



Report of the Presidential Task Force on the Social Determinants of Mental Health

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I. OVERVIEW

This report serves as the final report of the American Psychiatric Association's (APA) Presidential Task Force on Social Determinants of Mental Health established under the leadership of President Vivian Pender and approved by the APA Board of Trustees in May 2021. Herein we summarize the work of the Task Force following our year of meetings and analyses on recommended actions the APA should support and undertake to address social determinants of mental health (SDoMH), which include racism and other societal structures.

The relevance and impact of social status on the risk for mental illness has been well recognized for over a century but has not been a central focus for social policy or advocacy, nor has it been adequately addressed in psychiatric education, research, or clinical care. Nonetheless, the SDoMH account for a major portion of mental illness in the United States.

The Task Force was convened in the extraordinary time of the COVID-19 pandemic, with a massive mental health crisis emerging as a result and ongoing, with social and public health repercussions (Surgeon General, 2022; Vahratian et al., 2021). Concomitantly, the US is experiencing an epidemic of "deaths of despair" fueled by an ongoing period of growing wealth inequality, economic instability, racial violence, political polarization, climate crisis, and insurrection (Brookings Institute, 2021). The Task Force was charged with recommending implementation steps to advance the 2018 APA Position Statement on Mental Health Equity and Social and Structural Determinants of Mental Health and on the prior Presidential Task Force on Systemic Racism, which we wholeheartedly endorse.

We implore the APA to use education and advocacy to address the poverty, trauma, and disadvantage impacting mental health across the entire population in addition to addressing the structural racism that affects the health of Black, Indigenous and People of Color (BIPOC). These long-overdue efforts and the current focus build on the actions of three Black women organizers (Alicia Garza, Patrisse Cullors, and Opal Tometi), who created the "Black Lives Matter" movement when George Zimmerman was acquitted in the shooting death of Trayvon Martin in 2012 in Florida. The movement grew nationally with the shooting death of Michael Brown in Missouri and the suffocation death of Eric Garner in New York, and finally became a worldwide movement when George Floyd was murdered in Minneapolis, Minnesota.

The disparate impact of COVID-19 on the morbidity and mortality of persons who face discrimination and its ensuing physiological effects because of their racialized identity, immigration status, gender identity, sexual orientation, ethnicity, and disability over these past two years cannot be overlooked. The impacted persons also included those with serious mental illnesses and those with developmental disabilities and cognitive decline.

This visibility provides the essential and requisite moment for the APA to step forward and help ameliorate the mental health disparities that arise from the social inequities that are embedded in our societal structures. Herein we propose new activities, initiatives, and opportunities for the APA to reduce the mental health burdens from the SDoMH and act to enhance social justice and health equity. Current APA activities relevant to the SDoMH do emanate from the ongoing actions of the organization, but these are insufficient and unfocused.

The establishment of this Presidential Task Force was a timely and necessary effort to reengage the APA and American psychiatry in newly energized efforts to improve the mental health of the nation by tackling the SDoMH. This requires a wholesale commitment of the APA to reconsider research, education and training, policy advocacy and development, and the professional roles of psychiatrists. The close linkage of

this effort to the pursuits of social justice and health equity is an essential feature of this effort, which calls American psychiatry to expand its vision of the role and work of psychiatrists.

This time of national mental health emergency brings an extraordinary intensity and urgency to the work of the Task Force and to implementation of the 2018 policy statement. Please read this report with the gravity of these times in mind. Intense engagement with the SDoMH is needed, and the members of the Task Force agree that this work must project far beyond the duration and means of the Task Force. We are left with this understanding: No time is ordinary. But some times are exceptional. This is our time. What will we do?

II. BACKGROUND

Why and How to Address the Social Determinants of Mental Health

Social factors drive the opportunities for mental health and well-being as well as the risks and severity of mental illness. Neglecting this reality has had wide social consequences. In recent decades, science made clear that social factors are the dominant contributors to mental morbidity and illness and drive the enormous inequities in health and mental health. Until recently, American psychiatry has largely distanced itself from understanding and addressing the SDoMH. This retreat from “the social” had real implications for the healing not only of people but of society. Global attention is increasingly paid to the connections between SDoMH and the big challenges of sustainability, well-being, and justice. However, organized psychiatry in the US has been largely silent on these crucial visions for the human future, such as advancing the UN Sustainable Development Goals (Lund, 2018). The accelerating realities of climate change only make such efforts more critical, and also more vulnerable.

The Task Force on the SDoMH brought a renewed focus on the critical social issues facing America and, by necessity, American psychiatry. This opportunity must be seized fully. Failure to do so will be widely noticed and have negative consequences for the organization and our profession. Moreover, a failure of American psychiatry to act demeans the scale and seriousness of what is at stake for people. The lives of millions of Americans are in the balance based on whether we can expand our vision of what psychiatry is and does by embracing the SDoMH framework not as a niche area, but as a foundation.

It is a historic moment, bringing immense challenges. Structural issues in society that have been illuminated include wealth inequality, economic instability, rampant racism, sexism, xenophobia, and classism. Our social safety net, into which much of American psychiatry is interwoven, is frayed. Many Americans lack the nutritional, healthcare, housing, educational, and occupational opportunities needed to be secure and to thrive, with significant impact on their overall health, including their mental health. Disrupting these chains of social damage and growing a now-atrophied paradigm that lives up to the dominance of social factors in mental health and mental illness will require sustained and broad attention. The APA needs new permanent capacity, commitment, and expertise to take this on—to join and help lead the allies, advocates, institutions, policymakers, and other professions in order to comprehensively address the SDoMH.

Psychiatry, American psychiatrists, and the APA have an obligation to address the challenges on the one hand, but also to enact new foundations for emotional thriving that in turn contribute to shrinking these problems. Based on our knowledge and our commitment to serve, we have sway as to whether these cycles of suffering continue or new roles and skills for psychiatrists can advance the prevention of mental illness rooted in the SDoMH. This requires more than just another manual or more review articles. It means organizational and professional commitment to a long game. The prevailing narrow biological focus in psychiatry did not emerge overnight. It has deep roots in our institutions, knowledge base, tools, career paths, business models, and political and other alliances and networks. A long-term commitment is needed

to grow similar, deep roots for a social determinants-based paradigm for psychiatry. Let's put the "social" back into biosocial models.

Psychiatrists are in a Privileged Position to Redress the SDoMH

It is clear that some of our profession's privileged economic status is built on the casualties that society produces. We have expertise to bring to bear on our nation's challenges, not to solve these complex problems on our own, but to join with entities seeking to address the massive environmental and socioeconomic pressures we face at this historic time. Psychiatry has untapped capacity to contribute to that effort and to grow and flourish as a profession as a result. Reengaging with "the social" opens new paths: expanded areas of research, broadened clinical focus, increased "task-sharing" with nonprofessionals, development of a public health perspective for psychiatry, and participation in formulating new social and economic policies that can be routes to primary prevention.

High Ambitions For the Impact of This Task Force

Our effort is not to put another paper on a shelf. It is not about more reports. It is a call to action on the SDoMH. It is a call for APA to increase the resources and activity necessary to take on this mission credibly and seriously. We need to animate, help, equip, and engage the APA members and other needed partners to shoulder this effort. Our urgency is clear: The moment is now. We must act decisively. To do less is to deny our knowledge and our commitment to serve, undermining the pillars of our profession and our personal integrity, leaving us to the unkind judgment of history. This scope of purpose and change is not hyperbole. It is necessary. Let's act like that future starts now.

