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APA Resource Document

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Advocating for Anti-Racist Mental Health Policies
with a Focus on Dismantling Anti-Black Racism

Approved by the Joint Reference Committee, October 2021

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." -- *APA Operations Manual*.

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Executive Summary

Racial injustices have long contributed to mental health disparities for minority and underserved populations. More than 50 years ago, Dr. Melvin Sabshin and colleagues documented the "structured pattern of racism" in psychiatry in a series of articles in the American Journal of Psychiatry. Insufficient progress has been made in eradicating institutionalized racism in psychiatry. Race-based disparities in psychiatric care and mental & behavioral health reflect this lack of progress and reproduce racial inequities that span all sectors of our society.

For centuries, Black Americans in particular have long suffered from the effects of interpersonal and systemic racism. The medical system, including psychiatry, perpetuates racism from disparities in diagnosis to undertreatment of pain based on patient race. Just like the violent acts and atrocities arising out of racism covered in the media, racism in our medical system can be lethal, e.g., the rising death rate of Black women due to preventable childbirth complications. Anti-Black racism in psychiatry has been prevalent since its inception, with historic figures in psychiatry, like Benjamin Rush, who coined the term "Negritude," the disorder of being Black. Recently, the reports and recordings of numerous killings, injuries, and episodes of harassment and violation of Black women, men and children have brought the lived experiences of Black Americans to the forefront and led to a ricochet of anti-racism statements across institutions and systems.

On January 18, 2021, the APA issued an apology to Black, Indigenous, and People of Color (BIPOC) for its perpetuation of systemic racism in psychiatry. But, now what? As chairs, members, and fellows of APA's councils, we believe that all APA members play a critical role in eliminating racism in psychiatry and translating statements of commitment into action. We believe that while addressing inequities in the diagnosis and treatment of mental illness is essential, psychiatry as a field must find additional pathways to promote racial health equity. For example, the inequitable allocation of social resources directly and disproportionately harms the mental health and mental healthcare of BIPOC communities. Given this reality, psychiatrists who seek to eliminate racial inequities must move beyond traditional notions of the physician role and expand into areas that address the social and structural determinants of health in clinical care, research, education and advocacy. This is consistent with recent APA position statements.

This document seeks to review a wide range of policies that relate to the quality and experience of mental healthcare and mental healthcare outcomes. Many of the policies reviewed go beyond the realm of strict healthcare policy into areas, like the social and structural determinants of health, that have been demonstrated to contribute to the health disparities and inequities faced by our patients. We begin with definitions of key terms and an overview of structural competencies. We then review the types of policies that can be advocated for at multiple different levels: patient, physician, practice, health system, community, local government, state government, and federal government, and conclude with a synopsis of best practices for advocacy. We hope this document will be a starting point for APA members who seek to address and eliminate all forms of racism, including anti-Black racism, from a broad range of policies that impact the mental health and mental healthcare experience of our patients.

I. Introduction - The introduction explains that this document is not the first step in the APA's effort to address all forms of racism and its impact, nor is it the last. The authors hope this APA resource

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document will advance the discourse around anti-racism advocacy in Psychiatry and beyond for APA members, and, because of its horrific legacy and devastating impacts, given anti-Black racism special consideration. This document was developed to reflect the many voices within the APA, and was designed to center the voices of BIPOC APA members in particular. While its focus is on anti-Black racism, the authors acknowledge that racism touches all BIPOC communities, and that experiences by these varied communities are vast, complex, and require intentional excavation and discussion.

The purpose of this document is to help APA members engage in effective advocacy across multiple systems with the goal of dismantling racist systems that disproportionately impact minority and underserved populations, especially communities of color, and rebuilding these systems using anti-racist policies that promote health equity for these populations. This resource document will help APA members to:
- Define the relevant issues (e.g., describe existing structural racism in mental health and the need for anti-racist policies);
- Identify anti-racist policy solutions, especially those that address anti-Black racism, at the level of the patient, physician/staff, practice/institution, community, health system, local/regional government, state government, and federal government;
- Address the centrality of anti-racist policies that impact the wellbeing of Black, Indigenous, and People of Color (BIPOC) communities beyond psychiatric and mental health systems themselves; and
- Promote advocacy "best practices" for APA members and other mental health groups in order to advance anti-racist structural solutions.

II. Definitions - A glossary of terms used throughout the document is offered to provide clarity and consistency.

III. Structural Competency and Structural Action in Anti-Racism Mental Health Policy Advocacy - From a public health perspective, many of the factors that contribute to mental health disparities are related to unmet social needs. When social needs are addressed, mental health and well-being improves for minority and underserved populations. Therefore, advocates must look beyond mental health policy and healthcare interventions and advocate for anti-racist public policies that address social issues including:
- Criminal Justice Systems
- Housing Instability
- Educational Inequities
- Food Insecurity
- Workforce Issues
- Poverty and Income Inequality

IV. Anti-Racism Advocacy at the Patient, Physician and Clinic Levels - Systemic problems at the patient, physician and clinic levels include racialized diagnostic and treatment protocols (e.g., overdiagnosis of psychotic disorders in BIPOC populations), difficulties with access to behavioral healthcare, lower quality of behavioral healthcare, lower patient satisfaction with care, higher dropout rates, and overrepresentation in more restrictive and coercive treatment environments among minoritized populations. Contributions to these problems include a severe lack of diversity in the behavioral health workforce, physicians' frequent lack of awareness of the impact of their own implicit biases, lack of cultural competence and cultural humility, and historical neglect of racism and other social determinants of mental health in psychiatric training.

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As a result, disparities in mental healthcare reproduce and reinforce structural racism in other sectors. There are a range of potential anti-racist solutions that advocates may consider.

- To improve access to care and diagnostic and treatment inequities, advocate for culturally responsive care that is community-based; consider engaging the evidence-based Collaborative Care Model.
- To decrease stigma about accessing care and increase relevance of care, advocate for training the workforce to better meet the needs of BIPOC patients and embrace care models that address Structural Determinants of Mental Health.
- To diversify and expand the workforce, advocate for increasing staff diversity and improving training in cultural sensitivity and competency.
- To address inequities in coercion and mass incarceration, advocate for tracking the use of coercive measures, crisis care reforms, and mitigating the harms of mass incarceration.

V. Anti-Racism Advocacy at the Healthcare System Level - Systemic problems at this level include inequitable insurance coverage e.g., what insurance patients have available to them and which hospital systems accept that insurance, racial disparities in overall coverage (insured vs uninsured) as well as type of coverage (private vs public), physical barriers (e.g., distance from BIPOC neighborhoods to health facilities); scheduling disparities, and presence of law enforcement personnel in clinic settings. Anti-racist solutions at this level should:

- Review payer mix and billing practices;
- Address barriers to access by improving or increasing tele-behavioral health services including audio-only, clinic locations in the community, public transportation accessibility, and easy access appointment scheduling;
- Evaluate security measures and law enforcement presence such as front-door security measures, patients in custody, and law enforcement presence in hospitals and outpatient clinics;
- Improve community-based care and reduce the risk of "falling through the cracks" by increasing care coordinators, HIPAA compliant communications, and centering the patient perspective;
- Increase representation, recruitment and retention of BIPOC personnel in all levels of healthcare settings.

VI. Anti-Racism Advocacy at the Community Level - To advocate for anti-racist policies in the community, advocates must listen to and learn from community members and identify strengths and assets of the community, including prosocial behaviors, talents, skills, resilience, and interconnectedness. Advocates must assess community needs through a health equity perspective, analyze sociopolitical factors that contribute to local community distress and unhealthy coping behaviors, and study professional and organizational acts of omission. Upon this foundation, advocates must:

- Invest time, funding and resources into community-based organizations;
- Develop goals, visions and aims under the guidance of community-based partnerships relying on the insights of community-based organizations, activists and leaders;
- Respond quickly to community distress and concerns, e.g. targeted community mental health interventions in the wake of an extrajudicial police shooting;
- Establish local pipelines and education & training programs that support a diverse mental health workforce reflective of the community being served;
- Pair up with organizations that provide employment, housing and nutrition support, and provide services, supports and resources in non-medical community-based settings;
- Utilize Community Health Worker initiatives as a mechanism to enhance community trust;

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- Extend community engagement beyond superficial advisory roles that instead offer key leadership positions (on boards and executive committees) to community members;
- Avoid biased evaluations of services and programs and instead evaluate professional and health system impacts by garnering ratings from community members; and
- Measure success, re-evaluate antiracism outcomes and course-correct as necessary.

VII. Anti-Racism Advocacy at the Local and State Levels - Systemic problems at this level include policies and regulations that are poorly implemented, not enforced, or were put into place with intent to harm BIPOC, and especially Black communities. Loopholes exist within services so that patients may "fall through the cracks" as a result of poor coordination and fragmentation of services across social service agencies, and between local, state and federal-supported care, as well as variance in policies between localities (e.g., county to county). Potential anti-racist solutions that advocates can use include evaluating the impact of local and state policies on:
- Social and structural determinants of mental health
- Perpetuation of white privilege at the expense of BIPOC, and especially Black, communities
- Decreased access to mental health care
- Quality and type of mental health services provided
- Quality, training, diversity, and quantity of mental health professionals available

VIII. Anti-Racism Advocacy at the Federal Level - Advocates must apply an equity lens to all advocacy activities. When considering endorsement of a potential law or regulation, advocacy groups must always conduct policy analyses that critically assess for any potential impacts on BIPOC communities. All pieces of legislation are opportunities for including explicit language or intentional strategies that promote an anti-racist agenda. Furthermore, the mental health advocacy portfolio should be expanded to include bills, rules, and other policies that are primarily focused on anti-racism, including:
- Funding for mental health services—both specialty behavioral health clinics as well as integrated behavioral health in primary care settings—that provide care to predominantly BIPOC communities;
- Demonstration programs and grant opportunities that outreach, engage, and provide sustainable mental health services to people of color, including in religious and social settings;
- Partnerships with social services and coordination with law enforcement agencies to improve services and reduce criminal-legal system involvement;
- Alternative payment models that link reimbursement to measures of equity and incentivize reduction in disparities;
- Accreditation and accountability programs that require equity analyses as a routine part of continuous quality improvement activities;
- Initiatives aimed at increasing diversity in the mental health workforce and in leadership positions; and
- Research funding into disparities, Structural Determinants of Mental Health, and services interventions tailored to BIPOC communities.

IX. Advocacy Best Practices - The focus of this advocacy work is on anti-racism and the eradication of health inequities, especially for vulnerable and racial and ethnic minoritized communities. The historical context of structural racism in our organizations, including the APA, must be recognized, and how racism, classism, and privilege continue to propagate power dynamics and inequities. Advocates must:
- Develop personal structural competency, and in particular, structural humility, including engaging in self-reflection and performing a self-inventory to evaluate implicit assumptions and biases and address behaviors that may negatively impact others;

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- Recognize the role of listening, collaboration, and learning from community members before using dated interventions of leading;
- Assess relevant indices of mental health and inequities resulting from systemic racism in order to be able to decide on which system to focus more deeply;
- Identify the institutional or governmental system to be targeted by anti-racist policies and develop a strategic approach with a focused campaign;
- Work in collaboration with communities and facilitate decision-making by community members;
- Prioritize the needs and benefits to BIPOC and under-resourced communities over the needs and benefits for themselves or the field of medicine; and
- Monitor the effectiveness of advocacy efforts by using measurable outcomes.

