12

Racial and Ethnic Minority Mental Health Advocacy: Strategies for Addressing Racism

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> "Not everything that is faced can be changed; but nothing can be changed until it is faced."
> — James Baldwin

Clinician Advocacy

The last 10 years have revealed a significant increase in articles discussing clinician, physician, and health care provider advocacy [1–6]. A 2009 endorsement by the American Medical Association (AMA) states that "Physicians must advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" [7]. Scholars such as Earnest and colleagues define physician advocacy as "action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise" [1]. They note that advocacy is not limited to addressing individual patients' needs; rather, it is a broader practice that addresses root causes of societal struggles and inequities.

As Dobson and colleagues examine the role of the physician as a health advocate, they note that "The main barrier to productive conversations about the place of health advocacy appears to be a lack of clarity around what a physician should do as a health advocate and how this should manifest in daily practice" [8]. Additionally, Croft and colleagues note that development of the physician advocate begins with "experiences that improve a physician's ability to advocate along a continuum, from

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issues arising for individual patients to those affecting health care policy" [3]. One critical facet of their conceptualization is the viewpoint of advocacy education not as a supplement to a workload but, rather, as "an organizing force, one that can increase physician's awareness of their professional ecology" [3]. Furthermore, as Dharamsi and colleagues point out, "medical systems that tend to focus largely on the individual relationship between the physician and the patient, with little attention to the doctor's role and responsibilities to society, will face difficulty serving vulnerable groups" [2]. Thus, building advocacy skills hinges on conceptualizing a comprehensive definition of physician advocacy, as well as a mechanism for building the necessary skills and abilities.

Arguing against the need for clinician advocacy, Thomas Huddle remarks that "Advocacy must remain an occasional and optional avocation in academic medicine, not a universal and mandatory commitment" [9]. The authors of this chapter disagree with that sentiment and maintain that clinician advocacy is essential for academic medicine and medical training. Though physicians such as Huddle have argued that forms of advocacy could threaten objectivity or serve as a distraction [9], the authors agree with Croft and colleagues [3], who maintain that the medical profession cannot afford such a simplistic argument as to why advocacy should not be a part of academic medicine and medical practice.

In working toward a unified definition of physician advocacy to address racism, the work of the nineteenth-century physician and anthropologist Rudolph Virchow must be considered. Virchow wrote that:

> Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the answers for their actual solution.…The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction [10].

Simply put, the physician advocate addresses race and racism by identifying, understanding, and responding to the intersection of the social, political, and economic barriers that influence and constrain patient care. Armed with this understanding, we turn now to the role of advocacy in addressing racism, with a particular focus on the field of psychiatry.

Historical Accounts: Addressing Racism Within the Field of Psychiatry

Advocacy exists in response to a stimulus (e.g., a social, political, environmental, or economic stimulus). It is important to trace the history of mental health advocacy back to the time of American slavery, when diagnoses of mental illness were overwhelmingly dominated by racism and the perceived inferiority of African Americans [11]. Mental disorders thought to be peculiar to enslaved men and women included "drapetomania" and *dysaethesia aethiopica*, the former referring to the tendency to run away from slave owners [12] and the latter being described as "a form of madness manifest by 'rascality' and 'disrespect for the master's property' that was to be 'cured' by extensive whipping" [13]. African Americans were structurally and ideologically segregated from the rest of American health, and many states had mental hospitals devoted only to African Americans [14]. As Metzl notes, "even at the turn of the twentieth century, a leading academic psychiatrist shamefully claimed that 'Negroes' were 'psychologically unfit' for freedom" [13]. These racial attitudes, born out of slavery, continued to determine the diagnosis and treatment of African Americans [15]. Throughout the twentieth century, medical professionals commonly believed that if African Americans had mental disorders at all, they were much more likely to be diagnosed with disorders such as psychosis and schizophrenia, while rarely being diagnosed with affective disorders such as depression and bipolar disorder [16]. Historically, African Americans have experienced limited access to the mental health system, have been more likely to be involuntarily committed, and have received suboptimal mental health treatment [15, 17, 18].