III. THE SOCIAL DETERMINANTS OF MENTAL HEALTH

The WHO and the CDC Increased Their Focus

Beginning in the early years of the 21st century, the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) increased their focus on social determinants of health (SDoH). This is a welcome development for improving the health of populations and the healthcare of patients. The WHO gave several examples of the SDoH that profoundly shape inequities and influence health equity: (1) income and social protection, (2) education, (3) unemployment and job insecurity, (4) work-life conditions, (5) food insecurity, (6) housing, basic amenities, and environment, (7) early childhood development, (8) social inclusion and nondiscrimination, (9) structural conflict, and (10) access to decent-quality, affordable health services. The CDC listed the following examples of SDoH that have a major impact on people's health, well-being, and quality of life: (1) Safe housing, transportation, and neighborhoods, (2) Racism, discrimination, and violence, (3) Education, job opportunities, and income, (4) Access to nutritious foods and physical activity opportunities, (5) Polluted air and water, and (6) Language and literacy skills.

Limitations of the Current Conceptualization of Social Determinants of Health

All the SDoH listed by the WHO and CDC are clearly also important determinants of mental health, based on national and international research. This work shows that achieving equity in health, well-being, and mental health will depend on large-scale macro initiatives to address structural problems in society. American psychiatry must develop the capacities to operate at the supra-clinical levels of communities, regions, states, and nations. At the same time, it is equally clear that micro- and macro-level research and innovative practice development are essential at the clinical and organizational levels. Clinicians and local policymakers can improve the well-being of individual communities through place-based initiatives and clinical care innovations. As with macro-level initiatives, there are some laudable attempts at micro-level research, policy implementation initiatives, and innovative practice in local communities. Unfortunately, neither macro- nor micro-level work has received adequate attention.

More importantly, the SDoMH and their relationship to ensuing mental illnesses have not received the requisite focus they deserve. As psychiatrists and APA members, we need to rethink the SDoMH as they apply to the people of our nation. In the midst of a national mental health crisis, our current model of clinical care is inadequate for addressing the challenges faced by the people of our nation. We need to develop the capacity to reduce the incidence, prevalence, and burden of mental illness and to promote mental health, well-being, and resilience in the general population, especially among those at greatest risk and who are or will become our patients. Notably, there are more people with mental illnesses and substance use disorders in prisons and jails than in hospitals, reflecting the stigma against these conditions, the structural inequities experienced by minoritized communities and the otherwise disenfranchised, and the limitations of our past actions. We need to ensure that our patients (people with psychiatric disorders) receive the needed treatments and the resources for a good quality of life while providing intervention to prevent premature morbidity and mortality. We must broaden the definition of SDoMH to include exposures that impact the health and healthcare of persons at risk for psychiatric disorders and for those who are already afflicted. We must also prioritize prevention of mental illness and stress-related disorders starting in early childhood and across the lifespan, including perinatally.

It is time for the APA to embrace the science showing the association of social determinants with psychiatric outcomes. Already, most medical professional organizations, governmental agencies, healthcare providers and systems, and health insurance payers have focused their attention on these issues. These social determinants of health have an even more prodigious impact on mental health. In addition to being risk factors for mental illness including substance use disorders (e.g., discrimination, unemployment, housing instability, food insecurity, poor access to healthcare), these same exposures are frequent consequences of serious mental illnesses and substance use disorders. These SDoMH are likewise the drivers of the comorbid medical conditions that produce early mortality and great morbidity for psychiatric patients.

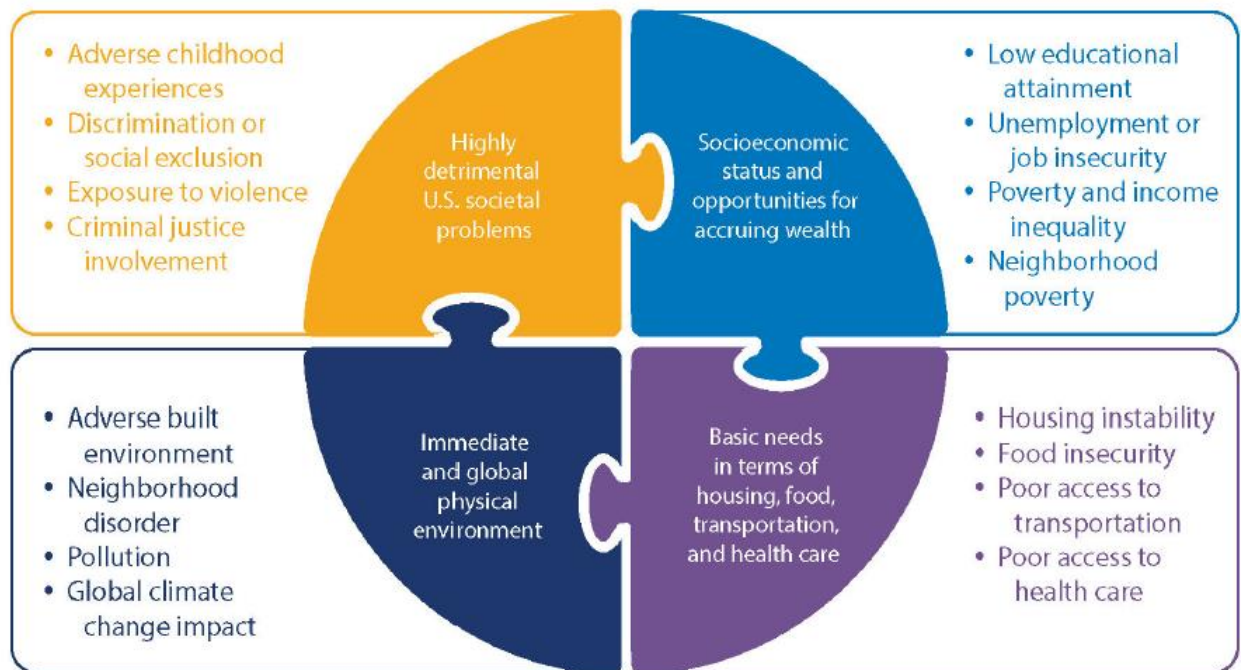


Figure 1: Sixteen Categories of Social Determinants of Mental Health, in Four Broad Buckets.

Source: New York State Office of Mental Health, [The Social Determinants of Mental Health](#).

IV. THE AMERICAN PSYCHIATRIC ASSOCIATION

As a leader in psychiatry and mental healthcare, the American Psychiatric Association (APA) acknowledges the social determinants of health as defined by the WHO and as outlined above. The APA is committed to studying and addressing the SDoMH and has begun to increase engagement among its internal and external stakeholders on the SDoMH. Beyond improving patient outcomes and reducing costs of psychiatric disorders, the APA recognizes the clear association of addressing the SDoMH with their values of health equity and social justice.

The APA's Previous Activities Relevant to Social Determinants of Mental Health

1. There was an APA Council on Social Issues from 2003 until 2008, which was then eliminated.
2. The DSM-IV had an Axis 4 for social aspects of illness, but it was eliminated in the DSM-5.
3. In 2018, however, the APA released a "Position Statement on Mental Health Equity and Social and Structural Determinants of Mental Health" (Enrico G. Castillo, Helena Hansen, Evita Rocha).

