Southeast (HHS Region 4)
MHTTC
Mental Health Technology Transfer Center Network
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STRUCTURAL COMPETENCY TRAINING GUIDE

INCORPORATING STRUCTURAL COMPETENCY INTO PEER INTERACTIONS

SAMHSA
Substance Abuse and Mental Health Services Administration

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TRAINING GUIDE OVERVIEW

Structural Competency is an emerging practice and tool used to promote mental health equity and reduce disparities in mental health services and interactions. This training guide will help peer specialists and peer-focused behavioral health organizations implement structural competency into their daily interactions, policies, procedures, and overall attitude. This guide only touches the surface of structural competency; however, various articles and products will be provided throughout this guide. You will encounter checkpoints throughout the guide to assess your growing familiarity and comprehension of structural competency and its precursors, cultural and linguistic competency, and cultural humility.

The question addressed in this guide: How can structural competency be utilized to improve the interpersonal interactions between peer specialists and their peers in the behavioral health system?

This question will be answered by the following objectives:

Understand the history and development of structural competency

Application of structural competency in the medical field to inform peer specialists

What structural and historical barriers are there in the behavioral health system and how can we overcome this

Provide recommendations for and encourage the implementation of structural competency by peer specialists and stakeholders

Recognize how cultural competency and humility are precursors to structural competency

Provide context of the barriers and obstacles faced in the Southeast region in regards to implementing these changes

KEY TERMS

The following terms will be used throughout the training guide:

Certified Peer Specialists (CPS)

CPS play a key role in promoting mental health equity. A CPS is someone who has **personally experienced** psychiatric and/or substance use disorders and who provides **recovery-focused support** services to people, i.e., peers, who are currently struggling with these issues.[1] CPS engaging with peers is mutually beneficial because of the emotional connection between both parties.[2] Because of this instrumental alliance and dynamic, CPS are a **promising avenue** for introducing structural competency in the public mental health system. [Public] mental health and behavioral health will be used interchangeably in this guide.

Behavioral Health Equity

Health equity, according to SAMHSA, occurs when minoritized communities **(i.e., Black, Indigenous, Latinx, LGBTQ+, immigrant, Asian-Americans and Pacific Islanders, non-men, rural communities, intellectual, developmental, and physically disabled)** have the support they need to access healthy living in the same manner as dominant groups.[3] Health equity considers race, ethnicity, gender, religion, geographic location, ability status, socioeconomic background, and sexual orientation when ensuring all groups have the same opportunity.

Checkpoint: What is the purpose of this guide and who are the intended viewers?

Structural factors that can hinder access to mental health services

- Employment status
- Unstable housing
- Insurance status
- Accessibility to resources
- Culturally inadequate care

Equity in mental health ensures that these structural barriers do not prevent people from receiving treatment and services for their mental and behavioral health, and it also ensures improvements in mental health diagnoses and struggles.[4]

KEY TERMS (con't)

Social Determinants of Health (SDOH)

Structural conditions that impact the health and well-being of people daily. The conditions include where people "are born, grow, work, live, and age."[5]

Examples of SDOH

- Economic barriers
- Poor housing infrastructure
- Inaccessibility to healthcare
- High insurance premiums
- Quality of schooling
- Accessibility to healthy foods

Social Determinants of Mental Health (SDOMH)

Similar to SDOH, Social Determinants of Mental Health focuses on the aforementioned influencers, but in regards to how these factors affect mental health.[4,6]

Checkpoint: What similarities do you see between structural factors that can hinder access to mental health resources and the SDOMH?

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CULTURAL AND LINGUISTIC COMPETENCY

To understand the importance and timeliness of structural competency, it is necessary to understand the practices and ideologies that came before it.

