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POSITION PAPER

Taking Action on Racism and Structural Violence in Psychiatric Training and Clinical Practice

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Introduction

Recent events in Canada, such as the discovery of graves of Indigenous children at former residential schools and the emergence of Black Lives Matter, have highlighted inequities long endured by Black, Indigenous, Asian and other racialized minorities, and mobilized efforts to address the effects of racism on health, mental health and well-being.[1–8] The Canadian Psychiatric Association published a position statement, *A Call to Action on Racism and Social Justice in Mental Health*, which was prepared by the Transcultural Psychiatry Section, to advocate for diversification of the mental health workforce, cultural and structural safety in educational and clinical environments, dismantling of racist mental health theory and practice, and transformation of institutional structures to make them more equitable and responsive.[9] This paper advances that call by taking the position that Canadian psychiatry must act now to redress the ongoing problem of systemic racism through concerted changes in training and mental health services as outlined in this paper. The objectives of this position paper are to:

1. Clarify key terms and concepts and present an overview of racism in psychiatry.
2. Describe systemic racism and inequities embedded in training and clinical practice in Canada.
3. Identify priorities to address the impact of structural racism on patients.
4. Describe the role of psychiatrists and other mental health professionals, and their professional associations, in challenging racism and structural violence in training and clinical practice.
5. Provide evidence-informed recommendations and best practices to transform psychiatric training and clinical practice in Canada.

Key Terms and Concepts

Race is a culturally constructed identity that divides humanity into groups based on notions of shared ancestry and physical traits presumed to indicate biological attributes.[10–13] Racial constructs have varied widely throughout history in response to political and economic priorities of dominant social groups, often to legitimize systems of oppression including slavery, colonialism and apartheid.[14–16] North American racial constructs and categories can be traced to the post-Enlightenment period of European history,[17] and reflect the interests of powerful groups as well as the human propensity to distinguish ingroup and outgroup and to construct essentialized categories.[18] Although human populations show substantial genetic variation as they adapt to local culturally constructed environments,[19–21] human genetic variation across groups follows a graduated pattern of single-trait gradients, instead of clustering into discrete racial categories.[10,22] The global inter-mixing of human populations has not resulted in distinct groups that would justify a categorical construct like race.[23] Moreover, research finds much greater genetic variation among individuals from the same group than between individuals from different racialized groups.[24,25]

Given the lack of biological support for the concept, it is more accurate to replace the term *race* with *racialized* to highlight its socio-culturally constructed nature and use,[26] and how this process of social construction undergirds patterns of racial discrimination, oppression and social exclusion[27,28] that result in marked inequities in mental health.[22,29–31] As Ta-Nehisi Coates puts it, "Race is the child of racism, not the father."[32,p.7]

Describing Racism at Micro, Meso and Macro Levels

Racism exists at the *micro*, *meso* and *macro* social levels of individuals, institutions and societies and is used to justify the inequitable distribution of power and resources to racialized groups.[33–37]

Racism at the Micro Level

The micro level of racism involves individual acts of discrimination and interpersonal violence, including

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everyday *microaggressions*, which are acts of disrespect, slights, bias, misrecognition and exclusion that may or may not be deliberate.[38] Microaggressions include drawing unnecessary attention to a person's skin colour, hair or clothing or making stereotyped assumptions about their traits and abilities.[39,40] Racism may also be internalized by individuals as negative self-images that cause suffering and impair functioning.[41,42] A common assumption is that racism only takes the form of malevolent acts by a few "bad" people.[43] Most psychiatrists, including those benefiting from White privilege, would not view themselves as racist. However, while overtly racist acts of hateful speech, discriminatory actions and physical violence are not uncommon, interpersonal expressions of racism often take a less explicit form. The general public is socialized to accept and believe racist discourses, including stereotypes, prejudices and implicit biases. Mental health providers are similarly influenced by pervasive systemic racism "that functions independently from the intentions or self-images of individual actors."[43, p. 20]

Racism also affects who is considered a credible authority and what counts as knowledge or evidence. *Epistemic injustice* refers to the way the knowledge claims of some individuals or groups are deemed illegitimate (*testimonial injustice*) and how they are denied the authority to use their own frameworks to interpret the meaning and validity of truth claims (*hermeneutic injustice*).[44] Epistemic injustice has profound implications at the micro-level in psychiatric settings, where the voices of racialized people may be ignored, silenced or marginalized, not only within clinical encounters, but in the production of knowledge through research and its translation into evidence-informed practice.

Overtly positive stereotypes can also have negative psychosocial effects.[45,46] The stereotype of the *model minority* is often used to situate Asian communities in relation to a racist White-Black hierarchy. In addition to its damaging effects on individuals,[47] this stereotype downplays the extent of anti-Asian racism, maintains a racist hierarchy, pits marginalized groups against each other and deepens racism against other racialized groups.[48] The concept of model minority highlights how diverse communities experience racism in different ways.

Racism at the Meso Level

The meso level involves discriminatory or exclusionary institutions, laws, policies and practices through which macro forces impact on communities and individuals.[29,35]

Institutional racism characterizes racist ideologies and practices embedded in institutions such as government, law-enforcement, education and health care,[29,49] while *institutional injustice* refers to how resources are inequitably distributed to racialized minorities.[50] These processes are evident in the racial bias of the criminal justice system (such as police violence, high incarceration rates), teaching curricula, academic hiring and promotion, and the under-representation of racialized communities in many professions, including psychiatry.[51–53] Institutional racism may also be expressed through preferential treatment of those who have positively valued racialized identities. The concept of "privilege" refers to the unearned social advantage based on racialized identity that some sectors of society take for granted. *White privilege* specifically refers to the lack of experienced discrimination, and the power, resources and opportunities available to those assigned to the category of "White" based on the colour of their skin.[54]

Racism at the Macro Level

At the macro level, racism manifests in structures and systems. *Structural racism* recognizes that racism cannot be reduced to single institutions or actors but is built into the structure of society in terms of social class and caste, and the organization of space.[29] Structural racism results in *structural violence*, including poverty, educational and health inequities, and lack of recognition or sovereignty.[55] *Systemic racism* points to the ways in which institutions, structures, ideologies and practices work together to make racism part of how the social system functions. Importantly, systemic racism can occur even when individuals who participate in the system are not consciously racist.

Environmental racism is another macrosocial phenomenon that refers to racialized groups being differentially exposed to unhealthy environmental conditions.[56–58] This occurs on local and global scales and is especially salient for Indigenous Peoples, many of whom have a close connection to the land, so that environmental depredations represent profound attacks on the person and community.[59–62]

Health and Social Consequences of Racism

Racism affects all areas of life.[63] Based on 2016 Canadian Census data, racialized populations had a higher unemployment rate than their non-racialized counterparts (9.2 vs. 7.3 per cent) and earned less money (78 cents and 59 cents for racialized men and women respectively per dollar earned by non-racialized men), with disparities

among racialized immigrants extending for three generations and beyond.[64] Indigenous people face ongoing structural violence, rooted in the legacies of colonization including the residential school system and the Sixties Scoop, that perpetuates limited access to clean food and water, stable housing, education and adequate health funding.[65,66]

The health disparities experienced by racialized groups include shorter life expectancy and higher rates of obesity, high blood pressure, cardiovascular disease and diabetes.[30] The concept of *allostatic load*,[67] which describes physiological alterations due to chronic stress, may account for some of the effects of racism on health conditions.[68] The interaction of social adversities and lack of access to health resources also contributes to inequities.[69]

Microaggressions contribute to an interpersonal burden that has physical, psychological and social consequences.[38,70] Microaggressions are ubiquitous, occurring in personal and work relationships as well as public settings.[10,15] Coping with microaggressions in these contexts requires specific strategies—all of which demand energy and time.[71,72] The cumulative exposure to these discriminatory acts has long-term health effects on people from ethnic minorities.[73]