Below is the December 2018 APA Board of Trustees-approved "Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health" following approval by the APA Assembly in November 2018.

The APA Position

The American Psychiatric Association:

- Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities.
- Advocates for the dissemination of evidence-based interventions that improve both the social and mental health needs of patients and their families.
- Urges healthcare systems to assess and improve their capabilities to screen, understand, and address the structural and social determinants of mental health.
- Supports medical and public education on the structural and social determinants of mental health, mental health equity, and related evidence-based interventions.
 - Urges medical school and graduate medical education accrediting and professional bodies to emphasize educational competencies in structural and social determinants of mental health and mental health equity.
 - Urges psychiatry residency training directors and other psychiatric educators to use systematic approaches to teaching about structural and social determinants of mental health.
 - Supports the training of psychiatrists, in graduate and continuing medical education, in best practices to address the structural and social determinants of mental health and promote health equity.
- Advocates for increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery and to develop new evidence-based interventions to promote mental health equity.

This APA position statement on mental health equity and the SDoMH embodied the philosophy that the "unequal access to social resources perpetuates mental health disparities, particularly for patients and their families who belong to groups that are marginalized or under-resourced. Unequal allocation of resources and application of institutional and public policies worsens these disparities" (Castillo et al., 2018). Well-planned, sustained effort with collaboration among all major stakeholders can transform today's broken mental healthcare system into a model for the rest of the world. The key SDoMH listed

include social support, employment, civic engagement, socioeconomic and educational status, discrimination, and mental health stigma. SDoMH include actions and norms of systems such as the economic, legal, political, and healthcare systems. The road to health equity includes not only providing or promoting access to health-related resources and opportunities when needs are equal, but providing enhanced opportunities where needs are greater. All the while, we must vigorously address the systemic issues that perpetuate inequalities. Psychiatrists have a key role in promoting mental health equity in clinical care, research, education, administration, public health and place-based initiatives, and public policy advocacy. Psychiatry as a profession has an extraordinary opportunity and professional obligation to participate in, and at times lead, the pursuit of health equity.

The APA's Current Attitudes and Activities for Addressing the SDoMH

The Task Force requested and received environmental scans on APA's current efforts and those of component activities to address the SDoMH as of November 2021. The extraction of the information was overseen by Regina James, M.D., director of the APA Division of Diversity and Health Equity and compiled by Ricardo Juarez, the APA staff member for the Task Force. This report considered existing diversity, equity, and inclusion (DEI) initiatives that directly and indirectly address SDoMH. The analysis explored the APA's ongoing efforts and cross-sector collaborations to ensure it provides the highest quality of care, programming, and resources to the APA's internal and external stakeholders while championing health equity in practice and in all policies. To conduct the scan, information on activities was obtained from 10 APA chiefs of programmatic and/or revenue-generating divisions/departments in response to a survey. These responses were categorized based on the Healthy People 2030 Social Determinants of Health (2021) domains (e.g., healthcare access and quality, neighborhood and built environment, social and community context, economic stability, and education access and quality). These variables were meant to capture "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Additional work subcategorized the efforts as socio-ecological factors (e.g., individual, interpersonal, institution, community, and public policy).

While the Task Force learned of an extensive array of activities, these were felt to occur in the absence of a robust, comprehensive, and organized APA initiative. Further, the methodology used to categorize the activities was potentially biased in favor of inclusion as an SDoMH activity. It included independent submissions for Annual Meeting presentations and individual unsolicited submissions to APA journals. Compared to other national and international professional and governmental institutions, in our opinion, the APA is not on the cutting edge of organizational initiatives.

Psychiatrists and other mental health professionals have a moral responsibility to shape these public policies and social norms for the equitable treatment of persons in populations they serve. This includes shaping laws, rules, regulations, and, just as important, our healthcare system. Jeste and Pender (2022) asserted that "the time is ripe for our healthcare system to begin to incorporate SDoMH in all parts of its operation."

V. TASK FORCE RECOMMENDATIONS: ANALYSES, INITIATIVES, AND OPPORTUNITIES

The Task Force and Ongoing APA Caucus Will Address SDoMH

We are 13 APA-member psychiatrists who are seasoned experts in the realms of research, policy, clinical practice, and public health and will lead four subcommittee workgroups: (A) Clinical, (B) Public Health, (C) Policy, and (D) Research and Education. Input to the Task Force for developing recommendations to the APA was also provided by the Board of Trustees. A continuing caucus on SDoMH was proposed to further these recommendations.

Transforming Psychiatric Care, Research, and Training Through SDoMH

This Task Force has functioned as a think tank for recommending innovative strategies to potentially help reshape the future of psychiatric healthcare through an SDoMH-focused lens, impacting clinical care, research, and training, public health practice, place-based initiatives, and advocacy on public policy. This will require moving from the generalities succinctly presented in the 2018 Position Statement to characterizing concrete steps needed to transform mental healthcare and psychiatric practice. The first step in that process is broadening the list of evidence-based SDoMH.

Broadening the Social Determinants of Mental Health

Below we list important social factors impacting our patients, which are not included in the WHO and CDC lists. We must address these as well, as they correlate with those that drive mental health inequities, including social exclusion and discrimination which lead to disparities and inequities in mental health services for BIPOC.

1. **Stigma Against Persons with Mental Illness and Psychiatric Treatments:** The pervasive global stigma against mental illness and substance use disorders and persons living with them has major health impacts:
 - a. It reduces psychiatric patients' opportunities for education, employment, buying or renting a residence, getting loans, etc. All these factors impact their health.
 - b. Stigma against treatments like electroconvulsive therapy (ECT) makes it much harder to receive ECT in many parts of the country, possibly increasing the risk of suicide and other adverse events.
 - c. Stigma may contribute to less access to general medical care for people with serious mental illness (SMI). Not only do people with SMI have an average life span that is 15 years shorter than that of the general population, but this **gap in longevity has increased in recent decades**, due in part to psychiatric patients benefiting less from modern advances in medicine.
 - d. Stigma may also contribute to over-representation in the criminal justice system. There are more people with mental illnesses and substance use disorders in prisons and jails than in hospitals. This is in stark contrast to physical illnesses.
 - e. Stigma prevents people from learning about the nature of mental illness and causes them to discount its importance or its effects. All told, it promotes societal ignorance of the entire subject of mental health and illness.
2. **Lack of Mental Health Parity:** Despite the legislation passed two decades ago and renewed 15 years ago, there is still a massive gap in reimbursement for psychiatric care compared to general healthcare.
3. **Social Connections:** Social connection is crucial to human development, health, and survival. Meta-analyses have shown that there is perhaps no other factor that can have as large an impact on both length and quality of life, from the cradle to the grave. Yet, social connection is largely ignored as a health determinant because public and private stakeholders are not entirely sure how to act.
4. **Loneliness:** Considerable research has shown that loneliness and social isolation are as dangerous to health as smoking and obesity, and are an important risk factor for Alzheimer's disease, major depression, and generalized anxiety disorders as well as cardiovascular and metabolic diseases. According to US government statistics, more Americans die from loneliness-related conditions than from stroke or lung cancer. The prevalence of loneliness has doubled in recent decades. Loneliness is much more common in people with SMI than in the general population.