Historically black colleges and universities (HBCUs) served as early sites for advocacy against racism. Founded shortly after the end of the American Civil War, both Howard University and Meharry Medical College provided training for African-American clinicians, including psychiatrists and other mental health workers. Both institutions were often considered to be ahead of their time in promoting community mental health care for African Americans. One of the first professional forms of advocacy emerged with the founding of the National Medical Association (NMA). This organization was established in 1895 because African-American physicians were not allowed to join the AMA until the 1960s. Included among the group's sections was a section dedicated to psychiatry and behavioral sciences, and indeed much of the literature on racism and African-American mental health has been published in the *Journal of the National Medical Association* [19]. In 1957, Dr. E.Y. Williams founded the Department of Psychiatry at Howard University College of Medicine, which included a biopsychosocial model of African-American mental health, addressing such issues as racism and discrimination [20]. Shortly afterward, Dr. Lloyd Elam founded the Department of Psychiatry at Meharry Medical College, which also addressed the impact of racism on mental health [21]. Both departments had faculty members who were actively involved in their local communities and offered services to the indigent at a time when many mental health services were absent in African-American communities [21].

The social and political unrest of the 1960s and 1970s generated further collaborative professional activism. The Black Psychiatrists of America association was founded in 1967 to address racial and ethnic issues that the more mainstream psychiatric organizations were not prioritizing, including the experiences of black physicians in the field of medicine and also the emotional and psychological development of African Americans in the USA. Dr. Chester Pierce served as the group's first president. The issue of racism in psychiatry was a key point of discussion at the 1969 annual meeting of the American Psychiatric Association (APA). Members including Drs. J.A. Cannon, James P. Comer, Chester Pierce, James Ralph, and Raymond Wilkerson led a protest insisting that the APA not only grant to its African-American members all rights and privileges of full membership but, most importantly, take immediate steps to improve the mental health care of African Americans in the USA. The APA responded positively by appointing African-American psychiatrists as observer consultants to its councils, boards, and task forces [22]. Moreover, the APA formed various committees, including a Committee on Black Psychiatry, a minority caucus, and an office of minority affairs. Two leaders of this office, Drs. Jeanne Spurlock and Annelle Primm, were both very effective in terms of advocacy for racial and ethnic minorities [15, 23].

The establishment of new organizations and creation of specific structures within organized psychiatry to address the role of black psychiatrists and the mental health needs of minority patients were direct outgrowths of physician advocacy. In parallel were other efforts to promote race equity in the field of psychiatry. For example, in 1970 a group of psychiatrists—Drs. Melvin Sabshin, Herman Diesenhaus, and Raymond Wilkerson—published an article in the *American Journal of Psychiatry* in an effort to advance the conversation on racism. This article, titled "Dimensions of Institutional Racism in Psychiatry" [24], was written specifically to white psychiatrists and mental health professionals. The authors noted that "When confronted with crises in black–white relations, most white psychiatrists tend to focus on the helping role that they can play in resolving these conflicts for *other* organizations rather than looking closely at the ways that psychiatry has perpetuated myths of black inferiority" [24]. Highlighting phenomena such as the lack of data about black Americans' mental health needs, the lack of mental health services for black Americans, and the racialized obsession with black psychopathology, Sabshin and colleagues argued for a more systemic focus on institutional racism within psychiatry—this is still very relevant to today's conversation regarding race and racism.

Other examples of advocacy include research and scholarship addressing racist commentary written about African-American patients, the subjects of race and mental illness in the criminal justice system, and research on the intersection of race, gender, and mental health. These efforts were led by psychiatrists such as Drs. Carl Bell, Ezra E. Griffith, and Phyllis Harrison Ross [25, 26]. Dr. James Carter's work on racism and its impact on mental health is an example of clinician research and scholarship as a tool for advocacy. His 1992 article titled "Racism's Impact on Mental Health" challenged mental health professionals to reassess their viewpoints on racism [23].