Racialized individuals, particularly Black and Indigenous people, have more negative experiences in the education system, including exposure to racial stereotyping and hostility, lack of encouragement to pursue education, lack of role models and impoverished opportunities,[74–76] which, along with other inequalities, contribute to lowered expectations, unemployment and the overrepresentation of racialized people in the Canadian criminal justice system.[77] In addition, Black and Indigenous children are overrepresented in the Canadian child welfare system, which may be related to implicit biases and the effects of systemic violence and racism.[78–80]

Historically, Canadian law has colluded with racist agendas to disadvantage communities of colour.[81] The Indian Act (1876/1985) considered Indigenous Peoples as wards of the state and instituted oppressive measures.[82] Although modified through the years, the Indian Act continues to contribute to structural racism.[83] Racialized individuals and communities experience increased police and justice system contact.[84–86] One study found that whereas Indigenous people make up only five per cent of the general population, they account for 30 per cent of Canadian federal inmates.[87] Black youth in Canada are twice as likely as White youth to be searched by the police, 50 per cent more likely to be detained before trial, have more conditions imposed when given bail, and are

incarcerated at four times the rate as Whites.[88] Recent studies in Montreal found that Black psychiatric patients were at higher risk of coercive intervention,[89] particularly when the courts or police were involved.[90]

There is a long history of anti-Asian racism from the building of the Canadian Pacific railroad to the Chinese head tax, the Chinese Exclusion Act and the Japanese Canadian Internment in World War II, to recent anti-Asian racism in response to the COVID-19 pandemic. In a 2021 national survey, 50 per cent of Chinese Canadians experienced being insulted because of the pandemic, and 43 per cent were personally threatened or intimidated. In the first year of the pandemic, about 1150 anti-Asian racist attacks were voluntarily reported to websites, including 11 per cent involving physical contact and 10 per cent being coughed or spat on.[91]

Racialized populations also suffer when discriminated against based on their religion, with intersecting ethnic and race-based prejudice. Many instances of hate crimes that target religious minorities have been documented in Canada.[92–95]

Racism and Discrimination in Clinical Psychiatry

Racism is deeply embedded in the languages we speak and the structures of our society[96,97] and is evident in the institutional practice of psychiatry.[98,99] As reflected in the writings of colonial psychiatrists like Antoine Porot and J.C. Carothers,[100,101] racism has shaped the institutions of psychiatry within countries and internationally.[102] Colonial writers promoted stereotypes of racialized communities that persist in psychiatry to the current day.[103] Despite well documented health care disparities for people of colour and immigrants, racism remains a persistent problem in Canadian medicine and psychiatry.[104–106] In the Canadian context, racism and discrimination have been under-reported, undetected and unacknowledged even though structural racism affects patients and caregivers at all levels of society.[107,108]

Racialized immigrants and minorities face systemic and structural difficulties accessing mental health care.[109] Some of these difficulties include limited financial resources, a poor understanding of mental health-care systems, lack of services in areas where racialized people live and limited availability of interpreters for newcomers.[110] Access to care for racialized minorities born in Canada, in contrast to immigrant racialized minorities, has been little studied, but some national data suggest a link between discrimination and poor access to services, with worse mental health outcomes, for example, in perinatal conditions like post-partum depression.[111,112]

Despite well-documented employment inequities in Canadian higher education,[113] discriminatory practices in academia that exclude people of colour are often overlooked.[114] In general, data on the ethnicity of Canadian physicians is difficult to obtain, but available information shows a lack of diversity at all levels from health ministers to medical school faculty.[115] The 2016 Canadian Census found that although Indigenous peoples represented four per cent of the population fewer than one per cent of medical specialists and general practitioners identified as Indigenous.[116]

According to the Black Canadian National Survey Interim Report,[117] 49 per cent of Indigenous and 70 per cent of Black Canadians experience racism and most report that racism is a problem in health care. In a systematic review and meta-analysis, Paradies et al.[118] found that while racism is significantly correlated with poor health status, the association between racism and poor mental health, especially post-traumatic stress disorder (PTSD), was twice as large as that for poor physical health. Experiences of racism carry serious short- and long-term consequences for racialized people, including impaired life satisfaction and self-esteem[119] and more helplessness and suicide behaviour.[120] Systemic racism also contributes to poor quality of health care for Indigenous people[121,122] and avoidance of mental health services by Chinese, other Asian, and Black Canadians.[123]

Additional problems that racialized patients may face due to racism include disparities in diagnosis and course of illness, such as: being diagnosed with more psychiatric disorders overall,[124–129] being misdiagnosed with psychotic disorders instead of depression and PTSD,[130,131] developing more delusional ideation or other psychotic symptoms,[132,133] having a relatively more severe course of illness[134,135] as reflected in an excess of police and ambulance contact prior to emergency psychiatry evaluation,[136] and being more likely than non-racialized patients to be involuntarily admitted to the hospital.[137] A meta-analysis found anti-Asian racial discrimination to be associated with mental distress, with Chinese and South Asian ethnicities being independent predictors of illness severity, presence of psychotic symptoms and involuntary hospital admission.[138] Among various ethno-racial groups studied, Chinese Canadians reported the weakest sense of belonging to local communities and the poorest self-rated mental health.[123]

Addressing Racism in Canadian Psychiatric Training and Professional Development

Despite growing recognition of the need for anti-racist practices, few training programs for mental health professionals address issues of racialized identity and racism.[78,139–141] There is a crucial need to educate professionals in ways to identify and address the effects of racism on their patients and themselves, as well as on the health-care institutions and systems in which they work. Professionals also need to understand how the colonial past and present, as well as histories of racism and exclusion, affect current practices. The unexamined racism in the profession risks making psychiatry an unattractive career choice for potential trainees of colour.

Curriculum development can begin by outlining key learning objectives in terms of attitudes, skills and knowledge, using the CanMEDS Framework, and describing competencies that can be evaluated with Entrustable Professional Activities (EPAs).[142] These in turn must be integrated with In-Training Evaluation Reports (ITERs) and Royal College examination content whenever possible because evaluation drives learning and signals institutional commitment.[143]

Residency curricula need to ensure that trainees deepen their understanding of the intersectional nature of racialized identity, racism, power, privilege and oppression,[144] while being grounded in the social and historical contexts of diverse marginalized and oppressed groups.[145] Racism needs to be understood on personal, relational and eco-social levels,[9,49,146] and across its various forms and contexts, including internalized racism, micro-aggression, interpersonal racism, institutional racism, structural/systemic racism, colonial histories of racism, and ultimately, how these issues interweave to produce disparities in mental health.[147] Training programs need to provide safe spaces and role models to enable faculty and trainees to reflect on their own biases[106,148–150] and focus on developing the necessary knowledge, skills and attitudes to deliver culturally safe care.[149,151–153] Being aware of racism is not enough: trainees and psychiatrists alike must be actively opposed to racism and have the tools to address biases and discriminatory practices.

To recognize and address systemic racism, training needs to emphasize a more systemic approach, including skills in assessing family, socio-cultural factors and structural inequalities,[154] promoting inclusivity of spiritual, cultural, systemic and environmental dimensions and the perspectives of diverse clients.[155] A systemic view can better equip clinicians to create safety in the micro-dynamics of the clinical encounter and appraise the social dimensions of suffering.[156]

Reflection on the history of structural and systemic racism should be linked to actions that can transform the health-care system.[157,158] Making links from theory to

Table 1. Anti-racist Practices in Psychiatry Across Micro, Meso and Macro Levels.

