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Structural competency in mental health nursing: Understanding and applying key concepts

Roberta Waite *, Dena Hassouneh

Drexel University, United States of America

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ABSTRACT

Achieving mental health equity requires that nursing address structures that impede the ability of individuals and populations to achieve optimal mental health. Consistent with calls for structural change, this paper intends to promote structural competency in mental health nursing by applying this concept to the field. The first half of the paper discusses structural competency and key concepts vital for its development, namely, structure, social influencers of mental health, equity, structural justice, and historical understanding. In the second half we apply structural competency to mental health nursing at the educational, practice and system levels and conclude with recommendations for change.

Enhancing structural competence to promote mental health equity

Assuring that conditions of optimal mental health are provided for all people should be a collective goal of societies. But structural contexts influence access to resources and exposure to stressors inequitably across populations, resulting in social conditions that create and perpetuate avoidable mental health inequities. In response to this problem, scholars and policy makers have worked to create educational and social policy change to improve health in populations who have suffered from systematic societal disinvestment and eliminate health inequities (Crewe & Gourdine, 2019; Gil-Rivas, Handrup, Tanner, & Walker, 2019; Spencer, Raman, O'Hare, & Tamburlini, 2019; Williams, Phillips, & Kaoyama, 2018; World Health Organization, 2018). Political will and justice-oriented action is necessary to redress the injustice of inequities.

Striving for mental health equity implies that every person has a fair and just opportunity to attain optimal mental health which requires global and societal structures be aligned with this goal including a constellation of approaches that improve prevention, diagnosis, and treatment of mental ailments to lower morbidity (Shim, Kho, & Murray-García, 2018; Spencer et al., 2019). Increasingly, evidence compels us to consider factors beyond both clinician offices and entire health care systems to tackle social influencers of mental health and other structural barriers (Shim et al., 2018). Consistent with recent calls for structural change, the purpose of this paper is to promote structural competency in mental health nursing by applying this concept to the field. Structural competency offers clarity about how structural elements impact mental health in individuals and populations. We define structural competency as the ability to recognize the ways in which economic, political, and other societal structures intersect to create structural vulnerability in populations whose positionality imposes patterns of inequity and suffering and take appropriate action to effect change (Metzl & Petty, 2017; Quesada, Hart, & Bourgois, 2011). The paper begins by reviewing the concept and role of structure, social influencers of mental health, equity, structural justice, and history as integral to structural competency. In the second half of the paper we apply structural competency to mental health nursing at the educational, practice and system levels and provide recommendations for change. Although the concepts and recommendations offered in this paper can be applied to any national context, we frequently use the United States (US), the nation with which we are most familiar, to exemplify their application.

Key concepts for understanding structural competency

Structures

Metzl and Hansen (2014) observed that structure is a concept with a complex theoretical history "from Marx to Giddens to Levi-Straus" (p.128). We acknowledge this theoretical history while adapting and expanding on Metzl and Hanson's conceptualization of structure. We define structure as a multi-dimensional construct with four components:

* Corresponding author.
E-mail address: rlw26@drexel.edu (R. Waite).

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1) infrastructure such as roads, buildings and transportation networks, and food, water, and waste distribution systems; 2) assumptions embedded in language reified in educational settings and the media that privilege some groups while disenfranchising others; 3) economic and financial policies that create and perpetuate gaps in wealth and access to education and health care; and 4) diagnostic and bureaucratic approaches to biomedicine that reinforce inequities.

Structures determine the means by which classes of individuals, often based on the positionality of race, ethnicity, social class, sexual or gender orientation, disability, religion, immigration, or nationality, become vulnerable to disease. An uneven distribution of power leads to inequities in access to resources and opportunities, a sense derservedness or not, and the tendency to recognize what it means to be treated justly or suffer injustice (Gajaria et al., 2019; Oberlander et al., 2019). Structural elements are the underlying mechanisms that create mental health inequities in oppressed groups (Hicken, Kravitz-Wirtz, Durkee, & Jackson, 2018; Shim et al., 2018). For example, racism, inequitable access to education and housing, and economic structures unite to produce conditions of poverty and other forms of social inequality that result in adverse mental health outcomes.

Social influencers of mental health

Social influencers of mental health are the environments where individuals reside, learn, work, play, worship, and age that alter mental health outcomes and risks (Shim et al., 2018).

These influencers are affected by the distribution of money, power and resources within and across nations (Epplin & Ford, 2018; Sederer, 2016). Social influencers of mental health are damaging largely via the body's stress response system; over time, stressful environments adversely change our psychology and physiology causing illness. Recognizing the impact of the social influencers of mental health (otherwise known as social determinants) is integral to structural competency. The authors prefer to use the term "influencers of health" rather than "determinants of health." We see it as more representative of factors that impact health; the word determinant connotates a fixed perspective or fate while the word influencer represents power structures that shape outcomes that can be changed.

Social influencers of mental health are essentially the same as the social influencers of chronic physical health conditions which can be tackled via policies and programs, environmental modifications, and both collective and personal decisions within society (Compton & Shim, 2015). Many common mental disorders are influenced by a range of social (adverse childhood experiences; discrimination), economic (unemployment and underemployment; poverty), and physical environments (poor housing quality and housing instability; exposure to toxins) that are detrimental to individuals and populations at various stages of life. Risk factors for a host of mental disorders are strongly linked with social inequalities; greater levels of inequality are associated with higher levels of inequality in risk (Sederer, 2016). Not only do individuals disproportionately suffer who are impoverished and deprived, persons at the midpoint of the social gradient are distressed too. Intentional actions to improve conditions throughout all life stages can afford opportunities for both improving population mental health and lowering risk of those mental disorders that are linked to social inequalities.