Cultural Competency

Developed in 1989, Cultural Competency is a common term used in Public Health and Medical fields often referring to Practitioner-Patient relationships and dynamics.[7] Being culturally competent means to have **general awareness** of your own identity, assumptions, and values when serving patients, clients, and groups of culturally diverse people in order to provide person-centered care that leads to reducing health disparities.[8,9] Navigating cross-cultural situations involves a harmonious set of behaviors, attitudes, and policies that are enforced in a system, agency, or among professionals.[7]

Linguistic Competency

Similar to cultural competency, being linguistically competent involves having the skills and awareness to successfully **communicate** information that can be understood by a number of diverse people with varying English proficiencies and abilities.[8]

Examples of Cultural & Linguistic Competence in Non-Mental Health Settings

1. A physician practicing in high Latinx populated area being mindful that cultural food practices differ from their own **but** do not provide adequate food substitutions.

2. A physician practicing in a low-income area being **mindful** that it may be difficult for a patient of color to exercise because of inadequately built environment **yet** not providing alternative recommendations.

3. Members of social worker staff speak more than one language **but** not a language most common among clientele.

Application to Public Mental Health[10]

While much of the literature regarding the continuum does not explicitly focus on behavioral health, findings can be adapted to address the needs public mental health.

Providing behavioral health educational materials and resources in a language other than English and with accessible formats.

Non-Black CPS being patient with and mindful of their Black male client in discussing mental health struggles because of cultural views on mental health.

Hiring culturally and linguistically competent staff, faculty, and leaders.

CULTURAL AND LINGUISTIC COMPETENCY (con't)

Cultural Competency is Outdated

Cultural Competency can be effective at the individual level but is simply not broad enough to adequately support diverse peers.[11] There is no mention of why simply **understanding** differences is not adequate in embracing and effectively interacting with cultures other than one's own. Cultural competency instigates inequalities in power between the practitioner and the patient and societal prejudices.[9] With the belief that learning and gaining skills surrounding culture can reach a limit, a sense of entitlement to knowing about another culture, and inadequate resources that still maintain inappropriate policies and practices of incompetent management, Cultural Competency is merely step one in an inevitable, continual process for growth, i.e. Cultural Humility.[7,8,12]

Checkpoint: What personal examples can you think of where you practiced cultural competency?

CULTURAL HUMILITY

Developed in 1998, Cultural Humility is a **process-oriented approach** that advocates for **lifelong** learning and critical **self-reflection**, holding institutions and systems **accountable**, and recognizing **power imbalances** that need to be transformed.[12-15] What makes humility an improvement over cultural competence is its innate suggestion that learning about other cultures and practices is infinite. It centers the peer when providing services and care.[9]

A White Peer Specialist will never truly understand the experiences of their Non-White peer. Yes, both individuals have lived experiences with substance use and/or mental health struggles, but the cultural and racial differences vary significantly between both parties.

Lifelong Learner Model[15,16]

An important aspect of Cultural Humility is engaging in **active learning, listening, and self-reflexivity**. **Self-reflexivity** is the process of regularly challenging your assumptions and self-evaluation to acknowledge that you may not be as knowledgeable as you believe you are. Being self-reflexive allows for lifelong learning to occur and to not emotionally detach oneself from the learning process. The mindset of the learner – whether that be an individual, organization, or system – is simply to learn followed by incorporating behaviors, attitudes, and policies that exemplify inclusivity, equity, and flexibility.

CULTURAL HUMILITY (con't)

Accountability of Institutions and Systems

Policies and curricula that discourage cultural diversity, presume that everyone has the same experience of life, and hold contradictory ideas are at the foundation of oppressive policies, behaviors, and attitudes.[15] It is important for institutions and systems to embody humility because of the minoritized populations they have historically harmed.

Revisions and reforms to policies such as the implementation of the 988 Suicide and Crisis Lifeline re-centers minoritized groups who commonly face barriers to accessing mental health care and timely response.[17]

Breaking Down Power Imbalances[14,15]

The dynamics between practitioner and patient are inherently imbalanced and unfair. The practitioner is traditionally viewed as the expert and the ultimate authority on any condition or behavior the patient is going through or expresses. By breaking down this power imbalance, the patient is viewed as the cultural expert with the practitioner deducing the best way to be of assistance to their patient without overstepping boundaries.[15] In doing so, a mutually respectful and beneficial relationship can emerge.

Application of Cultural Humility in Public Mental Health

While much of the literature regarding cultural humility does not explicitly focus on behavioral health, findings can be adapted to address the needs in the public mental health system.