A. Micro-level (individual/clinical) actions
1. Support self-reflection about racism as part of training and continuing medical education.
2. Reflect on one's own background, experiences of discrimination and positions of privilege, including internalized stereotypes and biases about self and others.
3. Become familiar with the experiences of racialized groups.
4. Become culturally competent, exploring racialized identities and everyday discrimination.
5. Adopt a proactive stance against racism.

B. Meso-level (professional/institutional) actions
1. Identify institutional racism in psychiatry and medicine; systematically document racism and inequity in psychiatric services, administration and research, replacing them with anti-racist practices; ensure that there are consequences for racists acts.
2. Develop anti-racist training curricula for trainees and staff to respond to racism in clinical and individual interactions.
3. Professional organizations like the CPA must diversify education committees, provide relevant presentations at annual conferences and partner with Black and Indigenous trainee and physician organizations to engage in advocacy.
4. Develop anti-racist clinical and professional services by engaging minority communities and integrating organizational cultural and structural competence, safety and humility.
5. Ensure structurally competent care with linguistic interpreters, consideration of travel distance and flexible hours of service.
6. Build assessment of anti-racist practice into professional, training program and hospital accreditation, with accreditors requiring clear plans to address racist content in teaching curricula, clinical care and student supervision.
7. Hire, fund and support staff from racialized communities.
8. Hire, fund and support equity, diversity and inclusion (EDI) leaders for each academic department of psychiatry.
9. Gather access-to-care data with the input of racialized communities.
10. Advocate for non-police responses to mental health crises.

C. Macro-level (social/ideological) actions
1. Recognize racism in Canadian society, including the profession's history and complicity in systemic racism, colonization, slavery, genocide and mental health care inequity, and the ways these forces are currently at play.
2. Engage in advocacy to address structural inequities, including immigration detention, access to care for the uninsured and the excess incarceration of racialized people.
3. Ensure access to culturally safe and structurally competent mental health services.
4. Foster pluralism and diversity as core values in society and implement equity through collaboration with communities.
5. Ensure equitable representation of diverse communities at all levels of society, including mental health services, research and administration.

clinical practice and to systemic advocacy is critical to creating meaningful change at all levels.[159,160] This requires training to address racism at micro, meso and macro levels to facilitate working with racialized individuals, families and communities through collaboration and collective empowerment.[8,161]

Undergraduate and postgraduate medical education need to have an integrated developmental approach to addressing racism through providing knowledge and conceptual frameworks in didactic presentations, cultivating attitudinal change through experiential and reflective learning, and building clinical and advocacy skills through supervision and modelling.[9, 162,165] Learner-led discussion groups can provide additional spaces for dialogue complementary to the formal curriculum.[166,167] Above all, racialized trainees need a safe space to learn, with mentors and supervisors who recognize and address the racism that they encounter in patient interactions, as well as with colleagues, institutions and the wider society. Some trainees and faculty may require specific mentorship from supervisors with lived experience of racism.

Faculty need to prioritize anti-racism initiatives to establish trust and ensure sustainability, and they must be trained in anti-racist pedagogy, cultural safety, cultural humility, and cultural and structural competence to address issues of racism that appear in clinical supervision.[163,168–172] Engaging community members and service users in training is key to unmasking the lived reality of racism and confronting biases and stereotypes. Facilitating long-term interdisciplinary and community collaborations can foster self-transformation and collective action.

Addressing Racism in Clinical Practice

Facing the complexity of historical and ongoing racism, many clinicians and members of racialized communities may have doubts about whether mental health-care systems can ever provide equitable care. Rather than retreating from their responsibility, all clinicians and institutions must critically examine the biases embedded in practices and policies to avoid perpetuating racism and discrimination.[173] Ensuring diversity in the health-care workforce and conveying a willingness to acknowledge

and discuss issues of racism can contribute to more equitable access to care.[174] Explicit anti-racist actions are needed at the micro, meso and macro levels (Table 1).

Consistent with the previous training recommendations, Cénat[147] outlines core approaches to anti-racist practice for health-care practitioners at the micro level, emphasizing self-awareness, recognition of diversity within and among groups, knowledge of the impacts of racism and discrimination on mental health and clinical services, and specific skills in interviewing, assessment and treatment. Antiracist policies and laws against discrimination should be applied to health-care settings, as reflected in documents like Jordan's Principle[175] and Joyce's Principle,[176] which assert Indigenous rights to equitable services. Anti-racist practices in clinical work begin with self-awareness, openness and the willingness to explore issues with colleagues and patients.

Unfortunately, many clinicians either avoid addressing racism altogether or do not distinguish non-racist from anti-racist attitudes.[74,75,177] A non-racist attitude refers to passive rejection, even denial, of racism, while an anti-racist attitude implies active efforts to acknowledge systemic racism and remove its effects from the structures of society.[178] When patients or colleagues raise issues related to racism, their experience may be minimized, discounted or ignored by those who adopt a 'non-racist' attitude. Clinicians may become defensive, deflecting, denying or even blaming discriminatory experiences on victims' perceptions, attitudes and actions or viewing patients' legitimate mistrust as an expression of suspicious or paranoid thinking.[173] These responses have been reported by patients from racialized communities who may then disengage, or remain untrusting and unwilling to speak openly about their experiences of racism.[153,179] Similarly, racialized psychiatrists may experience micro-aggressions on an almost-daily basis from their patients or colleagues. These experiences often go unseen so may be unnoticed by peers and health administrators. Acceptance of the reality of systemic racism is a necessary first step towards change that will support anti-racism advocacy, allyship and equity efforts.

Countering racism at a meso level requires attention to institutional structures and routines, such as providing access to linguistic interpreters and culture brokers. For psychiatry, this may include modifying the multidisciplinary clinical team, ward, department, faculty, hospital and other practice settings[180] to reduce access barriers and improve the quality of services. Countering racism at a macro level requires acting at a societal, policy and broader structural level through

program development, advocacy and research that calls for change in the structures and practices that perpetuate racism in different sectors and institutions (e.g., police, immigration, education, employment, health care). Ensuring diversity within the profession is an important step toward equity and institutional change. In Canada, where Indigenous Peoples[116] and many other groups are under-represented in the health professions, funding and hiring strategies that lead to recruitment of minority medical students and residents can contribute to a long range shift within psychiatry toward greater diversity and inclusiveness in the mental health workforce and equitable representation of racialized groups.[181,182] More than mere numerical representation, racialized psychiatrists and trainees need the mental health system to change to become actively anti-racist and welcoming of diversity.

One way to increase diversity in the profession over the long term would be for organizations like the CPA to partner with other professional medical organizations, like the Canadian Medical Association and Canadian medical schools, to develop community partnerships with under-represented groups to increase the number of competitive medical school applicants. Reserving training spots, providing scholarships or financial support, and increasing international medical graduate integration have been successful strategies to increase equitable representation for Black, Indigenous and other underrepresented racialized groups. Educators can work with Black medical student and physician organizations and Indigenous physician organizations to develop other strategies for equity and inclusion. In addition, addressing racism and inequities embedded in career advancements, academic promotions, and leadership and power opportunities, as well as support for racialized professionals to prevent burnout, are urgently needed. Given the limited number of racialized professionals in psychiatry, they tend to become overburdened and need resources to function effectively. Organizations need to be sensitive to the time, emotional toll and distraction associated with these tasks and give appropriate recognition for these roles.

The knowledge and experience of diverse psychiatrists is crucial to improving care for racialized patients and working toward broader change in health-care institutions and systems.[106,163,183] In the meantime, health-care institutions and professional organizations must stop current "colourblind" approaches that are common and continue to perpetuate discrimination against people of colour.[184] One important step would be for each academic department of psychiatry in Canada to identify an equity,

diversity and inclusion (EDI) leader. This new position would be given significant status, responsibilities, resources and decision-making power to encourage and support clear anti-racist policies that could be implemented at the meso and macro level (see Table 1). This should however be considered a starting point and not a sign that racism has been dealt with adequately at the institutional level.