Dr. James P. Comer, one of the founders of the Black Psychiatrists of America, once remarked that "Psychiatrists working with individual patients are not going to make the big difference for the black community." Dr. Comer's sentiment is not unlike that of statements made by black civil rights activist Stokely Carmichael to a group of mental health professionals in 1968. Carmichael expressed that he focused not on the individual in society but, rather, on the institution and, in particular, institutional racism. He stated that institutional racism is "less overt, far more subtle, [and] less identifiable in terms of specific individuals committing the acts, but is no less destructive of human life" [27–29]. Comer and Carmichael's comments similarly draw attention to the differences between individual, institutional, and structural levels of racism. Even though numerous prominent physician leaders have made considerable contributions in addressing race and racism within psychiatry, and despite the call made by Sabshin and colleagues in 1970, there remains a significant need for more advocacy to address both structural and institutional racism. The work done by groups such as the Black Psychiatrists of America remains invaluable, but, in order to make more institutional change to address race, there is a need for more systemic advocacy.

Framing Racism: Anthropology and Sociology in Conversation with Psychiatry

This chapter's framework for the development of antiracist advocacy strategies is shaped by anthropology, sociology, and psychiatry. Insights from anthropology and sociology provide guidelines for developing strategies that move beyond cultural competence to address the structural formation and reformation of racial bias in society in general and in medicine in particular.

The perspectives of medical anthropologists are particularly useful for shedding light on issues and concerns of health, illness, and healing, because of their examination of how the health of individuals, larger formations, and the environment are affected by "a range of interrelationships…including: cultural norms and social institutions; micro and macro politics; and forces of globalization" [30]. Alternatively, sociology seeks to identify the causes, consequences, and characteristics of the social world(s) in which we live. More specifically, medical sociologists focus on the social determinants of health (society's structural components) by exploring the relationship between the material conditions in which people are born, live, and die, and how these determinants intersect to influence health and well-being. When combined, these disciplines provide robust insight into the examination of society's problems as "public issues rather than simply personal troubles" [31]. Without contributions from social sciences, public issues such as race and racism, and the production and reproduction of health inequality, are not completely understood. Regrettably, until very recently, the medical profession relied only on an interdisciplinary model rather than on a multidisciplinary model of education.

In 2011, the Association of American Medical Colleges (AAMC) called for "rigorous training in social and behavioral sciences," noting that "a complete medical education must include, alongside the physical and biological sciences, the perspectives and findings that flow from the behavioral and social sciences" [32]. Until that time, the core of medical education had centered on histology, chemistry, and pathology, which represented the holy trinity of knowledge, and the physician–researcher represented the model practitioner [33]. Such a basic science curriculum left little, if any, room to address cultural and philosophical aspects of health and health care. While the 1910 Flexner Report was foundational for medical education, even Flexner noted in 1925 that "scientific medicine in America…is today sadly deficient in cultural and philosophic background" [34].

In 1948, a generation after Flexner's lament regarding the deficiencies of medical education, the World Health Organization offered a social and theoretical framework describing health as a "state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity" [35]. Today, researchers have begun to empirically recognize how the absence of cultural aspects and, in particular, psychosocial aspects of health and well-being [36], as well as the role of race and scientific racism [37], result in an incomplete understanding of, and response to, a patient's disease. This transgression raises a range of questions. Chief among them, for this inquiry, are the following: How does racism influence a patient's disease, as well as their experience of illness? Which disciplines can offer the robust framework of analysis necessary to unpack the impact of racism on the practice of medicine?

In answering this question, readers should turn to Jonathan Metzl and Helena Hansen for a new model of engagement when searching for methods to address racism in health and health care. Metzl and Hansen note that social scientists "add important conceptualizations of structure as a system that produces and reproduces the social world, and that is thus deeply linked to culture because it provides the system of values affixed to bodies and disease" [28]. The "structural" contribution of social scientists shifts the discussion of race and racism away from the individual, as the unit of analysis (i.e., the interaction between the clinician and the patient), toward the forces of society. The social forces of society—the customs and beliefs, recreated in institutions (e.g., hospitals and schools) and codified in law—interact to create and recreate a disparate distribution of power. More specifically, a structural approach recognizes "the economic and political conditions that produce health inequalities in the first place" [38].