Trauma Informed Care is evolving to be intentionally mindful of sociocultural factors that influence how an individual experiences and reacts to trauma. A cultural humility approach minimizes further harm done to minoritized populations.[18]

Checkpoint: Think about a recent interaction with a peer or CPS. Did you utilize the Lifelong Learner Model? Why or why not?

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Cultural Humility is Satisfactory

Cultural Humility is an excellent practice that fills the gaps cultural competency cannot. Cultural Humility is a way for practitioners to address internal implicit biases **and** structural issues faced by patients in order to provide patient-centered care effectively.[11] Cultural Humility is step two in an inevitable, continual process for growth and addressing the root causes of patient health disparities, i.e. Structural Competency.

STRUCTURAL COMPETENCY

Checkpoint: List the similarities and differences between cultural & linguistic competency and cultural humility.

The future of advancing mental health justice and equity lies in Structural Competency. Structural Competency offers clarity and nuance to the injustices encountered by all minoritized groups, **while maintaining the focus on eliminating power disparities and holding institutions and systems accountable.** Developed by Jonathan Metzl in 2010 and expanded in 2013 by Jonathan Metzl and Helena Hansen, Structural Competency transcends all notions and understandings of Cultural Competency and Humility due to its innate purpose of radically changing medical curriculum and training to rectifying health disparities faced by patients because of structural inequities.[19]

Structural Competency is having the ability to **detect** traditionally clinical symptoms (i.e., high blood pressure, diabetes, obesity, trauma, etc.) as the **reflection of** inequitable institutional and sociopolitical practices, policies, and decisions in patients and in the case of CPS, in peers.[4,19-21]

Structural Competency focuses on the systemic root factors that collectively harm and create structural vulnerability among minoritized groups.[4,19,22]

STRUCTURAL COMPETENCY (con't)

Five Core Competencies of Structural Competency [4,19]

Structural Competency can be implemented by following these 5 competencies:

1 "RECOGNIZING THE STRUCTURES THAT SHAPE CLINICAL INTERACTIONS"

Being able to identify the economic (cost of prescription), sociopolitical (insurance and polices impacting cost), and physical (accessibility to healthy foods) factors with a Black elderly woman who does not want to take her hypertension medication.[19]

2 "DEVELOPING EXTRA-CLINICAL LANGUAGE OF STRUCTURE"

Having knowledge and awareness of how structural factors are seen in other fields such as architecture & urban planning (gentrification, infrastructure failure, environmental racism) and how this can affect your peer. Building relationships with other disciplines whom work with minoritized populations could also help to build non-clinical vocabulary.

3 "REARTICULATING CULTURAL PRESENTATIONS IN STRUCTURAL TERMS"

Discern between cultural factors and structural factors.

For example, is your Black peer late for their appointment because of the stereotypes surrounding their race, or is your peer late because of the social, infrastructural, and economic factors that hinder their timeliness? [19]

4 "OBSERVING AND IMAGINING STRUCTURAL INTERVENTION"

Historical, political, and ethnographic observations in order to impactfully address health infrastructures with interventions such as familiarizing oneself with earlier medical and public health initiatives to address social justice issues.

5 "DEVELOPING STRUCTURAL HUMILITY"

Recognizing that even structural competency has limitations and continual collaboration with patients and communities to address structural vulnerability.

STRUCTURAL VULNERABILITY

Structural Vulnerability is the **position** where a member of a minoritized group experiences life in the social hierarchy.[11,22,23] The social hierarchy can exist in one setting or simultaneous settings. For example, a Republican White, cisgender, heterosexual, able-bodied, gainfully employed man living in an affluent area is at the top of a socioeconomic hierarchy while a Democrat Indigenous, cisgender, queer, physically disabled, unemployed person living in poverty in a high pesticide area is at the bottom of the hierarchy. The stark contrast is on a spectrum with any and every mixture of people in between.

Bonus Checkpoint: What would happen if gender or race were to be switched? Why do you think that is?

Bonus Checkpoint: What if both had the same credential and characteristics except for ability status? Why do you think that is?