A public health approach framed mainly around social justice allows one to see how social influencers of mental health relate to each other in intricate ways, wielding their effects capriciously across the lifespan (Compton & Shim, 2015). Social influencers of mental health deliberately act in concert to effect unfavorable mental health outcomes and inequities. This stems from the calamitous effects of decisions arising from public policies and social standards that are detrimental to some while benefitting others. Moreover, these social influencers are principally accountable for intentional practices that create gender, race, and class-based health inequities. Recognizing the complex interplay of social influencers of mental health on individuals and populations will promote the elimination of mental health inequities and highlight opportunities for prevention (Compton & Shim, 2015).

Equity

Equity is an approach that provides more to people who do not have much and not as much to people who have more. Accordingly, equity diminishes inequities by allocating resources and burdens within and across populations in ways that promote fairness. Justice, an ethical principle aligned with equity, acknowledges that some facets of health inequity are invisible and that historical, discriminatory and oppressive structures shape and are embedded in policies and processes at multiple levels (Hall, 2019). An equity lens is not aligned with a basic needs approach or poverty approach which places emphasis on individuals who are impoverished and the disempowered without linking their status to rich, powerful and over-privileged (Hall, 2019). Consequently, the foundational assumption is that some populations and communities are deprived not merely by individual choices but because of structural inequities (e.g., education, housing, employment and income) (Agbedia, 2019).

Structural justice

Structural justice reveals how oppression and re-victimization is inherent in the nature of structures requiring a response of unyielding restructuring (Burnett, Swanberg, Hudson, & Schminkey, 2018). Pervasive structural injustice is the result of oppressive practices embedded in unquestioned norms, habits, and symbols. Distinctive markers that frequently designate whether individuals or populations are subjugated (disadvantaged) or more liberated (privileged) by structural injustice include gender, race, sexuality, class, disability and national origin.

Toporek (2018) asserted that societal systems and structures must "develop and exercise capacities" that influence opportunities for individuals and communities "to live a good life as they define it (p.94)." Hence, an underlying tenet of structural justice entails purposeful action that intentionally changes the system and its structures to attain equity and promote human dignity. Structural justice envisions a humane system based on the notion that we are part of a common interdependent experience regardless of our social location, allowing our innate abilities for health and well-being to flourish. Ultimately, a structural justice approach is an ethical imperative and essential to guide practices intended to undo structural oppression, otherwise known as structural reconciliation (Burnett et al., 2018; Zurba, 2015).

Considering the above-mentioned key concepts, advocating for structural changes to promote social justice and mental health equity is about improving the health and well-being of individuals, communities, and populations experiencing oppression and inequality as well as being responsible nurse scientists, faculty, and clinicians. Change in educational, practice, and system settings is needed to extend the view of mental health ailments from an individual to public health lens. Ford-Gilboe et al. (2018) contended that promoting mental health equity is both a social justice and a practical matter that entails attending to the pressing health needs of individuals, communities, and populations as well as addressing present-day and historic injustices unveiled in core social structures, systems, and policies; these are the root causes of mental health inequities.

Connecting history with contemporary structures and social influences of mental health

The world is characterized by profound inequities both within and across nations. To understand how current structures and structural processes produce and reproduce injustice, one must have an accurate foundational understanding of how past structures have developed, operated in the past, evolved over time and are currently

operationalized. James Baldwin stated,

> "For history, as nearly no one seems to know, is not merely something to be read. And it does not refer merely, or even principally, to the past. On the contrary, the great force of history comes from the fact that we carry it within us, are unconsciously controlled by it in many ways, and history is literally present in all that we do. It could scarcely be otherwise, since it is to history that we owe our frames of reference, our identities and our aspirations (Shadravan & Bath, 2019, p. 2)."

For centuries, colonialism and imperialism (i.e., a dominant group formally or informally applying economic, political and social power and enforcing values and practices on subjugated groups, for the gain of the dominant group) have created inequitable health outcomes. Both entail collective structural advantages across time and generations by a select population who align based on a shared identity, affiliation or circumstance (Borell, Barnes, & McCreanor, 2018). Specifically, colonialism and imperialism are racialized "processes of dispossession" (Jones, 2008, p. 919) that have primarily been perpetrated by "Europeans or peoples of European descent against non-Europeans: the peoples of the Americas, the Caribbean, Africa, the Pacific Islands, Australia, New Zealand, India, South and South-East Asia and the Middle East" (p. 922). Racial ideologies asserting the superiority of European religion, cultures and civilizations over "the inferior, uncivilized and barbaric nature" (Jones, 2008, p. 922) of non-Europeans have long served as justification for colonialist and imperialist actions. Historical methods of dispossession have included ethnic cleansing, removal of indigenous people from their lands, annexation of private property, land, and resources, and coercive control of labor through compulsory labor laws and taxation regimes (Cavanaugh & Vericini, 2017; Jones, 2008).

Reification of colonial racialized "civilizing" discourses continue to be used as justification for these and other violent actions worldwide, which in turn both reflect and produce structural inequities (Hickel, 2018). Examples include the claim that Western aggression in the Middle East and Central Asia stems from a desire to promote democracy and women's rights (rather than exploit land and resources), and President Trump's efforts to exclude Middle Eastern, Central American, and Mexican immigrants and refugees from entering the United States to avoid an influx of people from "shithole" (i.e. "inferior") countries (Altawaiji, 2014; Ettinger de-Cuba, Bovell-Ammon, & Cutts, 2019; Gee & Shen, 2018; Hauslonher, 2019).