The problems of race and racism as public issues must be addressed at the structural level of society. This analysis allows for examination and interpretation of the various patterns of social behavior within the world where we live. Moreover, this theoretical approach—which combines anthropology, sociology, and psychiatry—allows for examination of the multiple forms of racism and analysis of the production and reproduction of ideas and beliefs about people, including the inferiority or superiority of races, classes, and genders [39]. Armed with this understanding, an antiracist framework can provide a lens to address the structural impediments contributing to disease, illness, health and health care.

Race and Racism

In order to identify strategies for addressing racism, the authors believe that it is important to define race and racism. Race is not viewed as a biological construct. Instead, the authors rely on Michael Omi's and Howard Winant's definition of race, which they frame as "a concept that signifies and symbolizes social conflicts and interests by referring to different types of human bodies" [40, 41]. With this definition, they emphasize the social construction of race but also highlight how the phenotypic continues to matter [41]. Dr. Camara Jones, in her well-known essay "The Gardner's Tale," identifies three levels of racism: personally mediated, internalized, and institutional [42]. Personally mediated racism is defined as "prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race" [42]. This can be intentional or unintentional. Jones argues that this is what most people think of when they hear the word "racism." Jones defines internalized racism as "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth" [42]. The third level of racism that Jones addresses is institutional racism, which is defined as "differential access to the goods, services, and opportunities of society by race" [42]. Jones notes that institutional racism is structural, hence the frequent use of these terms interchangeably. By use of the term "structural," Jones asserts that institutional racism has been "codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.…Institutionalized racism manifests itself both in material conditions [i.e., in education and health care] and in access to power [i.e., in differential access to information]" [42].

Jones uses her essay to illustrate these levels of racism and ultimately asserts that systems-level change requires institutional racism to be addressed [42]. Critical race theorists Joe Feagin and Zinobia Bennefield similarly argue that medical education needs more instruction regarding systemic and structural racism at the macro level. Writing about structural racism and the US health care system, they note that "Part of the work that needs to be done is to also shift the perception about racism, so that yes, healthcare providers are addressing personally mediated racism and forms of discrimination, but [also] that there is more emphasis on strategies to address structural and institutional racism" [29]. Within the field of psychiatry, there is a significant need for more advocacy to address the multiple levels of racism. As was illustrated in the US Surgeon General's supplemental report on mental health, racial and ethnic minorities have less access to mental health services than white Americans and are less likely to receive needed care [17]. In a study of ethnic and racial health care disparities, McGuire and colleagues found that the values of overall spending on outpatient mental health care for African-American and Latinx populations are about 60% and 75%, respectively, of the amount spent on care for whites, after the need for care is taken into account [43]. Research has also shown that African Americans are less likely to receive evidence-based psychotherapy and lack exposure to effective treatment, which clearly reduce the likelihood of recovery and increase the illness burden [44–46]. In comparison with white Americans, African Americans are less likely to receive specialty mental health services, even when potential confounders such as socioeconomic status, educational attainment, and gender are controlled for [47]. Additionally, African Americans with serious mental illnesses are far more likely than whites to be involuntarily hospitalized, to use crisis intervention services, or to be brought to the emergency room by law enforcement [48–50].

Advocacy is a key tool for addressing racism and the ways in which racism affects health care delivery and health outcomes for racial and ethnic minorities. In the following sections, the authors provide strategies for advocacy against racism in four areas:

1. Explicit antiracism training
2. Changes in medical education curricula
3. Social justice advocacy
4. Research advocacy

Strategy One: Explicit Antiracism Training and Dialogue

While there is significant advocacy in the mental health field regarding stigma and prejudice against people with mental disorders [6], the majority of these programs do not center race and racism in the conversation. Advocacy in response to power imbalances that occur at the interpersonal, community, or organizational levels is essential to developing the moral character and ethical action required to undo the choke hold of racism. There is a need for an antiracism framework to understand how institutions and legislation reproduce society's prejudicial attitudes and beliefs regarding ethnic and racial minorities, resulting in differential treatment of minorities and differential access to, and distribution of, resources. As advocated by Stergiopoulos and colleagues, such program content must focus on "transforming these unequal social relations and restoring power imbalances" [51]. The training must be thoughtful and deliberate, with institutional support and well-defined measures that *all* participants must meet at some level [1].