Questions such as these circle back to the SDOH as previously stated in this guide. Questionnaires such as the Structural Vulnerability Assessment Tool is useful in determining how the SDOMH affects an individual and where to positively intervene in power hierarchies.[11,23] Thus, the assessment tool is essential in promoting and embodying structural competency.[23]

STRUCTURAL VULNERABILITY (con't)

The 8 Domains of the Structural Vulnerability Assessment Tool[23]

Below are the 8 domains of the Structural Vulnerability Assessment Tool and questions you can ask your peers related to each domain. Each domain can positively or negatively affect a peer's recovery journey. This 43-item tool includes probes to gain deeper insight on your peer and their current life experiences that may affect their recovery process.

Financial Security
Asking your peer if they have enough money to pay for basic necessities such as rent, telephone bills, food, etc.
Do you have enough money to pay for healthy food and your telephone bill?

Residence
Asking your peer if they have a safe, stable, and clean place to call home and store their belongings.
Does your current residence feel like home? Can you safely store your possessions there?

Risk Environments
Asking your peer if their daily social and physical environments are safe and healthy to live and work.
Do you live in a neighborhood that can negatively affect your recovery journey?

Food Access
Asking your peer if they have access to grocery stores with healthy foods.
Would you say your daily nutrition is filled with fruits, vegetables, other healthy foods? Why or why not?

Social Network
Asking your peer if they have a good support system of friends, families, or other people.
Do you have friends and family members who you trust and are conducive to your recovery journey?

Legal Status
Asking your peer if they have any legal troubles.
"Are you scared of getting in trouble because of your legal status?"

Education
Asking your peer about their literacy status, languages they speak or write in, and level of education reached.
What languages do you speak and are most comfortable with speaking and writing?
"What level of education have you reached?"

Discrimination
Asking your peer about their negative experiences from others based on their physical, linguistic, gender-based, sexual orientation, and socioeconomic characteristics.
"Have you experienced discrimination based on your skin color, your accent, where you are from, or any other reason?"

Checkpoint: Do you as a CPS already ask your peer questions listed in these domains? How do you think you can improve these conversations?

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BARRIERS HINDERING STRUCTURAL COMPETENCE IN THE SOUTHEAST

Despite the relevance of Structural Competency, barriers are still present to effectively practice the approach.

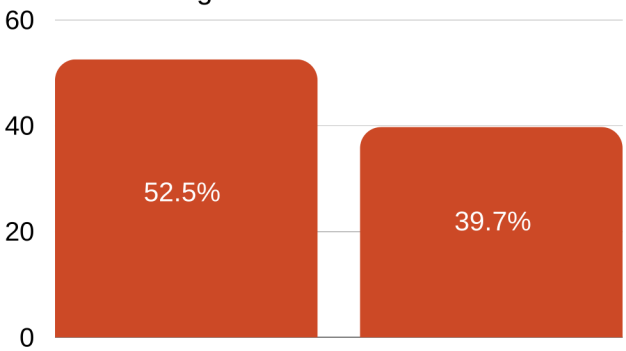
1

While not a structural barrier, the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care could be updated to consider structural competency for the country's healthcare institutions and practitioners, which includes the behavioral health system. Introduced by the Health and Human Services Office of Minority Health (OMH) in 2000 and refined in 2013, these are the highest standards in terms of encouraging access to care, enhancing health equity, and reducing healthcare disparities.[24]

3

Additionally, in each state, the poverty rate is disproportionately higher for communities of color than their White counterparts.[25]

Tennessee and Alabama had the highest share of adults reporting needing mental health treatment but not receiving services due to cost at roughly 53%. This is higher than the national average of 39.7%. [25]



2

Of the 8 Southeastern states in our region, Georgia and Florida have the **highest rates** of people who do not have health insurance at 12.7% and 12.1%, respectively.[25] These rates are higher than the national average of 8.6%.

4

It has been found that lower income and poorer mental health outcomes are **associated**.[26] As such, individuals who experience substance use struggles tend to be more vulnerable to being uninsured.[27]

Please view a custom report generated through the Kaiser Family Foundation regarding the 8 states in the Southeast region.

Checkpoint: Given the information learned from this guide and prior knowledge, ask yourself - what historical, political, and social factors are the *root cause* of the above barriers?