Preventing the Mental Health Consequences of Systemic Discrimination

The structural inequities of Canadian society disproportionately affect racialized peoples. Redressing these inequities requires structural interventions including advocacy, public health interventions and policy change. Psychiatrists can engage on these issues at multiple levels: at the micro level by modifying clinical care and taking personal responsibility for developing knowledge and skills in anti-racism, at the meso level by adapting programs, and at the macro level through systemic advocacy, that is, working to modify policies or procedures that broadly impact vulnerable groups or communities.[185] Although not all clinicians will address each of these levels, it is important to understand how they are interrelated. Offering clinical care to racialized populations, without attending to higher-level structural issues, may unintentionally treat mental health difficulties as problems arising from the individual rather than due to systemic racism. Specialized programs, which include anti-oppressive and anti-racist principles, offer meso-level interventions. Examples of such programs are SAPACCY, a program specifically created for African Canadian and Caribbean Youth,[174] ethno-specific services developed in partnership with communities such as Hong Fook, Across Boundaries and the Asian Initiative in Mental Health in Toronto,[186] and the Cultural Consultation Service in Montreal.[155] In addition, there are programs that work collaboratively and respectfully with Indigenous mental health services by forging partnerships with rural, remote and isolated Indigenous communities to solve locally identified mental health challenges.[187]

Engaging in structural advocacy is less familiar to many psychiatrists.[160] This form of advocacy targets root causes of inequity which impact health such as detention of migrants, family separation, precarious employment, culturally unsafe social institutions, racist media representation, poverty and homelessness.[188] To engage at the structural level, psychiatrists may join or initiate advocacy coalitions that work with affected communities and employ a diversity of tactics, such as organizing open

letters and opinion pieces,[189] to address policy, judicial, legal or political engagements. Advocacy aims not only to correct structural racism but to ensure that marginal voices are heard in the context of human rights and social justice frameworks.[190]

Preventing racism by changing institutions, attitudes and practices requires ongoing dialogue among stakeholders to clarify competing values, provide a safe space for critical self-reflection, and develop collaborative interventions.[191,192] This position paper cannot replace ongoing discussions, seminars and workshops at the local level to determine how to decolonize curricula and prevent racism in policy and clinical practice. Advocacy efforts are not without risks;[193] for example, in efforts to rapidly gain consensus, the complexity of issues and the diversity of experience within groups may be oversimplified with the result that racialized communities may be stereotyped as helpless, passive and lacking resilience.[192] To avoid these pitfalls, participatory engagement of communities that have largely been excluded from research or planning efforts, will be key to ensuring that the advocacy process is collaborative, co-developed and empowering rather than paternalistic or merely tokenistic.[194]

Conclusion: Transformative Change Through Reflection, Advocacy and Solidarity

Diversity is a great strength of Canadian society. However, racialized and minoritized groups continue to face bias and discrimination in psychiatry. These forms of injustice will not be resolved by simply adopting an attitude of 'colour-blindness' that ignores the lived experience and structural embedding of racism. Denial of systemic racism and structural violence operates at all levels of Canadian society.[195] This paper takes the position that Canadian psychiatry must act now to redress the ongoing problem of systemic racism through concerted changes in training and mental health services as outlined in this paper. Within the profession, psychiatrists may feel unconcerned or unjustly targeted, insisting that they do not have racist attitudes or beliefs and are not "privileged." Unfortunately, indifference and defensiveness perpetuate systemic racism. The Turpel-Lafond Report (2020) concluded that racism pervades health-care systems, but specific actions endorsed by policy can affect change.[196] Progress comes about when individuals reflect on how their own beliefs and behaviours contribute to racism in Canadian society. Countering racism at a micro level (personal or clinical)

starts with self-reflection and psychologically and culturally safe dialogue. This requires acknowledging uncomfortable feelings, recognizing the experiences of others, realigning one's privileged status and developing equitable relationships, leading to advocacy for systemic change at the meso and macro levels. Professional organizations, like the CPA, must lead in this process. Psychiatry must become a safer professional environment for diverse trainees as well as patients. The essential systemic changes will come about as psychiatrists work in partnership with other professions, government and communities. Institutions that actively counter racism can gradually transform the structures of discrimination that harm our patients, our colleagues and ourselves contributing to a more equitable health-care system and society.

Acknowledgements

References

1. American Psychiatric Association. APA presidential task force to address structural racism throughout psychiatry begins its work. Washington (DC): Author; 2020 [cited 2020 Sep 16]. Available from: https://bit.ly/3HdBGae.

2. Black Psychiatrists of America, Inc. BPA press release on June 3, 2020 [cited 2022 Aug 21]. Available from: https://bit.ly/3FASTsI.

3. Canadian Psychological Association. CPA statement against anti-Black racism and discrimination. Ottawa (ON): CPA; 2020 [cited 2020 Sep 26]. Available from: https://cpa.ca/humanrightsandsocialjustice/.

4. Dr. Kenneth Melville McGill Black Faculty Caucus. McGill plan for addressing anti-Black racism [Statement]. Montreal (QC): Author; 2020 [cited 2022 Aug 21]. Available from: https://bit.ly/3W2f7cS.

5. Royal College of Psychiatrists. *President's open letter on systemic racism*. London (UK): Author; 2020 Jul 14 [cited 202 Sep 26]. Available from: https://bit.ly/3Bdaq7Z.

6. Royal College of Physicians and Surgeons of Canada. Statement on racism. Ottawa (ON): Author; 2020 [cited 2022 Aug 21]. Available from: https://newsroom.royalcollege.ca/statement-on-racism/.

7. University of Toronto. Strategic plan 2020-26. Toronto (ON): Author; 2020 [cited 2020 Sep 26]. Available from: https://bit.ly/3YijjHp.

8. Schouler-Ocak M, Bhugra D, Kastrup MC, et al. Racism and mental health and the role of mental health professionals. Euro Psychiatry. 2021;64(1):e42.

9. Kirmayer LJ, Fernando S, Guzder J, et al. A call to action on racism and social justice in mental health: un appel à l'action en matière de racisme et de justice sociale en santé mentale. Can J Psychiatry. 2021;66(6):590-593.

10. Gravlee CC. How race becomes biology: embodiment of social inequality. Am J Phys Anthropol. 2009;139(1):47-57.

11. Hogarth K, Fletcher WL. A space for race: decoding racism, multiculturalism, and post-colonialism in the quest for belonging in Canada and beyond. New York (NY): Oxford University Press; 2018. p. 129.

12. Keita SO, Kittles RA. The persistence of racial thinking and the myth of racial divergence. Am Anthropol. 1997;99(3):534-544.

13. Lock M. The concept of race: an ideological construct. Transcult Psychiatr. 1993;30(3):203-227.

14. Frederickson G. Racism: A short history. Princeton (NJ): Princeton University Press; 1998. p. 207.

15. Muckhopadhyay CC, Moses YT. Reestablishing "race" in anthropological discourse. Am Anthropol. 1997;99(3):517-533.

16. Witzig R. The medicalization of race: scientific legitimization of a flawed social construct. Ann Intern Med. 1996;125(8):675-679.

17. Smith JE. Nature, human nature, and human difference. Princeton (NJ): Princeton University Press; 2015. p. 312.

18. Machery E, Faucher L. Why do we think racially? Culture, evolution, and cognition. In: Cohen H, Lefebvre C, editor. Handbook of categorization in cognitive science. North York (ON): Elsevier; 2017. p. 1135-1175.

19. Boyd R, Richerson PJ. The evolution of ethnic markers. Cultural Anthropol. 1987;2(1):65-79.

20. Laland KN, Odling-Smee J, Myles S. How culture shaped the human genome: bringing genetics and the human sciences together. Nat Rev Genet. 2010;11(2):137-148.