X. Conclusion - As psychiatrists, we must lead the fight to optimize access and quality mental health care for minoritized and underserved communities. We must advocate for the dismantling of existing racist policies and practices that underlie mental health disparities and disproportionately impact all BIPOC communities. Despite the persistence of substantial, long-standing, systemic problems, there are a myriad of potential solutions that physician-advocates can use to call for change. In addition, advocates must recognize that to most effectively curtail race-based disparities in mental healthcare, we must address the upstream, social determinants of health—financial security, adequate housing, affordable and quality education—to effect long-term change in the racist policies and practices that contribute to worsening mental health outcomes for BIPOC communities.

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APA Resource Document: Advocating for Anti-Racist Mental Health Policies With a Focus on Dismantling Anti-Black Racism

Forward

This APA Resource Document was developed to provide guidance on antiracism advocacy strategies and practices to APA members and other health care professionals committed to advocating for and engaging in anti-racist practice. This document was conceived as a joint product of members and leaders from three of the APA's Councils: the Council on Advocacy and Government Relations, the Council on Minority Mental Health and Health Disparities, and the Council on Healthcare Systems and Financing. APA Resource Documents are products of the APA components (including Councils) and are intended as a resource for APA members and for the field. They are not intended to be an APA directive or policy statement, which are generally reflected in Action Papers or Position Statements. Though the document is primarily directed at physicians, much of the advocacy described herein can and should also be pursued by other types of clinicians and mental health advocates, including families and people with lived experience—this work must bring together broad coalitions to maximize the likelihood of success.

Throughout the process of writing, reviewing, and revising this document, it has been a priority to center the voices of Black, Indigenous, and People of Color ("BIPOC;" see Definitions below). The authors determined that while the core focus of this document gives special consideration to anti-Black racism and the need to dismantle white supremacy, they also recognize the efforts to address anti-Black racism will impact many BIPOC communities and that some, though not all, potential solutions to address anti-Black racism may also benefit other minoritized populations.

From the outset, the authors aimed to proactively develop and transparently communicate a clear review process and timeline to ensure that the many voices within the APA were included and heard. We invited direct feedback on a draft of this document from a range of stakeholders including the APA Councils, the Presidential Task Force to Address Structural Racism Throughout Psychiatry, and the Minority and Underrepresented (MUR) Caucuses. We received 26 responses describing a range of views, including some invaluable input that led us to more carefully address the history of racist drug wars, inclusion of language describing Asian American and Pacific Islander populations as part of BIPOC, and clarifying the definition of equity and several other terms. We also received multiple comments describing this document itself as racist because it separates people by race, suggesting instead that all people should be treated equally regardless of skin color; in response to these viewpoints, we added a paragraph about so-called colorblind racism to the introduction, and we encourage all readers to review this important framing for this document. Finally, the authors responded to suggestions from the APA's Joint Reference Committee after its initial submission in May 2021.

This document is neither the first step in the APA's effort to address racism and the resulting mental health disparities experienced by our patients, nor is it the last; this document aims to advance the discourse around antiracism advocacy within mental health care and beyond.

I. Introduction

Racial injustices have long contributed to mental health disparities for minority and underserved populations. More than 50 years ago, Dr. Melvin Sabshin and colleagues documented the "structured pattern of racism" in psychiatry in a series of articles in the *American Journal of Psychiatry*.[1] Insufficient progress has been made in eradicating institutionalized racism in psychiatry, and race-based disparities that exist in behavioral health care reflect this lack of progress[2] and reproduce racial inequities that span all sectors of our society.

For centuries, Black Americans in particular have long suffered from the effects of interpersonal and systemic racism. The medical system, including psychiatry, perpetuates racism from disparities in diagnosis to the undertreatment of pain based on patient race. Just like the violent acts and atrocities arising out of racism covered in the media, racism in our medical system can be lethal, e.g., the rising death rate of Black women due to preventable childbirth complications. Anti-Black racism in psychiatry has been prevalent since its inception, with historic figures in psychiatry, like Benjamin Rush who coined "Negritude," the disorder of being Black. Recently, the reports and recordings of numerous killings, injuries, and episodes of harassment and violation of Black women, men and children have brought the lived experiences of Black Americans to the forefront and led to a ricochet of antiracism statements across institutions and systems.

In response, members of the American Psychiatric Association have forcefully called for doing everything possible to advance anti-racist policies by effecting change in the systems that perpetuate health disparities. In 2018 and 2020, the APA released Position Statements condemning racism and police brutality,[3,] and in 2020, the APA President convened a "Presidential Task Force to Address Structural Racism Throughout Psychiatry." The charge of that Task Force included "developing achievable and actionable recommendations for change to eliminate structural racism in the APA and psychiatry…."[4] The charge embodies the APA's forceful call for advancing anti-racist policies to change the systems and institutions that perpetuate behavioral health care disparities. Most recently, the APA issued an apology "to its members, patients, their families, and the public for enabling discriminatory and prejudicial actions within the APA and racist practices in psychiatric treatment for Black, Indigenous and People of Color."[5]

Some individuals, including psychiatrists who provided feedback on this document, argue that they are "colorblind," meaning that they think about, approach, and treat all people (including patients, colleagues, etc.) "equally" or "the same," regardless of skin color. This assertion is grounded in a belief that race-based differences in our society do not exist or do not matter, in effect equating being colorblind with being anti-racist. We believe the opposite is true; that the (often unintended) effect of a colorblind stance is to uphold and support the current racist status quo in the United States. Colorblindness, in this context, suggests that all people have equal opportunities to good healthcare and health, regardless of the color of their skin; implies that systemic racism has been eradicated; denies the experience of people of color living in a society where race clearly matters; and makes it more difficult to speak openly about race and racism in a meaningful way, as well as phenomena such as implicit bias.[6,7] (In fact, since people obviously do have different skin colors, to claim to be blind to or not influenced by skin color is to deny the existence of any kind of implicit biases or assumptions about race.) The authors strongly believe that we do not live in a colorblind world and that stating one is colorblind is at odds with that reality, a reality that is overwhelmingly experienced by BIPOC.

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To the question of who is or is not "racist," Ibram X. Kendi says, "what I'm trying to do with my work is to really get Americans to eliminate the concept of "not racist" from their vocabulary, and realize we're either being racist or anti-racist. We're either expressing ideas that suggest certain racial groups are better or worse than others, superior or inferior than others. We're either being racist, or we're being anti-racist. We're expressing notions that the racial groups are equals, despite any cultural or even ethnic differences. We're either supporting policies that are leading to racial inequities and injustice, like we saw in Louisville, where Breonna Taylor was murdered, or we're supporting policies and pushing policies that are leading to justice and equity for all."[8] Kendi highlights that anyone, regardless of race, can engage in both racism and antiracism by their actions or inactions. In fact, the foundational presence of white supremacist power dynamics may precipitate conflict within and between BIPOC communities, which must also be taken into account when implementing anti-racist policies.

Effective advocacy by psychiatrists and the institutions they represent and work with calls for critical self-reflection, along with an understanding of specific ways to effectively advance structural solutions that address race-based disparities that characterize and undermine our care for the diverse range of BIPOC communities. Many of the policy issues relevant to mental health disparities pertain to access to care (e.g., reimbursement parity, collaborative care, crisis services, etc.), for which the APA has advocated strongly. Beyond this, many policies that contribute to mental health inequities go beyond what is traditionally considered under the umbrella of healthcare policy. To that end, this document covers an array of policy related to the social and structural determinants of mental health in areas such as housing, the criminal legal system, and income inequality. A critical review and understanding for how structural racism impacts policies that contribute to mental health inequities, and how these impacts may impact different BIPOC communities differently, can help advocates build consensus around the types of solutions needed to effect transformational systemic change.

The authors of this document seek to provide a resource that helps to facilitate critical advocacy by APA members and other entities for mental health policies that optimize access to and quality psychiatric care for all of our patients. We also seek to identify resources to facilitate change at all levels of the healthcare system and address underlying causes of mental health disparities. The APA's aim is to facilitate the pursuit of antiracism in allyship with other professional organizations whose goals are anti-racist practices, and with community-based movements on the frontlines whose members are often the victims of the racist policies currently in place at all levels of our behavioral health care system. This facilitation can happen at the level of the APA itself, at the District Branch level, or through the work of individual APA members.

This document seeks to review a wide range of policies that relate to the quality and experience of mental healthcare and mental healthcare outcomes for BOPIC communities. Many of the policies reviewed go beyond the realm of strict healthcare policy into areas, like the social and structural determinants of health, that have been demonstrated to contribute to the health disparities and inequities faced by our patients. We begin with definitions of key terms and and an overview of structural competencies and additional issues underlying mental health care disparities to ensure a shared understanding of the problem given its complexity, enormous scope and pervasiveness. We then review the types of policies that can be advocated for at multiple different levels: patient, physician, practice, health system, community, local government, state government, and federal government, and conclude with a synopsis of best practices for advocacy. Lessons from one level may apply to others, and this redundancy is unavoidable; racism at any level or system interacts with, reinforces and is reinforced by racism at neighboring and distantly related levels. Examples of potential solutions are identified at each of these levels for potential use by the APA, District Branches, individual members, and other

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advocates. The document concludes with a section on advocacy best practices that may be applied to advocacy in any context. We hope this document will be a starting point for APA members who seek to address and eliminate all forms of racism, including anti-Black racism, from a broad range of policies that impact the mental health and mental healthcare experience of our patients.

II. Definitions

Before delving further into the content of this APA Resource Document, it is essential to have a shared understanding of terms. The following definitions are provided to level-set around how we are addressing complex topics related to racism and policy. The definitions that follow are consistent with or adapted from the APA Presidential Task Force Glossary of Terms:
https://www.psychiatry.org/psychiatrists/structural-racism-task-force/glossary-of-terms

We recognize that several terms in this glossary may not do justice to the overarching concept, group of people, or breadth and complexity that they are at times interpreted to cover. The process for developing new, more inclusive and complex terms is likely to be iterative and come as a result of antiracism frameworks themselves. For instance, the term BIPOC, which refers to individuals who identify as Black, Indigenous and/or People of Color, is not meant to equate the experiences or identities of those from an extremely wide range of ethnic and racial backgrounds, but rather to highlight communities that have been oppressed in different ways and to different degrees by the downstream effects of white supremacy. We also acknowledge that there is nuance within and between racial and ethnic groups that is missed by clustering minoritized populations under an umbrella such as BIPOC and may lead to misinterpretation of data and cultural misunderstandings. It is also important to consider and address the identified problems and potential solutions that relate to the framework of intersectionality, as BIPOC individuals and communities can identify with and be influenced by their many different identities that go beyond race, such as gender, sexuality, age, ability, socioeconomic status, and immigration status. For the sake of brevity, but at the expense of clarity, we are using the term "BIPOC" in this document with the assumption that intersectionality is also a vital lens with which to advocate for equity and equality and that the experiences of BIPOC individuals and communities greatly vary, particularly when specifically taking into consideration anti-Black racism. Generally, we have tried our best to include terms that are as inclusive as possible with the understanding that there are known limitations and terminology is continually evolving.