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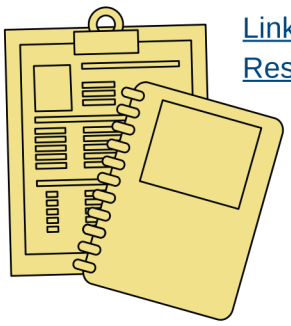
RECOMMENDATIONS FOR IMPLEMENTING STRUCTURAL COMPETENCY IN THE SOUTHEAST

Given the limited literature and resources regarding Structural Competency in the Public Mental Health sphere and the current usage and promotion of cultural humility, many promising practices are performed in the medical field with origins in California. With the information provided by these institutions, groups, academic divisions, and medical practitioners in hospitals, we can model their success in the Southeast.

California

STRUCTURAL COMPETENCY WORKING GROUP

Founded in 2014 in the San Francisco Bay Area, the SCWG is a collective of "healthcare workers, scholars, public health professionals, students, educators, and other community members" with the same vision of promoting the incorporation of Structural Competency in professional training across the country and around the globe. This Group has developed publicly available structural competency curricula. Members of the group (represented at New York University, University of California, Los Angeles (UCLA), and Yale University provide findings that weaving Structural Competency in Psychiatry programs is beneficial for both the resident and minoritized communities affected. [28]



Link to Training Resources

UCLA CENTER FOR SOCIAL MEDICINE AND HUMANITIES

This center, housed in the UCLA David Geffen School of Medicine, brands itself as a "community of scholars" with varying and multidimensional backgrounds from the social sciences and humanities to apply to "the urgent challenges of health, disease and scientific and clinical practice, with a commitment to social justice." Dr. Helena Hansen, co-founder of Structural Competency, is affiliated with this department.[29]

HEALTH BEGINS

Founded in 2012 by physicians, HealthBegins founders are trained in Public Health and devote their time to train and consult healthcare and community partners to "improve the social drivers of health and equity at all levels" with a structural competence framework. [31]

Connecticut

Yale University School of Medicine

The Yale School of Medicine is home to the Social Justice and Health Equity Curriculum with a structural competency track for its psychiatry residents. All trainees are exposed to a social justice and health equity lens with the option to choose between structural competency, human experience, advocacy, and history of psychiatry track – the latter three have some aspect of structural competence woven into the teachings.[30]

INTERDISCIPLINARY APPROACH OF PUBLIC HEALTH WITH STRUCTURAL COMPETENCY IN THE SOUTHEAST

The interdisciplinary working group leads by example how crucial it is to approach collective and individual health through a multifaceted lens.[32] Four universities in the Southeast region have dedicated departments or initiatives to Structural Competency with two exclusively for medical students while the other two are available to all students, undergraduate and postgraduate. Public Health and Social Medicine (offset of Structural Competency) can work together for a better future for ALL populations, especially minoritized communities.

Florida

The Florida State University, College of Medicine is home to the **Department of Behavioral Sciences and Social Medicine**. Students can engage in structural competency through their degrees and by participating in research labs with select faculty.[36]

North Carolina

At the University of North Carolina, Chapel Hill (UNC Chapel Hill) School of Medicine, the **Department of Social Medicine** is home to a variety of faculty ranging from clinical medicine, the humanities, and social sciences to help inform "teaching, research, and services that addresses the social dimensions of health, illness, and doctoring."[34]

Georgia

The Emory Urban Health Initiative at Emory University in Atlanta, Georgia provides an intensive, month-long Social Medicine elective that is offered to undergraduate and postgraduate students in any discipline to help "address societal issues, and develop the skills and attributes of critical thinkers and [conscientious] citizens."[33]

