirical data can result in the idea that women do not have cognitive disabilities and if they do, they are not severe enough to be studied or researched. Similarly, it can result in uninformed treatment recommendations being given to women. I intend to fill these gaps by advocating for increasing health research on women with ADHD as this will help scholars and healthcare practitioners to address their gaps in understanding what ADHD looks like. My hope is that through increased research, women will be able to receive diagnoses at a faster rate than they would have otherwise.

This data gap perpetuates a limited understanding of the experiences of these women and makes it difficult to examine the factors that result in underdiagnosed or late diagnoses of cognitive disabilities. For instance, in a Canadian review of studies that collect data on ADHD patients, it was concluded that overall that men are twice more likely to receive a diagnosis than women (Espinet et. al, 2022). Within this same review, it was noted that the gender and ethnicity of patients were only noted in one of the studies (Espinet et. al, 2022). This data gap in acknowledging race and ethnicity in one's lived experiences can result in the idea that these factors do not play a role in one's experiences which is arguably incorrect after exploring the way racism affects racialized women in numerous institutions. In addition, Fuller et. al (2016) and Skinner (2001) note that the lack of data collected on women results in the lack of understanding of how illnesses affect women. This consequently makes it difficult for healthcare practitioners and Canadian policymakers to create effective programs that support racialized women because they are not sure what their needs are. Skinner (2001) highlights that the historic exclusion of health research conducted amongst women has resulted in limited opportunities for effective medical intervention and diagnosing criteria that is based on the experiences of men. I seek to resolve this gap by engaging in research that values the experiences of women by referring to work that highlights womens lived experiences being undiagnosed or diagnosed later in their life.

Some scholars like Fuller et. al (2016) acknowledge that the change in terminology from ADHD to ADD in recent years may play a role in the limited numbers of diagnoses amongst individuals who do not seem to exhibit hyperactivity on the outside. This is relevant to the discussion of factors that result in underdiagnosis of illnesses as many women are often underdiagnosed due to the difference in their outwardly presenting symptoms in comparison to men (Fuller et. al, 2016). Moreover, one could determine the change in terminology and limited knowledge of the different types of ADHD in the past contributed to less diagnoses for women who did not seem to be hyperactive. However, this change does not answer why women who are hyperactive on the outside are underdiagnosed. As a result, this source can explain a few cases of women receiving diagnoses later, but it leaves out women who have different experiences and does not acknowledge the institutional nature of the diagnosis gaps between men and women. I try to fill this gap by naming institutionalized racism and sexism as factors that contribute to the underdiagnosis of cognitive disabilities. The gaps in knowledge of the experiences of racialized women are a reason why I chose an intersectional feminist lens to conduct my research.

Intersectional feminist lens

Crenshaw (1989) coined the term intersectionality and explains that this lens considers the various aspects of one’s identity in their oppression. Crenshaw (1989) argues that experiencing a societal advantage on multiple axes can result in a very different manifestation of oppression than someone who faces a disadvantage on one axis. She initially created the term intersectionality because she noted significant differences in black women's experiences in comparison to white women’s with the intention of being able to apply to a variety of groups (Crenshaw, 1989). Nash (2008) argues that it is crucial to examine the assumptions that individuals have even within intersectional analysis to ensure that one is not generalizing the experiences of a specific category of women. She critiques Crenshaw's (1989) work for the suggestion that the shared axes of identity like black women results in equivalent lived experiences and highlights that the lack of a defined methodology for intersectionality can make the work complicated (Nash, 2008). While the lack of a singular methodology for intersectional feminist research can make it difficult to acknowledge the complexities of analyzing intersectional identities, I believe that it also gives scholars the opportunity to create a methodology that fits the aims of their research.

Since my research is conducted through an intersectional feminist lens, I focus on studies and journals that consider the experiences of racialized women from a place of understanding and empathy. Despite Nash's (2008) critique, Crenshaw's (1989) work is significant in feminist studies as she encouraged scholars to examine the complexities of one's identity in their lived experiences. I will add to the developments made in both of these sources by creating a methodology for this project that follows a community-based research approach and takes aspects from a historical institutionalist approach. Way's (2004) explores the use of historical institutionalism as an approach to conduct intersectional research and improve equity within various systems. As a result, I revised the current Canadian policies that are meant to promote equality for racialized women. Way's (2004) furthers the conversation of intersectionality and explains how historical institutionalism has helped scholars understand the experiences of women in the criminal justice system. Despite mentioning other institutions, I will apply this theory to improve the accessibility of healthcare services. I add to this work by proposing the a variety of solutions meant to address the inequities in Canadian healthcare system. Moreover, my use of this approach can serve as an example for other intersectional feminist research studies as there is no defined singular methodology for these projects.