The historical effects of colonialism and imperialism are seen not only across but also within nations. Recognizing that countries affected by colonialism and imperialism have overlapping but distinct histories, we use the US as an example of how historical processes impact mental health equity in a single nation. In the US, native and African populations endured chattel slavery. Whiteness continues to confer dominance and structural privilege to groups who are able to claim it. As such, when Europeans came to the US, individuals were recognized chiefly by their country of origin and the term "white" was not in existence; however, with upheaval and rebellions, the reigning elite in the settler colonies grasped the capacity for working class Europeans and blacks to conquer the instituted social order. Consequently, ruling elites started giving individuals who were poor and of European ancestry token-level integration into the prevailing racial structure. Being able to take part in slave patrols was an integral illustration of this approach however these class-based strategies did not provide poor white individuals with any significant upward mobility. Relatedly, this launched the process to establish the category white by making it appear that Europeans and their "pure" descendants were superior to all other groups (Cabrera, 2017). As noted in Galonnier (2015), DuBois remarked that it is vital to be acknowledged as white to benefit from the *wages of whiteness* in a racially stratified society such as the US. Explicitly, whites could be poor but nevertheless they were not black or native and this social boost for some through racial debasement for others was fundamental to the construction of whiteness— at its core, whiteness disparages persons who do not phenotypically resemble Europeans, particularly those with black and brown skin. Whiteness, a social concept therefore, is a distinctive form of social oppression.

The explicit denial of rights (e.g., voting, immigration and naturalization, reading, gun ownership, property ownership, and the right to intermarry) to those considered non-white produced a system of classification through exclusion in the US (Cabrera, 2017). Thus, the system embarked on a journey to delineate whiteness by repudiating rights to persons of black and brown skin domestically as well as non-white immigrants and their descendants. Those untouched by these rulings by default were labelled white since they continued to have complete entrée to their "inalienable" rights. This is a hegemonic perspective such that white is often framed in the US as the standard for humanity and civilization as well as being an American (Cabrera, 2017). The practice of whiteness across time has granted more economic opportunities (privilege), improved access to housing accommodations, credit, healthcare, political representation, employment, freedom of speech and police protection for some but this change was only possible by denying rights and opportunities to black and brown-raced individuals. The amalgamation of these historical actions contributed to the formation of a US system of white supremacy. Undeniably, this was much more than merely the collective of anti-minority views; it originated and persists as a self-perpetuating system of racial oppression (Cabrera, 2017).

The structures and systems briefly described above operating across time (historical and current conditions) influence mental health equity in the US. Toward the end of the 19th century, the mental health field customarily perceived blacks and African Americans as both biologically inferior with structurally smaller brains and innately inclined for hard labor. Thus, mental health professionals have been complicit with long-standing racism by pathologizing blackness, thereby upholding systems of white supremacy. As an illustration, Dr. Benjamin Rush, often referred to as the father of American Psychiatry, founded the diagnosis "negritude" (Warren, 2016). He labelled this as a form of black leprosy causing the skin to become black, lips to appear big, hair to develop as a woolly texture, and the persons nose to look flat; if left "untreated" this disease would become intergenerational (Warren, 2016). Rush believed that blacks obtained their color not because of the melanin but rather because of this disease (i.e., negritude). Around 1792, Rush noticed white spots on the body of Henry Moss (who was enslaved); in three years his skin appeared practically white in color. Today, we know this hereditary disease as vitiligo. Henry Moss's gradual loss of skin pigmentation, for Rush, supported his notion that the standard for the color of a "healthy person" was white (Shadravan & Bath, 2019). Rush viewed blacks as safe to perform servant responsibilities but unsafe as sexual partners, and recommended they be medically supervised (Powell, 1999). Rush also promulgated that a white woman who was with a black man would acquire a dark color and features of a black person if she married or resided with him (Wolfensberger, 1983). Thus, blackness was seen as the ultimate pathogen, endangering black and white raced individuals (Powell, 1999). In 1971 another psychiatrist, Thomas Szasz, reanalyzed Rush's work and supported the theory of negritude at a time when the country was still grappling with the social and legal changes caused by passage of the Civil Rights Act of 1964 (Wolfensberger, 1983).

Moreover, African Americans had been labelled with mental health disorders when they stood up against oppression. For instance, enslaved individuals were labelled by Dr. Samuel Cartwright as having drapetomania, a conjured up mental disease which supposedly led enslaved Africans to run away; quite naturally the oppressor's treatment for prevention was whipping. Cartwright's evaluation permitted the institution of slavery to avoid culpability rather than considering the desire of enslaved individuals to be granted liberty as a normal and adaptive reaction to an oppressive and pathological system (Medlock et al., 2017;

Shadravan & Bath, 2019). These mental health professionals sanctioned slavery as scientifically sound, ethically defensible, and aligned with natural order. Similarly, African Americans who fought for equality in the Abolitionist and Civil Rights movements were branded as schizophrenic due to their postulated pathologic longing for egalitarianism; mental health practitioners were pervasively complicit in producing mental health inequities (Medlock et al., 2017).

History is clear that the oppression and subjugation of black and brown raced individuals and concomitant privileging of Eurocentrism and whiteness is rooted in ideological factors, as well as the past and present world order. Accordingly, historical and contemporary structures operate to hinder mental wellness. As our US example demonstrates, multiple life-course factors, involving history, biography and hierarchical social structures affect mental health outcomes.

Historical analyses of other countries affected by colonialism and imperialism have revealed distinct but also similar patterns (Fanon, 1952; Fernando, 2017; Grant, 2019). Educating nurses on structural competence is necessary along with understanding the role of historical and contemporary colonial and imperial processes that continue to affect people's lives and mental wellness; this must be a priority when striving to attain mental health equity.

