

# Structural Competency MGH/McLean Adult Psychiatry Residency Didactics Guide

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## Structural competency definition and use in residency teaching:

- Definition: The ability for health professionals to recognize and respond with self-reflexive humility and community engagement to the ways negative health outcomes and lifestyle practices are shaped by larger socioeconomic, cultural, political, and economic forces.
- In our didactics series, we use structural competency as a framework to teach residents how to better understand and act on the structural factors (i.e. social determinants of health) that impact their patients.
- The goal is to teach the core concepts of structural competency and to bring these concepts from the abstract to a useful skillset that can be utilized in a residents' day to day work.
- We aim to lead residents to consider structural forces as critical in all of their patient interactions and to motivate them to begin address structural factors from the individual to systemic level, thinking about their work in direct patient interactions, advocacy, leadership, etc.

## **PGY1**

### PGY1 Session 1

#### Background:

- 50 minutes
- Group of 7-8 students and 1-2 teachers
- Printed handouts 1, 2 and 3 (to be dispersed at specific points in didactics)
- Use of white board

#### Objectives:

1. Understand the concepts key to the structural competency approach, including social determinants of health, societal structures, structural violence
2. Apply a structurally competent approach to a relevant case example
3. Explore the importance of structural competency as a core concept in psychiatry training

#### Session Outline:

- Introduction (10min) – large group exercise
  - Large group round table discussion. Students and teachers introduce themselves and their interests.
  - Leaders explain their interest in the topic of structural competency (SC) and key points to frame the concept and series throughout four years of residency.<sup>1</sup>
    - Name goal of today's session and goal of series.
      - Today's session – Introduce the group to the concept of SC and it's use as a framework in individual clinical encounters.
      - Series - Structural competency will be a core concept one leaves residency understanding, akin to skills in psychopharmacology, therapy,

etc. Thinking about and addressing SC will be considered a part of regular clinical practice.

- Key definitions (10min) – large group exercise, handout 1
  - Ask members of the group to volunteer to provide definitions for the following terms and lead group discussion around definitions to lead to shared understanding.
    - Social history
    - Social structure
    - Social determinants of health (SDOH) – write examples of list on board to use in discussion
    - Structural violence
    - Structural vulnerability
    - Structural competency
      - Basic definition for all residents to understand: The ability of a clinician to identify the upstream structural forces (i.e. SDOH) that impact our patients and begin to intervene on these forces.
  - Provide handout 1 at the end of this exercise.
- Levels of intervention (10 min) – large group exercise, handout 2
  - Draw public health pyramid (Freiden) to show interconnectedness with public health work.



- Write out different levels of intervention within SC to be able to show where our group work in this session will fit.
  - Individual
  - Interpersonal
  - Clinic/institutional
  - Community
  - Policy
  - Research
- Distribute handout 2: structural vulnerability assessment tool. Review and discuss use in clinical work.
- Case vignettes pair and share – small group exercise
  - Provide handout 3 with case vignette and specific questions for discussion in groups of 2-3.
  - Large group sharing of discussion.
    - Within discussion, review example of creating a structural formulation for case and structural interventions utilized.

## PGY1 Session 2

### Background:

- 50 minutes
- Group of 7-8 students and 1-2 teachers
- Printed handout 4 (to be dispersed at specific point in didactics as needed)
- Use of white board

### Objectives:

1. Practice applying a structurally competent approach to clinical cases.
2. Explore ways in which physicians can intervene to address SDOH