21. Tishkoff SA, Kidd KK. Implications of biogeography of human populations for 'race' and medicine. Nat Genet. 2004;36(11):S21-S27.

22. Smedley A, Smedley BD. Race as biology is fiction, racism as a social problem is real: anthropological and historical perspectives on the social construction of race. Am Psycholo. 2005;60(1):16-26.

23. Van Arsdale AP. Population demography, ancestry, and the biological concept of race. Annu Rev Anthropol. 2019;48:227-241.

24. Lewontin RC. The apportionment of human diversity. In: Dobzhansky T, Hecht MK, Steer WC, editors. Evolutionary biology. New York (NY): Springer; 1972. p. 381-398.

25. Long JC, Kittles RA. Human genetic diversity and the nonexistence of biological races. Hum Biol. 2003;75(4):449-471.

26. Miles R, Brown M. Racism. 2nd ed. New York (NY): Routledge; 2003. p. 216.

27. Hacking I. Why race still matters. Daedalus. 2005;134(1):102-116.

28. Song M. Challenging a culture of racial equivalence. Br J Sociol. 2014;65(1):107-129.

29. Bailey ZD, Krieger N, Agénor M, Graves J. Structural racism and health inequities in the USA: evidence and interventions. Lancet. 2017;389(10077):1453-1463.

30. Berger M, Sarnyai Z. "More than skin deep": stress neurobiology and mental health consequences of racial discrimination. Stress. 2015;18(1):1-10.

31. Krieger N. Discrimination and health inequities. Int J Health Serv. 2014;44(4):643-710.

32. Coates TN. Between the world and me. New York (NY): Spiegel & Grau; 2015. p. 176.

33. Adams ME, Bell LAE, Griffin PE. Teaching for diversity and social justice. New York (NY): Routledge; 2007. p. 478.

34. Jones CP. Toward the science and practice of anti-racism: launching a national campaign against racism. Ethn Dis. 2018;28(Suppl 1):231-234.

35. Nazroo JY, Bhui KS, Rhodes J. Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. Sociol Health Illn. 2020;42(2):262-276.

36. Phillips C. Institutional racism and ethnic inequalities: an expanded multilevel framework. J Soc Policy. 2010;40:173-192.

37. Williams DR, Lawrence JA, Davis BA. Racism and health: evidence and needed research. Ann Rev Public Health. 2019;40:105-125.

38. Lui PP, Quezada L. Associations between microaggression and adjustment outcomes: a meta-analytic and narrative review. Psychol Bull. 2019;145(1):45-78.

39. Sue DW, Spanierman L. Microaggressions in everyday life. Hoboken (NJ): John Wiley and Sons; 2020. p. 284.

40. Ward M, Premack R. What is a microaggression? 14 things people think are fine to say at work – but are actually racist, sexist, or offensive. Insider. 2021 [cited 2022 Aug 16].

41. David EJR, Schroeder TM, Fernandez J. Internalized racism: a systematic review of the psychological literature on racism's most insidious consequence. J Soc Issues. 2019;75(4):1057-1086.

42. Steele CM. Whistling Vivaldi: how stereotypes affect us and what we can do. New York (NY): WW Norton and Company; 2011. p. 256.

43. DiAngelo R. White fragility: why it's so hard for White people to talk about racism. Boston (MA): Beacon Press; 2018. p. 192.

44. Fricker M. Epistemic injustice: Power and the ethics of knowing. London (GB): Oxford University Press; 2007. p. 208.

45. Czopp AM, Kay AC, Cheryan S. Positive stereotypes are pervasive and powerful. Perspect Psychol Sci. 2015;10(4):451-463.

46. Kay AC, Day MV, Zanna MP. The insidious (and ironic) effects of positive stereotypes. J Expl Soc Psychol. 2013;49(2):287-291.

47. Cheryan S, Bodenhausen GV. When positive stereotypes threaten intellectual performance: the psychological hazards of "model minority" status. Psychol Sci. 2000;11(5):399-402.

48. Shih KY, Chang T, Chen S. Impacts of the model minority myth on Asian American individuals and families: social justice and critical race feminist perspectives. J Fam Theory Rev. 2019;11(3):412-428.

49. Fernando S. Institutional racism in psychiatry and clinical psychology. London (GB): Palgrave Macmillan; 2017. p. 209.

50. Hui A, Rennick-Egglestone S, Franklin D, et al. Institutional injustice: implications for system transformation emergin from the mental health recovery narratives of people experiencing marginalisation. PLoS One. 2021;16(4):e0250367.

51. Ansloos J, Stewart S, Fellner K, et al. Indigenous peoples and professional training in psychology in Canada. Can Psychol. 2019;60(4):265.

52. Chan W, Chunn D. Racialization, crime, and criminal justice in Canada. Toronto (ON): University of Toronto Press; 2014. p. 240.

53. Henry F, Dua E, Kobayashi A, et al. Race, racialization and indigeneity in Canadian universities. Race Ethn Educ. 2017;20(3):300-314.

54. Kendall G. Understanding White privilege: creating pathways to authentic relationships across race. 2nd ed. New York (NY): Routledge; 2013. p. 240.

55. Farmer PE, Nizeye B, Stulac S. Structural violence and clinical medicine. PLoS Med. 2006;3(10):e449.

56. Pulido L. Geographies of race and ethnicity II: environmental racism, racial capitalism and state-sanctioned violence. Prog Hum Geog. 2017;41(4):524-533.

57. Waldron I. Re-thinking waste: mapping racial geographies of violence on the colonial landscape. Envirol Sociol. 2018;4(1):36-53.

58. Waldron I. In your place and out of place: mapping spatial violence in urban and rural African Nova Scotian communities. Can Rev Sociol. 2020;57(4):733-736.

59. Dhillon C, Young MG. Environmental racism and First Nations: a call for socially just public policy development. Can J Human Soc Sci. 2010;1(1):23-37.

60. McGregor D. Mino-Mnaamodzawin: achieving indigenous environmental justice in Canada. Environment and Society. 2018;9(1):7-24.

61. Norgaard KM, Reed R. Emotional impacts of environmental decline: what can native cosmologies teach sociology about emotions and environmental justice? Theory Soc. 2017;46(6):463-495.

62. Willox AC, Harper SL, Edge VL, et al. The land enriches the soul: on climatic and environmental change, affect, and emotional health and well-being in Rigolet, Nunatsiavut, Canada. Emot, Space Soc. 2013;6:14-24.

63. Paradies Y. A systematic review of empirical research on self-reported racism and health. Int J Epidemiol. 2006;35(4):888-901.

64. Block S, Galabuzi-Grace E, Tranjan R. Canada's colour coded income inequality. Ottawa (ON): Canadian Centre for Policy Alternatives; 2019. p. 26.

65. Brittain M, Blackstock C. First Nations child poverty: a literature review and analysis. Ottawa (ON): First Nations Children's Action Research and Education Service (FNCARES); 2015. p. 175.

66. Truth and Reconciliation Commission of Canada (TRC). What we have learned: principles of truth and reconciliation [Internet]. Ottawa (ON): Author; 2015. Available from: https://bit.ly/3QJfLd3.

67. McEwen BS, Gianaros PJ. Central role of the brain in stress and adaptation: links to socioeconomic status, health, and disease. Ann NY Acad Sci. 2010;1186:190-222.

68. Geronimus AT, Hicken M, Keene D. "Weathering" and age patterns of allostatic load scores among Blacks and Whites in the United States. Am J Public Health. 2006;96(5):826-833.

69. Shonkoff JP, Slopen N, Williams DR. Early childhood adversity, toxic stress, and the impacts of racism on the foundations of health. Ann Rev Public Health. 2021;42:115-134.