In an article on race and racism in medical education, David Acosta and Kupiri Ackerman-Barger maintain that medical school faculties do not necessarily possess the tools to implement racial discussions and dialogues, and that the first step in addressing racism must begin with faculty training [52]. Like Earnest and colleagues, Acosta and Ackerman-Barger note that faculty development should be "intentional and it must stimulate deep introspection, a willingness to be honest, and a commitment to change" [52]. They also argue that this faculty training should extend beyond the more traditional and "safer" approach of completing online modules or simply reading books and journal articles on race and racism [52]. They suggest that academic health centers should implement approaches from other fields that can foster the needed dialogue and training to address resistances and obstacles that health care providers may encounter when talking about race and racism.

Developing the knowledge, skills, and abilities to reflect on and understand the inextricable relationship between race and racism in the USA begins with study. Resources such as the People's Institute for Survival and Beyond, RacismReview, and Project Implicit are excellent training resources. The People's Institute for Survival and Beyond facilitates workshops on undoing racism. Established in 1980, the institute offers workshops and consultations around the country to assist "individuals, communities, organizations and institutions [to] move beyond addressing the symptoms of racism to undoing the causes of racism so as to create a more just and equitable society" [53].

RacismReview provides scholarly content and strategies proposed by scholars and researchers from the USA, Canada, Europe, and elsewhere. The website is "intended to provide a credible and reliable source of information for…members of the general public who are seeking solid evidence-based research and analysis of 'race,' racism, ethnicity and immigration issues" [54]. In continuous operation since 2007, this website provides a range of resources, including a bibliography and documentary sources.

Lastly, Project Implicit provides an interesting approach to race by educating the public about "hidden bias." The Implicit Association Test (IAT) measures "attitudes and beliefs" about race, gender, and other topics. When visiting the website, participants can choose the Race IAT, which "requires the ability to distinguish faces of European and African origin. It indicates that most Americans have an automatic preference for white over black" [55]. While this resource is not as explicitly antiracist and focuses on biases beyond race, the project provides insight into bias and assessment of it, allowing groups to further explore how race and racial preferences are socially constructed.

Incorporating an antiracism lens into the field of psychiatry represents an important step toward undoing racism. This helps clinicians and providers to be more mindful of how racism is experienced and how it can contribute to unequal outcomes. Engaging clinicians and providers in recognizing and responding to unequal treatment helps sharpen their recognition, analysis, and response to social injustice. As noted earlier, HBCUs train the majority of African-American physicians and have long histories of addressing issues of racism and poverty in their medical school curricula. The curricula of some of these institutions may serve as models for incorporating antiracism pedagogy. Partnerships between HBCUs and predominantly white institutions (PWIs) have been found to be productive for encouraging advocacy [56].

Strategy Two: Clinician Advocacy and Social Justice

The authors believe there is a great need for more social justice clinician advocacy within medicine and, specifically, in psychiatry. One place to begin is with existing entities such as the advocacy and policy groups of the APA. These groups can explicitly discuss the impacts of structural racism on vulnerable populations in the USA as a form of advocacy. Especially when one considers broader issues of poverty, the criminal justice system, educational disparities, and their impact on mental health, there is a need for psychiatrist advocacy.

Other opportunities for physician and physician trainee social justice advocacy include organizations such as WhiteCoats4BlackLives, the medical student–run organization born out of the National White Coat Die-In demonstrations, which took place in December 2014 [57]. The mission of the organization is to "eliminate racial bias in the practice of medicine and recognize racism as a threat to the health and well-being of people of color" [57]. The group prioritizes such goals as raising the awareness of racism as a public health concern and advocating for funding and promotion of research on the health effects of racism. The group also encourages physicians and physician organizations to publicly recognize racism as a public health issue. As a student-led group, WhiteCoats4BlackLives also emphasizes the need to prepare future physicians to be advocates for racial justice.