### Session Outline:

- Introduction (15min)
  - Review key concepts as a group:
    - Social determinants of health (write list on board)
    - Structural competency
    - Structural vulnerability
    - Structural formulation
    - Levels of intervention for structural competency
- Large group discussion (10min)
  - Ask students to discuss where they have noticed structural inequities arising in their clinical practice.
- Case vignettes pair and share exercise (25min)
  - Ask students to think of at least one case to discuss with a partner that highlights the structural forces impacting a patient's presentation and/or treatment. Ask them to complete a brief structural formulation, listing the SDOH that arose in their work with the patient and the different ways SDOH were or were not addressed.
  - If students do not have examples at hand, provide handout 4 as a prompt.
  - Return to larger group discussion.
    - Review structural formulations and SDOH identified within each case, including interventions that were or were not completed.
    - Take opportunity to review structurally competent resources already available within our hospitals and healthcare system. Point out that despite the feeling of helplessness that can often arise when thinking of insurmountable SDOH, there are many ways in which we address SDOH and may not even realize it.
    - Review levels of intervention and remind that these clinical examples from our experiences are at level 1, but bring up many issues in other levels.
      - If time and/or need for further discussion topics, can brainstorm what types of work could be done within other levels of intervention to address particular issues that arose in case vignettes.

## **PGY2**

### PGY2 Session 1

- Small group sessions (ranging from one on one to two on two) with review of above concepts in a conversational frame, utilizing examples from PGY2 public and community psychiatry core rotation where residents are working directly with multiple Department of Mental Health shelter clients in a consultant role.
- Specific review of definition of structural competency, how to write a structural formulation, and ways to incorporate a structural plan into client write-ups.
- Continue to review above concepts throughout weekly supervision sessions with residents.

### PGY2 Application of SC

- Provide example of client case write-up (supplement 1) with structural formulation and ask residents to include a structural formulation and structural plan in their final client write ups as a part of the Public and Community Psychiatry rotation.

## **PGY3**

### PGY3 Session 1

#### Background:

- 50 minutes
- Group of 10-14 students and 1-2 teachers
- Use of white board or laptop with large display
- Identify student prior to session who plans to present an outpatient or consult-liaison case where structural issues impacting care may be highlighted

#### Objectives:

1. Review structural competency key concepts and approach
2. Apply structural competency approach to a wide-range of clinical settings, including outpatient and consult-liaison work
3. Practice generating structural formulation and plan for a real clinical case

#### Introduction (10min):

- Review core concepts and definitions of structural competency.
  - Key terms include: social determinants of health, social structures, structural vulnerability, structural competency
  - Consider that not all students may have had second year work (research track residents not completing public and community psychiatry rotation), that each of these sessions can be up to a year apart, and that some students may have missed prior sessions due to call or other obligations.

#### Case Presentation (10min):

- Third year resident presents full case from outpatient clinic or CL service, allowing for clarifying questions at the end of presentation.

#### Large group discussion (30min):

- Complete structural formulation as a group, identifying key SDOH/structural factors that impact the case and outlining each component of those factors with possible plans for intervention.
- Write formulation and plan on white board or shared document on laptop displayed on large screen.
- Brainstorm as a group to identify areas for resident to intervene and resources to assist resident in furthering care of the patient.
- Review difficult areas for intervention and what types of changes would need to take place across all levels of intervention to address those difficulties. Discuss options for advocacy work or shorter-term interventions that group members may be able to act upon.

#### PGY3 Session 2:

Repeat session 1 with a different volunteer with a new outpatient case to discuss. May be able to spend less time reviewing concepts if most group members are similar from session 1 to session 2.

### **PGY4**

#### Background:

- Case conference series for PGY4 residents to present difficult cases and hear perspectives from multiple experts.
- PGY4 resident prepares a comprehensive write up and sends to case conference series leader, residents, and discussants in advance.
- Select a structural competency expert to serve as one of multiple expert discussants for 3 case conferences. Structural competency expert was added during the 2019 - 2020 year as a new discussant to complete the structural competency didactics series.

#### Objectives:

1. Solidification of structural competency as a core area of expertise to be skilled at as psychiatrists.

#### Case presentation (45min):

- Resident presents cases to classmates and discussant panel.

#### Discussion (75min)

- Experts in psychodynamic therapy, psychopharmacology, consult liaison psychiatry, cognitive behavioral therapy, dialectic behavioral therapy in addition to structural competency discuss their case formulations and recommendations from the lens of their area of expertise.