Term	Definition
Anti-Black racism	Prejudice, attitudes, beliefs, stereotyping or discrimination that is directed at people of African descent and is rooted in their unique history and experience of enslavement and colonization.
Anti-racism	The active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably.
Anti-racist policy	A policy that advances racial justice and dismantles structural, systemic, and institutional racism.
BIPOC	Throughout this document, we use the term BIPOC (Black, Indigenous, and

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Term	Definition
	People of Color). For the purposes of this document, the term BIPOC includes Latino/a/x, Asian Americans and Pacific Islanders.
Community partnership	Pursuing long-term strategies (including changes in law, policies, and systems) to build healthier neighborhoods, expand access to housing, drive economic development, and advance other upstream initiatives aimed at eradicating the root causes of poor health, especially in low-income communities.
Disparate impact	Legal term referring to practices in housing, employment, and other areas that disproportionately and adversely affect a group based on a protected characteristic, despite the legislation/policies that govern these practices being formally neutral.
Individualized/ Interpersonal racism	Racism that includes face-to-face or covert actions toward a person that express or reflect prejudice, hate or bias based on race.
Inequality/equality vs. Inequity/equity	Inequality refers to an uneven distribution of resources or health. Inequity refers to unjust and avoidable differences in resources or health that arise from processes of exclusion. Equality has to do with giving everyone the exact same resources, whereas equity involves distributing resources based on the needs of the recipients.
Institutional racism	Refers to the policies and practices within and across institutions that produce outcomes that chronically favor or put a racial group at a disadvantage.
Internalized racism	Internalization of racial oppression by the racially subordinated.
Intersectionality	The complex, cumulative way in which cultural identity and the effects of multiple forms of discrimination (such as racism, sexism, ableism and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups.
Microaggression	Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional that communicate or are experienced as hostile, derogatory or negative prejudicial slights and insults toward any group, particularly culturally marginalized groups.
Prejudice vs. Discrimination	Prejudice is a belief that is often rooted in unfair assumptions. Discrimination is an action that is motivated by prejudice from a person or group from societal power towards a person or group that has been oppressed (for example White to BIPOC).
Public policy	A formal statement or action plan developed by a government agency or statutory body in response to an identified problem. Policymakers include legislators (federal and state), regulators, accreditors, licensing boards, and managers at state and local behavioral health agencies, physician organizations,

Term	Definition
	and insurance companies.
Race	A social construct or creation of a social reality, based on physical characteristics, such as skin color and hair texture.
Racism	A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race").
Racial bias	An implicit or explicit aversion to, stereotyping of, or discrimination against racial and ethnic groups.
Social determinants	The Social determinants of health, as defined by the World Health Organization, are non-medical factors that influence health outcomes and include income, food insecurity, education, employment, housing, work and living conditions, early childhood development, access to health services, and transportation. Social determinants of mental health (SDOMH) are social determinants that specifically impact mental health.
Structural competency and Structural humility	Structural competency is a medical education rubric, developed by Drs. Helena Hansen and Jonathan Metzl. Structural competency draws attention to the "forces that influence health outcomes at levels above individual interactions" including laws, institutional policies and practices, economic trends, and social forces like racism. Structural competency emphasizes physicians' roles in comprehending and acting on these upstream forces to eradicate health and social inequities. Structural humility is the "trained ability to recognize the limitations of structural competency" and the development of critical awareness of one's own limitations and expertise in structural competency. Structural humility encourages clinicians to be listeners, collaborators, and allies when working toward structural change.
Structural determinants	Structural determinants are the upstream laws, governing processes, institutional policies, economic policies and trends, and social norms (e.g., racism, stigma) that influence the social determinants of health and are at the root of health, healthcare, and social inequities.
Structural racism, Systemic racism	A combination of public policies, institutional practices, social forces, ideologies, and processes that generate and perpetuate inequities among races.
Trauma-informed	Emphasize respecting and appropriately responding to the effects of trauma at all levels, including trauma that has its roots in past and/or ongoing racism; "what has happened to this person" vs "what is wrong."
White supremacy	Frances Lee Ansley defines white supremacy as, "A political, economic and cultural system in which whites overwhelmingly control power and material resources, conscious and unconscious ideas of white superiority and entitlement are widespread, and relations of white dominance and non-white subordination are daily reenacted across a broad array of institutions and social settings."

III. Structural Competency and Structural Action in Anti-Racism Policy Advocacy

We Must Look Beyond Healthcare and Health Policy: Structural Determinants of Mental Health and Well-Being

Research has shown that only a small proportion of health is determined by healthcare.[1] Only 20% of variations in health and mortality are related to healthcare quality and access. By contrast, 50% of variations in health and mortality are related to the social determinants of health (e.g., food and financial security) and the physical environment (housing quality, environmental pollution). Structures—institutional policies and procedures, legislation, social norms, racism, and economic forces—exert powerful effects on health, healthcare, the social determinants of health, and the physical environment. These structures are at the root of racial inequities in mental health. Prominent examples include racism within US drug policies (e.g., so called "War on Drugs"), which contributed to heightened stigma and criminalization of substance use, the disproportionate and militarized policing of minority communities, and contemporary mass incarceration of people with substance use disorders and serious mental illness.

Other evocative examples of the influence of structures (food policy, financial benefits) on downstream mental health outcomes come from social protection studies, which examine the mental health effects of providing resources like cash and food aid.[2] For example, a study in Ecuador randomized neighborhoods to receive $40 equivalents of cash, food vouchers, or food versus a control arm. The investigators found that all of the neighborhoods receiving food resources showed improvements in family well-being, decreased marital stress and conflict, and decreased physical and/or sexual violence toward women, compared to the control condition.[3] A 2015 Swedish study examined the effects of cash-assistance benefits on depression, finding that a group receiving monthly $73 cash allowance for 9 months showed significant improvements in depression and anxiety symptom severity as well as quality of life and social networks.[4] A large cluster randomized controlled trial of a Kenya unconditional cash transfer program ($20 monthly cash transfers) resulted in 24% lower odds of depression among cash recipients compared to individuals who did not receive such payments in control communities.[5] These are examples of non-healthcare interventions improving well-being and other mental health outcomes. In brief, unmet social needs worsen mental health outcomes; addressing social needs improves them.

In 2015, a group of physicians alerted the public to an epidemic of lead poisoning among children in the city of Flint, Michigan.[6] In that example, physicians connected gross racial inequities in health outcomes (lead poisoning) to structural determinants (e.g., the city's 2014 decision to use the Flint River as its water source and aging lead pipes). It was physicians' actions, in partnership with community leaders and organizations, that drew public awareness and structural changes to address that public health crisis. Similarly, racial inequities in mental health and well-being outcomes can be traced to structural determinants that disproportionately affect BIPOC people and other minoritized communities. To help patients and populations achieve optimal mental health and well-being, advocates working from within healthcare systems must look beyond health policy and healthcare interventions and advocate for anti-racist public policies.[7]

Principles for Identifying Anti-racist Policies

Developing principles that guide how one may identify and intervene on policies outside of mental health care is a key first step to this work. It is important that the focus of this advocacy work be on anti-

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racism and the eradication of health inequities, especially for vulnerable and racial/ethnic minoritized communities, rather than on partisanship or other political concerns.[8] It will also be important to recognize the historical context of structural racism in our organizations (including the APA) and our work and the ways racism, classism, and privilege continue to propagate power dynamics and inequities.[9] It will be important for us to engage with these issues, noting the importance of first developing structural competency, and in particular, structural humility as we move towards interventions and advocacy.[10] Recognizing the role of listening, collaboration, and learning from community members first—prior to typical interventions of leading, acting as subject matter experts, and decision-making--will be essential. Additional principles which may guide anti-racist work are as follows:

- Elevate anti-racism within strategic planning at all levels.
- In analyzing policies and advocacy opportunities, it is critical to examine policies' effects on health, healthcare, and social inequities. The 2018 APA "Position Statement on Mental Health Equity and the Social and Structural Determinants of Health" states that the APA "Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities."
- In all advocacy efforts, the needs and benefits to BIPOC and other under-resourced communities should be prioritized over the needs and benefits to psychiatrists, in cases when they are in conflict.
- Engage in needs assessments with not just members of professional organizations and healthcare systems, but with communities experiencing racial inequities in mental health outcomes.
- Incorporate anti-racist action within long-term action plans including community partnerships, with structural humility.
- Monitor the effectiveness of this work using measurable outcomes. In particular, define outcomes from the point of view of community stakeholders, including the eradication of health inequities and incorporation of specific, measurable anti-racist goals and processes within public systems/policies.

As noted, building community partnerships and collaborating with organizations outside of organized medicine are key strategies by which we can identify areas of focus - outside of mental health services - where we can advocate for anti-racist policy actions. An important example of the APA engagement in this work is the organization's past advocacy regarding immigration policies, including the detention and separation of families at the border as well as changes to the Flores Settlement Agreement.[11] In these instances, the APA collaborated with human rights and legal organizations, other organized medicine groups, faith-based groups, and organizations which represent communities who are disproportionately affected by these immigration policies.[12] In each of these instances, the APA signed onto letters developed by multi-group coalitions for advocacy.[13-14] This collaborative and community-engaged approach should be continued and expanded as part of all work towards targeting racial inequities in mental health outcomes and should be employed by those endeavoring to engage in meaningful and impactful anti-racist advocacy efforts.

> **Box 1: Examples of Anti-Racism Advocacy Efforts Beyond Mental Health Policy**. When working to advocate for anti-racist mental health policies, it is fundamental that efforts target all policies and structures that negatively impact the mental health and well-being of BIPOC communities. This ultimately must entail advocacy efforts beyond health policy. This document will discuss healthcare-

specific policy areas in subsequent sections; prior to moving to those topics, we consider it essential that the reader consider the relevance of the following examples as central to any anti-racism advocacy work aimed at improving mental health for BIPOC individuals and communities.

Criminal Justice Systems
- Recognize that BIPOC and especially Black people, as well individuals with mental illness, are over-represented in the criminal-legal system.
- Support policies put forward by the Movement for Black Lives and other national organizations on divesting from criminal-legal and carceral systems, reimagining non-law enforcement solutions to mental health crises, and investing in community-based interventions and alternatives to incarceration.[15]
- Recognize the racial inequities that exist at every level of the criminal-legal system within the US including policing, arrests, pre-trial processes such as bail, trial practices, sentencing, incarceration, use of prolonged solitary confinement, probation, parole and re-entry support. Support policies focused on changing these practices (e.g., minimum sentencing reform, implicit bias training requirements).[16-17]
- Encourage the development of diversion programs and community-based alternatives to incarceration.[15]
  - Recognize the importance of providing community-based care to BIPOC and other minoritized populations who are over-represented in the criminal-legal system prior to arrest.[17]
- Support the development and expansion of mental health courts, as well as the collaboration with court systems regarding mental illness and interventions[18] through programs, including the American Psychiatric Association Foundation's Judges and Psychiatrists Leadership Initiative.
- Recognize the negative impact of punitive drug policies at the state and federal level, including mandatory minimum sentencing, the focus on incarceration and punishment rather than rehabilitation and treatment, and the differential effects of these policies on BIPOC communities. Advocate for decriminalization and reorientation toward a treatment-based approach to substance use.

