VIEWPOINT

Advocacy as Key to Structural Competency in Psychiatry

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Structural competency is an approach to clinical training and practice that aims to improve health care by directing attention to the social inequities that are among the root causes of health disparities.[1] Recognizing these forms of social adversity may allow clinicians to better understand patients' predicaments. However, to move beyond mere recognition, psychiatrists must find ways to address social structural issues and work toward systemic change. Without specific actions, structural competency risks being an academic exercise. Advocacy is one crucial way to translate insights into the social determinants of health into structurally competent practice. In this Viewpoint, we argue that advocacy can be a key aspect of structural competency.

Professional organizations, as well as training and accreditation bodies, have recognized that physicians can play a vital role as health advocates.[2] However, some psychiatrists may see advocacy as beyond their mandate and expertise. Critics of advocacy argue that it involves political debates in which health care professionals have no special expertise and engages with contentious issues in which there is little consensus. However, scholars in population health and social medicine have long argued that addressing the social structural determinants of health is essential for effective prevention and health promotion. We believe that psychiatrists are well positioned as witnesses to mental health problems rooted in poverty, racism, colonialism, and structural inequalities to understand not only the proximate causes of disorders but also their social, structural, and systemic antecedents.

Advocacy as a Core Competency in Psychiatry

Advocacy includes health promotion activities that address not only the biological bases of mental disorder but also the social, cultural, environmental, behavioral, political, and economic factors that are major contributors to mental health problems and impediments to recovery. The scope of advocacy includes working with agencies and institutions to change health and social policy, modifying health care systems and clinical practices, educating and informing the public, and supporting coalitions and groups that seek to address the causes of illness. Advocacy thus requires a wide range of skills, including the ability to identify the right systemic levels and settings to promote change and the rhetorical skill to present evidence and arguments in ways that are compelling. Although most practitioners will not have all these skills, working together with other stakeholders, clinicians can lend their unique expertise to promote change and have a potential effect on health on a scale beyond what is possible through clinical care.

In relation to structural competency, 3 levels of engagement in advocacy can be distinguished: (1) recognizing and understanding the structural determinants of health and incorporating this knowledge into professional education, clinical practice, and community intervention; (2) supporting coalitions and collective action that aim to change policy and practice; and (3) initiating, mobilizing, and organizing action to challenge social injustices. This third level will be undertaken by only a few clinicians and researchers because of the high level of commitment that it requires. However, all 3 levels can make significant contributions to addressing structural inequities in health care.

Advocacy as Recognition: Cultural Safety and the Mental Health of Indigenous Peoples

Many indigenous communities around the world currently have elevated rates of mental health problems, including suicide, particularly among youths.[3] The recent Truth and Reconciliation Commission in Canada concluded that these problems could be traced to the legacy of European colonization and the transgenerational effects of policies of forced assimilation through Indian Residential Schools and continued social marginalization.[4] There is evidence that addressing the resultant mental health problems requires not only providing access to services but also improving economic opportunities and strengthening local community control of basic institutions, including health and social services. Driven by indigenous scholars and health care practitioners, the Mental Health Commission of Canada embraced cultural safety as a framework for explicitly recognizing and responding to ongoing structural violence.[4] Cultural safety requires that practitioners recognize the ways that the legacy of historical injustice and ongoing inequities influence the clinical encounter and the organization of health care systems and work toward redistributing power in the health care system. Ensuring that communities have an active voice in health policy and practice is one key way to redress this inequity. Advancing structural competency through cultural safety for indigenous peoples provides a model for recognizing the needs of other groups in society through changes in psychiatric training, services, policy, and practice.

Working With Community Groups to Address Cultural and Linguistic Diversity

Cultural diversity is associated with mental health disparities among ethnocultural groups because of differential exposure to social determinants of health and access to services. Although one approach to these disparities is to assume that they are attributable to

maldistribution of resources, there is evidence that problems also arise because of a poor fit between community needs and the type of mental health services available.[5] Work on cultural competency has made strides in addressing this lack of fit, as exemplified by the recent publication of the Cultural Formulation Interview in *DSM-5*. Structural competency aims to complement the cultural competency approach by emphasizing the social structural determinants of health. Our work with a cultural consultation service, which provides specialized psychiatric consultation for patients referred from primary care, regularly foregrounds structural problems in the health care system and wider society, including the effects on mental health of precarious migration status; exposure to xenophobia, racism, and discrimination; unemployment or underemployment; poverty; and lack of culturally and linguistically appropriate mental health services.[6] Clinical recognition and research documentation of these issues have led to advocacy in collaboration with communities to address issues of discrimination and cultural and linguistic barriers to mental health services.

Advocacy for Change in Refugee Policy

We live in a time of massive displacements of populations, with the largest numbers of refugees since World War II. Refugees and irregular migrants, including pregnant women and children, are routinely detained in camps, detention centers, and jails in many countries, and the profound costs to their mental health are well documented. Psychiatrists in North America, Europe, and Australia have raised the alarm about the dire mental health effects of prolonged detention of refugees. After struggling to support individual patients experiencing the effects of detention, a Canadian coalition of psychiatrists, pediatricians, general practitioners, lawyers, and child advocates established an intersectoral network to advocate for change in immigration policy. The coalition released a statement that called for the end of the detention of children.[7] Signed by prominent national medical organizations, human rights organizations, and individual health care professionals, the statement urged the Canadian government to act to protect the rights and health of migrant children. This joint advocacy has had positive outcomes, and the government is now moving to reform the immigration system to prevent the detention of children. In the years to come, there will likely be massive displacements of populations through war, climate change, and other catastrophes, and psychiatrists can play an important role in advocating for immigration policy and service systems to mitigate the health consequences of forced migration.

Conclusions

Faced with the complexity of social inequities and the many challenges of advocacy, psychiatrists may feel discouraged and decide to limit their efforts to more individual patient-centered work. To support broader forms of advocacy, we need to develop guidelines, strategies, and tools to encourage practitioners to work in partnership with communities. Professional organizations can provide training and guidance on how to create coalitions, gain institutional support, and engage in productive dialogue with stakeholder communities and policy makers. The examples presented in this article illustrate how structural advocacy needs to be tailored to specific national contexts but also how we can move practitioners from indifference to action and promote transformational change in health policy and practice. Local, national, and international networks to share our successes and failures as advocates for structural change can provide a way to advance this critical dimension of psychiatric practice and improve mental health.

ARTICLE INFORMATION

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