## Evaluation

Through this didactic series, our goal is to equip residents with the tools to consider and intervene upon structural factors at both individual and system levels. Ultimately, we hope that this approach will improve patient outcomes by better addressing the social determinants of health that lead to disparities in health. We also hope to empower residents to consider the ability to examine and address social determinants of health as a core competency in psychiatry. Our plan is to evaluate to what degree our didactics series has impacted the practice of residents throughout the four years and to what extent residents believe that the skills of structural competency will continue to be critical to their practice. Over the next month in the course of passing leadership of the didactics series to junior residents on our graduation, we plan to develop and circulate a survey assessing current understanding of and attitudes towards structural competency approaches to patient care. We hope this will inform ongoing improvement of the curriculum to meet the needs of residents and above stated goals.

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<sup>1</sup> Examples include:

- *Share about one's personal experience of learning about social determinants of health in a factual fashion in medical school without clear discussion of actionable steps towards addressing these social determinants of health as a physician. Note the impression often given that structural forces impacting individuals' health are immutable facts of society. This was a frustrating experience for us as medical students. When we learned about SC, which seeks to empower physicians to both understand and address social determinants of health, it was a relief, in that it addressed this frustration that had arisen in medical school.*
- *Discuss that structural competency was developed in part as a response to the concept of cultural competency, which the originators of SC felt often over focused on the individual and their background as contributing to components of their illness or social situation. SC seeks to identify systemic, upstream, societal forces impacting the individual to contend that we are not navigating complex cultures as much as violent societal systems that need to change and/or be addressed via systems interventions to best promote wellness.*
- *To garner buy-in from psychiatry residents regarding the importance of factoring SC into patient care, share analogy of psychiatrist being like a type of primary care doctor, who is uniquely positioned to learn of certain issues impacting their patients' life and wellbeing and therefore responsible for addressing those issues as possible. This may mean referring to and collaborating with resource coordinators, case managers, social workers, financial services etc. The presence of those clinical staff does not remove the burden from psychiatrists in addressing social determinants of health, but increases the critical importance that psychiatrists are identifying and effectively triaging those issues.*
- *Join with group in naming the difficulty of discussing this type of work due to the fact that so many of these structural forces are incredibly powerful and difficult to change, particularly in one individual encounter. Share that the hope is that long term, psychiatrists and other health professionals learning about this work will drive changes in the many layers of systems, from clinical to hospital to community and societal levels.*

## References

Bourgois P, Holmes SM, Sue K, Quesada J. *Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care*. Acad Med. 2017;92(3):299-307.

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Metzl JM, Hansen H. *Structural competency: theorizing a new medical engagement with stigma and inequality*. Soc Sci Med. 2014;103:126-133.

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## Handouts and Supplement

### Handout 1:

#### Definitions of Key Terms Used in This Perspective

| Term                                     | Definition   |
|--|--|
| Social history                           | The section of the clinical history in which social factors that may be clinically significant are noted. <sup>1</sup>   |
| Social structure                         | The way a society is organized in hierarchies through institutions, policies, economic systems, and cultural or normative belief systems such as race, socioeconomic status, gender, and sexuality. A society's social structure generates its specific patterns of "social determinants of health." <sup>2</sup>  |
| Social determinants of health            | The social structural forces that affect health outcomes, ranging from individual- and national-level factors such as socioeconomic status, income inequality, racialized hierarchies, and institutional policies (public versus private health care, incarceration rates, etc.) to global political and economic factors such as per capita gross national product, international trade relations, and military disruptions or political embargoes. <sup>10</sup>   |
| Structural competency                    | The ability for health professionals to recognize and respond with self-reflexive humility and community engagement to the ways negative health outcomes and lifestyle practices are shaped by larger socioeconomic, cultural, political, and economic forces. <sup>6</sup>  |
| Structural violence                      | "Structural violence is one way of describing social arrangements that put individuals and populations in harm's way... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people." <sup>3</sup>  |
| Structural vulnerability                 | An individual's or a population group's condition of being at risk for negative health outcomes through their interface with socioeconomic, political, and cultural/normative hierarchies. <sup>4,5</sup> Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, cultural) and institutional and policy-level statuses (e.g., immigration status, labor force participation) constrain their ability to access health care and pursue healthy lifestyles. |
| Structural vulnerability assessment tool | The questionnaire and observational guide introduced in this Perspective for screening and evaluating a patient's level of health risk imposed by societal forces in order to organize a comprehensive health treatment plan that mobilizes supportive resources both inside and outside the clinical setting (see Chart 1). The tool operationalizes for clinical practice a means to intervene on the negative health effects of what public health has identified as the social determinants of health and structural violence.   |

Bourgeois P, Holmes SM, Sue K, Quesada J. *Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care*. Acad Med. 2017;92(3):299-307.