Education
- Support policy changes that seek to eradicate the school-to-prison pipeline, and in particular:[20]
  - Change zero-tolerance policies which have resulted in Black students facing harsher punishments compared with White students.
  - Stop exclusionary disciplinary policies, which have resulted in significantly more out-of-school suspensions and expulsions for Black students compared with White students. These policies remove students from the school environment and are associated with less access to education, and an increased likelihood of underemployment, unemployment and eventual incarceration.[20-23]
- Recognize ongoing racial segregation in schools and encourage policies that move towards desegregation, equitable school funding allocations, and district mapping as an essential aspect of equitable access to education.[24-25]
- Support inclusion of anti-racist principles within curricula, including examining the historical roots and contemporary manifestations of racism.[26]
- Develop and disseminate school-based assessments that are anti-racist and discourage the

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overuse and misuse of standardized testing in schools.[27-28]
- Move towards comfort with talking about racism in the classroom, culturally sensitive training of teachers, educating students regarding the historical roots of racism and how this affects society in general and mental health in particular; encourage active participation in promotion of building empathy, solidarity, belonging and compassion in schools.

Housing
- Advocate to protect the Disparate Impact legal doctrine in the US Department of Housing and Urban Development and the US Justice Department, which is a legal doctrine that states a policy may be deemed discriminatory if it has a disproportionate adverse impact against a group based on race, color, national origin, sex, religion, family status, or disability. [29-30]
- Advocate against predatory lending and the purchase of such loans for securitization by Wall Street.[31]
- Advocate for policies and protections that eradicate discrimination by race/ethnicity in housing and homeownership.[32]
- Support policies and initiatives that increase BIPOC homeownership, particularly for Black communities, as part of addressing longstanding inequities in wealth by race in America.[33]
- Support policies and initiatives that protect the value of BIPOC-owned homes and neighborhoods, to combat systematic devaluation of Black property and the furtherance of wealth inequities by race.[34]

Poverty and Income Inequity
- Support policies put forward by the Movement for Black Lives and other national organizations: reparations, universal basic income, housing and healthcare for all, investment in Black communities and business, and divestment from criminal-legal and carceral systems.
- Advocate for financial assistance, eviction protections, and rental forgiveness during this COVID-19 pandemic.[35-36]
- Support the expansion of critical safety net programs like universal paid family leave programs, financial assistance for childcare, funding for social service programs.[37]
- Support policies to eradicate structural racism in wages and employment, including policies to require all companies to publicly report hiring and pay information data, corrective monetary payouts with interest to address wage gaps that cannot be explained by qualifications, monetary damages for companies found to racially discriminate in hiring and wages.[38]
- Support employee protections (e.g., workplace discrimination protections), healthcare and other benefits (retirement plans), and rights for independent contractors.[39]
- Support policies that invest in BIPOC-owned businesses, particularly Black-owned businesses, to counteract the underrepresentation of BIPOC entrepreneurs in many industries and inequities in economic opportunities and wealth by race in America.[40]
- Combat policies that exacerbate employment and workplace discrimination for BIPOC and other marginalized (e.g., LGBTQ) populations.[41]

IV. Anti-Racism Advocacy at the Patient, Physician, and Clinic Levels

Overview

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Structural racism at the patient, physician, and clinic level often form the foundation of negative experiences that lead to patient mistrust and avoidance of mental health services altogether. The undertones and ramifications of implicit bias that often characterize individual patient-physician interactions have profound consequences that not only impact the patient, but also their family, and the community at large. This problem is exacerbated by the dearth of physicians with the ability to evaluate and understand behavior within the context of the patient's culture, and the relative lack of BIPOC physicians working in mental healthcare. Unfortunately, these issues are indicative of a mental health system that centers whiteness while often pathologizing otherness. As a result, access to appropriate mental health care is limited and mental health disparities among BIPOC communities are increased. It is therefore incumbent upon physicians and clinicians, individually and collectively (through clinics), to create mental health care environments that are diverse, inclusive, and culturally competent. As patients, law enforcement, and policy makers look to mental health physicians for their professional guidance it is imperative that physicians individually acknowledge and examine their implicit biases, prejudices, and personal beliefs in order to deliver equitable care.

Problems

From its inception, psychiatry has been shaped by white supremacist ideologies. Pseudoscientific theories, such as "drapetomania" and "dysaesthesia aethiopis," have left a legacy of systemic anti-Black racism that continues to be reflected by the mental health disparities and inequitable health outcomes in not just Black people, but all people of color.[1,2] Psychiatric diagnosis has been used as a tool to prevent the advancement of Black people, through continued suggestions of innate immorality and criminality, and as biological justification for the control and oppression of Black people, e.g., protest psychosis.

These systemic racial inequities continue today in the form of a racialized diagnostic and treatment system, a severe lack of diversity in the behavioral health workforce, implicit bias among mental health clinicians, overwhelming cultural ineptitude, and historical neglect of racism and other social determinants of mental health (SDOMH) in psychiatric training. These factors have a direct impact on how systems of care are structured and the manner in which mental health care is ultimately delivered. As a result, disparities in mental healthcare reproduce and reinforce structural racism in other sectors such as education and the criminal legal system.

Examples of such inequities are numerous in psychiatry and shape diagnosis and treatment. One of the most impactful and well-described is the overdiagnosis of psychotic disorders in BIPOC populations, and particularly Black populations, which persist despite clear evidence of no true difference in prevalence, even when controlling for demographic and clinical variables.[3,4] Clinical descriptors such as hostility, suspiciousness, and dangerousness, when racialized, particularly with respect to Black individuals, underpin these diagnostic inequities and subsequent treatment decisions.[3,5] Consequently, Black patients are less likely to be diagnosed with mood disorders than their White counterparts, more likely to be treated with first generation antipsychotics, more likely to be treated with higher medication doses, and more likely to receive long acting injectable formulations.[6] The simultaneous under-recognition of mood symptoms in Black patients leads to decreased likelihood of receiving appropriate antidepressant or ECT treatment.[7,8]

Structural racism also influences the delivery and receipt of mental healthcare. Minoritized populations have less access to outpatient care, lower utilization rates, lower quality of care and satisfaction with care, and higher dropout rates.[9] At the same time, these groups are consistently overrepresented in

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more restrictive and coercive treatment environments. BIPOC individuals receiving mental healthcare are overrepresented in emergency rooms and inpatient settings, are more likely to have police involved and be handcuffed during transport to treatment settings, are more likely to be physically restrained, and are more likely to be civilly committed.[9-13]

These issues are of particular relevance in an era when there is much attention given to criminal legal system reform, with many suggesting that expansion of the mental healthcare system may be a means of mitigating the harms of the carceral state on minoritized populations. Yet, evidence suggests that the system as currently constructed is poorly suited for such a role. The structural racism and white supremacy that drive inequities in mass incarceration are reproduced in the healthcare system, including mental healthcare. Instead of serving as a solution to mass incarceration, the current system is interlocking with and reinforcing of the criminal legal system.[14]

Psychiatrists have been shown to be only 60% as likely to accept Medicaid or private insurance compared to physicians in other specialties in part because these payers reimburse at prohibitively low rates, creating additional bureaucratic burden, and often resulting in the denial of medically necessary mental health care.[15] This exacerbates access to care issues given that the economic legacy of structural racism has left BIPOC individuals more likely to be uninsured or publicly insured, and less likely to be able to afford out of pocket care.

The underrepresentation of BIPOC individuals in the mental health workforce at all levels contributes to outcome inequities, as physicians of color are more likely to care for underserved patients. Additionally, care team diversity is associated with increased quality of care and patient trust.[16,17] According to the American Association of Medical Colleges less than 5% of active psychiatrists are Black.[18] Evidence shows that the lack of physician diversity, particularly in a field with a history of structural violence against oppressed groups, is a factor that deters help seeking behavior.

Anti-Racist Solutions

Table 1 summarizes anti-racist solutions that can be implemented at the patient, physician, and clinic levels. For each area, it is important for advocates to engage in ongoing performance review to identify progress and problems (e.g., evaluate if there are unmet service needs, gaps in services, unacceptable wait times for appointments), and to identify and then measure the mental health outcomes associated with any quality improvements.

It is essential to note that a critical component of anti-racism work at the physician level is medical education. Anti-racism, structural competency and advocacy education and training is at best inconsistent across medical and graduate medical education programs across the country, and oftentimes completely absent from curricula. This alarming gap in education of medical professionals urgently needs to be addressed via the development and implementation of new competencies and standardized curricula aimed at providing comprehensive education focused on structural competency, cultural humility and the importance of advocacy for improving the lives of BIPOC and other minoritized populations. Resources developed for both medical school, graduate medical education and continuing medical education should include the National CLAS (Culturally and Linguistically Appropriate Services) Standards; AAMC Framework for Addressing and Eliminating Racism at the AAMC, in Academic Medicine, and Beyond; the DSM overview of cultural formulation; and selected publicly available curricula and trainings in structural competency.

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Table 1. Approaches to advancing anti-racism in patient, physician, and clinic-level mental health policies.

Advocacy Area	Policy Considerations	Approaches to Advancing Anti-Racism
Access to Care and Diagnostic and Treatment Inequities		
Payer Mix	Individual physicians and clinics should consider diversifying forms of payment that they accept, to increase access to psychiatrists beyond Medicaid or private insurance.[15]	Physicians and clinics should monitor whether their payer mix reflects the broader community they serve and if it is not, consider how this might impact access to mental health care for BIPOC individuals.
Exclusionary Clinic Policies	Physician and clinic policies that make significant demands on patients, especially when a condition of receiving treatment, such as no-show policies and requirements for drug abstinence should be examined and reconsidered.[19] Consider avoiding public safety personnel screening and metal detectors at the entrances to health care system service areas, as these might deter help seeking.	Consider whether due to already existing inequities, exclusionary policies might disproportionately impact BIPOC individuals. Provide access to telehealth and telephonic visits
Culturally Responsive Care	Ensure that all physical spaces are culturally centered, accessible, inclusive, representative of the population that is being served and welcoming. Physicians should also ensure appropriate accommodations are made for patients with limited english proficiency such that this status doesn't result in exclusion from care. Acknowledgement and understanding of the complexities of power dynamics; a move towards culturally humility and humanistic approaches to these dynamics to establish rapport in the clinical setting and holistically enhance belonging and connection	Examples of efforts to achieve these goals might include: easily available interpreters, holiday decor for all traditions celebrated by patients who come to the clinic, decor that is reflective of the community, spaces that are accessible for people with disabilities, promoting community events such as screenings of historical documentaries, following National CLAS Standards.