Educating for structural competence

It is critical that nurses learn to distinguish how a multitude of concerns described clinically as symptoms, attitudes, or diseases (e.g., depression, nonadherence to medication, trauma, psychosis) also characterize the downstream effects of numerous upstream determinants of mental health such as zoning laws, urban and rural infrastructures, medicalization, or even common definitions of health and mental illness (Metzl & Hansen, 2014). Educating nursing students and practicing clinicians about structural competency and the key concepts underlying it is necessary for the development of this ability.

Currently, mental health nursing education offers inadequate information about social influencers of mental health and the role of history in determining these forces. Of particular concern, is the emphasis on cultural competency which tends to emphasize stereotypes (e.g., racial, ethnic and linguistic) by locating these cultural groups at a lower standard than dominant raced populations and professionals (Downey & Gómez, 2018). Cultural competency also often fails to effectively prepare nurses to address the structural causes of mental health inequities.

In contrast to cultural competency which tends to lack a critical perspective on systemic interventions, structural competency presents an opportunity to engage in ethical practice by avoiding negative judgments about persons whose mental health outcomes were generated by upstream structures beyond their control (Downey & Gómez, 2018). For example, individuals who reside in marginalizing conditions have a greater risk of numerous acute and chronic mental health concerns. Being informed about structures, the expression "marginalizing conditions" is used to bring awareness to the social, political, and economic circumstances influencing mental health and mental health care inequities. We must also strive to avoid the trend to describe marginalization as a feature of a person or groups, and instead denote it as conditions in which people exist. For instance, mental health concerns like anxiety, depression, and exposure to trauma (e.g., interpersonal and community violence) are more common among individuals subjected to socioeconomic hardship; these variations develop via numerous processes such as chronic stress, environmental hazards and discrimination (Ford-Gilboe et al., 2018).

Knowledge about the tools, skills and collaborations necessary to enhance an individuals' mental health outcomes is requisite. Colon's (2019) take on needed educational changes is noteworthy:

> "To teach structural competency not as a tool, but as a pedagogy of transformative action is to choreograph with our students and communities of concern a paradoxical double move: as we discern and search for the means of our healing from the structures of violence that delimit our freedom and life chances while in the full confidence that there is nothing wrong with us – not a damn thing wrong with us, but that the system must be transformed root and branch if we are ever going to achieve a full flourishing that many of us call being a human or, to put it more sharply, what freedom might feel like in our bodies/spirits (p. 32)."

Structurally competent nurses have the capacity to better understand and more effectively attend to social and institutional influencers of health (Jones et al., 2019; Mattwick & Woodgate, 2017). They also appreciate and recognize the influence of both disproportionate entrée to care and resources for negotiating the clinical encounter (Hansen & Metzl, 2016). As it relates to stigma, a common factor identified that adversely effects a person's access or willingness to engage in care, Metzl and Hansen (2014) acclaimed "if stigmas are not primarily produced in individual encounters but are enacted due to structural causes, it then follows that clinical training must shift its gaze from an exclusive focus on the individual encounter to include the organization of institutions and policies, as well as of neighborhoods and cities, if clinicians are to impact stigma-related health inequalities (p. 127)."

Nurses who have been prepared to be structurally competent are able to employ moral practice and deal with dominant Eurocentric models in nursing education. These models currently fail to address practices that create unjust social influencers primarily through unequal distribution of the resources necessary to produce mental health. Some of these influencers include disparities in the treatment individuals encounter from health care organizations as well as professionals based on their respective positionalities (Downey & Gómez, 2018).

Learning and applying models of decolonization, which are critical of Eurocentric paradigms, is important for promoting structural competency in nursing education. Settler Colonial Theory can also constructively critique dominant Eurocentric approaches to educating nurses about mental health. A decolonizing lens combats the ways in which power, privilege, and oppression are currently reproduced via racialized and ethnicized practices (Waite & Nardi, 2019). Thus, a decolonial lens would show how social inequality is upheld and likewise would identify and disrupt power hierarchies clearly delineating how knowledge is produced, situated and embodied. As mental health professionals, we should be highly critical of our profession's grounding in Eurocentric values and complicity with Western paradigms that establish inherent power structures and biased views deterring from our ability to optimize mental health for all.

In the following section, we provide an exemplar of a patient interaction that exemplifies a structural competency approach which strives to highlight human dignity and promote a justice-oriented stance in clinical encounters. It provides an illustration of how to attend to structural and contextual factors powerfully related to mental health inequity. The case reflects structures and contexts extant in the US.

Structural competency in practice at the individual level: a case example

Woolsey and Narrruhn (2018) defined structural competency as "the trained ability to assess and diagnose a patient's symptoms including the larger context in which they live their lives (p. 589)." Maria's case shows how a Psychiatric Mental Health Nurse Practitioner (NP) demonstrated this ability. The case provides more detail than is typically found in the literature on structural competency in an effort to reflect the complex nature of structural injustice and how it manifests clinically.