## Handout 2:

### Structural Vulnerability Assessment Tool<sup>a</sup>

| Domain             | Screening questions and assessment probes <sup>b</sup>   |
|--------------------|--|
| Financial security | <p><b>Do you have enough money to live comfortably—pay rent, get food, pay utilities/telephone?</b></p> <ul style="list-style-type: none"> <li>• How do you make money? Do you have a hard time doing this work?</li> <li>• Do you run out of money at the end of the month/week?</li> <li>• Do you receive any forms of government assistance?</li> <li>• Are there other ways you make money?</li> <li>• Do you depend on anyone else for income?</li> <li>• Have you ever been unable to pay for medical care or for medicines at the pharmacy?</li> </ul>  |
| Residence          | <p><b>Do you have a safe, stable place to sleep and store your possessions?</b></p> <ul style="list-style-type: none"> <li>• How long have you lived/stayed there?</li> <li>• Is the place where you live/stay clean/private/quiet/protected by a lease?</li> </ul>  |
| Risk environments  | <p><b>Do the places where you spend your time each day feel safe and healthy?</b></p> <ul style="list-style-type: none"> <li>• Are you worried about being injured while working/trying to earn money?</li> <li>• Are you exposed to any toxins or chemicals in your day-to-day environment?</li> <li>• Are you exposed to violence? Are you exposed regularly to drug use and criminal activity?</li> <li>• Are you scared to walk around your neighborhood at night/day?</li> <li>• Have you been attacked/mugged/beaten/chased?</li> </ul>  |
| Food access        | <p><b>Do you have adequate nutrition and access to healthy food?</b></p> <ul style="list-style-type: none"> <li>• What do you eat on most days?</li> <li>• What did you eat yesterday?</li> <li>• What are your favorite foods?</li> <li>• Do you have cooking facilities?</li> </ul>  |
| Social network     | <p><b>Do you have friends, family, or other people who help you when you need it?</b></p> <ul style="list-style-type: none"> <li>• Who are the members of your social network, family and friends? Do you feel this network is helpful or unhelpful to you? In what ways?</li> <li>• Is anyone trying to hurt you?</li> <li>• Do you have a primary care provider/other health professionals?</li> </ul>   |
| Legal status       | <p><b>Do you have any legal problems?</b></p> <ul style="list-style-type: none"> <li>• Are you scared of getting in trouble because of your legal status?</li> <li>• Are you scared the police might find you?</li> <li>• Are you eligible for public services? Do you need help accessing these services?</li> <li>• Have you ever been arrested and/or incarcerated?</li> </ul>  |
| Education          | <p><b>Can you read?</b></p> <ul style="list-style-type: none"> <li>• In what language(s)? What level of education have you reached?</li> <li>• Do you understand the documents and papers you must read and submit to obtain the services and resources you need?</li> </ul>   |
| Discrimination     | <p><b>[Ask the patient] Have you experienced discrimination?</b></p> <ul style="list-style-type: none"> <li>• Have you experienced discrimination based on your skin color, your accent, or where you are from?</li> <li>• Have you experienced discrimination based on your gender or sexual orientation?</li> <li>• Have you experienced discrimination for any other reason?</li> </ul> <p><b>[Ask yourself silently] May some service providers (including me) find it difficult to work with this patient?</b></p> <ul style="list-style-type: none"> <li>• Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments?</li> <li>• Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care?</li> <li>• Is this patient likely to elicit distrust because of his/her behavior or appearance?</li> <li>• May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?</li> </ul> |

<sup>a</sup>This tool should be used along with common questions regarding intimate partner violence, alcohol/substance use, diet, and exercise.