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Advocacy Area	Policy Considerations	Approaches to Advancing Anti-Racism
Community-Based Care	Policies that allow individual physicians to literally meet patients "where they are" should be encouraged. Examples of specific interventions include telehealth, use of mobile health clinics, and partnerships with community-based organizations (including schools, jails, libraries, shelters, food pantries, and community centers) that can provide evidence-based interventions in a culturally responsive manner.[19]	Involving the community being served in the development of community-based interventions will be helpful in ensuring that the interventions meet the community's needs. Engage in community outreach regarding access to benefits and resources.
Collaborative Care Model	Promote the use of the evidence-based collaborative care model (CoCom)which is shown to decrease barriers and promote easier connection to mental health services, better communication between physicians of physical and mental health services, and may help some individuals with accessing mental health services who would not go to traditional mental health clinics due to stigma. Research has shown that CoCom decreases health inequities by reducing stigma.	Track use of mental health care services across race within the collaborative care model, to monitor for disparities in utilization that might still emerge.
Disparities in Diagnosis and Treatment	Physicians should monitor for racial inequities in diagnoses given and treatments provided at the individual physician and clinic level.	Clinicians should be familiar with and/or use the DSM Outline for Cultural Formulation, Cultural Formulation Interview, and the Culture-Related Diagnostic Issues sections in the narrative descriptions of disorders. Rigorous diagnostic scrutiny including application of the cultural formulation published in DSM has been shown to dramatically reduce diagnosis of psychotic disorders in minoritized individuals.[20]
Increase Relevance of Care to Oppressed Groups		
Training the workforce to better meet the needs of BIPOC Patients	Clinics and individual physicians should pursue training in structural competency and racism, cultural humility, and implicit bias to better address structural racism and other	Clinics and physicians should embrace policies that make conversations about racism and structural determinants of health part of routine clinical practice both with patients and between

Advocacy Area	Policy Considerations	Approaches to Advancing Anti-Racism
	inequities in exposure to SDOMH that drive outcomes.[2,21,22]	physicians. The use of SDOMH screening methods such as the Structural Vulnerability Assessment Tool could help normalize such discourse.[23]
		Ensure that physicians have had specialized training in trauma-related care, especially race-related trauma, and the intergenerational transmission of trauma
Embrace care models that address SDOMH	Given that structural racism creates differential exposure to structural vulnerabilities, clinics and physicians should embrace models of care that address SDOMH and barriers to accessing both physical and mental health care. Examples include Assertive Community Treatment, Integrated Care and expanded training and use of community mental health workers and case managers.[24,25]	Implement models of care delivery that help simultaneously address structural disadvantages that disproportionately impact BIPOC individuals.
Physician Advocacy	Policies that encourage physicians to advocate for issues that impact their patients, including those directly related to provision of clinical care as well as larger policies that impact mental health (e.g., mass incarceration, immigration, and residential segregation).[21] Policies that ensure protection for physicians engaged in advocacy.	Conversations around various SDOMH that disproportionately impact BIPOC individuals should be normalized in clinical settings, and addressing these issues should be explicitly made to be part of the physician's role.
Diversify and Expand the Workforce		
Staff Diversity	Support and implement hiring practices that enhance diversity as well as clinic protections and reporting procedures that protect BIPOC staff from discrimination.	Individual clinics should consider whether the racial composition of their staff reflects the community they serve.
		Increase BIPOC individuals in positions of leadership.
		Prioritize BIPOC individuals from low-income backgrounds and support

Advocacy Area	Policy Considerations	Approaches to Advancing Anti-Racism
		diversity within BIPOC mental health physicians.
		Improve patient-physician ratios
Cultural Sensitivity & Competency	Institute Continued Education activities that directly address interpersonal relations and workplace culture.	Implementation of mandatory implicit bias training, using tools such as Project Implicit.
		Organizational Diversity, Equity & Inclusion (DEI) curriculum to address common issues.
Inequities in Coercion and Mass Incarceration		
Tracking the use of coercive measures	Measures such as use of restraint, involvement of police in care, and civil commitment should be tracked and reported in a disaggregated manner and used as quality metrics.	Mental healthcare does not effectively track the system's use of heavily coercive measures such as civil commitment.[26] Tracking of this data should give special attention to racial inequities in the use of these measures. Individual physicians and clinics should examine practices that contribute to inequities.
Crisis care	Programs designed to minimize the involvement of police and security personnel in mental healthcare crisis situations.[26,27]	In place of police and security, mental health crisis teams including community members and members with lived experience, will help to disentangle mental health crisis responses from the carceral system.
Mitigating the harms of mass incarceration	For patients who are involved with the criminal legal system, clinics and individual physicians should design and partner with already existing programs that help address the unique structural determinants associated with incarceration and assist with re-entry into the community.	Promising examples include Physician-Public Defender collaborations and other medical-legal partnerships[28], as well as clinics specifically aimed at serving formerly incarcerated patients.

V. Anti-Racism Advocacy at the Healthcare System Level

Overview

Structural racism at the level of healthcare systems contributes to racial inequities in access to mental health care. Within healthcare systems, racism impacts the ability of those systems to care for BIPOC communities. Here, we discuss specific recommendations for large and multi-site clinics, hospitals and larger healthcare systems to identify racism within their systems and develop anti-racist policies to support equity in healthcare. We use the term healthcare system throughout, which is meant to be inclusive of all medium (e.g., multi-clinic) to large (e.g., interstate multihospital) systems, and expands on the discussion introduced in Section IV which focused more on advocacy at the patient-physician and single-clinic level. It is important that each component of the organization critically examine how racism contributes to inequities within itself, as well as having overarching support from a Chief Diversity Office and Officer to support this work. Any targeted advocacy approach must be crafted with the decision-making structure of the specific healthcare unit in mind. Of note, many of the processes identified and the subsequent required changes involve both policies within the healthcare system as well as ongoing advocacy by the healthcare system outside of the organization (i.e., local, state and federal governmental levels). Racism, structural and otherwise, affects nearly every aspect of access from insurance status to the physical location of and proximity to services as well as the quality of the services. Change in healthcare systems can often be a complex process, requiring both evaluation and change within the system as well as change to local, state and federal policies.

Problems

In this section, we briefly review the myriad problems that arise from the integration of racism into all levels of healthcare systems. Some of these have been foreshadowed in the previous section, and many will be referred to again in discussions of policies that may be targeted at the local, state and federal level. As mentioned previously, this redundancy is unavoidable; racism at any level or system interacts with, reinforces and is reinforced by racism at neighboring and distantly related levels. By level, this is meant to include the individual level as well; individual and interpersonal manifestations of racism permeate the provision of healthcare and the design of healthcare systems. To engage in anti-racist advocacy, one must intentionally and thoughtfully examine every potential level of a healthcare system and engage in root-cause analyses to identify solutions that dismantle racism and racist policies.

Problems that are more explicitly borne from healthcare systems are emphasized here. A key arena for discussion is insurance coverage, given that a major factor contributing to racial inequities in mental health care is unequal access to care, via what insurance patients have available to them and which hospital systems accept that insurance. Although the passage of the Affordable Care Act reduced racial inequities in health care coverage, there still remain significant racial disparities in both overall coverage (insured vs uninsured), as well as type of coverage (private vs public) (Buchmuller et al., 2016).

Physical barriers and scheduling disparities also negatively impact equitable access to care. Our nation's history of racist housing policies and practices and city planning has created multiple physical barriers to care, including increased distance to healthcare offices, specialty care clinics, hospitals and pharmacies (Tsui et al, 2020). There is also significant evidence for the existence of racial inequities in appointment scheduling (Wisniewski and Walker, 2020), including time from request to appointment and follow up, times offered for appointments, insurance verification requests, and opportunities for scheduling multiple appointments in a single day to reduce number of days needed to travel to specialty clinics.

Police presence is central to the discussion of mental health care provision, as many hospital systems utilize law enforcement personnel (LEP) to address security and safety concerns, often without ensuring adequate training in mental health nor exploring alternative options for ensuring hospital and clinic

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safety prior to utilizing this option. LEP in hospitals and clinics may discourage access by those who have experienced systemic racism and violence, and when security personnel do not have adequate training in mental health this runs the risk of violence and abuses against patients, resulting in both direct harm as well as discouraging further engagement to access treatment.

Representation of local communities is woefully inadequate. Healthcare and hospital systems make inadequate (if any) efforts to consistently and proactively engage BIPOC communities, nor endeavor effectively to employ a workforce that is representative of the populations they serve.

Anti-Racist Solutions

Table 2 summarizes anti-racist policies that can be implemented at the health system level to address the problems of insurance status, barriers to access, and law enforcement presence in health care settings, while promoting community-based care and increasing BIPOC representation in the workforce.

Table 2. Approaches to advancing anti-racism in health system mental health policies.

Advocacy Area	Examples of Policy	Approaches to Advance Anti-Racism
Insurance Status		
Payor Mix	Ensure that payor mix in all clinical services reflects the payor mix in community served, especially with regards to accepting public insurance products.	Assess payor mix across clinical services, ensure all services accept public insurance programs, examine charity care and financial assistance programs, advocate for adequate reimbursement from these programs and seek out contracts with state when indicated to equitably improve access care.
Billing practices	No aggressive collections or use of legal actions to recover unpaid balances.	Evaluate billing practices and change policies, especially for uninsured patients.
Barriers to Access		
Tele-behavioral health	Encourage expansion of telehealth, including audio-only, to reduce physical barriers associated with in-person care.	Include provisions that provide broadband and technology access and assess acceptability among communities of color.
Clinic locations	Locate clinics within communities which are served, embed specialty care within primary care offices. Support presence of pharmacies as well.	Monitor location of clinics compared to home location of patients, utilize collaborative care models (as discussed elsewhere).

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Advocacy Area	Examples of Policy	Approaches to Advance Anti-Racism
Public transportation	Support expansion of public transport within communities and with proximity to specialty clinics and hospital care.	Assess patients' commutes to specialty clinics and hospitals, support access to efficient transport including multiple models of funding transport and advocating for better public transport infrastructure.
Appointment Scheduling	Support a wide range of clinic hours outside of typical hours, ensure intakes and follow ups are scheduled in clinically appropriate manner, support multiple appointments on same day.	Assess clinic wait times and talk with patients about requesting time off from work, if needed. Support scheduling multiple appointments on same day.

Security Measures and Law Enforcement Presence

Advocacy Area	Examples of Policy	Approaches to Advance Anti-Racism
Front-Door security measures	Minimize where possible metal detectors at entrances to healthcare facilities, security screening prior to entry.	Consider avoiding public safety personnel screening and metal detectors at the entrances to health care system service areas.
Patients in LEP Custody	To reduce undue influence, clinical assessments should be performed separate from LEP even while in custody and systems should support patients receiving indicated care regardless of LEP custody status.	Evaluate the presence of hospital policies which support clinical assessments and recommendations be carried out independent of LEP custody status.
LEP presence in hospitals	LEP presence is minimized, behavioral response teams are used where appropriate, weapons are not used to control or "manage' patients.	Evaluate the presence of hospital policies to support this, evaluate the volume and support seen by behavioral response teams and sitters. In acute treatment settings where LEP are often involved in patient care, clear policies need to be adopted to protect patient rights and begin to disentangle healthcare from the carceral state.
LEP presence in outpatient clinics	LEP presence is minimized, training provided regarding recognizing mental illness, behavioral response teams are used where appropriate.	Evaluate the presence of clinic policies to support this and provide training when needed. Policies should be put in place such as those outlined in the White Coats for Black Lives Racial Justice Report Card that require

Advocacy Area	Examples of Policy	Approaches to Advance Anti-Racism
		hospitals and clinics to report on and meet institutional policy standards that discourage a reliance on policing with a goal of making healing settings feel "like sanctuaries, not prisons."

Community-based Care, Reducing Risk of "Falling Through the Cracks"

Advocacy Area	Examples of Policy	Approaches to Advance Anti-Racism
Care coordinators	Ensure funding for care coordinators and other roles that can serve as liaisons between different specialties.	Evaluate the presence of policies to support this, advocate for increased funding for such.
HIPAA compliant communication	Automatic communication among EMRs of community, academic, private and other clinics to improve coordination of care.	Identify and address barriers to communication across systems, institutions and specialties.
Centering the patient perspective	Conduct regular surveys of patients and community members regarding their experience with the hospital system and factors leading to engagement/disengagement.	Advocate for policies that center the patient voice in identifying areas for improvement. Establish a task for identifying areas of improvement.