Connecting institutionalized racism to healthcare

Despite considerable research articles identifying barriers to accessing healthcare systems for marginalized people, I found that institutionalized racism is rarely linked to the Canadian healthcare system (Banting & Debra Thompson, 2021; Chan & Chunn, 2014; Williams & Mohammed, 2009). Banting & Debra Thompson (2021) highlight how racial inequity is embedded in Canada's economic policies and Chan & Chunn (2014) attribute institutionalized racism to being the reason for disproportionate numbers of racialized women facing more severe sentences in the Canadian criminal justice system. Similarly, Hardeman et. al (2018) provides evidence of health inequities in the Canadian healthcare system and highlights a gap in public health literature; that institutionalized racism is often not named as a factor or determinant of health inequities. This led me to question if institutionalization of racism is factor results that contributes to the underdiagnosis of cognitive disabilities for racialized women but simply is not named.

If racism is mentioned in healthcare literature, it is mentioned as determinant of health for Indigenous peoples in Canada (Gunn 2016, Murdock, 2020). Since Indigenous people were displaced, colonized, and oppressed by the Canadian government, the institutionalization of racism is an evident factor. However, there is systemic discrimination that racialized women face who hold a cultural or ethnic background that are not Indigenous (Banting & Thompson, 2021; Williams & Mohammed, 2009). While the experiences of Indigenous people in accessing healthcare services is relevent to the discussion of racialized women, it is crucial to note that there may additional factors that affect other racialized groups (Williams & Mohammed, 2009). To a similar effect, there may be factors that disproportionately affect certain racialized groups than others. For instance, colonization is often linked as a determinant of health for Indigenous people (Murdock, 2020). However, there is systemic discrimination that racialized women face who hold a cultural or ethnic background that is not Indigenous (Gunn, 2016; Williams & Mohammed, 2009). In addition, Hamilton (1996) states that the lack of a common language and having cultural barriers make immigrants hesitate to reach out for help which can result in illnesses going undiagnosed. However, I find this to be an oversimplification of the problem at hand as it only applies to a select group of racialized women. Moreover, this puts the responsibility on patients for not knowing the language or being from a different background rather than on Canadian policymakers and healthcare practitioners for ensuring that their care is culturally competent.

After reviewing existing policies meant to encourage equality, diagnosing criteria, and literature in feminist studies, gender studies, and public health, it is evident that there institutionalized racism and seixsm continue to discriminate against racialized women. Although there is increasing amounts of research that identify gender and race as social determinants to health, there is still a limited amount of data conducted on women with a cognitive disability like ADHD. This results in a chain reaction of not knowing how cognitive disabilities affect women and what they need to be better supported by healthcare practitioners. The recognition of institutionalized racism and sexism in other disciplines and the acknowledgement of institutionalized racism as a determinant to Indigenous peoples health helped me identify these as factors that result in underdiagnosed cognitive disabilities. I will allow me to contribute to existing literature by naming institutionalized racism and sexism not only as factors that affect racialzied womens experiences in healthcare, but also as factors that can cause late diagnoses or misdiagnoses of cognitive disabilities.

Analysis and Recommendations

My preceding analysis of existing literature indicates gaps in existing literature and key areas that will help in developing strong policy recommendations to increase diagnoses for racialized women. I provide recommendations that will make changes at the systemic level by targeting the areas of research, education, and support for patients. I argue that if these recommendations are used in conjunction with one another, ADHD diagnoses for racialized women will increase. Since Canada has universal healthcare throughout the nation and provincial Canadian healthcare systems rely on the policies established at a federal level, demolishing, and creating a new system is unlikely to gain support from government officials. Contrastingly, layering recommendations as a method of gradual change is likely to gain support from government officials and policymakers since it involves the implementation of changes over a long period of time.

Recommendation #1: Increasing health research conducted with racialized women, improving equity in health research, and educating practitioners about new research findings

I suggest that Canadian researchers should increase health research conducted on women with ADHD in Canada and improve equity within research to ensure that womens experiences are being explored and represented in their findings. This can be accomplished by hiring more female researchers and creating safe spaces for women to participate in research. This can be facilitated is by engaging in community-based research projects. Since CBR projects are helpful for conducting feminist research and conducting health research for marginalized communities, I believe that this will be an appropriate solution to try to increase health research of racialized women (Halseth et. al, 2016). Many feminist scholars gravitate towards a CBR approach, likely due to the similar goals of increasing engagement between researchers and subjects and listening to the lived experiences of those affected by an issue. I believe that evaluating information through a feminist lens and conducting research in collaboration with community members will ensure that there is in an increase in both the quantity and quality of research.