<sup>b</sup>The questions in bold function as initial screens that could potentially be quantified. They are followed by assessment probes to elicit more detail and context.

Bourgois P, Holmes SM, Sue K, Quesada J. *Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care*. Acad Med. 2017;92(3):299-307.

### Handout 3:

#### Case 1:

MV is a 50 year-old Spanish-speaking woman from the DR who presented to the emergency department on a Section 12 after she ran down the hallway of her apartment building screaming at her neighbors about witchcraft. She was found to be profoundly hypothyroid, and was admitted medically to the hospital. She had a history of schizophrenia and hypothyroidism and had stopped taking all medications approximately 6 months prior because she believed people in her building were trying to poison her through her medication. She was transferred to Blake 11, where she was started on Zyprexa. She was unwilling to sign a CV, in part because she was undocumented and did not want to sign anything for fear of legal issues. Additionally, she was adamant about leaving the hospital the day after transfer because she had to go to her housing office that day to renew her lease, or she was going to lose her low-income housing. She was organized enough by the time of transfer, that the team felt they could not hold her on a section. She agreed to take Zyprexa as an outpatient.

1. What are some influences of social structures on this patient's health?
2. What are some influences of social structures on the patient encounter?
3. How might a structural competency approach differ from a cultural competency approach in this case?

#### **Handout 4:**

##### Case 2:

JB is a 38 year-old African American man who lives in Dorchester with his parents, is unemployed and relies on family for financial support and has a reported past psychiatric history of schizophrenia, schizoaffective disorder, BPAD with psychosis, MDD, PTSD, unspecified anxiety. He presented to the MGH ED in police custody from Nashua Street Jail where he had been for 1 day post arraignment for assault and battery. He was not given the option to post bail. He was brought in from Nashua Street Jail due to “bizarre behavior” and report of CAH to hurt himself. Collateral from brother reveals decline in function for the patient over the last 8 years such that he has been unable to maintain a job and has had multiple psychiatric hospitalizations. He has no incarceration history nor history of arrests. Patient reports the A&B charges were a misunderstanding from a dispute he had with people in his parking garage, where he felt they were following him, so he yelled back at them. On presentation he is dysphoric, generally linear in speech, reporting fear of being followed, voices telling him to harm himself, visual hallucinations of demons, low mood/energy/motivation, feelings of guilt and hopelessness, flashbacks to prior trauma. Further history reveals that he is father to 4 children under 9 years old who are in custody of their mother. He visits them weekly. He immigrated to the US as a refugee at 10yo and witnessed the death of multiple family members in his home country. He ultimately returned to jail with communication of psych eval impression and suggestion for post arraignment 18A.

1. What are some influences of social structures on this patient’s presentation?
2. What are some influences of social structures on the patient encounter?
3. How might you think about intervening in a structurally competent way?

### **Supplement 1 (excerpted from full case write-up, structural formulation and plan highlighted):**

... It is important to consider the large contributory factor of Mr. KY's social context in what has above been discussed as psychiatric symptomatology. The most notable factors relating to his social context are his immigration status as a refugee, history of significant trauma and persecution for his ethnicity, and his being a non-native English speaker. An understandable mistrust of the legal and healthcare system can be read as guardedness. Difficulty explaining his history or responding to questions in English could be read as thought blocking, impoverished speech content. It is likely that these social factors are at least partially playing a role based on his course at the shelter with note of increased socialization with a native Swahili speaker and less guardedness and paranoia as he has become more familiar with the shelter and his green card application being in process has been reinforced. Though it is highly unlikely that these factors would be entirely explanatory, it is likely that they are at least strongly contributory and therefore confound the diagnosis of a mental illness.

#### Evaluation of strengths and challenges

It is important to reflect on both Mr. KY's assets that provide a promising outcome and the significant barriers he and his care providers face in enacting that outcome. They are outlined below.