5. **Social Media:** Hurtful communication via social media has added considerable stress to the lives of people with mental illnesses and their families and has contributed to a number of suicides, especially among adolescents and young adults.
6. **Immigration:** Stresses and traumas associated with immigration have become globally prominent in recent years. Multiple issues related to stigma, fear, financial burden, social rejection, cultural dissonance, language barriers, family separation, and loss of social connections have led to mental and physical health crises, exacerbated by a lack of access to even moderate-quality healthcare.
7. **Social Despair and Hopelessness:** Across the country, people are being left behind by economic and social developments. The “deaths of despair”—suicide, overdose, and alcohol-related deaths—lead to a decrease in life expectancy, particularly for those with a high school education or less.
8. **Positive Psychosocial Determinants:** It is necessary to stress the mutually reinforcing and interdependent connections between SDoMH and mental health promotion. SDoMH not only are risk factors of mental illness (i.e., income precarity increases risk), but they also serve as foundations for mental health (i.e., income security improves mental health). SDoMH also underpin the ability to cultivate psychosocial strengths like resilience, empathy, solidarity, emotional literacy, compassion, and secure attachment. All of these foundations and strengths both benefit and rely on a range of social outcomes (e.g., maintaining employment and income security). Yet, these strengths are not assessed or targeted in routine medical or psychiatric interventions and practices. While Positive Psychology has become widely popular, it remains well outside the recommended practice guidelines. At the same time, there is growing interest among the populace in meditation, mindfulness, and compassion training, and in movements like Compassionate Communities, which can positively impact mental health. A wide array of community spaces and institutions can promote and nurture these strengths, even in the face of adversity.

What We Missed in Education and Research

In former National Institute of Mental Health (NIMH) Director Thomas Insel’s recent book *Healing* (2022), he acknowledges the shortcomings of his focus on genetics and neurobiology as not addressing the real needs of patients and families. He raises the essential importance of social determinants in mental health outcomes, both as factors directly affecting patient lives and as factors influencing the funding and structures of care.

Medical students and psychiatry trainees need to go beyond diagnosis, genetics, and neurobiology and learn about the central role of SDoMH in the lives of their patients and how to address their basic needs to improve patient outcomes. There is a wide array of strategies to help train clinicians to see social structures that have an impact on the mental health of their patients. These range from educational and experiential opportunities to institutional and regulatory requirements. In a scoping review of undergraduate medical education in SDoH, Doobay-Persaud, et al. (2020) found common themes in the course content including community engagement, understanding the local context, health policy and advocacy teaching, and professional development for students, but a lack of “clearly defined instructional tools and strategies, evidence of consistent and universal application and standardized competencies for educators.” A national survey of residency programs (Vance & Kennedy, 2020) found seven that have an advocacy curriculum, including either community or legislative advocacy efforts, and the authors suggest creating a best-practices guideline including core components and goals. A survey of child and adolescent psychiatry fellowship program directors (Kronsberg et al., 2022) found consensus on the need to teach about SDoMH, yet the focus on such topics varied among programs. Structural and historical factors were rated as less significant than familial factors and were viewed as being taught less effectively and were allotted less time in didactics. Further surveys of the state of education of SDoMH in psychiatry are needed.

Several curricula related to SDoMH and health equity are published. Isom et al. (2021) report on health equity curricula in three residency programs, which all emphasize social determinants of health and structural competency, and explain the process of creating the strategic vision, implementing the curriculum, and overcoming barriers. Legha et al. (2021) describe a curriculum for child and adolescent psychiatry (CAP) fellows on the foundations of racism, addressing the gap in teaching historical and structural aspects of SDoMH. In the MedEd Portal, Neff et al. (2020) have adopted the concepts of structural competency, as described by Metzl and Hansen (2014), as a model for training in the role and impact of social determinants of health. They suggest trainees should be able to:

- Identify influences of structures on patient health
- Identify influences of structures on the clinical encounter
- Generate strategies to respond to the influences of structures in the clinic
- Generate strategies to respond to influences of structures beyond the clinic
- Describe structural humility as an approach to apply in and beyond the clinic

Currently there is a broad range of uptake of these ideas. Some schools and training programs are being influenced by the societal calls for social justice in the aftermath of George Floyd's homicide, have implemented DEI efforts, and have made efforts to address their own hiring as well as medical school selection practices, teaching expectations, and clinical care inequities. There is still a tremendous amount of work to be done, and a limit to what can be done by the individual clinician or individual training program. Advocacy around training expectations and standards is needed to support the deeper and more consistent integration of these concepts. Beyond that, systemic changes in healthcare access and delivery and national standards of care are essential, as well as societal efforts to dismantle racism in housing, criminal justice, and education.

Anti-racism and SDoMH

One year prior to the COVID-19 pandemic and for the first time, more than half of the nation's population under age 16 identified as a racial or ethnic minority, making children and adolescent populations the fastest-growing racial and ethnically diverse group in US history (Shim & Starks, 2021). This cultural demographic shift, mostly influenced by the growth of the Hispanic/Latino and Asian American populations, has the potential to significantly impact what we do and how we act (Mather, 2019).

Racism is a primary driver of social determinants of mental health. Racism drives the inequities in housing, income, education, and health, especially among BIPOC communities. In fact, racism is not just one of the social determinants of health, it is the major underlying structural determinant that sets the stage for all other social determinants (Shim & Compton, 2020; Medlock et al., 2017). Racism plays a fundamental role in an individual's social determinants of mental health, and a dedicated curriculum in psychiatry residency education is required to address health inequities in BIPOC communities (WHO, 2021; Legha, 2021; Jordan, 2021; Kronsberg et al., 2020). Academic psychiatrists must remain at the forefront of teaching structural and social determinants of mental health, with an appreciation that structural competency training is necessary, especially since socioeconomic status or childhood poverty alone do not explain the disparities in the utilization of mental health services by "racialized" or ethnically diverse groups or the lower quality of the services rendered (Shim & Compton, 2020). Legha et al., in preparation, developed curriculum and tools for clinical supervision that share an anti-racist approach to SDoMH, call for accountability to the legacy of racism, and align with the work of other reputable academic leaders (Isom et al., 2021; Castillo et al., 2020), calling for a new phase of Accreditation Council for Graduate Medical Education (ACGME) competencies for graduate medical education within the three subthemes of structural competency (knowledge), structural action (skills), and social responsibility (attitudes).

Gordon et al. (in review) created an educational report that outlines a systematic approach to implementing a model anti-racism curriculum on SDoMH for CAP trainees that aligns with the larger institution's diversity, equity and inclusion (DEI) strategic goals and infrastructure at the University of Maryland. The sustainability of these types of training and educational resources depends upon the quality

of the existing institutional DEI infrastructures. This curriculum is innovative in that it scaffolds anti-racism and social determinants of mental health education with a DEI infrastructure for sustainability and future growth. This educational case report describes the University of Maryland's DEI predevelopment, alignment, and implementation phases in creating a novel anti-racism SDoMH curriculum for the CAP Fellowship Program. This report underscores the prerequisite for a department-wide initiative and DEI infrastructure before embedding structural competency and anti-racism pedagogy into an existing psychiatry residency education curriculum in a clinical learning environment. We aim to prevent psychological harm while building structures for more liberated spaces and courageous conversations that push past bygone rhetoric of psychological safety so as to unburden the minority tax to URM (underrepresented minorities) in psychiatry (Harmon, 2021). This stepwise approach supports recruitment and retention by advancing leadership, health equity, and wellness of minority and underrepresented faculty, staff, and residents, fostering an inclusive environment for all faculty development while bolstering built-in accountability measures that support future growth and sustainability of social justice and health equity curriculum (McDade, 2019).