Maria's case

Maria presented seeking resources and support from a community organization serving survivors of intimate partner violence. The organization identified her as appropriate for one-on-one trauma counseling with the volunteer NP. Maria's psychiatric symptoms included severe nightmares and poor sleep, flashbacks to multiple episodes of child and

intimate partner abuse, anxiety, irritability, and hypervigilance. The NP gathered Maria's history which was significant for severe psychological and physical abuse during childhood perpetrated by both parents and a sibling; both parents had serious mental illness due to their own formative experiences with racism, extreme poverty, and war. Adverse conditions at home led Maria to leave at the age of 12 with subsequent gang involvement through her teens. She was also a survivor of severe intimate partner violence in previous relationships. At the time of her assessment, Maria was in her 30s and pregnant with twins. She had four other children ranging in age from 1 to 13 years old. One of the children had a particularly traumatic history having been kidnapped and separated from Maria at an earlier age for a year. Maria described multiple parenting challenges with this particular child. Maria's current relationship with the father of her twins Carlos was described as positive and supportive but Maria also expressed concern that Carlos did not contribute to the family financially. Carlos was underemployed and had difficulty finding employment due to his criminal record. Although fluent in both English and Spanish, Maria had not finished high school and her employment history had been limited to work that exacerbated her trauma symptoms. Maria lived in subsidized housing and was receiving TANF (i.e. Temporary Assistance for Needy Families) and food stamps to support her family. She expressed an interest in applying for Social Security Disability Insurance to obtain a more stable income, stating that multiple trauma triggers and overwhelming symptoms prevented her from working. Although Maria was covered by Medicaid, she did not have a primary care provider and was not seeing a psychiatrist or NP at the time of her assessment. She was distrustful of the health care system and had particularly negative feelings about Child Protective Services which had frequently intervened with families residing in the housing complex where she lived.

The NP verbalized understanding of Maria's concern about Child Protective Services and openly acknowledged that there are inequities in the system. During her assessment of Maria's history, the NP immediately recognized the roles that sexism, racism, colonialism, and poverty had played in Maria's family and personal history, giving rise to unequal opportunity, adverse childhood and adult experiences, and lack of education. The NP understood Maria's distrust of the system and worked to build a trusting relationship that validated her concerns while emphasizing her strengths as a person and as a mother.

After a few months of therapy, Maria found a hidden notebook with sexually graphic drawings belonging to her child. She came to therapy in tears and shared the notebook. The NP assessed the situation and determined that the child had been sexually abused during the year that she was separated from Maria. There was no evidence that the abuse was continuing. The NP worked with Maria to make an appointment for the child at a clinic that specialized in physical and psychological assessment of childhood sexual abuse. Maria was eager to have her child evaluated and followed through promptly.

Although the NP recognized that Maria continued to be limited by structures and social influences of mental health, over the course of their work together the clinician was impressed by Maria's resilience and commitment to being a good mother. During treatment, the NP served as Maria's "secure base," serving as a bridge and advocate while connecting Maria with vital resources for herself and her children including establishing with a primary care provider, establishing with a psychiatric prescriber, connecting Maria and her traumatized child with a play therapist, encouraging the development of healthy social supports and the setting of boundaries with abusers in her family as well as former intimate partners. After further assessment, the NP also worked to support Maria's application for Social Security Disability Income (SSDI).

Case analysis

In this case example, the NP recognized the influence of inequitable structures and social influencers on Maria's experiences as a child and adult and their connection to her trauma symptoms and life choices. In contrast to an individualistic view of health which would likely find fault with Maria's life choices and see her interest in SSDI suspiciously as a desire for secondary gain, or a cultural competency view that would seek cultural explanations for Maria's case, the NP's structurally competent view enabled an understanding of Maria's situation in the context of structural injustice while focusing on her strengths as a mother. This structural approach provided a foundation for the development of a strong therapeutic alliance despite Maria's lack of trust in the health care and child welfare systems. This trust provided the basis for their work together, including Maria's decision to disclose the disturbing sexual drawings she discovered and seek treatment for her child.

Structural competency at the system level

Structurally competent nurses not only understand the factors that affect individual mental health and have the ability to enact feasible interventions (Woolsey & Narrruhn, 2018), they also act on the systemic causes of mental health inequities by working to effect institutional and policy change. This work requires privileging the voices of disenfranchised populations and communities in educational and practice settings, and policy work that focuses on social justice and distributive justice. Spencer et al. (2019) argue that social justice is a matter of life and death. Relatedly, Valderama-Wallace and Apesoa-Varano (2019) reported that social justice is a fundamental principle of nursing professionalism, which confers a responsibility on nursing education institutions and practitioners to address those social influencers of inequity that are within their scope of influence. This responsibility manifests at the curricular level but also through more distal pathways in terms of research, advocacy, and leadership (Jones et al., 2019). Nurses must position themselves as allies of oppressed groups and actively reject common practices that reify and reinforce mental health inequities. Common examples include social and economic policies that create unequal access to mental health care and education at the local, national, and global levels. Such work involves respectful partnerships with populations, organizations, and communities and prioritizing population health over profit. Accordingly, policy and practice initiatives in clinical care are vital to informing mental health. For instance, health policies affect the structure and operationalization of health care systems. Similarly, public policies with downstream forces impacting a person's mental health include the tuition rates for post-secondary education, city and county zoning ordinances, as well as federal minimum wage laws. While initially these public policies may not appear to be health policies, they indeed direct the social influencers of mental health, which sequentially directs risk and in due course for mental health outcomes (Compton & Shim, 2015). This undoubtedly influences personal and population health. Also, political advocacy is key to achieving mental health equity (Sherer, 2016). Action must be universal and provided proportionate to need to make a positive difference since social influencers of mental health impact risk, including genetic risk caused by disparate distribution of opportunity (Allen, Balfour, & Marmot, 2014; Compton & Shim, 2015).

An important mechanism for creating system level change in nursing is to create standards for health care and educational institutions. These standards should include mandates that require structural competency at the clinician, organizational, national, and international levels. Examples of international and national standards include policies set forth by the World Health Organization, the International Council of Nurses, and various national level bodies such as the US-based Centers for Medicare and Medicaid that endorse and recommend structural changes to improve mental health equity. Examples of standards applied to health care organizations include documentation of clinician development and policies supporting structural competency, and service patterns and outcomes that contribute to and demonstrate mental health equity. Examples of standards for educational institutions include faculty and student preparation for structural competency, and admission and graduation patterns that are effective in promoting the kind of diverse workforce needed to achieve mental health equity.