#### Strengths:

- Goal oriented: Consistent goals and though limited achievement of these goals at present, Mr. KY is taking steps towards them including speaking with his brother, attending BU psych rehab, planning to attend Center Club.
- Resilience: Mr. KY demonstrates remarkable resilience in the face of adversity. This is evidenced by his fleeing his home country as a teenager, completing high school as a non-english speaking refugee in the US, working and having his own apartment for multiple years.
- Work ethic: Mr. KY demonstrates an impressive work ethic based on his past academic and work efforts and engagement in care at LSH.
- Relationship: Despite many encounters leading to reasons for mistrust of others' intentions, Mr. KY was able to work with treatment teams at LSH and the Lindemann shelter over time towards key accomplishments like applying for a replacement green card, attending groups, transferring to the shelter.

#### Challenges:

- Individual:
  - o Ongoing negative and cognitive symptoms affecting ability to achieve goals.
  - o Question of connectivity to family and ability to return to family.
  - o Limited insight into mental illness and possible limited understanding of legal difficulties, healthcare system, housing and job systems.
- Systems:
  - o Non-citizen with permanent resident status and loss of permanent resident card.
  - o Physical separation from family.
  - o Ongoing legal charges and probation.
  - o Lack of insurance.
  - o Non-native English speaker.
  - o Persistent persecution based on ethnicity (both in fleeing his home and in his interactions with law enforcement in the US).
  - o Homelessness.

- Lack of financial resources (and unable to apply for SSI without resident status).

There are clearly immense systemic forces driving Mr. KY's continued challenges. Though some may be difficult for care providers to change, there are many that care providers can begin to address. Given pattern both at LSH and at the Lindemann of initial guardedness and reluctance to engage but later engagement, Mr. KY likely has hesitancy in trusting others, which as discussed above may be a developed coping style established through years of trauma and may also relate to a history of difficult engagement with the mental health and criminal justice system and lack of awareness of US systems. With this in mind, a careful approach to client relationship development should be considered as a key strategy to best help Mr. KY's care team engage him and assist him in utilizing his strengths to achieve goals of return to Colorado, reconnection with family and acquiring a job.

**Plan:**

Psychiatric care

1. Medications:
  - a. Continue Risperdal 3mg nightly, Cogentin 0.5mg BID.
  - b. Could consider trial of alternative antipsychotic given client has only had one true trial and had ongoing negative symptoms. Would weight this with the cost/benefit of titrating while patient is relatively stable.
  - c. Ongoing metabolic monitoring.
2. Further workup:
  - a. If not complete, could consider pursuing completion of first break workup including HIV, RPR.
3. Psychosocial
  - a. Encourage ongoing relationship development with clients and staff at the shelter.
  - b. Support process of developing increased day structure.
    - i. Consider possibility of volunteer work, increased coursework through BU psych rehab, ongoing attendance at center club.
  - c. Encourage ongoing communication with family.
    - i. Consider offering to have a phone call with client and his brother given current reluctance to allow care team to contact family.
  - d. Recommend ongoing work with PGY2 resident for ongoing relationship development in order to assist with above.

Medical care

1. Iron deficiency anemia.
  - a. Consider repeat CBC and iron studies if appropriate.
2. Sinus congestion/seasonal allergies.
  - a. Engage with client around effective symptom management options.
3. Weight loss
  - a. Monitor weight, appetite and discuss diet and meals with client.

Substance use

Continue to encourage sobriety.

## Structural

### 1. Legal

- a. Communication with probation officer and full documentation of pending court dates and probation requirements to promote encouragement of adherence to probation.
- b. Engage in discussions with client around prevention of future interactions with criminal justice system.
- c. Continue to communicate with necessary parties regarding status of replacement permanent resident card.

### 2. Insurance

- a. Submit MassHealth application when possible. Current limitation of lack of identification. Unfortunately patient cannot obtain insurance until he obtains replacement permanent resident ID.

### 3. Housing

- a. Assist with plan to return to Colorado. Engage in dialogue with client regarding importance of care team communicating with family to begin process.
- b. Submit housing applications in Massachusetts when possible.

### 4. CBFS

- a. Assistance with above including connection to probation officer and ongoing support navigating legal system, communication with family when possible.