In an article titled “Remembering Freddie Gray: Medical Education for Social Justice,” Wear and colleagues argue for the incorporation of social justice in medical curriculum and training. Achieving this, they maintain, begins with “the willingness of educators to examine uncomfortable realities that are exceedingly difficult to confront…the messy landscapes that are America’s legacy of racism, brutality, violence, poverty, hopelessness, and despair” [58]. While their work focuses on medical education, we believe that physician organizations can adopt many of the suggestions for deeper social justice engagement. These physician organizations can implement a small group model, whereby physicians receive the opportunity to engage in critical reflection on issues of power, privilege, and oppression. This type of social justice framework allows physicians the chance to reflect and strategize about advocacy and social justice platforms on both community and national levels.

Strategy Three: Changes in Medical Curricula

Medical education in the USA needs to address the impact of race and racism, particularly the history of racism in medicine and racial bias in decision making [25, 57]. In particular, there is a need to discuss the history of medical racism in the field of psychiatry, as mentioned in this chapter’s introduction, as well as the ways in which racist folklore continues to linger in the field. An example comes from a 1921 article about black Americans from the *American Journal of Psychiatry*, which stated:

> The alien ancestors of most of the families of this race were savages or cannibals in the jungles of Central Africa. From this very primitive level they were unwillingly brought to these shores and into an environment of higher civilization for which the biological development of the race had not made adequate preparation [59].

Many white psychiatrists expressed similar sentiments during the earlier decades of the twentieth century [25]. As medical historian John Hoberman notes, included in this literature are numerous confessions by these doctors that they “simply do not understand their black patients” [25]. This type of history should not be silenced in medical education, as the history of physician racism and racial folklore shape health care delivery. While today this type of racialized thinking is less pervasive among physicians, there is a need for more education and awareness about deeply embedded racial folklore and bias in the field of psychiatry and more broadly in medicine. One strategic way to address this gap in education is through curricular changes. Medical curriculum standards need to place less emphasis on the celebration of diverse cultures and more on education that involves critical analysis and reflection on power, marginalization, oppression, and disparities [29, 58].

Rather than solely focusing on the subject of cultural competence, medical curricula need to include the concept of structural competence [28] at both the undergraduate and graduate medical levels. Structural competence is defined as:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g. depression, hypertension, “non-compliance,” trauma) also represent the

> downstream implication of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, [and] medicalization, or even about the very definitions of illness and health [28].

Cultural competence allows physicians and trainees to better hear and examine the "cross-cultural" aspect of patient stories, which enhances clinical dialogue but does very little to address the relationship between clinical symptoms and sociopolitical and economic systems [28]. Physicians need to listen to both individual stories and structured stories.

Curricula and pedagogy that focus on advocacy need to be dynamic and engaging. Subject areas such as health advocacy, the social determinants of health, structural competence, and ethics must provide learners with the opportunity to move from knowledge to practice [2]. Dharamsi and colleagues suggest that trainees need to be part of a community of practice that works closely with other providers within the health care system. This in turn creates the opportunity for more expansive service learning and interprofessional collaboration and advocacy. Because of recent amendments in accreditation standards for service learning, there is an opportunity for academic medical centers to develop more innovative approaches to education about physician advocacy.

Medical ethics plays a key role in medical education and can serve as a source of authority for undoing racism. The source of professional conduct of physicians does not arise from some abstract notion of good or bad. Rather, the assessment of professional conduct arises from an understanding of, adherence to, and action in upholding the AMA Principles of Medical Ethics [60]. Principle III states that "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." Because of the historical legacy of slavery and its enduring structural and institutional racism, the need to recognize and respond to the legal structure is key. Whether it is done by confronting policies, practices, rules, or laws that maintain inequity, antiracist work is an ethical obligation to not only speak truth to power but also fight in turn for the elimination of racism. Thus, undoing racism not only represents an obligation not to harm patients but also demands that we address how the actions of the social system in which we live are harmful.