Increasing Representation

Advocacy Area	Examples of Policy	Approaches to Advance Anti-Racism
Recruitment and retention of BIPOC individuals in healthcare settings	Comply with Title VII and the Equal Opportunity Employment Act. Implement training requirements including implicit bias training and bystander intervention training. Comply with ACGME Common Program Requirement on diversity and inclusion, 2019. Implement APA Position Statement on Diversity and Inclusion in the Physician Workforce, 2019.	Complete annual assessments examining discriminatory hiring practices, aggressions and microaggressions in the workplace, reporting mechanisms and pay differentials. Create a diversity plan including measures of accountability for meeting plan's goals. Admissions to medical schools and residency programs should take a holistic approach and affirmatively race-conscious decision making should be employed. Medical schools, residencies, and academic medical centers should report transparent and disaggregated data on the diversity of trainees, faculty, and senior leadership.

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VI. Anti-Racism Advocacy at the Community level

Overview

Mental health professionals and health systems often struggle to align their interests with the values and goals of the communities of color that they serve. Through direct and indirect harms (both past and present) they have engendered mistrust in these groups. If organizations seek to propel anti-racism advocacy and practices, impacts should be felt locally and interventions targeted to directly address BIPOC community needs. Community is defined as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.[1] Community advocacy should be conceptualized as transformative strategies that benefit BIPOC residents of counties, municipalities and neighborhoods. Professionals and health systems should "start at home" by building community partnerships through meaningful engagement. They must develop awareness of local factors (e.g., over-policing; disparate distribution of education, economic, and housing resources) and their intersections with the mental & behavioral health outcomes of their communities.

Evidence suggests structural racism plays a role in the overrepresentation of BIPOC residents in under-resourced communities.[2] It is imperative that professionals and health systems examine barriers, pose solutions, eliminate disparities and improve health outcomes to mitigate the broken infrastructure, economic divestment, workforce scarcity, environmental challenges, differential impacts of climate change, and burdens of chronic health condition that disproportionately impact these communities.

Problems

Historical racist policies such as school segregation and housing exclusion through redlining continue to influence modern-day harms of impoverishment, incarceration and adverse health outcomes.[3,4,5] Households of color are less likely than white household to be homeowners—a marker of familial wealth and stability—even when controlling for protective factors such as region/state, marital status, education, income, and age.[6] Police officer-involved killings of unarmed Black people (Breonna Taylor, George Floyd, and Ahmaud Arbery, among many others) highlight the repeated and unnecessary use of excessive, lethal force on BIPOC, and particularly Black, individuals.[7,8,9] While episodes of police violence directly impact the individual and families victimized, they also have spillover effects on the mental health of the local community.[10] Through racist policy design, BIPOC neighborhoods and communities disproportionately have inadequate resources for schools, safe housing, public transportation, nutrition access and community-oriented policing.

Anti-Racist Solutions

Community outreach and engagement including community health fairs, community-based screenings, and preventative care are necessary for equitable change at the community level. Community-driven models may be customized for the specific population receiving the intervention; place-based multi-sector initiatives like *Purpose Built Communities*, *Promise Neighborhoods*, and *Choice Neighborhoods* serve as examples of this approach.[11,12,13] Mental health professionals and systems should advocate for reforms that promote access to nutrition services, housing supports, unemployment benefits, financial assistance, public school funding fixes, and community health worker programs in BIPOC communities to achieve socioeconomic and racial equity. Additionally, to reduce lethal and non-lethal harms, mental

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health professionals and systems should collaborate with local law enforcement agencies to develop both anti-racist, mental health training programs and alternatives to police response for crisis interventions. Advocacy should be driven by community outreach and engagement, as described in Table 3.

Table 3. Approaches to advancing anti-racist mental health policy in communities.

Directly Examine Community Vulnerabilities and Strengths	Plan and Execute Strategy to Promote Community Engagement and Support	Evaluate and Measure Outcomes to Enhance Community Performance
Listen to/Learn from and engage with community members studying acts of omission. Study professional and organizational acts of omission, acknowledge mistakes, atone for harms. Identify strengths and assets of the community – prosocial behaviors, talents, skills, resilience, and interconnectedness. Assess community needs through a health equity perspective. Analyze sociopolitical factors that contribute to local community distress and unhealthy coping behaviors.	Invest time, funding and resources into community-based organizations. Develop goals, visions and aims under the guidance of community-based partnerships relying on the insights of community-based organizations, activists and leaders. Respond quickly to community distress and concerns (e.g., targeted community mental health interventions in the wake of an extrajudicial police shooting). Establish local pipelines and education & training programs that support a diverse mental health workforce reflective of the community being served. Provide services, supports and resources in non-medical community-based settings to cover gaps that limit access. Utilize Community Health Worker initiatives as a mechanism to enhance community trust. Pair up with organizations that provide employment, housing and nutrition support. Extend community engagement beyond superficial advisory roles that instead offer key leadership positions (on boards and executive committees) to community members.	Measure success, re-evaluate anti-racism outcomes and course correct as necessary . Avoid biased evaluations of services and programs and instead evaluate professional and health system impacts by garnering ratings from community members; act on such community feedback.

VII. Anti-Racism Advocacy at the Local and State Levels

Overview

The right to access quality mental health care has been determined to qualify as an international human right: the United Nations' Universal Declaration of Human Rights, in Article 25, states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family,

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including … medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[1]

The structure and processes of nearly all US state governments reflect the structure and processes of the US federal government. All states but Nebraska have a bicameral state legislature, i.e., are composed of a state house and senate (or equivalent), and all states have an elected official, the governor, who serves as the chief of the executive branch. States do vary in terms of the frequency and duration of their legislative sessions (e.g., the Massachusetts legislature convenes annually whereas the Texas legislature is in session every other year.) Proposed bills usually move through a relatively transparent process that typically includes a public hearing before a state legislative committee, followed by a simple majority vote to move the bill out of committee and into the house and senate chambers. At this point, a simple majority vote in each chamber is required to move the bill onto the governor's desk where the bill can either be signed into law, in which case the bill usually will become law after a short period of time (e.g., 10 days.), or they can be vetoed or ignored. Bills that are vetoed typically require a supermajority vote to override the governor's veto. States have a variety of agencies led by commissioners who are usually appointed by the governor. These agencies are responsible, among many duties, for translating laws into regulations.

In contrast, the structure and processes of local government across the US demonstrate far greater variation. For purposes of brevity, we will use "local" to reference all governing structures below the state level including regional, county, municipal, township, village and other governing structures. Tribal governments also often have independent jurisdiction from neighboring areas. In general, local government utilizes fewer paid staff and more citizen-volunteers in positions of power than do state or federal governments, especially around the development, ratification, implementation, oversight, and enforcement of local policies and regulations. Because of higher levels of citizen engagement and geographical proximity, local governments often have a larger interface with the communities they serve.

Local and state governments are expected to provide many critical services needed for the communities they serve. Most, if not all of these services are intimately connected with the social and structural determinants of mental health. These include but are not limited to the policies and procedures that regulate and/or fund the following: schools and other educational programs; public safety, law enforcement, racial profiling laws and criminal-legal services; cash bail and mandatory minimum sentencing; housing and residential zoning; public transportation; elder and child services; libraries and community centers; voting and election procedures and zoning; access to food employment services, minimum wage requirements and family and medical leave policies; health systems, insurance regulations and crisis and emergency services; deadly force/stand your ground laws; affirmative action; and financial aid services.

Problems

In this section, we describe typical problems related to mental health that arise out of racist attitudes and policies that have been intentionally and/or unintentionally "baked-in" to the state and local government structure and processes since America's birth in 1776. All state and local governments have at least some, if not many, racist laws, policies, and procedures that negatively impact BIPOC communities and contribute substantially to a range of mental health disorders, including increased rates of anxiety, depression, trauma-related issues, and substance use. Each of the social and structural

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determinants previously described are part of a larger system historically built on racist principles that lead to negative impacts on BIPOC communities, including health disparities.[2,3] In addition, often the interface between local and state government services result in gaps in services and/or fragmentation in care. These gaps further disadvantage and harm the health and well-being of BIPOC communities. Since local governments have a larger interface with the communities they serve, as described earlier, they may function in additional ways that are actively harmful to BIPOC communities.

It is important to recognize that racism can occur at internal, interpersonal, and structural levels. Racism at any one of these levels can reinforce and validate racism in the other levels, often in a circular or bi-directional fashion. Thus, any anti-racist effort must address racism at all levels.

Some of the typical ways that policies, laws, regulations, procedures, and protocols are racist and negatively impact the mental health and well-being of BIPOC communities include:
- Policies and regulations may disproportionately benefit whiteness and white privilege in that White people may receive higher quality services and access to mental health care than members of the BIPOC community.
- Policies may have been actively put into place to harm BIPOC, and especially Black communities.
- Policies and regulations are poorly implemented and/or not enforced.
- Loopholes exist within services so that patients may "fall through the cracks."
- Poor coordination and fragmentation of services across social service agencies, and between local, state and federal-supported care (i.e., there are both gaps in services and gaps in eligibility, as in the case where a person qualifies for city assistance but makes too much for state assistance).
- Locally run services are often overseen by local commissions with area citizen-volunteers, while oversight of state-run services is often the responsibility of appointed citizens. In both cases, citizens may (1) have been appointed for political reasons; (2) not reflect the racial composition of their communities; (3) lack key qualifications; and/or (4) have an array of racial perspectives that are not anti-racist.
- Inadequate or no insurance or coverage for mental health services.
- Inadequate or no funding and poor staffing of mental health services and programs (e.g., all K through 12 programs need access to a mental health resource staff person or counsellor); divergence in physician to patient ratios across communities.
- Inadequate training of mental health physicians especially on issues of how to evaluate and treat racial trauma and the intergenerational transmission of trauma as well as lack of implicit bias training.
- Variance in policies between localities (e.g., county to county) which increases barriers to access as a result of both confusion and varying bureaucratic requirements (e.g., recovery support services, housing, employment, schools, and the criminal-legal system).
- Regulators and other individuals afforded the power to implement and enforce regulations may not approach these actions with an anti-racist perspective.
- Local governments may not have ACT college admissions programs, provide homeless services, including food and shelter programs, immigrant welcome centers, and other services.

Anti-Racist Solutions

The goal for state and local governments is to both thoughtfully and intentionally replace racist policies, laws, procedures, and protocols with ones that are actively anti-racist,[4] and result in equitable mental health outcomes for BIPOC communities. This would mean a mental health service system that is fully

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funded, easily accessed, welcoming, and inclusive in its physical features, and is staffed by qualified professionals trained in anti-racism, who use a patient-centered approach that is based in structural competency and cultural humility. In Table 4, we offer solutions organized around existing barriers and areas of identified concern. For the sake of brevity, we will use the term "policy" to include a bill, law, regulation, procedure, and/or protocol.

Table 4. Approaches to advancing anti-racism in state and local mental health policies.