70. Nadal KL, Griffin KE, Wong Y. The impact of racial microaggressions on mental health: counseling implications for clients of color. J Counsel Dev. 2014;92(1):57-66.

71. Sue DW, Alsaidi S, Awad MN. Disarming racial microaggressions: microintervention strategies for targets, White allies, and bystanders. Am Psychol. 2019;74(1):128.

72. Spanierman LB, Clark DA, Kim Y. Reviewing racial microaggressions research: documenting targets' experiences, harmful sequelae, and resistance strategies. Perspect on Psycholl Sci. 2021;16(5):1037-1059.

73. Wallace S, Nazroo J, Bécares L. Cumulative effect of racial discrimination on the mental health of ethnic minorities in the United Kingdom. Am J Public Health. 2016;106:1294-1300.

74. Codjoe HM. Fighting a "public enemy" of Black academic achievement—the persistence of racism and the schooling experiences of Black students in Canada. Race Ethn Educ. 2001;4(4):343-375.

75. Durham JI. Perceptions of microaggressions: implications for the mental health and treatment of African American youth. J Infant Child Adolesc Psychother. 2018;17:52-61.

76. Hardeman RR, Medina EM. Structural racism and critical race theory: contributions to adolescent health inequities and outcomes. In: Barkley L, Svetaz MV, Chulaini V, editor. Promoting health equity among racially and ethnically diverse adolescents. New York (NY): Springer; 2019. p. 55-63.

77. Salole AT, Abdulle Z. Quick to punish: an examination of the school to prison pipeline for marginalized youth. Can Rev Soc Policy. 2015;72/73:124-18.

78. Adjei PB. The (em)bodiment of blackness in a visceral anti-Black racism and ableism context. Race Ethn Educ. 2018;21(3):275-287.

79. Ontario Association of Children's Aid Societies. One vision, one voice: changing the Ontario child welfare system to better serve African Canadians. Practice framework: part 1: research report. Toronto (ON): Author; 2016 [Cited 2022 Aug 16]. Available from: https://bit.ly/3h5kKbo.

80. Boatswain-Kyte A, Esposito T, Trocmé N. A longitudinal jurisdictional study of Black children reported to child protection services in Quebec, Canada. Child Youth Serv Rev. 2020;116:105219.

81. Thornhill EMA. So seldom for us, so often against us: Blacks and law in Canada. J Black Stud. 2008;38(3):321-337.

82. Government of Canada (1876/1985). Indian Act [Internet]. Minister of Justice [cited 2022 Aug 16]. Available from: https://laws.justice.gc.ca/PDF/I-5.pdf.

83. Parrot Z. Indian Act [Internet]. Historica Canada. Published online 2006. Last edited 2020 [cited 2022 Aug 16]. Available from: https://www.thecanadianencyclopedia.ca/en/article/indian-act#.

84. Khenti AA. Homicide among young Black men in Toronto: an unrecognized public health crisis? Can J Public Health. 2013;104(1):e12-4.

85. Boyd RW. Police violence and the built harm of structural racism. The Lancet. 2018;392(10144):258-259.

86. Stewart E, Baumer E, Brunson R. Neighborhood racial context and perceptions of police-based racial discrimination among Black youth. Criminology. 2009;47(3):847-887.

87. Sheppard C, Thermitus T, Jones D. Understanding how racism becomes systemic. The Globe and Mail [Online Ed]. 2020 Jul 24; Opinion. Available from: https://bit.ly/3Pbgnrz.

88. Owusu-Bempah A, Wortley S. Race, crime and criminal justice in Canada. In: Bucerius S, Tonry M, editor. The Oxford handbook of ethnicity, crime, and immigration. New York (NY): Oxford University Press; 2014. p. 1-50.

89. Tran DQ, Ryder AG, Jarvis GE. Reported immigration and medical coercion among immigrants referred to a cultural consultation service. Transcult Psychiatry. 2019;56(5):807-826.

90. Knight S, Jarvis GE, Ryder AG, et al. Ethnoracial differences in coercive referral and intervention among patients with first-episode psychosis. Psychiatr Serv. 2021;73(1):1-7.

91. Kong J, Ip J, Huang C, Lin K. A year of racist attacks: anti-Asian racism across Canada one year into the COVID-19 pandemic. Toronto (ON): Chinese Canadian National Council Toronto Chapter; 2021 [cited 2022 Aug 16]. Available at: https://bit.ly/3YgPln4

92. Ontario Human Rights Commission. Policy on preventing discrimination on creed. Toronto (ON): Author; 2015 [cited 2022 Aug 16]; p. 173. Available from: https://bit.ly/3FcM9QE.

93. Moreau G. Police-reported hate crime in Canada, 2019. Ottawa, ON: Statistics Canada; 2021 [cited 2022 Aug 17]; p. 38. Available from: https://bit.ly/3Pb0YaX.

94. Montpetit J. Quebec City mosque shooting [Internet]. Historica Canada. Published online 2019. Last edited 2022 [cited 2022 Aug 16]. Available from: https://www.thecanadianencyclopedia.ca/en/article/quebec-city-mosque-shooting#.

95. Muslim family in Canada killed in 'premeditated' truck attack. BBC News online. Posted June 8, 2021 [cited 2022 Aug 16]. Available from: https://www.bbc.com/news/world-us-canada-57390398.

96. Gibson NC, Beneduce R. Frantz Fanon, psychiatry and politics. London (GB): Rowman & Littlefield International; 2017. p. 307.

97. Gordon LR. What Fanon said: a philosophical introduction to his life and thought. New York (NY): Fordham University Press; 2015.

98. Downs J. Maladies of empire: how colonalism, slavery and war transformed medicine. Cambridge (MA): The Belknap Press of Harvard University Press; 2021.

99. Hickling FW, Hutchison G. Post-colonialism and mental health. Psychiatr Bull. 2000;24(3):94-95.

100. Keller R. Madness and colonization: psychiatry in the British and French empires, 1800-1962. J Soc Hist. 2001;35(2):295-326.

101. Mahone S, Vaughan M, editors. Psychiatry and empire. London (GB): Palgrave Macmillan; 2007. p. 254.

102. Heaton MM. The politics and practice of Thomas Adeoye Lambo: towards a post-colonial history of transcultural psychiatry. Hist Psychiatry. 2018;29(3):315-330.

103. Jarvis GE. Changing psychiatric perception of African Americans with psychosis. Eur J Am Cult. 2008;27(3):227-252.

104. Dryden O, Nnorom O. Time to dismantle systemic anti-Black racism in medicine in Canada. CMAJ. 2021;193(2):e55-e57.

105. Ben-Cheikh I. Psycho-education on racism: psychiatry's role and responsibility in dismantling institutional racism. Int J Soc Psychiatr. 2020;68(2):239-243.

106. Fernando S. Mental health, race and culture. 3rd ed. London (GB): Palgrave; 2010.

107. Elliot JL, Fleras A. Unequal relations: an introduction to race and ethnic dynamics in Canada. Toronto (ON): Prentice Hall; 1992.

108. Satzewich V. Racism in Canada. New York (NY): Oxford University Press; 2011.

109. Edge S, Newbold B. Discrimination and the health of immigrants and refugees: exploring Canada's evidence base and directions for future research in newcomer receiving countries. J Immigr Minor Health. 2013;15(1):141-148.

110. Salami B, Mason A, Salma J, et al. Access to healthcare for immigrant children in Canada. Int J Environ Research Public Health. 2020;17(9):3320.

111. Khan M, Kobayashi K, Lee SM, et al. (In)Visible minorities in Canadian health data research. Popul change lifecourse strategic knowl cluster discuss pap ser. 2015;3(1):Article 5.

