VIEWPOINT

From Cultural to Structural Competency—Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism

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Reckoning With Social Threats to Mental Health

Psychiatrists in training launch their careers in a time of inequalities and structural barriers to their patients' health. Many believe that the uncertain funding and regulation of the US health care system and a frayed social safety net have led to a crisis in mental health care. The United States has fewer mental hospital beds per capita than almost all peer countries, while US suicide rates are at a historic high.[1] Prisons and jails have become the largest provider of "care" of those with severe mental illness. Systemic violence and discrimination based on race, ethnicity, religion, sex, and sexual orientation have increased.[2] These broader forces not only likely contribute to psychiatric disorders but also make living with these disorders significantly more difficult.[3]

Over the last 50 years, psychiatric training and education have incorporated the revolution in the neurosciences. At the same time, psychiatric education has paid little attention to the powerful social determinants of mental health, which call on us to rigorously train our residents to understand and work at systems levels to eliminate the structural causes of illness. While cultural competency initiatives train residents in beliefs and behaviors of patient groups that experience health inequalities, cultural competency often falls short of systemic intervention. As a result, psychiatrists may not have the tools to improve their patients' outcomes, which may lead to professional burnout, departure from clinical practice, and severe shortages of psychiatrists in the public sector.[4]

As psychiatrists also trained in the social sciences, we have adopted what we call a structural competency approach[5] in training residents in US programs to address the social determinants of mental illness. The approach builds on a rich tradition of social and community psychiatry in the United States by specifying competencies for clinical training based on the following 3 fundamental principles: (1) understanding patients' experiences of illness in the context of structural factors (eg, unstable housing and violent neighborhoods leading to anxiety and trauma-related disorders), (2) intervening to address structural factors at institutional levels (eg, to work with community groups to promote recovery, to collaborate with schools and law enforcement to divert symptomatic people from arrest to clinical care, or to testify to city and state legislatures on the association between housing availability and mental health), and (3) developing community connectivity and structural humility, a posture of collaboration with community leaders and with other disciplines and of patience with the slow pace of structural change. These competencies are critically important for improving mental health outcomes for patients who are socially marginalized by virtue of their race, ethnicity, sexual identity, socioeconomic status, and where they live and work. Structural factors, such as inequalities in law enforcement, housing, education, access to health care, and other resources, ultimately shape the ways in which individuals experience and recover from illness. The term *structural* brings into focus institutions and policies that can be altered to promote health equity, while *competency* signals that there are tangible skills clinicians should acquire to address the social structure factors that act as barriers to improved mental health outcomes. Because physicians learn through practice, this shift in focus from individuals to institutions requires bridging the gap between the literature documenting social determinants of health and clinical strategies to rectify them.

Integrating Social Theory and Clinical Practice

Along with clinical educators from leading medical centers across the country, we are developing structural competency curricula (see structuralcompetency.org) for trainees. We present herein some general principles from psychiatry residency programs at our 3 institutions, including New York University, University of California, Los Angeles, and Yale University. While we have developed our curricula independent of each other, they converge on major points. First, we believe that all residents need training in structural competency as a fundamental aspect of what it means to be a psychiatrist. Regardless of whether one plans to become a psychotherapist or a laboratory scientist, rigorous training in structural competency is as central to psychiatric training as psychopharmacology or neurobiology. We must take the results from neuroscience that show the influence of social environment on biology and symptom expression (eg, in neuroplasticity and epigenetics) and then translate the findings from social science to intervene on the social environment.

Second, our institutions have instituted didactic courses and seminars that draw interdisciplinary faculty from psychiatry, anthropology, sociology, medical humanities, and health policy to cover germane topics. These topics range from race, sex, and socioeconomic class in psychiatric diagnosis, treatment, and pharmaceutical marketing to the history of psychiatric deinstitutionalization, the politics of the "recovery movement," and the association between mass incarceration and mental health. These courses provide substantive knowledge about the structural determinants of

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mental health and a theoretical framework that residents use in their clinical practice. In the process, we foster “critical thinking” skills that residents can use outside of the classroom setting.[6]

Third, we link theory with practice through structural competency rotations. New York University requires second-year residents to rotate at a New York State mental health clinic in Harlem, where a peer (a person with lived experience of a severe psychiatric diagnosis) mentors residents on visits to community organizations and social agencies to build relationships between the clinic and the community and to gather information for an online community resource map that the clinical team uses in treatment planning. Similarly, Yale University has developed a structural competency community initiative that pairs residents with community residents and peers to tour local neighborhoods and service agencies. Residents complete assignments, such as taking public transportation to a clinic or service agency, surviving on $2 a day, and finding fresh produce in a neighborhood, that confront residents with the structural factors shaping illness (eg, food insecurity, unemployment, and unsafe housing) and ways they can be alleviated. Ultimately, the goal is to inculcate an enduring habit of observing patients' living conditions and continuously educating oneself about structural barriers to mental health.

Fourth, research and advocacy are critical components of structural competency. They engage residents' imaginations and hope in alleviating many of the seemingly intractable social forces that lead to illness and exacerbate suffering. At New York University, residents document and analyze the association between community engagement efforts and treatment planning, referrals, and patient outcomes. The University of California, Los Angeles, has a clinical ethnography program in which residents write self-reflective field notes as a part of assertive community treatment teams. With faculty supervision focused on identifying the structural vulnerability[7] of patients, residents analyze their notes to identify the ways in which homelessness, incarceration, and gentrification shape the experience and course of severe mental illness in Los Angeles. At Yale University, residents participated in a mentored policy advocacy program in which they helped to write 2 bills to improve access to mental health services and lobbied the Connecticut legislature, which enacted both bills into law. While not all residents will pursue research or policy advocacy in their professional careers, giving them the tools to do so (when critical to improving patient outcomes) will foster the participation of psychiatrists in both knowledge production about mental health equity and their participation in health policy, where their perspectives as practitioners are needed.

Conclusions

The conditions that challenge psychiatry residents make it impossible for us to ignore the social predicament of our most vulnerable patients. When we incorporate the principles of structural competency, psychiatry addresses the structural problems of communities that make people sick and keep them from getting well.

ARTICLE INFORMATION

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