An example of a CBR project could be working with women who received an ADHD diagnosis in adulthood rather than childhood, when diagnoses are typically given to patients, along with women who may self-identify as having ADHD and are waiting for a practitioner diagnosis. I suggest having various focus groups to separate women primarily by their ethnic and racial backgrounds. Within these groups, there could be further divisions to include one's age, socioeconomic background, and their sexual orientation or fluid gender identity. Moreover, each individual will have the opportunity to answer interview questions that inquire about their experiences in receiving access to a diagnosis for ADHD. Questions like; what was your experience like getting diagnosed, did you face any obstacles when getting your diagnosis, did you feel like your treatment from healthcare practitioners was based on prejudice and discriminatory beliefs, and giving the opportunity to people to share personal anectodates could be answered.

Although the increase of health research conducted on women improves the availability of research findings on womens' experiences with ADHD, there is no guarantee that these findings will be shared within healthcare facilities and incorporated within practitioners' approaches to diagnosing a patient. As a result, I argue that healthcare facilities should create information sessions or implement trainings for family doctors to participate in trainings about new research findings every few years to ensure that they are upto date with knowledge on certain illnesses or disabilities. This will allow practitioners to examine their knowledge on disabilities like ADHD and correct their biases about the illness, like the notion that it primarily affects young boys, that symptoms of girls and women are not as serious as boys and men, and that a girls and women cannot have it if their symptoms do not present themselves in a stereotypically hyperactive way. I argue that family doctors will be the most beneficial group as they are usually the first points of contact for most patients. They also have the authority and power to diagnose an individual themselves or give patients referrals to receive a diagnosis, if they are not to provide one themselves. As a result, it is crucial for them to have a strong understanding of what ADHD looks like in order to ensure that patients are receiving an accurate diagnosis. Educating doctors on new research findings will not only help patients with ADHD, it can also improve the rate in which women are diagnosed with other ailments. In addition, the increase in research and implementation of trainings to share this knowledge will also hopefully increase the comfortability that patients have with their practitioners, allocating for a previously noted effect of the data gap on womens' health (Ackerly, 2020).

A limitation of this policy recommendation is that it may primarily help racialized women who already hypothesize that they have ADHD or have been diagnosed with another cognitive disability. However, this recommendation can be beneficial even for individuals that are not sure of their impairment as long as practitioners are knowledgeable enough to identify symptoms without the individual having to bring ADHD. This can only be possible if practitioners are genuinely trying to check their biases and increase their understanding of how ADHD presents in women and affects women. Another limitation of this recommendation is that it may be more helpful in diagnosing women as opposed to children. This is because children may not be able to fully express their symptoms to the extent in which a woman can who is able to recognize differences in their behaviour and lifestyle. However, I believe that if this recommendation is used in conjunction with others, the rates of diagnosis for racialized children and women will increase.

Along with increasing health research, I suggest creating and developing tools to improve equity in research. This will help address the knowledge gaps that practitioners have on how ADHD affects women. Improving the knowledge that practitioners have on ADHD will hopefully result in faster diagnoses for girls and women, hopefully, with these diagnoses happening in childhood rather than adulthood. Porroche-Escudero & Popay (2020) acknowledges the existence of health inequities and highlight a toolkit that was developed in the United Kingdom to improve equity in conducting health research. I suggest that Canada implements a similar toolkit in order to improve equity in health research in Canada. I also believe that this will help in increasing the health research conducted on women in general.

This toolkit serves as a point of comparison for Canadian policymakers to create a similar toolkit. Since the U.K. has similar government and healthcare structures to Canada, the implementation of a similar solution is likely be feasible for the Canadian government and healthcare practitioners to implement. However, this solution alone likely will not be able to tackle the issue of underdiagnoses illnesses. As a result, I add to the idea of this toolkit by pairing it with program-based solutions and increasing health research for women.

Recommendation 2: Creating partnerships with community organizations and non-traditional actors

Murdock (2020) states that having equitable access to health services facilitates earlier diagnosis and have lasting positive impacts on one's physical, mental, and emotional health. This note supports my recommendation of collaborating with non-traditional groups, organizations, and educators that can better support girls and women with ADHD. These collaborations and partnerships could help women who have no other health ailtments and suspect they have ADHD and women have been diagnosed with another cognitive disability or illnesss and want to see if they also have ADHD. I argue that collaborating with non-traditional actors will make these services more inviting for women to reach out to on their own. These collaborations can act as places of support where women are more comfortable to ask questions and learn about their disability than reaching out to their family physician.