Tennessee

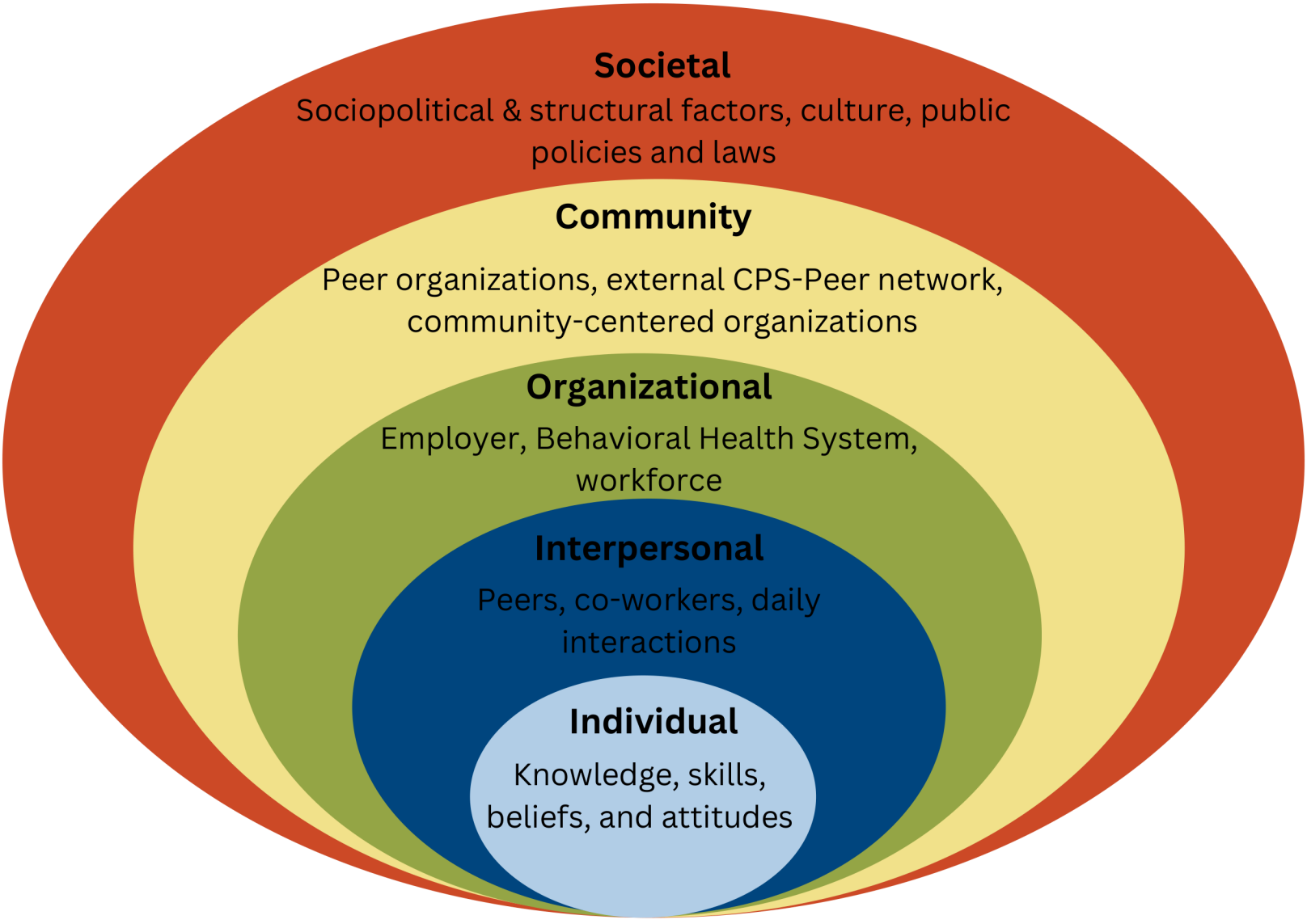
At Vanderbilt University, the **Department for Medicine, Health, and Society** curricula is provided as a major and minor for undergraduate students, and a degree for Master's level students. This curriculum incorporates all aspects that Structural Competency strives to improve.[35]

HOW TO TAKE ACTION: INCORPORATING STRUCTURAL COMPETENCY IN PEER INTERACTIONS & ORGANIZATIONS[37]

Now that you are familiar with the histories of cultural competency, cultural humility, and structural competency, you may have already thought of how to incorporate this practice into your own interactions and/or organization. If you have not, try these 7 recommendations.