Conclusion and recommendations for change

Learning about structural forces functions as an essential move toward acknowledging the maze of interpersonal networks, political/socioeconomic dynamics and environmental forces that are important for nurses to be aware of in clinical encounters. Simultaneously, structural competency offers a way to promote knowledge about mental health promotion, mental wellness and mental disorders, and offers conceptual tools for evaluating and changing structures that create vulnerability to disease that are based solely on a person's social location.

Addressing mental health inequities requires changes in how we educate for and practice mental health nursing while effecting institutional and social policy changes at the global, national, and community levels that create equal access to resources. Structural competency in nursing education and practice is essential to our ability to achieve mental health equity. It offers both a framework and a process for working effectively with disenfranchised individuals and populations and effecting institutional and social change. We offer the following recommendations for mental health nursing and nurses at all levels of preparation to engage with as they seek to improve their structural competency.

1. Acknowledge structures that impact clinical interactions using the structural vulnerability tool and develop and use similar tools appropriate for use in middle and low-resource nations (Bourgois, Holmes, Sue, & Quesada, 2017). Results from such tools can direct priorities for immediate intervention and follow-up processes to advance beyond mere problem recognition. Elevated vulnerability scores allow for timely triage by nurses to help meet basic needs. In the US, examples include vouchers for clothing, housing, food, legal services, rehabilitative therapies, and mental health and substance abuse treatments (Bourgois et al., 2017). Nurses must also develop familiarity with surrounding communities in which they operate, identify and develop community-centered social service resources to act on meeting patient needs. Operationalizing these processes in clinical practice will likely require development of interprofessional health care teams and coordination with community stakeholders. Similarly, in nursing education structural vulnerability tools help students reason with clarity, critically, and realistically regarding the ways social structures produce mental illness especially for individuals who are disinvested in by society (Bourgois et al., 2017). These steps help to construct clinical language about structure and can aid in transforming cultural interpretations to structural ones, which in turn allows for the development and implementation of structural interventions (Metzl & Roberts, 2014).
2. Understand history relevant to mental health diagnosis and have particular suspicion of race-based disparities in diagnosis. For example, the overdiagnosis of schizophrenia in African American men and similarly neurologic syndromes in Latin American people in the US were originally thought to arise from biological distinctions among "ethnic" populations. Overtime these disparities were acknowledged as originating from social or structural etiologies (Metzl & Roberts, 2014).
3. In practice, nurses must build collaborative relationships with other disciplines and stakeholders that work with individuals who are vulnerable to optimize health. Such collaboration is needed to tackle the various entwined structural forces that have an effect on mental health. For instance, stable safe housing is a key facet that can impact a person's mental health. Programs such as Medical-Legal Partnership in the US are often instituted in federally qualified health centers (FQHCs; a community health center) which offers services to all individuals irrespective of their ability to pay for care or insurance status. Medical-Legal Partnership links professionals such as advanced practice nurses and lawyers to bring legal assistance as a central part of an individual's health care to address the multifaceted needs of persons who are low-income. Such approaches broaden the lens to community-level factors by trying to meet essential needs such as safe housing rather than being solely concerned with addressing an illness (Metzl & Roberts, 2014). Another example is partnering with food distribution services such as the US-based Farms to Family (St Christopher's Foundation for Children, 2017) which supplies boxes of subsidized fruits and vegetables especially in areas considered a food desert. Nurse-led community-based FQHC's such as the Stephen and Sandra Sheller 11th Street Family Health Services operated in partnership with the Family Practice and Counseling Network serve as distribution sites working with community members to enhance distribution. Maynard et al. (2018) stated that food insecurity is an incessant worry even in high-income nations and is linked with poor mental health. Collaborative relationships among nursing professionals, community members and community organizations along with policy makers is vital to address social and structural influencers of mental health (Metzl & Roberts, 2014).
4. Broaden our knowledge base to include sociology, anthropology, history, critical race theory, and critical anti-discriminatory pedagogy to heighten consciousness about the ways racism and other systems of oppression are entrenched in institutions and function beyond individual bias. Colorblind policies that center on individuals often uphold racial structural injustice (Metzl & Roberts, 2014) and professional mental health nurses must be informed about this reality.
5. Deepen self-reflective practices and understand historical origins of race and racism. The predominance of liberal individualism in healthcare, along with pervasive culturalist and racializing practices in nursing education avoid dealing with structural conditions associated with mental health and healthcare and are therefore inadequate to redress inequities (Garneau, Browne, & Varcoe, 2016). It is necessary for nurses to implement skills that impart their caring practices from a contextual stand point to thwart racism and discrimination in healthcare and address mental health inequities. Critical thinking is essential to nurses' ability to link positionality with health and unearth the structural and systemic-related assumptions that provide a common basis for practice. Exploring their own experiences as structurally produced can promote nurses' development of this contextualized view of the world and promote awareness about how they can more effectively act against the effects of discrimination in mental healthcare. Embodiment of critical consciousness is then realized which goes beyond mere consciousness raising about the structural issues (e.g., racism and discrimination) driving mental health inequities— critical consciousness with action is needed (Garneau et al., 2016).
6. Professional nurses must politically advocate more vociferously about structural issues that affect patients and populations. The present-day political landscape in many high and middle resource nations often represents voices that fight for dismantling of government funded social-support systems and infrastructures that strive to mitigate the consequences of structural violence. Single entity professional nursing organizations need to partner to reconcile their power along with other like-minded constituents who will protest the ongoing dominance of neoliberal trends which perpetuate and extend current system flaws that do not allow for meaningful mental health benefits, especially for populations that are marginalized. Arguing for guaranteed equitable mental health and health care for everyone is a moral requirement and must be a shared goal (Metzl & Roberts, 2014).