Examples of non-traditional actors include the subscribers or listeners of channels or influencers like How to ADHD on Youtube, 'The Pysch Doctor MD' on Instagram, 'Little Miss ADHD' on Tiktok, and 'ADHD as Females Podcast' on Spotify (McCabe, 2023; Patel, 2023; Hamdani, 2023; Farmer & Mears-Reynolds, 2023). Although two of these individuals are doctors, they emphasize that the advice or experiences they provide on their channels should not be mistaken for medical advice (Patel, 2022; Hamdani, 2022). This demonstrates how even people that are medically trained have to give a disclaimer to the information they spread online, showing the importance of having policy recommendations that can be trusted and endorsed by public health practitioners. Two of these channels are run by women who are not medical professionals but women who share with their audience information they have learned throughout their life experience with ADHD (McCabe, 2023; Farmer & Mears-Reynolds, 2023). With the collaboration of individuals and organizations, I believe that it is important to work with a wide selection of individuals to get a larger breadth of the female experience with ADHD. For instance, How to ADHD (McCabe, 2023) is a Youtube channel run by a white woman that has served as a resource for women and men that have ADHD. However, in order to continue wokring with my intersectional feminist approach, I would encourage collaborating with people like Patel (2022) or Hamdani (2022) as well, as they are able to share aspects of how their ethnicity or racial identity has affected their experiences. Moreover, even if influencers do not explicitly share about how all aspects of their identity has affected their experience living with ADHD through their content, I believe that the presence of having someone that can relate to patients on multiple levels is still impactful.

These collaborations can be facilitated both in-person at provincial levels and can be made accessible to people across Canada through hybrid models that incorporate virtual aspects or local smaller partnerships. Although each province has their own approach to health-care, I believe that a pilot program or initiative could be implemented in one province and this could then be tweaked depending on the province. However, since a lot of non-traditional support groups are already online, I believe that it would be feasible to adopt hybrid programs. The development of these programs might face scrunity from healthcare practioners that hold the beliefs that they do not need to reach out to external individuals or organizations for further knowledge or support in providing care to patients. In the event that some practitioners may not support these solutions, I advocate for these collaborations and partnerships to be done with individuals that see the benefit of it and are interested in increasing equitable access of care for racialized women. I argue that having practitioners that are genuinely interested in supporting these recommendations is more likely to result in care that is inclusive, equitable, and safe for patients. An issue that may arise with the implementation of this recommendation is that policymakers and Canadians may feel that these collaborations are encouraging the use of non-medical groups. However, this can be combatted through the appropriate marketing of these collaborations, specifically emphasizing that these collaborations and partnerships are happening at publicly funded healthcare centres. An issue that may arise with implementation is the upfront costs that federal and provincial governments have to commit to in order to facilitate these partnerships.

Other partnerships that I suggest are with non-profit organizations that either support women and people with cognitive disabilities and mental health issues. For instance, collaborating with the Centre for ADHD Awareness in Canada the Canadian Mental Health Association, Autism Canada, and ADDitude may help in providing more information on the experiences of women with ADHD and the co-existing illnesses that many patients have (Centre for ADHD Awareness Canada, 2023; Canadian Mental Health Association, 2023; Autism Canada, 2023; ADDitude, 2023). Since these are non-profit organization, there may be fewer costs associated with getting them to agree to a partnership as opposed to an ADHD lifestyle coach or influencer who relies on their work for a living. This may help in ruling out other illnesses that practitioners may confuse with ADHD and also help in diagnosing ADHD in conjuction with another illness or disability.

In addition to working with individuals and organizations, I argue that there should be opportunities for educating teachers to be better equipped to understand how ADHD presents in girls. This could be in the form of creating and giving trainings to teachers so they can pinpoint what to symptoms to look for in girls. However, the way that girls symptoms' present differs from boys, this may make it difficult for teacher's to spot, even if they are aware of these differences. As a result, in order to make this solution more effective, I suggest pairing it with a with a plan for teacher's to create comfortable and safe spaces for their students where they can have conversations with them about their daily life and approach to learning. While this solution can be helpful, it must be used in conjunction to other recommendations, as it is may too be much to rely on teachers for diagnosing children. However, since many teachers often recognize ADHD in boys and this helps them receive diagnoses faster, it would be helpful to see improvements in this are for diagnosing girls as well.

Conclusion

Throughout my research project, I named institutionalized racism and sexism as factors that contribute to the underdiagnosis of cognitive disabilities for racialized women. I paired my intersectional feminist analysis with a review of policies meant to protect equality rights and of diagnosing criteria and systematically reviewed literature in feminist and gender studies, and public health. The exploration of my research question contributes to existing Canadian literature on health inequities by identifying institutionalized racism and sexism as factors in the Canadian healthcare systems. I suggest increasing health research of racialized women and educating practitioners on these findings and forming partnerships between healthcare facilities and community-based organizations that support women with ADHD. I argue that these recommendations will improve womens' access to receiving diagnoses for cognitive disabilities and other healthcare services. However, in order to ensure that multiple areas are targeted in these solutions, I recommend that both recommendations are implemented. Since there is a minimal amount of health research conducted on how ADHD presents in women, some individuals may still be undiagnosed, and some diagnosed individuals may refrain from participating in studies that advance health research in this area, there may be other factors that answer my research question that I was unable to explore in this paper.

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