112. Urquia ML, PJ, Heaman MI. Revisiting the immigrant paradox in reproductive health: the roles of duration of residence and ethnicity. Soc Sci Med. 2012;74(10):1610-1621.

113. Henry F, Dua E, James CE, et al. The equity myth: racialization and indigeneity at Canadian universities. Vancouver (BC): UBC Press; 2017. p. 392.

114. Bumpus N. Too many White senior academics still resist recognizing racism. Nature. 2020;583(7818):661.

115. Kassam A. Canadian medicine has a diversity problem. Toronto Star online. 2017 Sep 3 [cited 2022 Aug 16].

116. Ohler Q. Access to Aboriginal doctors a struggle for Indigenous population. Global News. 2018 Dec 17 [cited 2022 Aug 16].

117. Foster L, Park S, McCague H, et al. Black Canadian national survey interim report. Institute for Social Research: York University, Toronto (ON); 2021.

118. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS One. 2015;10(9):e0138511.

119. Cénat JM, Hajizadeh S, Dalexis RD. Prevalence and effects of daily and major experiences of racial discrimination and microaggressions among Black individuals in Canada. J Interpers Violence. 2022;37(17-18):NP16750-NP16778.

120. Gajaria A, Guzder J, Rasasingham R. What's race go to do with it? A proposed framework to address racism's impacts on child and adolescent mental health in Canada. J Can Acad Child Adolesc Psychiatry. 2021;30(2):132-138.

121. Shaheen-Hussain S. Fighting for a hand to hold: confronting medical colonialism against Indigenous children in Canada. Montreal (QC): McGill-Queen's University Press; 2020; (97). p. 360.

122. Nerestant A. Racism, prejudice contributed to Joyce Echaquan's death in hospital, Quebec coroner's inquiry concludes. CBC News online. Posted October 1, 2021 [cited 2022 Aug 22].

123. Chiu M, Amartey A, Wang X. Ethnic differences in mental health status and service utilization: a population-based study in Ontario, Canada. Can J Psychiatry. 2018;63(7):481-491.

124. Aichberger MC, Bromand Z, Rapp MA, et al. Perceived ethnic discrimination, acculturation, and psychological distress in women of Turkish origin in Germany. Soc Psychiatry Psychiatr Epidemiol. 2015;50:1691-1700.

125. Benner A, Wang Y, Shen Y. Racial/ethnic discrimination and well-being during adolescence: a meta-analytic review. Ame Psychol J. 2018;73(7):S855-883.

126. Bhui K, Stansfeld S, McKenzie K. Racial/ethnic discrimination and common mental disorders among workers: findings from the EMPIRIC study of ethnic minority groups in the United Kingdom. Am J Public Health. 2005;95:496-501.

127. Heinz A, Müller D, Krach S. The uncanny return of the race concept. Front Hum Neurosci. 2014;8:S836.

128. Henssler J, Brandt L, Müller M, et al. Migration and schizophrenia: meta-analysis and explanatory framework. European Arch Psychiatry Clin Neurosci. 2020;270(3):325-335.

129. Cénat JM, Kogan C, Noorishad PG, et al. Prevalence and correlates of depression among Black individuals in Canada: the major role of everyday racial discrimination. Depress Anxiety. 2021;9:886-895.

130. Jarvis GE, Toniolo I, Ryder AG. High rates of psychosis for Black inpatients in Padua and Montreal: different contexts, similar findings. Soc Psychiatry Psychiatr Epidemiol. 2011;46(3):247-253.

131. Adeponle AB, Thombs BD, Groleau D. Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. Psychiatric Serv. 2012;63:147-153.

132. Janssen I, Hanssen M, Bak M, et al. Discrimination and delusional ideation. Br J Psychiatry. 2003;182(1):71-76.

133. Chakraborty A, McKenzie K. Does racial discrimination cause mental illness. Br J Psychiatry. 2002;180(6):475-477.

134. Asonye U, Apping N, Lopez LV. Health disparities in Black patients with severe mental illness and the role of structural racism. Psychiatr Ann. 2020;50(11):483-488.

135. Veling W, Pot-Kolder R, Counotte J. Environmental social stress, paranoia and psychosis liability: a virtual reality study. Schizophr Bull. 2016;42:1363-1371.

136. Jarvis GE, Kirmayer LJ, Jarvis GK. The role of Afro-Canadian status in police or ambulance referral to emergency psychiatric services. Psychiatr Serv. 2005;56(6):705-10.

137. Lebenbaum M, Chiu M, Vigod S. Prevalence and predictors of involuntary psychiatric hospital admissions in Ontario, Canada: a population-based linked administrative database study. BJPsych Open. 2018;4:31-38.

138. Chiu M, Lebenbaum M, Newman AM. Ethnic differences in mental illness severity: a population-based study of Chinese and South Asian patients in Ontario, Canada. J Clin Psychiatry. 2016;77(9):e1108-e1116.

139. Cénat JM, Blais-Rochette C, Morse C, et al. Prevalence and risk factors associated with attention-deficit/hyperactivity disorder among US Black individuals: a systematic review and meta-analysis. JAMA Psychiatry. 2021;78(1):21-28.

140. Fante-Coleman T, Jackson-Best F. Barriers and facilitators to accessing mental healthcare in Canada for Black youth: a scoping review. Adolesc Research Rev. 2020;2:115-136.

141. von Werthern M, Robjant K, Chui Z, et al. The impact of immigration detention on mental health: a systematic review. BMC Psychiatry. 2018;18(1):382.

142. Kirmayer LJ, Fung K, Rousseau C, et al. Guidelines for training in cultural psychiatry. Can J Psychiatry. 2021;66(2):195-246.

143. Fung K, Andermann L, Zaretsky A. An integrative approach to cultural competence in the psychiatric curriculum. Acad Psychiatry. 2008;32:272-282.

144. Taylor D, Richards D. Triple jeopardy: complexities of racism, sexism, and ageism on the experiences of mental health stigma among young Canadian Black women of Caribbean descent. Frontiers Sociol. 2019;4:43.

145. Legha RK, Richards M, Kataoka SH. Foundations in racism: a novel and contemporary curriculum for child and adolescent psychiatry fellows. Acad Psychiatry. 2021;45(1):1-6.

146. Ohueri CW, Brown VA, Lawson WB, et al. Racial and ethnic minority mental health advocacy: strategies for addressing racism. In: Medlock M, Shtasel D, Trinh NH, et al., editor. Racism and Psychiatry. Towtowa (NJ): Humana Press; 2019. p. 217-232.

147. Cénat JM. How to provide anti-racist mental health care. The Lancet Psychiatry. 2020;7(11):929-931.

148. Hairston DR, Gibbs TA, Wong SS, et al. Clinician bias in diagnosis and treatment. In: Medlock MM, Shtasel D, Trinh N-HT, et al., editors. Racism and psychiatry: contemporary

issues and interventions. Towtowa (NJ): Humana Press; 2019. p. 105-137.

149. Holm AL, Rowe Gorosh M, Brady M. Recognizing privilege and bias: an interactive exercise to expand health care providers' personal awareness. Acad Med. 2017;92(3):360-364.

150. Kareem J, Littlewood R, editors. Intercultural therapy: themes, interpretation and practice. New York (NY): Blackwell Scientific Publications; 1992. p. 294.

151. Benuto LT, Casas J, O'Donohue WT. Training culturally competent psychologists: a systematic review of the training outcome literature. Train Educ Prof Psychol. 2018;12(3):125-134.

152. Gamst G, Dana RH, Der-Karabetian A, et al. Cultural competency revised: the California brief multicultural competence scale. Meas Eval Couns Dev. 2004;37(3):163-183.

153. Moodley R, Lee E, editors. The routledge international handbook of race, culture and mental health. New Your (NY): Routledge; 2020.