Given that mental health nurses may work within stressed systems, structural competency is a means to increase awareness of the need to organize for transformative change and promote structural justice. Changes in structure are not accomplished by individual nurses alone.

Accordingly, structurally competent mental health care requires collective force, skill, and ingenuity; it also performs a vital role in

assisting mental health nurses to develop a vision of mental health as part of overall community well-being, which advantages both patients and nurses (Downey & Gómez, 2018).

References

Agbedia, O. (2019). Exploring inequity in health, an ecological approach. *International Journal of Forensic Medical Investigation, 4*(2), 35–39.

Allen, J., Balfour, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392–407.

Altawaiji, M. (2014). Neo-imperialism thesis: Post-9/11 US and Arab world relationship. *Arab Studies Quarterly, 36*(4), 303–313.

Borell, B., Barnes, H., & McCreanor, T. (2018). Conceptualising historical privilege: The flip side of historical trauma, a brief examination. *AlterNative, 14*(1), 25–34.

Bourgois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017). Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Academic Medicine: Journal of the Association of American Medical Colleges, 92*(3), 299–307.

Burnett, C., Swanberg, M., Hudson, A., & Schminkey, D. (2018). Structural justice: A critical feminist framework exploring the intersection between justice, equity and structural reconciliation. *Journal of Health Disparities Research and Practice, 11*(4), 52–68.

Cabrera, N. (2017). White immunity: Working through some of the pedagogical pitfalls of "privilege." Journal Committed to Social Change on Race and Ethnicity, 3(1), 78–90.

Cavanaugh, E., & Vericini, L. (Eds.). (2017). *The Routledge handbook of the history of settler colonialism*. New York: Routledge.

Colon, E. (2019). *This ain't no tool. This ain't no toolbox*. In Hansen, & Metzl (Eds.). Springer.

Compton, M., & Shim, R. (2015). The social determinants of mental health. *Focus, 13*(4), 419–425.

Crewe, S., & Gourdine, R. (2019). Race and social policy: Confronting our discomfort. *Social Work in Public Health, 34*(1), 1–11. https://doi.org/10.1080/19371918.2018.1562397.

Downey, M., & Gómez, A. (2018). Structural competency and reproductive health. *AMA Journal of Ethics, 20*(3), 211–223.

Epplin, W., & Ford, T. (2018). *Beyond the clinic: A national health equity review*. Health and medicine Policy Research Group. Retrieved from http://hmprg.org/wp-content/uploads/2018/07/National-Health-Equity-Research-Paper.-March-2018.pdf.

Ettinger de-Cuba, S., Bovell-Ammon, A., & Cutts, D. (2019). Constructing invisible walls through national and global policy. *Children, 6*(7), 83. Retrieved from https://doi.org/10.3390/children6070083.

Fanon, F. (1952). *Black skin, white masks*. New York: Grove Press.

Fernando, S. (2017). *Institutional racism in psychiatry and clinical psychology: Race matters in mental health*. Cham, Switzerland: Palgrave Macmillan.

Ford-Gilboe, M., Wathen, C., Varcoe, C., Herbert, C., Jackson, B., … Browne, A. (2018). How equity-oriented health care affects health: Key mechanisms and implications for primary health care practice and policy. *The Milbank Quarterly, 96*(4), 635–671.

Gajaria, A., Izenberg, J. M., Nguyen, V., Rimal, P., Acharya, B., & Hansen, H. (2019). Moving the global mental health debate Forward: How a structural competency framework can apply to global mental health training. *Academic Psychiatry, 43*, 617–620. https://doi.org/10.1007/s40596-019-01073-3.

Galonnier, J. (2015). The racialization of Muslims in France and the United States: Some insights from white converts to Islam. *Social Compass, 62*(4), 570–583. https://doi.org/10.1177/0037768615601966.

Garneau, B., Browne, A., & Varcoe, C. (2016). Integrating social justice in health care curriculum: Drawing on antiracist approaches toward a critical antidiscriminatory pedagogy for nursing. In *2nd International Critical Perspectives in Nursing and Healthcare, Sydney, Australia*. Retrieved from http://sydney.edu.au/nursing/pdfs/critical-perspectives/blanchet-garneau-browne-varcoe-integrating-social-justice-2.pdf.

Gee, B. & Shen, A. (2018, January 29). Are non-white immigrants 'dregs'? USA Today.

Gil-Rivas, V., Handrup, C., Tanner, E., & Walker, D. (2019). Global mental health: A call to action. *American Journal of Orthopsychiatry, 89*(4), 420–425.

Grant, D. (2019). *Black men, intergenerational colonialism and behavioral health: A noose across nations*. Cham, Switzerland: Palgrave Macmillan.

Hall, C. (2019). Epidemiology and ideology: Why health equity is problematic in the United States. *Florida Public Health Review, 16*(6). Retrieved from https://digitalcommons.unf.edu/cgi/viewcontent.cgi?article=1207&context=fphr.

Hansen, H., & Metzl, J. (2016). Structural competency in the U.S. healthcare crisis: Putting social and policy interventions into clinical practice. *Journal of Bioethical Inquiry, 13*(2), 179–183.

Hauslonher, A. (2019, September 24). During first two years of 'Muslim ban,' Trump administration granted few waivers. The Washington Post. Retrieved from: https://www.washingtonpost.com/immigration/during-first-two-years-of-muslim-ban-trump-administration-granted-few-waivers/2019/09/24/44519d02-deec-11e9-8dc8- 498eabc129a0_story.html.