Advocacy Area	Examples of Local/State Policies that Require Examination	Approaches to Advance Anti-Racism
Social determinants of health	Policies related to schools and other educational programs. Public safety and law enforcement policies, racial profiling laws, criminal-legal services, prison/carceral policies, deadly force/stand your ground laws, cash bail regulations and mandatory minimum sentencing. Housing, real estate, residential zoning, and public transportation policies. Access to libraries and community centers. Voting and election procedures and zoning. Access to food services, minimum wage requirements, family and medical leave policies, elder and child services, affirmative action, financial aid services, immigration policies. Drug policies including minimum sentencing laws and emphasis on incarceration versus rehabilitation.	Ensure all social determinants that affect mental health outcomes in BIPOC communities are identified and reviewed (e.g., consider utilizing the Area Deprivation Index[5] and other applicable measures). Re-evaluate policies and practices to assess whether changes in policies have led to equality and equity in health outcomes. Advocate for policy change for all local and state policies that negatively impact BIPOC communities. Support stakeholders at all levels to reflect on how existing policies and practices are not anti-racist. Advocate for policies aimed at decriminalization and rehabilitation, including dismantling minimum sentencing for drug-related offences.
Perpetuation of white privilege at the expense of BIPOC communities	Policy variation between high and low-income communities. Housing and real estate policies (e.g., historical red-lining). Variation in policies between public school districts.	Investigate and reflect upon whether policies maintain white power/supremacy and privilege, and advocate to dismantle and rebuild such systems on an anti-racist foundation.

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Advocacy Area	Examples of Local/State Policies that Require Examination	Approaches to Advance Anti-Racism
Community Representation	Representation of BIPOC and community members on: • State and Municipal Legislative Committees • Public School Boards • Task Forces to Study Mental Health Services • Mental Health Clinic Advisory Board • Civilian Complaint Review Boards	Evaluate elected officials, paid staff, and citizen volunteers, in the context of their roles and participation on legislative and administrative groups that impact how policy is developed, implemented, and evaluated. Review community boards by considering the following questions on a recurring basis: • Are robust anti-racist training programs required for all persons engaged in government processes? • How is the "group culture" evaluated and if problems are identified, addressed? • Is there equitable representation of the community at large, including in leadership positions? • Do citizen voting policies at the local and state level allow for full representation of BIPOC communities? • What degree of power and independence are given to these groups?
Access to Mental Health care	Number and location of mental health clinics in a community, and hours that mental health clinics are open for care. Availability of services provided by a public mental health system (e.g., intensive outpatient programs and assertive community treatment). Ability of clients to access telehealth and audio-only telephonic services.	Examine policies to determine if they exclude or disproportionately limit access to care for BIPOC (e.g., increased bureaucratic requirements). Advocate for policies that expand access to telehealth and promote the Collaborative Care Model. Co-locate mental health providers in K through 12 educational systems. Include full pharmacy benefits and broaden options for filling prescriptions. (Refer to healthcare sections of this document for additional approaches.)
Nature of Mental Health Services	Composition of mental health oversight boards and commissions. Policies that define how payment for mental health services is collected. Policies that dictate how	Engage in regular needs assessments and communicate with community members to identify unmet needs. Implement an ongoing process that includes representative members of local/state BIPOC communities to evaluate current mental health services in order to identify disparities, analyze barriers to care, implement effective policy

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Advocacy Area	Examples of Local/State Policies that Require Examination	Approaches to Advance Anti-Racism
	medication and other treatments are prescribed and paid for. Implementation of a full range of psychotherapeutic interventions. Addressing quality defecits (e.g., unmet service needs, gaps in services, unacceptable wait times for appointments).	changes, and hold stakeholders accountable. Provide opportunities with compensation for BIPOC individuals to be included in processes for mental health policy development, analysis, and decision making, including the presence of BIPOC individuals in leadership positions at least proportional to the BIPOC population in the community being served. Engage in ongoing performance review to identify progress and problems, including concerted efforts to collect demographic data. Evaluate improvement efforts and identify the mental health outcomes associated with any quality improvements implemented at the local or state level. Implement National Culturally and Linguistically Appropriate Standards (CLAS) for mental health care; if not required in the state in which care is provided, advocate for state legislation to adopt CLAS standards. Establish and implement policies/procedures for holding physicians and administrators accountable for actions.
Quality and Number of Mental Health Professionals	Workforce recruitment, onboarding and retention. Clinical and administrative support for mental health professionals, especially those who are BIPOC. Ongoing continued education, advocacy and competency training requirements mandated by training programs and the accrediting bodies. Policies that encourage students (e.g., starting in elementary school) to enter and continue to pursue science and health educational pathways. School funding, including	Increase number of mental health professionals per capita in BIPOC communities, which have historically been underserved.[6] Increase loan-forgiveness for mental health trainees working in historically underserved communities, especially BIPOC (e.g., the California Student Loan Repayment Program) Engage in outreach into BIPOC communities to identify and foster new students to train as mental health professionals. Recognize the stark inequity and inequality in the education system between BIPOC communities and their white counterparts that begins in early childhood. Support funding and access to equitable education at all levels across communities. Identify and support BIPOC children who may have an interest in the sciences to form a pipeline early on and facilitate retention in the field through medical

Advocacy Area	Examples of Local/State Policies that Require Examination	Approaches to Advance Anti-Racism
	investments in early education, spending per student and quality of education.,	school.
		Prioritize hiring of BIPOC from low-income backgrounds and promote diversity among BIPOC mental health professionals.
		Increase BIPOC in positions of leadership in mental health organizations.
		Ensure that mental health professionals offer culturally-centered and patient-centered care, have had robust anti-racist training and regularly engage in ongoing educational programs to foster improved awareness of their own implicit biases.
		Make advocacy and anti-racism training a central component of medical school education and residency training and formal requirements of training.
		Ensure that mental health professionals have had specialized training in trauma-related care, especially race-related trauma, and recognize the intergenerational transmission of trauma.
		Advocate for enforcement of the ACGME Common Program Requirement on diversity and inclusion that is aligned with the APA Position Statement on Diversity and Inclusion in the Physician Workforce

VIII. Anti-Racism Advocacy at the Federal Level

Structural racism is deeply entwined with federal mental health policy. Underfinancing of mental health services and psychiatric workforce shortages have disproportionate impact on BIPOC communities that have less reliable access to mental health services. Regulations implemented by federal health agencies often disadvantage the types of public and safety-net clinics and physicians that are best positioned to reach communities of color. Accountability mechanisms such as quality reporting and accreditation pay little regard to inequity or disparities. Legal rulings rarely favor people of color as the criminal-legal system overflows with people who are unjustly convicted and inadequately cared for. National approaches to disparities research and data collection fall far short of what is needed to fully describe the persistent inequities in our mental health systems.

Mental health advocates, including the APA often engage with federal policymakers on a wide range of issues, examples of which as described in Table 5. Payment reform and parity legislation are major priorities, with the objective of increasing mental health services capacity by augmenting existing funding mechanisms. Expanding access to care is also a major area of focus with advocacy focusing on dissemination of evidence-based approaches to treatment, including tele-behavioral health, the

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collaborative care model, Certified Community Behavioral Health Clinics (CCBHCs), Coordinated Specialty Care for first episode psychosis, mental health crisis services, and other initiatives to improve access. Workforce initiatives are also an important focus of federal mental health policy, both in terms of protecting international medical graduate (IMG) psychiatrists and recruiting the next generation of psychiatrists through incentives like loan repayment.

Although these efforts have advanced policies that may improve mental health care for BIPOC, they have not done so in an explicitly anti-racist manner that critically examines the potential for such proposed solutions to counteract the many racist structures that continue to perpetuate inequities and disparities in our field.

Anti-Racist Solutions

Efforts to dismantle structural racism, and especially anti-Black racism, within federal mental health policy merit a much more deliberate and targeted effort is needed to advance anti-racist policies. The following strategies are essential initial steps.

First, we must apply an equity lens to all advocacy activities. Federal mental health policies must only be promoted with consideration of their implications—positive or negative—on BIPOC. Examples of explicitly anti-racist approaches that could be pursued at the federal level are described in Table 5. When considering endorsement of a potential law or regulation, advocacy groups must always conduct policy analyses that critically assess for any potential impacts on BIPOC communities. All pieces of legislation are opportunities for including explicit language or intentional strategies that promote an anti-racist agenda.

Second, the mental health advocacy portfolio should ideally include bills, rules, and other policies that are primarily focused on anti-racism. Potential examples include:
- Funding for mental health services—both specialty behavioral health clinics as well as integrated behavioral health in primary care settings—that provide care to predominantly BIPOC communities;
- Demonstration programs and grant opportunities that outreach, engage, and provide sustainable mental health services to people of color, including in religious and social settings;
- Partnerships with social services and coordination with law enforcement agencies to improve services and reduce criminal-legal involvement;
- Alternative payment models that link reimbursement to measures of equity and incentivize reduction in disparities;
- Accreditation and accountability programs that require equity analyses as a routine part of continuous quality improvement activities;
- Initiatives aimed at increasing diversity in the mental health workforce and leadership; and
- Research funding into disparities, SDOMH, and services interventions tailored to BIPOC communities, as well as topics related to gun violence and criminal-legal system reform.

Policy activities like these should complement and enhance the approaches to emphasizing anti-racism in more general advocacy activities.

Finally, to demonstrate the impact of the anti-racist policies described thus far, it is essential to improve national data collection and disparities monitoring. The quality of race and ethnicity data is poor, with oversimplified and mismatched categories and inconsistent approaches to collection, which impedes optimal understanding of important trends. Even when data are available, rarely are basic analyses

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completed by stratifying outcomes by race and ethnicity. We must be able to "show our work," and developing an adequate data infrastructure is essential.

Table 5. Examples of approaches to advancing anti-racism in federal mental health policies.

Advocacy Area	Examples of Federal-Level Policy	Approaches to Advance Anti-Racism
Payment Reform		
Increased reimbursement rates	Update of Evaluation and Management codes for outpatient office visits, which is expected to increase payment for psychiatric care.	Assess if the new rates differentially impact physicians of color and physicians serving predominantly BIPOC communities.
Parity	Increase in oversight of non-quantitative treatment limitations (NQTLs) in the FY2021 omnibus package, building on provisions in the 21st Century Cures Act, the ACA, and the Mental Health Parity and Addiction Equity Act of 2008.	Additional regulations on disparate use of NQTLs to restrict payment authorization for BIPOC beneficiaries.
Medicaid expansion	The ACA provides increased federal match for certain Medicaid payments to states as an incentive to states to expand Medicaid eligibility to low-income populations.	State Medicaid parity requirements are not consistently enforced and could be strengthened with increased federal oversight to ensure equitable access and coverage for BIPOC.
Increasing funding for federal agencies	Increased appropriations to the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute of Mental Health (NIMH).	Include appropriations language that specifies distribution of enhanced funding goes towards personnel and activities that address DEI and SDOMH work.
Increasing Access		
Tele-behavioral health	Major expansion in setting of COVID-19 response; at least some components will be sustained following expiration of emergency order.	Include provisions that provide broadband and technology access and assess acceptability among communities of color.
Collaborative care	Introduction of Collaborative Care Model codes by Medicare and some Medicaid and private plans.	Promoting uptake of CCM codes by training physicians in BIPOC communities.