154. Guzder J. Family systems in cultural consultation. In: Kirmayer LJ, Guzder J, Rousseau C, editor. Cultural consultation: encountering the other in mental health care. New York (NY): Springer; 2014. p. 139-161.

155. Kirmayer LJ, Guzder J, Rousseau C, editors. Cultural consultation: encountering the other in mental health care. New York (NY): Springer; 2014.

156. Kirmayer LJ, Jarvis GE. Culturally responsive services as a path to equity in mental healthcare. Healthc Paps. 2019;18(2):11-23.

157. Sharma M, Pinto AD, Kumagai AK. Teaching the social determinants of health: a path to equity or a road to nowhere? Acad Med. 2018;93(1):25-30.

158. Castillo EG, Isom J, DeBonis KL. Reconsidering systems-based practice: advancing structural competency, health equity, and social resonsibility in graduate medical education. Acad Med. 2020;95(12):1817-1822.

159. Buchman S, Woollard R, Meili R, et al. Practicing social accountability: from theory to action. Can Fam Physician. 2016;62(1):15-18.

160. Kirmayer LJ, Kronick R, Rousseau C. Advocacy as key to structural competency in psychiatry. JAMA Psychiatry. 2018;75(2):119-120.

161. Fung KP, Lo HT, Srivastava R. Organizational cultural competence consultation to a mental health institution. Transcult Psychiatry. 2012;49(2):165-184.

162. Guzder J, Rousseau C. A diversity of voices: the McGill 'working with culture' seminars. Cult Med Psychiatry. 2013;37(2):347-364.

163. Kumagai AK, Lypson ML. Beyond cultural competence: critical consciousness, social justice, and multicultural education. Acad Med. 2009;84(6):782-787.

164. Schen CR, Greenlee A. Race in supervision: let's talk about it. Psychodynam Psychiatry. 2018;46:1-21.

165. Wear D, Zaroconi J, Aultman J. Remembering Freddie Gray: medical education for social justice. Acad Med. 2017;92(3):312-317.

166. Beder M, Batke A, Hamer D. The transcultural psychiatry reading group: a learner-led approach to cultural psychiatry. Acad Psychiatry. 2015;39:703-705.

167. Lam JS, Gajaria A, Matthews DM. Bridging cultural psychiatry and global mental health: a resident-led initiative. Acad Psychiatry. 2016;40(4):729-30.

168. Corneau S, Stergiopoulos V. More than being against it: anti-racism and anti-oppression in mental health services. Transcult Psychiatry. 2012;49(2):261-282.

169. Diffey L, Mignone J. Implementing anti-racist pedagogy in health professional education: a realist review. Health Educ Care. 2017;2:1-9.

170. Legha RK, Miranda J. An anti-racist approach to achieving mental health equity in clinical care. Psychiatric Clin North Am. 2020;43(3):451-469.

171. Hansen H, Braslow J, Rohrbaugh RM. From cultural to structural competency—training psychiatry residents to act on social determinants of health and institutional racism. JAMA Psychiatry. 2018;75(2):117-118.

172. First Nations Health Authority. Cultural safety and humility [Internet]. Vancouver (BC): Author; 2021 [cited 2022 Aug 22]. Available from: https://bit.ly/3Y6izER.

173. Williams MT. Managing microaggressions: addressing everyday racism in therapeutic spaces. New York (NY): Oxford University Press; 2020.

174. Gajaria A, Haynes K, Kosic Y. The substance abuse program for African-Canadian and Caribbean youth (SAPACCY): an innovative program serving the mental health needs of African, Caribbean, and Black youth. INYI Journal. 2021;11(1):1-11.

175. Assembly of First Nations. Accessing Jordan's principle: a resource for First Nations parents, caregivers, families and communities. Ottawa (ON). Author; 2018 [cited 2022 Aug 21]. Available from: https://bit.ly/3BhGsQg.

176. Council of the Atikamekw of Manawan and Council de la Nation Atikamekw. Joyce's principle. 2020 [cited 022 Aug 21]; p. 16. Available from: https://bit.ly/3Fe0sEz.

177. Cave L, Cooper MN, Zubrick SR. Racial discrimination and child and adolescent health in longitudinal studies: a systematic review. Soc Sci Med. 2020;250:112864.

178. King LJ, Chandler PT. From non-racism to anti-racism in social studies teacher education: social studies and racial pedagogical content knowledge. In: Crowe AR, Cuenca A, editor. Rethinking social studies teacher education in the twenty-first century. New York (NY): Springer; 2016. p. 462.

179. Moodley R, Ocampo M. Critical psychiatry and mental health: exploring the work of Suman Fernando in clinical practice. London (GB): Routledge; 2014. p. 294.

180. Ayonrinde OA. Managing multicultural and multinational teams in healthcare management for psychiatrists. In: Bhugra D, Bell S, Burns A, editors. Management for psychiatrists. 4th ed. London (GB): The Royal College of Psychiatrists; 2016.

181. Mulvey TA, Michalski DS, Wicherski M. 2008-09: Applications, acceptances, enrollments, and degrees awarded to master's- and doctoral-level students in US and Canadian graduate departments of psychology [Internet]; Washington (DC): American Psychological Association; 2010. Available from: https://www.apa.org/workforce/publications/10-grad-study/application.

182. Sudak DM, Stewart AJ. Can we talk? The role of organized psychiatry in addressing structural racism to achieve diversity and inclusion in psychiatric workforce development. Acad Psychiatry. 2021;45(1):89-92.

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

184. Shin H, Bonilla-Silva E. Racism without racists: color-blind racism and the persistence of racial inequality in the United States. TESOL Quarterly. 2006;40(3):652-654.

185. ACT Human Rights Commission. Systemic advocacy [website]. Canberra (Au); Author; 2021 [cited 2022 Aug 19]. Available from: https://hrc.act.gov.au/public-advocate/systemic-advocacy/.

186. Fung KP, Guzder J. Canadian Immigrant mental health. In: Moussaoui D, Bhugra D, Ventriglio A, editors. Mental health and illness in migration. New York (NY): Springer; 2018. p. 1–21.

187. Allen L, Hatala A, Ijaz S. Indigenous-led health care partnerships in Canada. CMAJ. 2020;192(9):e208-e216.

188. Kronick R, Rousseau C, Cleveland J. Asylum-seeking children's experiences of detention in Canada: a qualitative study. Am J Orthopsychiatry. 2015;85(3):287-294.

189. Beder M, Cohen M, Hui K. End immigration detention: an open letter. The Lancet. 2018;392(10145):381-382.

190. Willen SW, Mulligan J, Castañeda H. Take a stand commentary: how can medical anthropologists contribute to contemporary conversations on "illegal" immigration and health? Med Anthropol Q. 2011;25(3):331-356.

191. Featherstone D. Maritime labour and subaltern geographies of internationalism: Black internationalist seafarers' organising in the interwar period. Polit Geogr. 2003;49:7-16.

192. Bhabha J. Internationalist gatekeepers?: the tension between asylum advocacy and human rights. Immigration and Nationality Law Review. 2002;23:159-186.

193. Soklaridis S, Bernard C, Ferguson G, et al. Understanding health advocacy in family medicine and psychiatry curricula and practice: a qualitative study. PLoS One. 2018;13(5):e0197590.

194. Boatswain-Kyte A, Trocmé N, Esposito T, et al. Child protection agencies collaborating with grass-root community organizations: partnership or tokenism? J Public Child Welfare. 2021;16(2):1-27.

195. Williams MT, Roy AK, MacIntyre MP. The traumatizing impact of racism in Canadians of colour. Curr Trauma Rep. 2022;8(2):17-34.

196. Turpel-Lafond ME. In plain sight: addressing Indigenous-specific racism and discrimination in BC health care. 2020. Available from: https://bit.ly/3Y6xNtO.