Hickel, J. (2018). *The divide: Global inequality from conquest to free markets*. New York. W. W: Norton.

Hicken, M., Kravitz-Wirtz, N., Durkee, M., & Jackson, J. (2018). Racial inequalities in health: Framing future research. *Social Science and Medicine, 199*, 11–18.

Jones, B. (2008). Race in the ontology of the international order. *Political Studies, 56*(4), 907–927.

Jones, R., Crowshoe, L., Reid, P., Calam, B., Curtis, E., Green, M., … Ewen, S. (2019). Educating for indigenous health equity: An international consensus statement. *Academic Medicine: Journal of the Association of American Medical Colleges, 94*(4), 512–519.

Mattwick, A., & Woodgate, R. (2017). Social justice: A concept analysis. *Public Health Nursing, 34*(2), 176–184.

Maynard, M., Andrade, L., Packull-McCormick, S., Perlman, C. M., Leos-Toro, C., & Kirkpatrick, S. I. (2018). Food insecurity and mental health among females in high-income countries. *International Journal of Environmental Research and Public Health, 15*(7), 1424. https://doi.org/10.3390/ijerph15071424.

Medlock, M., Weissman, A., Wong, S. S., Carlo, A., Zeng, M., Borba, C., … Shtasel, D. (2017). Racism as a unique social determinant of mental health: Development of a didactic curriculum for psychiatry residents. *MedEdPORTAL: The Journal of Teaching and Learning Resources, 13*, 10618. https://doi.org/10.15766/mep_2374-8265.10618.

Metzl, J., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, (1982), 103*, 126–133.

Metzl, J., & Petty, J. (2017). Integrating structural competency into an innovative pre-health curriculum at Vanderbilt University. *Academic Medicine, 92*(3), 354–359.

Metzl, J., & Roberts, D. (2014). Structural competency meets structural racism: Race, politics, and the structure of medical knowledge. *American Medical Association Journal of Ethics, 16*(9), 674–690.

Oberlander, J., Buchbinder, M., Churchill, L., Estroff, S., King, N…Walker, R. (2019). The Social medicine reader: Differences and inequalities. Duke University Press: Durham, NC. Retrieved from https://www.dukeupress.edu/Assets/PubMaterials/978-1-4780-0282-6_601.pdf.

Powell, W. N. (1999). *Structural oppression of African Americans in higher education*. Oregon State University, Corvallis: Unpublished doctoral dissertation. Retrieved from https://ir.library.oregonstate.edu/concern/graduate_thesis_or_dissertations/5x21tj74m.

Quesada, J., Hart, L., & Bourgois, P. (2011). Structural vulnerability and health: Latino migrant laborers in the United States. *Medical Anthropology, 30*(4), 339–362.

Sederer, L. (2016). The socialdDeterminants of mental health. *Psychiatric Services, 67*(2), 234–235. https://doi.org/10.1176/appi.ps.201500232.

Shadravan, S., & Bath, E. (2019). Invoking history and structural competency to minimize racial bias. *Journal of the American Academy of Psychiatry Law, 47*(1), 2–6.

Shim, R., Kho, C. E., & Murray-García, J. (2018). Inequities in mental health and mental health care: A review and future directions. *Psychiatric Annals, 48*(3), 138–142.

Spencer, N., Raman, S., O'Hare, B., & Tamburlini, G. (2019). Addressing inequities in child health and development: Towards social justice. *BMJ paediatrics open, 3*(1), Article e000503. https://doi.org/10.1136/bmjpo-2019-000503.

St Christopher''s Foundation for Children. (2017). Farms to family initiative. Retrieved from https://scfchildren.org/farm-to-families-%20initiative/.

Toporek, R. (2018). Strength, solidarity, strategy and sustainability: A counseling psychologist's guide to social action. *The European Journal of Counselling Psychology, 7*(1), 90–110.

Valderama-Wallace, C., & Apesoa-Varano, E. (2019). "Social justice is a dream": Tensions and contradictions in nursing education. Public Health Nursing, 1-9. Retrieved from https://onlinelibrary.wiley.com/doi/epdf/10.1111/phn.12630.

Waite, R., & Nardi, D. (2019). Nursing colonialism in America: Implications for nursing leadership. *Journal of Professional Nursing, 35*(1), 18–25.

Warren, C. (2016). Black interiority, freedom, and the impossibility of living. *Nineteenth-Century Contexts, 38*(2), 107–121.

Williams, S., Phillips, J., & Kaoyama, K. (2018). Nurse advocacy: Adopting a health in all policies approach. *The Online Journal of Issues in Nursing*. Retrieved from http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-23-2018/No3-Sept-2018/Policy-Advocacy.html.

Wolfensberger, W. P. (1983). Training Institute Publication Series (TIPS) 03(2), 15. https://digitalcommons.unmc.edu/wolf_tips/15.

Woolsey, C., & Narrruhn, R. (2018). A pedagogy of social justice for resilient/vulnerable populations: Structural competency and bio-power. *Public Health Nursing, 35*(5), 87–597.

World Health Organization. (2018). The WHO special initiative for mental health (2019–2023): Universal Health Coverage for Mental Health. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/310981/WHO-MSD-19.1-eng.pdf?ua=1.

Zurba, M. (2015). Building common ground: Learning and reconciliation for the shared governance of forest land in northwestern Ontario. University of Manitoba Winnipeg. Retrieved from http://umanitoba.ca/institutes/natural_resources/pdf/theses/Zurba,%20Melanie.PhD%202015.pdf.