Anti-racism and SDoMH must become central knowledge in psychiatry and not be deemed a specialty topic by program directors. As above, we contend that the sustainability of these types of training and educational resources are dependent upon and limited by the quality and support of a program's existing institutional DEI infrastructure. An academic institution's DEI implementation and organization-wide alignment foster the development of an anti-racism SDoMH curriculum and has merit in achieving mental health equity for future generations of children and adolescents (Gordon et al., in review).

Childhood Trauma and Other Early Life Adversity

Among the most potent environmental risk factors for many psychiatric disorders is a history of significant childhood adversity (CA). CA increases vulnerability to mood disorders, substance use disorders, post-traumatic stress disorder, personality disorders, suicidality, high-risk behaviors, lower social functioning, poor mental health in general, and medical comorbidity (Lysaker et al., 2001; Edwards et al., 2003; Dube et al., 2003a, 2003b; Chapman et al., 2004; Anda et al., 2006; Lu et al., 2008; Harley et al., 2010; Fryers & Brugha, 2013; Pietrek et al., 2013; Guenzel et al., 2016; Sideli et al., 2020). In recent years, studies have also increasingly demonstrated the link between CA and psychotic disorders including schizophrenia (Cutajar et al., 2010; Galletly et al., 2011; Heins et al., 2011; Varese et al., 2012; Husted et al., 2012; Bonoldi et al., 2013; Matheson et al., 2013; Kraan et al., 2015a; Kraan et al., 2017; Ajnakina et al., 2016; Morgan et al., 2020; Sideli et al., 2020).

For example, in their umbrella meta-analysis, Radua et al. (2018) reported an odds ratio for schizophrenia of 2.87 (95% confidence interval 2.07-3.98) in the context of childhood trauma history, confirming CA as a risk factor. A review by Kim and Lee (2016) discusses how childhood trauma appears to be a critical determinant of treatment refractoriness in multiple disorders, and the relationship may be mediated by the cognitive impairment aspect of psychotic disorders. While much of the risk of violent aggression and violent victimization is mediated by drug- and alcohol-related comorbidity (Fazel et al., 2009), childhood trauma in individuals with schizophrenia is also associated with an increased risk for interpersonal violence (Storvestre et al., 2020). In addition, Lee et al. (2018) demonstrated that participants with schizophrenia and greater trauma severity reported worse physical health and had worse metabolic biomarker levels (such as higher fasting insulin levels and greater insulin resistance) than other participants, both those with schizophrenia and nonpsychiatric comparison subjects who did not have significant trauma.

While early detection, access to care and effective treatment can all help individuals with serious mental illness, on a structural level, community and government programs and supports such as unemployment benefits, well-resourced public schools, and community education about mental health and the effects of trauma can help struggling parents who are at increased risk of substance use, violence, or emotionally abusive behavior (Prinz, 2016). Educational resources and after-school programs can help at-risk youth

develop greater autonomy, empowerment, and engagement in activities that protect them from risky behaviors or abusive adults (Biglan et al., 2020). Reversing the impacts of the long history of discrimination and racist policies, such as redlining and mass incarceration, can help improve the health of neighborhoods, reduce social defeat, and lower the risk of losing a parent at an early age (Williams et al., 2019). The social and structural determinants that underlie many of these risks can start to be addressed by advocacy for effective policies that support equity and safer environments for children (Metzl & Hansen, 2014).

Trauma exposure is not the only aspect of childhood adversity that results from SDoMH. Living through the early years (in particular) of life in a household with housing or food insecurity; financial insecurity resulting from unemployment, underemployment, and/or inadequate access to childcare for an employed parent; and inadequate access to medical care for both mother and child, both prenatally and in particular during the preschool period, are all risk factors for inadequate readiness for school and other later problems.

Focus Groups' Input: Climate of SDoMH for Residency and Fellowship Leaders Today

As they are the future leaders in mental health, it is critical to incorporate our resident and fellow APA members' (RFMs) views and understanding of the importance of SDoMH in efforts to introduce preventive and intervention strategies for addressing mental illness and substance use disorders in an equitable and culturally sensitive manner.

The Task Force on SDoMH brought together national leaders in academic psychiatry and organized psychiatry to develop a comprehensive survey to assess the needs of RFMs today. These leaders also participated in a focus group and provided input regarding the needs of psychiatrists and other mental health professionals. A focused Jamboard discussion was conducted using a list of discussion questions for small breakout rooms based on Metzl and Hansen's 2014 article, which asked the following questions:

1. How can clinical eyes be trained to see social structures?
2. What competencies and interdisciplinary sensibilities are required in order to act on those structures?
3. Which imaginative structural approaches to promoting health equity might U.S. health practitioners adapt from global health, and might all health practitioners adapt from fields outside of medicine?
4. Which alliances with parties outside of medicine (e.g., urban planning, schools, corrections) and outside of the United States are needed in order to create structural change?
5. What are the conceptual contributions from epigenetics to "personalized medicine" that are based on mutual constitutions of biology and the environment as the mechanism underlying ethnic-, racial-, and class-based inequalities in health?
6. How can we operationalize medical education and clinical practice to appreciate the ways that social-environmental exposures drive genetic expression and have heritable effects, assuming that personalized medicine, if it is to incorporate newer life science paradigms of heritability, will have to address the social environments of patients and not just individual genetics?

Summary of Important Points from Other Focus Groups

Most program directors and leaders in medical student education felt that medical students learn clinical formulation with a structural framework and lens. It was suggested that we pilot more programs for medical students. Many leaders of the focus group suggested an underlying weakness/vulnerability in residency and fellowship education and referenced an article on the biopsychosocial formulation model and its vulnerability in equipping trainees to have the knowledge, skills, and attitudes to support structural humility and address SDoMH (Bourgeois et al., 2017).

It was recommended that this Task Force urge the ACGME to make modifications to common program requirements (in both Systems-Based Practice and Interpersonal Skills and Communication competencies), milestones, and trusted professional activities to include SDoMH (see Castillo & Isom, 2021). Others urged that a key factor for addressing SDoMH is faculty development initiatives and expressed concerns that the faculty and trainees may fail to recognize the needs of “newcomer” populations. Many argued that school mental health programs and interventions need the “buy-in” of the community outside of medicine. Some opined that the APA should broaden its scope by aligning with the American Psychological Association and the Royal College of Psychiatrists in the UK, which have made significant progress in addressing many facets of SDoMH, especially relative to the APA.

The AMA, often considered to be a conservative organization, has pursued SDoMH and anti-racism quite impressively through publication of various documents, at meetings, and by establishing a robust infrastructure within the organization. At least two members are involved intensively with the education of medical students and report sometimes being constrained by the framework of the DSM. Many were impressed with the work of Francis Lu to incorporate and advocate for the DSM-5 changes to address SDoMH with Z codes. They expressed the opinion that medical students must be exposed to SDoMH as early as possible in their careers. It was the consensus of this focus group that the degree to which APA members embrace and acknowledge SDoMH is quite variable. Will strategic approaches to engage more APA members be worthwhile?