Each recommendation coincides with at least one level of the **Socio-Ecological Model (SEM)**. The SEM is a multi-level health model that places an emphasis on the connections and relationships between multiple determinants that influence health.

The 5 levels discussed in this training guide are:[38]



HOW TO TAKE ACTION: INCORPORATING STRUCTURAL COMPETENCY IN PEER INTERACTIONS & ORGANIZATIONS(con't)

**These recommendations are inspired by the "Structural Competency Working Group Training Participant Workbook"*[39]*

Provide education

- Schedule a half-day training for you and your organization with the Structural Competency Working Group.
- The Working Group provides a 3-4 hours training with a robust curriculum and required and supplemental readings. See resource on page 14.

Actively listen to your employees and peer clientele

- Hold listening sessions, create cross-hierarchy committees, and ask for anonymous call for recommendations.
- Use the Structural Vulnerability Assessment Tool to avoid inserting your own thoughts and bias into peer interactions.

Update your policies, procedures, operations manuals, and any public facing resources

- Actively schedule time to update relevant documents with soft and hard deadlines. Delegate tasks to relevant parties. Hold yourself and your organization accountable for sticking with the deadlines. Double and triple check the updates.

Self-reflect on an individual, interpersonal, and organizational level

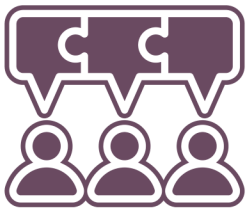
- Ask yourself: What can I do to effectively enact change? What power dynamics are present between me and my employees or peers?
- Consider: Why are you and your executive members having trouble incorporating the changes your employees want and need? What implicit biases do I hold that I may not realize?

Ask yourself: How do my experiences differ from my peer?

Return to recommendation #2.

Partner with community-centered organizations who are working on structural issues

- These organizations could provide a unique outlook on the experiences faced by minoritized populations.



HOW TO TAKE ACTION: INCORPORATING STRUCTURAL COMPETENCY IN PEER INTERACTIONS & ORGANIZATIONS (con't)

Practice cultural humility and structural competency simultaneously

Consider: How can I embody the updated rules and regulations of my organization to ensure my employees or peer clientele are satisfied and comfortable?

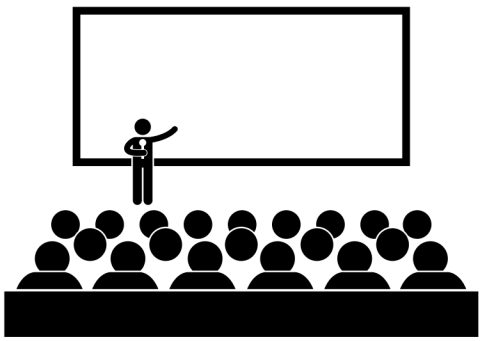
Practice, practice, practice

Understand that practicing Structural Competency is a lifelong process. Structural competency is not meant to be perfected. With deeply rooted structures at play, it is unlikely society will be perfect in a year, even 10. Use the information provided to you in this guide to make a difference in your organization and interactions.

Checkpoint: List 1 to 2 more recommendations that you can utilize in your peer interactions and organization.

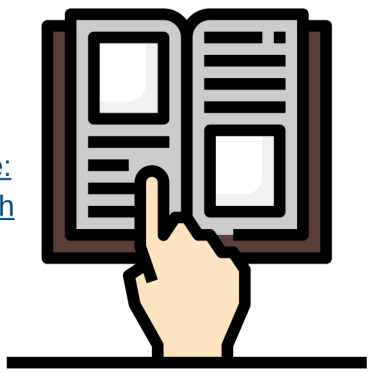
As the prominence of Structural Competency grows in medicine, it is probable that public mental health organizations, institutes, and departments will follow. Utilizing the resources from the organizations, working groups, and departments above will ensure structural competency's success in the Southeast and at your organization.

If you are interested in viewing more information about Structural Competency as it relates to public mental health, please view the resources below:



"From Cultural Competence to Structural Competence – Strategies for Achieving Mental Health Equity" Webinar

"Cultural & Structural Competence: Mental Health Equity" Factsheet



FINAL CHECKPOINT

What next steps will you take to implement what you have learned from this guide?

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