Lifelong learning remains a fundamental guideline for the medical professional, reflected in the AMA Principles of Medical Ethics. Specifically, principle V states that "A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated." Developing an antiracist framework requires consulting with or making referrals not only to those outside one's scope of practice but also to those outside the traditional network. Clinicians are obligated to promote good outcomes for their patients and collaborate with other experts to develop and implement an antiracist framework that serves to uphold the ethical obligation to promote good outcomes by constantly engaging in sharpening their skills, knowledge, and abilities in addressing racism and its impact on patients' well-being.

Strategy Four: Research Advocacy in Psychiatry

Research advocacy within the field of psychiatry includes the need to address racial and ethnic representation in research studies and clinical trials. Data have shown that racial and ethnic minorities are often not included in psychological, biological marker, or treatment studies [17, 61]. Some investigators claim that such study participants cannot be found, often because of a lack of knowledge, lack of relevant social contacts, or lack of awareness of how to reach out to people of color [15, 62]. Moreover, the history of mistreatment, including the Tuskegee syphilis study, does not encourage research participation by such groups [62, 63]. Yet, research indicates that African Americans will participate as often as other groups when given the opportunity, despite fears that research may be harmful [62, 64]. The Surgeon General's supplemental report on mental health reviewed racial and ethnic minority participation in clinical trials and noted that the numbers of such trial participants were very small in comparison with white Americans [17]. There is a need for increased population diversity in clinical trials. Increased research advocacy can lead to greater participation and also to improved knowledge about research, so that underrepresented groups can be partners in developing relevant research strategies. Strategies for clinical trial recruitment and retention include clear communication about the research, open dialogue about direct benefits for participants, and development of community advisory boards to help guide clinical research trials [64]. Programs could also include explicit discussion with racial and ethnic minorities about the history of medical experimentation in the USA—a practice that both addresses racism and empowers research participants in the process.

An additional area of advocacy includes research on racial bias in diagnosis. In a recent study, researchers found that African Americans with affective psychosis were overdiagnosed with schizophrenia despite the use of experts as multistage reviewers of patient interview transcripts [65]. Clearly, there is a need for additional research in this area. An important factor is the absence of people of African descent in field trials of diagnostic instruments. The field trials for the DSM-5 paid special attention to racial and ethnic representation, but there is a need for more research to study the potentially unique ways in which African Americans and other racial and ethnic minorities express their idioms of distress.

A final area for research advocacy lies at the intersection of mental health and the criminal justice system. US jails and prisons hold a disproportionate number of individuals who have substance use and mental health issues [66]. In addition, racial and ethnic minorities—in particular, African Americans—are overrepresented in the criminal justice system [66, 67]. Further evidence has shown racial disparities in mental health treatment among incarcerated populations. Persons of color are less likely than white inmates to receive treatment [66, 68]. These intersections of race, mental health, and criminal justice provide additional avenues for research advocacy to address structural racism. This type of research advocacy could focus on police encounters, access to care, research on mental health services for populations in the criminal justice system, and mental health treatment for formerly incarcerated individuals.

Conclusion

This chapter has introduced and defined the concept of clinician or physician advocacy, and has provided definitions of racism. The authors have shed light on historical accounts of physician advocacy to address racism within the field of psychiatry, and have shown why there is still a need for this type of advocacy in the present day. Antiracist strategies in four different areas are offered: training, social justice, curricula and education, and research. Clinician advocacy, particularly to address racism, is a necessary component of academic medicine and should play an active role in health care delivery. There is an urgent need for more advocacy in the US medical profession—advocacy that explicitly addresses multiple levels of racism. As Sabshin and colleagues noted nearly 50 years ago, "The only means to counter institutional racism is to create new and powerful antiracism mechanisms that will operate continuously and publicly throughout the country in all aspects of the psychiatric care system" [24].

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