Recommendations overall included the following:

1. Incorporate teaching of SDoH and SDoMH in premedical education, progressing through medical school education, residency training, and faculty development.
2. Clearly define what should be taught. A consensus should be made of the minimum components of SDoMH that should be included in the clinical formulation.
3. Interviews with patients can include their accounts of social struggles they faced growing up and the barriers to getting treatment.
4. Some state medical board license requirements have minimum hours of training on the safe prescribing of controlled substances, child abuse, and other issues. Training on SDoH is a possible area for mandatory requirements.
5. Incentives should be available for incorporating SDoMH into the training of residents and faculty evaluations on ACGME 2.0 milestones (Systems-Based Practice 2: System Navigation for Patient-Centered Care, ACGME Clinical Learning Environment Review HQ Pathway 6), Z codes, and CMS systems-based outcomes such as 30-day readmissions and “no shows” to appointments.
6. Other groups or associations can be formed with National Alliance on Mental Illness (NAMI), the U.S. Department of Housing and Urban Development (HUD), or disaster response efforts with more grassroots-level experience.
7. WHO has a commission on SDoH with available resources. Its GAP report (WHO, 2008) outlines a well-known internationally implemented program to reduce gaps in psychiatric treatment, with lessons to be learned.
8. There is ample literature on the effects of racial and poverty discrimination on stress, resulting in adverse physical/mental health outcomes. Easily accessible education can be created.
9. APA Council on Medical Education and Lifelong Learning (CMELL), and related organizations like American Association of Directors of Psychiatric Residency Training (AADPRT), American Academy of Pediatrics (AAP), and American Association of Colleges of Pharmacy (AACCP), can be other important collaborators for creating educational content.

APA/Substance Abuse and Mental Health Services Administration (SAMHSA) and Diversity Fellows Focus Group (Detailed in Appendix A)

The Workgroup on Education and Research also invited key RFMs to participate in a focus group discussion to address all forms of SDoMH. We invited the APA/SAMHSA and Diversity fellows to participate in a two-

hour focus group discussion on the role of SDoMH in improving psychiatric care. Following the focus-group discussion, which included a group Jamboard discussion for input on what RFMs deemed central today to equip them to advance SDoMH in their practice and clinical learning environments, the fellows were invited to complete a survey, which was also shared with all APA/APAF fellows.

The focus-group findings showed that most trainees agreed that their medical education and training had adequately covered and fostered the knowledge, skills, and attitudes to address SDoMH and fostered a better understanding of the impact of adverse childhood experiences (ACEs) on their patients. They supported SDoMH being a core competency and not a subspecialized portion, that DEI curriculum in their training made a difference in how they addressed SDoMH issues, and that the training and/or focus groups on SDoMH allow them to better intervene on behalf of their patients and their families.

On the other hand, there was significant disagreement on whether their training on SDoMH was adequate in providing training on key SDoMH factors. There was no agreement on whether they felt competent to assess economic (e.g., transportation access, food scarcity), family, cultural, and neighborhood factors; such domains as climate change, the COVID-19 pandemic, and environmental toxins; and vocational, educational, structural, and historical effects of urban/rural location and population density.

The most influential activities in their training were “referring patients to community-based resources to address SDoMH,” “screening patients for SDoMH,” and capturing SDoMH data in electronic health records. The barriers most endorsed were insufficient education or training on SDoMH, lack of time, and lack of community resources. There is clearly enthusiasm for developing the SDoMH for our early members.

Education Modules: Finally, members of the focus group were invited to also review a CME module, a course on SDoMH by Drs. Lu, Malaspina, and Trestman developed for both the LEAD Program and the APA Learning Center.

VI. SUBGROUP REPORTS

A. Clinical Workgroup

Composition: Francis Lu, M.D., Chair; Tresha Gibbs, M.D.; and Steve Koh, M.D., M.P.H., M.B.A., DFAPA

Focus: This workgroup focused on what clinicians should do to assess and intervene to address SDoMH in their everyday practice, as current practice largely ignores SDoMH. This section will impact future APA Practice Guidelines in various areas.

Target Audience for APA: (a) Psychiatrists and trainees who work with patients and families, (b) professionals from other disciplines including social workers, case managers, legal service providers, counselors, care coordinators, and others as part of a team or organization, and (c) clinicians from other mental health disciplines who work with patients and families.

Areas of Focus:

1. Evidence-based, reliable, and valid screening tools for identifying SDoMH; review what other organizations have already done.
2. Important changes about cultural and social and structural issues in the *DSM-5-Text Revision (TR)* that was published on March 19, 2022.

In Section I, the introduction:

- a. The section was re-titled “Cultural and Social Structural Issues” from the DSM-5’s “Cultural Issues” to acknowledge the importance of SDoMH.
- b. New sections were added on the impact of racism and discrimination on psychiatric diagnosis and how attention was paid to these issues in the DSM-5-TR. APA states, “Part of the changes implemented throughout DSM-5-TR is the use of language that challenges the view that races are discrete and natural entities:

- The term ‘racialized’ is used instead of ‘race/racial’ to highlight the socially constructed nature of race.
- The term ‘ethnoracial’ is used in the text to denote the US Census categories, such as Hispanic, White, or African American, that combine ethnic and racialized identifiers.
- The terms ‘minority’ and ‘non-White’ are avoided because they describe social groups in relation to a racialized ‘majority,’ a practice that tends to perpetuate social hierarchies.
- The emerging term ‘Latinx’ is used in place of Latino/Latina to promote gender-inclusive terminology.
- The term Caucasian is not used because it is based on an erroneous view about the geographic origin of a prototypical pan-European ethnicity.”

See: <https://psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/DSM-5-TR/APA-DSM5TR-AttentiontoCultureRacismandDiscrimination.pdf>

In Section II, the Culture-Related Diagnostic Issues and Sex- and Gender-Related Diagnostic Issues sections were updated with new text and references:

- a. More disorders contain these two kinds of sections.
- b. The Other Conditions that May Be a Focus of Clinical Attention are now primarily Z codes instead of V codes, aligning them with ICD-10.

Added also to this chapter was very important guidance for why they should be coded as part of the diagnosis: “A condition or problem in this chapter may be coded ... 3) if it plays a role in the initiation or exacerbation of a mental disorder; or 4) if it constitutes a problem that should be considered in the overall management plan.” These conditions or problems correlate well with the SDoMH, as studied by the Task Force.