Advocacy Area	Examples of Federal-Level Policy	Approaches to Advance Anti-Racism
Certified Community Behavioral Health Clinics (CCBHCs)	FY2021 increased funding for CCBHC expansion grants and extension of Medicaid demonstration.	Ensure that funded CCBHCs equitably distributed across communities of color; tailor outreach activities to BIPOC communities.
Coordinated Specialty Care	Continue support through the Mental Health Services Block Grant 10% set-aside.	Require federally funded programs to increase case-finding among BIPOC transitional age youth.
Crisis services	Continue support through the Mental Health Services Block Grant 5% set-aside and the 85% Federal Medical Assistance Percentage (FMAP) for mobile crisis.	Prioritize implementing crisis services in BIPOC communities that may avoid contacting emergency services due to fear of police response.
Information sharing reform	Increased alignment of 42 CFR Part 2 restrictions with HIPAA rules to improve substance use treatment information sharing.	Ensure that substance use treatment information for BIPOC individuals is being shared appropriately (not more or less than overall).

Workforce Expansion and Diversity

Immigration reform	Statements opposing policies related to DACA as well as H-1B and J-1 visas that would negatively impact the psychiatric workforce.	Explicitly address how these changes would worsen disparities given importance of IMGs serving in BIPOC communities.
Loan forgiveness	Continue support for HRSA's National Health Service Corps Substance Use Disorder Workforce Loan Repayment Program in 2018.	Promote programs among BIPOC trainees to incentivize careers in mental health.
	Programs that increase exposure to the mental health field for underrepresented individuals prior to and during medical and psychiatric training such as the HBCU C.A.R.E.S., APA Black Men in Psychiatry Early Pipeline Program and the SAMHSA Minority Mental Health Fellowships.	

Advocacy Area	Examples of Federal-Level Policy	Approaches to Advance Anti-Racism
Number of residency positions in psychiatry and quality of the training environment	GME funding through Medicare. ACGME Common Program Requirement in diversity and inclusion.	Advocate for increased residency slots. Psychiatry residency positions are almost 100% filled through the Match with many qualified applicants not matching. Need for psychiatrists will expand greatly as the Baby Boomer generation retires. Lack of psychiatrist will be felt most acutely in under-resourced populations. Advocate for enforcement of the ACGME Common Program Requirement on diversity and inclusion (effective 2019) that is aligned with the 2019 APA Position Statement on Diversity and Inclusion in the Physician Workforce.
Provision of culturally humble care		
Psychiatry residency and other specialty care training	Pediatric ACGME training requirements focused on advocacy and structural competency (where it has been shown that making advocacy a core competency increases advocacy behaviors and workforce engagement after residency[4]).	Make advocacy and structural competency training a required component of physician training at the national level (e.g., create a comprehensive ACGME requirement).

IX. Advocacy Best Practices

In this section, we offer some "advocacy best practices" to consider when advocating at the community, institutional, and governmental level to reform racist procedures, protocols, regulations and laws, and to increase BIPOC power and representation at all levels. The pursuit of specific and concrete anti-racist policy objectives must be paired with a commitment to fostering equity, social justice, compassion and relationship-building to sustain the broader fight against racism.

Best Practices for Working at the Institutional or Governmental Levels to Promote Anti-Racist Policies

The first step for all advocates seeking anti-racist policy change is to engage in self-reflection and perform a self-inventory to evaluate their own implicit assumptions and biases and address their own behaviors that may negatively impact others (e.g., microaggressions). Advocates should strive to improve their awareness of the myriad ways one can personally work towards being anti-racist. Pursuing

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this effort in an intensive and ongoing way will enhance one's ability to be an effective ally with and advocate for BIPOC communities.

The second step is to assess relevant indices of mental health (e.g., suicide rates, hospitalization rates) and inequities resulting from systemic racism (e.g., racial segregation, incarceration rate gaps, educational attainment gaps, economic disparity index, and employment disparity gaps) to guide which systems require deeper focus.

The third step is to identify the system that you plan to evaluate for racist mental health policies and practices: institutional or governmental (at the local, state, or federal levels). Assess those structures and systems thoroughly. If you are engaging at the community level, please see notes below for how best to engage at the community-level. Strategies to consider when deciding whether and how to engage at the institutional vs. government level include:

- Institutional:
  - Evaluate the organizational structure of the institution, including the reporting structure, and identify names of individuals in power and whether adequate BIPOC representation exists;
  - Understand the history of addressing social justice issues within the institution;
  - Assess relevant procedures and protocols that relate to mental health care;
  - Identify policies, procedures, and protocols that contribute to negative mental health and systemic racism indices.
- Government:
  - Understand the policy-making processes for the local, state or federal system in which the issue is focused (e.g., city council decision-making, state legislative procedure for how a bill becomes a law, federal rule-making);
  - Identify key officials with power to impact policy-making processes (e.g., caucus leaders or committee chairs who can bring a bill to the floor for a vote, and leadership of commissions and agencies that create rules and regulations);
  - How are BIPOC represented at various positions of power? E.g., amongst elected officials and appointed regulators and on task forces and commissions;
  - Understand the history of social justice issues within that government level; and
  - Identify policies and regulations that are the most likely contributors to negative mental health and systemic racism indices.

The next step is to develop a strategic approach. Rarely do advocates have unlimited resources of time, funding, and person-power who will work on addressing racist policy reform. It will therefore be necessary to develop a strategic approach in order to prioritize the work. Consider stratifying the identified racist policies to target in temporal terms (immediate, short-term, long-term) or in terms of effort required to pursue reform (e.g., easy, intermediate, difficult).

Once a strategy has been developed and an issue has been identified, use the following strategies to focus a campaign:

- Recruit allies and build an advocacy team.
- Develop an Issues Brief or Fact Sheet with a clear mission statement, at least three supporting arguments, relevant data sources, and contact information for the advocacy team.
- Reach out and meet with key stakeholders (e.g., local community leaders, advocacy organizations, and faith-based groups) to understand their perspective and align with their

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interests. Please see notes below for "Best Practices for Working with Communities on Anti-racist Policies."

- Identify and partner with anti-racist organizations to build a strong coalition.
- Be inclusive of other organizations if they can contribute to the larger coalition and help make change.
- Consider what systems, and the specific individuals within the identified system, need to be engaged (e.g., hospital or university system, department of public health, city council, mayor, executive/legislative/judicial branch of state government).
- Gather more information on the identified individuals in order to evaluate how best to recruit their support for the issue; methods include examining and reviewing their personal and professional websites, social media posts, voting records, and news articles.
- Contact identified individuals to educate them about the issue and request their support. Recruit allies, particularly BIPOC allies, to the extent that may be helpful.
- Continue to work on expanding the coalition of allies by reaching out to potential stakeholders.
- Consider a more extensive educational and media campaign (e.g., write Op-Eds, hold public educational forums, utilize social media tools to garner grass-roots public support).
- Follow the issue through the institutional or legislative process; attend all relevant meetings; provide testimony at all public hearings; and reach out to people in positions of power (e.g., an institution's CEO and elected officials) to educate, persuade and pressure.
- Persevere. Celebrate successes and learn from defeats. Keep advocating!

Best Practices for Working with Communities to Promote Anti-Racist Policies

Advocates must work in collaboration with communities to advocate for anti-racist mental health policies. By partnering with communities, the power of advocacy efforts is multiplied as the community's assets, including the voice of the community, are brought to bear on the issue at hand, and the strength in the numbers of the community puts pressure on decision makers to make concrete changes. Especially for anti-racism advocacy, it is critical to recognize that when healthcare physicians or decision makers engage communities the process will be impacted by power imbalances that cut across racial lines, and there is significant potential for misalignment of interests between the community and those who seek to partner with the community. In order to mitigate these challenges, one key principle is to ensure that throughout an advocacy project work is done with, rather than to, the affected communities.

An excellent tool for this purpose is the "Community Pediatrics Training Initiative" (which applies beyond pediatrics training). Once an advocacy issue is identified, it is important to identify communities impacted by the problem. Depending on the project, the community can be defined in different ways. For example, a project aimed at decreasing recidivism amongst recently incarcerated individuals in one city might focus on these individuals, their families, and those who work with these individuals. A project aimed at decreasing exposure to a harmful pollutant in a given neighborhood might define its community by all those living in one geographic area. Training reform in this area is essential in all aspects of health care.

Before engaging with communities, it is important to assess individual and organizational readiness for community-based partnerships. This involves taking stock of your resources and commitment to make the work successful, prior relationships with the community, and degree of cultural humility. Such reflection is critical in anti-racist community advocacy because health care institutions have a history of

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engagement in activities that have harmed BIPOC communities. As a result, there may be a justified legacy of mistrust by communities of these institutions and the individuals associated with them.

The importance of early engagement with the impacted community cannot be overstated—even before defining the mission, vision, and goals of the project. These steps should be undertaken in partnership with the community. The first step involves listening to the community's description of its own needs rather than telling the community what the project will entail. This process might involve individual meetings with key stakeholders, community-member forums, and in some cases may require a more formal needs assessment. The community should be involved in the process of designing a needs assessment, which may involve drawing on existing data and collecting new data to better define and understand the problem. At all stages of such engagement with the community, advocates must be aware of existing power dynamics and ensure that the voices of BIPOC are centered.

Advocates engaging with communities should adopt an asset-based approach instead of focusing on a community's deficits. It is more constructive to consider what assets the community already has that might help advance the cause of an advocacy initiative. Such assets include the talents and skills of individuals, networks of relationships, institutions and professional entities, and the physical and economic assets of the community. Asset mapping is a process whereby the existing strengths in a community can be inventoried and organized to facilitate engagement.

When engaging communities in the process of advocacy work, it is important to listen first. At the same time, advocate requests for community support should be concrete and have clearly delineated expectations and compensation for time and other resources. There should also be specific goals and metrics of success that are crafted with and meaningful to the impacted communities. The outcomes of the work should be re-evaluated frequently and course-corrected as necessary. Frameworks such as a "Plan-Do-Study-Act" (PDSA) cycle can help ensure accountability.

It is essential for advocates to be mindful of these principles while engaging in productive community advocacy. Anti-racism community advocacy in particular requires acknowledgment of and responsiveness to the racialized power dynamics that will inevitably shape the process. It takes a conscious and deliberate effort to ensure that the voices of marginalized groups, including BIPOC individuals, are centered in the process of performing work that is of value to impacted communities.

X. Conclusion

Psychiatrists must be leaders in the fight to optimize access to and quality of psychiatric care through the dismantling of existing racist policies and practices underlying mental health disparities that disproportionately affect BIPOC communities. As the authors hope this document makes clear, significant, long-standing problems as well as potential solutions can be identified at multiple levels: the individual patient and physician, the healthcare system, the identified community, and at all levels of government. This resource document provides resources, examples, potential pathways, and best practices to follow when advocating at each level. We also hope to have demonstrated that to effectively address race-based disparities in mental healthcare, one needs to move beyond healthcare per se and examine the upstream, social determinants of health—including financial security, adequate housing, affordable and quality education, and other factors—and to dismantle racist policies and practices in these areas as well.

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Identifying policies and practices designed to maintain and support white supremacy and proposing carefully targeted solutions is not enough. Psychiatrists and our partners have the power to summon formidable resources and proactively create change by employing effective advocacy strategies and practices at systemic, institutional, governmental and community levels for the purpose of reforming racist policies and increasing BIPOC power and representation at all levels. Advocating effectively for anti-racist change requires individuals to look inward and educate themselves about the social justice issues involved, including examining individual behaviors and assumptions. Striving toward being anti-racist on a personal level is essential as one advocates for the changes needed to provide equity and justice for BIPOC communities.

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