In Section III, the following changes were made:

- a. Outline for Cultural Formulation section titles remained the same except for Part D, where “treatment team and institution” was added: “Cultural features of the relationship between the individual, treatment team, and institution.” This change means that the cultural features of the social structural relationship between the individual and the treatment team/institution must be assessed.
 - b. Part C, titled “Psychosocial stressors and cultural features of vulnerability and resilience,” has the addition of this extremely important sentence, directly relevant to the SDoMH: “These [stressors, challenges, and supports] include social determinants of the individual’s mental health such as access to resources (e.g., housing, transportation) and opportunities (e.g., education, employment); exposure to racism, discrimination, and systemic institutional stigmatization; and social marginalization or exclusion (structural violence).”
3. Treatment plans that incorporate SDoMH:
Weiss MG, Aggarwal NK, Gómez-Carrillo A, et al. Culture and Social Structure in Comprehensive Case Formulation. *J Nerv Ment Dis*. 2021 Jul 1;209(7):465-466.
doi:10.1097/NMD.0000000000001346.
 4. Develop a mini library of key articles, books, and resource guides on SDoMH.
 - a. Resources have been added to the Task Force webpage and in Appendix C.
 - b. A course on SDoMH by Drs. Lu, Malaspina, and Trestman has been developed for both the LEAD Program and the APA Learning Center.
 - c. The Council on Children, Adolescents, and Their Families had a workgroup led by Drs. Gibbs and Fortuna that worked on the “APA Resource Document on SDoMH in Children and Youth” for May 2022 completion. See Appendix D.
 - d. This journal article was published:
Jeste DV, Koh S, Pender VB. Perspective: Social Determinants of Mental Health for the New

Decade of Healthy Aging. *Am J Geriatr Psychiatry*. 2022 Jun;30(6):733-736. doi: 10.1016/j.jagp.2022.01.006.

- e. An article on the SDoMH in clinical practice is in development for the Psychiatric Services column on SDoMH; the workgroup had been awaiting publication of the DSM-5-TR so the latest information can be incorporated.

Recommendations:

1. Increase SDoMH competency at the clinical level: Specify the micro-social skills and practices psychiatrists should be able to deliver, support, and/or advocate for prevention and promotion, especially in disproportionately affected communities.
2. Increase SDoMH competency at the social action level: Provide an orientation to public health issues and public policy that involves advocacy with other disciplines, organizations, and institutions to effect social changes. Describe and justify delivery models such as the science of “task sharing that has shown the broad range of skills that can be adopted by or co-created with lay people and extenders in community (non-clinical) settings enabling them to do much of the frontline tasks of direct care and prevention. (Singla, 2018). Clinicians take on roles as skill coaches and partners to these frontline social partners.
3. Enhance the use of the *DSM-5-TR*. Encourage the use of Z codes to link SDoMH to diagnostic codes for tracking, resource allocation, and ultimately reimbursement.
4. Encourage consideration of SDoMH by the Committee on Practice Guidelines and the various Councils.
5. For DSM-6, form a Workgroup on SDoMH to infuse the social determinants into the diagnostic process.

B. Education and Research Workgroup

Composition: Dolores Malaspina, M.D., M.S., M.P.H., Chair; Kimberly Gordon-Achebe, M.D.; Elie Aoun, M.D., M.R.O.; hoc member and contributor, Paul J Rosenfield, M.D.

EDUCATION COMPONENT

Focus for the APA: This component of the Task Force focuses on defining methods to deliver excellent grounded education to medical students, residents, and fellows on the SDoMH, aiming to partner with all entities setting educational competencies and goals.

Target Audience: All psychiatrists and other mental health practitioners and trainees, with the goal that the impact of SDoMH and the necessary clinical and other interventions to prevent and treat these persons become core knowledge in psychiatric practice.

Focus: Educators should seek to develop structural competency, and part of that task includes lecturing about SDoH and SDoMH in core didactics and incorporating this knowledge into clinical practice by utilizing comprehensive biopsychosocial formulations. Requiring trainees to demonstrate this understanding in case conference formulations and clinical skills verification exam presentations as well as in clinical notes can ensure trainees integrate it into their practice. Testimony from patients and peers can deepen trainees’ understanding of the personal impact of various social factors, such as the experience of homelessness or incarceration. Field trips to visit shelters, community residences, jails, and other institutions—and talking to consumers in those sites—can also provide a rich understanding of the personal experience of these conditions. Learning about and mapping community resources and strengths provides an antidote to the demoralizing impact of witnessing the structural obstacles. The DSM-5-TR

Cultural Formulation has been modified to mention explicitly the role of social determinants and social structural issues as part of a comprehensive interview, and this can help guide teaching in psychiatry.

In order to ensure the knowledge and skills regarding SDoMH are taught universally, the agencies that accredit medical schools and training programs will need to set this expectation, and standards will need to be developed. The ACGME common program requirements state that “residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including social determinants of health,” but the ACGME could go further in expanding its milestones project to require a more robust focus on health equity, social responsibility, and structural competency as part of its core competencies (Castillo et al., *Reconsidering Systems-Based Practice*, 2020). The AAMC has recently created a Collaborative for Health Equity focused on “research, policy and programmatic solutions” (<https://www.aamchealthjustice.org/get-involved/aamc-charge>) and a Center for Health Justice, and has published a brief summary on how teaching hospitals are addressing SDoH (<https://www.aamc.org/system/files/c/2/480618-aamc-teaching-hospitals-addressing-sdoh.pdf>) as well as a guide on DEI competencies. These examples demonstrate an effort to ensure SDoH and health equity are taken seriously by students.

The National Academies of Sciences, Engineering and Medicine (NASEM) has published a detailed framework for educating all healthcare professionals (not just trainees) on SDoH that includes three domains (education, community, and organization) with the “ultimate goal of achieving “impact on equity in health and well-being” (NASEM, 2016).). The World Health Organization has made educating healthcare workers in SDoH and promoting health equity a priority while maintaining awareness that there are shortages of healthcare workers internationally and limitations in resources available to provide adequate education in many countries (WHO, 2008).

Canada implemented a project called CanMEDS which is a “framework for improving patient care by enhancing physician training” (<https://www.royalcollege.ca/rcsite/canmeds/about-canmeds-e>) and has identified a range of roles for providers, including that of healthcare advocate. This offers a model for the US in standardizing expectations for providers, both trainees and graduates (faculty, independent practitioners). Faculty who are supervising and teaching residents need faculty development on SDoH as well; otherwise, trainees will get a piecemeal approach in which SDoMH are emphasized in some contexts and ignored in others.

Sharma et al. (2018) make an important point that just educating on the importance of SDoH without making major structural changes in the system will be hollow. They claim that the current approach to SDoH focuses on “facts to be known” rather than facts as “conditions to be challenged and changed.” Without this activism and commitment to social justice, curricular modifications may even perpetuate inequity.

Recommendations:

1. The Council on Medical Education and Lifelong Learning should establish a standing workgroup within the Council to create a strategic plan to implement this item of the Position Statement in coordination with AADPRT, ADMSEP, the Psychiatry RRC, and ABPN, among other organizations.
2. Evaluation of prospective candidates for APA-appointed representatives to the Psychiatry RRC and ABPN should include evidence of robust commitment to advocate for inclusion of SDoMH in the ACGME general psychiatry residency and fellowship competencies, ACGME milestones, and the ABPN examinations to better address the need to incorporate attitudes, knowledge, and skills related to SDoMH.

3. Refocus the knowledge and research base to include SDoMH, including structural racism, as central upstream mechanisms generating mental illnesses that can be targeted for prevention and early treatment. Consider the impact of life-course exposures and intergenerational trauma on mental health outcomes.

RESEARCH COMPONENT

Target Audience for APA

- Grant and funding agencies: To elevate research on the SDoMH to identify mechanisms for inclusion in genetic, neurobiology, and other paradigms, and for studies in the community to test and identify best approaches to prevent and address the mental health consequences of the SDoMH.
- Clinicians: To develop and utilize standard validated scales to assess SDoMH in clinical records. To identify mechanisms to address the immediate needs of patients.
- Researchers: To use the same scales as clinicians to characterize patients so the biological mechanisms that transduce adversity into mental and physical disease can be considered in research studies.
- Community partners: To identify, support, and partner in testing specific community interventions and treatments.

Research Areas of Focus

Beyond question, persons with the least resources and lowest socioeconomic status, and additionally those experiencing racism and social disadvantage, have higher risks for mental illness, substance use, medical morbidity, and early mortality. Social disadvantage is linked to the consequences of everyday stress, limited financial resources, poor housing, food insecurity, and other challenges beyond a person's or family's control. The biological impacts of adversities accumulate over the life course and may cross generations through mechanisms that are just beginning to be elucidated. These exposures clearly impact physiology, but the SDoMH are only now becoming a research priority for the NIMH and other funding agencies.

The gradient between exposures to the SDoMH and mental health risks and outcomes suggests that social disadvantage activates one or more pathways that propel higher risks for behavioral and substance use disorders as well as cardiometabolic risk factors. Across species, subordinate members have more adverse health and behavioral changes. Loneliness converges with marginalization, racism, and discrimination as a social threat that has substantial impacts on human health, as we are instinctually a social species.

When the same rigorous and standardized SDoMH assessments employed for research are also used in clinical records, record review studies can examine large enough data sources to begin identifying the pathways whereby social determinants influence health and mental health. Studies with community stakeholders are furthermore needed to identify, evaluate, and implement prevention, intervention, and treatment studies within communities.

Furthermore, having a mental illness can produce or amplify social disadvantage, limiting education, producing stigma, and increasing the social isolation of persons with psychiatric disorders. Psychopathological vulnerability can produce or amplify social disadvantage; for example, those with mental illness experience fewer opportunities for education and increasing isolation and stigma. The reciprocal relationship between mental illness and social disadvantage underlies some very poor outcomes in persons with mental illness who have the least resources, as reviewed by Alegria et al. (2018).

Separate from exposures to SDoMH is the keen importance of understanding and addressing the current basic needs of persons, something that is not done in many psychiatric settings. For example, there are several available scales of screening questions and assessment probes (Bourgois et al., 2017):

- Financial security: Do you have enough money to live comfortably, pay rent, get food, pay for utilities/telephone?
- Residence: Do you have a safe, stable place to sleep and store your possessions?
- Risk environments: Do the places where you spend your time each day feel safe and healthy?
- Food access: Do you have adequate nutrition and access to healthy food?
- Social network: Do you have friends, family, or people who help you when you need help?
- Legal status: Do you have any legal problems?

Knowledge on the factors that mediate these impacts can lead to a greater protective influence.

We must address these by advocating for research at several levels:

1. **Measures of exposures:** Studies must document the exposures of participants beyond their ZIP codes to include standardized information on individual SDoMH for each patient. This data can be used for individual attention when there are active threats, as below, and also for record research on outcomes. We propose aligning these with the standardized PhenX Social Determinants of Health Assessments Collection being developed by the NIH, which is available at <https://www.nimhd.nih.gov/programs/collab/phenx/>. This SDoH collection is being specifically developed to measure upstream socioeconomic factors like poverty, labor forces, and neighborhood segregation that can influence health outcomes. Through use of chosen standardized assessments, a common currency will be developed to study SDoH effects in the clinic, research mechanisms of risk and resilience by defining biological and other pathways linking adversity to poor mental health, and enable testing of effective community interventions. With these measures, SDoMH impacts on disease onset and progression can be addressed as well as pathways to resiliency and health.
2. **Research considerations:** In addition to utilizing standard definitions of exposures (NIMH PhenX), studies must account for temporal trends, cumulative effects, and appropriate controls in order to address selection biases. They must be scientifically rigorous to examine causality and interventions (longitudinal) and consider effects across age, gender, race/ethnicity, sexual orientation, and diagnosis. Critical periods across the life course must be identified wherein adverse exposures have the largest impact on health. The timing and nature of the most optimal interventions for these exposures must be defined through research. The interventions must also be studied to determine whether they are pragmatic and cost-effective, with consideration of the ease of their integration into community settings, particularly for those with mental and physical health challenges.
3. **Research participant inclusion:** Biological and treatment studies must immediately include marginalized persons. Research should benefit all persons, yet many diverse and minority populations are under-represented in treatment research, including intersection adults.
4. **Research on mechanisms:** Mechanisms to be examined include stress axis dysregulation, unrestrained glucocorticoid effects, epigenetics, inflammatory effects, and dysbiosis of the microbiome.
 - a. Microbiota may underlie or modulate the impact of pervasive, daily stress on health outcomes through biological pathways.
 - b. Epigenetic pathways.
 - c. Pro-inflammatory effects.
 - d. HPA stress axis.

5. **Bias and ignorance:** In addition to the systemic issues that limit the access of disadvantaged persons to any mental healthcare, practitioner biases pertaining to racialized identities or low social status must be measured and remediated. All funded researchers must affirm knowledge that racial differences reflect impacts of economic stratification, culture and immigration history, and the structural determinants of health and do not reflect biological differences and acknowledge that the structure of our society does not provide the same opportunities or resources for all persons.
6. **Comorbidity:** Studies must move beyond incidence and risk estimates for medical comorbidities in mental disorders to consider common pathways. The identification of the severity, comorbidity and chronicity of medical risk factors is essential among persons with psychiatric conditions. Increased comorbidities in persons with social disadvantage, particularly diabetes and cardiovascular disease, may provide key etiological information on the systemic pathways activated by exposure to the SDoMH.
7. **In the community and neighborhood:**
 - a. Develop best practices for implementing prevention, early intervention, and treatment of mental disorders with community.
 - b. Assess magnitude and impact of food deserts, lack of outdoor space and green environments, climate change impacts, and toxic exposures (pollution, lead, emissions from motor vehicles).
 - c. Identify and address the root causes of social determinants that will have the greatest impact on mental health outcomes—ending child poverty, providing a basic income, health insurance.
 - d. Address structural impediments to optimal health—targeting educational, environmental, and social detriments, among others—which offers hope, the subject of other workgroups, in a time frame that is far more immediate than clinical and basic research. Stop the cause of the causes!
 - e. Consider potential negative consequences of research: discrimination by providers and insurers.
 - f. Consider stigmatization, including disempowerment of persons and use of information against persons.
8. **Policy changes and population-level interventions:** While it is absolutely certain that social determinants of health substantially underlie mental health disparities, the excess suffering and cost must ultimately be addressed through public policy change and population-level interventions.

Recommendations:

1. APA must advocate for research specifically directed toward illuminating the impact and mechanisms whereby the SDoMH increase the risk for mental illness and work with community stakeholders to investigate how prevention, early intervention, and treatment can best be embedded in the community. Ideally, a dedicated APA Center for the SDoMH will work with and coordinate the APA councils.
2. The Research Council can advocate for specific research on the mechanisms whereby SDoMH impact the risk for mental illness and how the relevant upstream factors that generate the SDoMH can be targeted for the earliest prevention and intervention. This work should engage the community stakeholders in collaborations that test the best practices for prevention, early intervention, and treatment within the community.

3. In addition to the Research Council, the Council on Healthcare Systems and Financing can establish a standing workgroup within the Council to create a strategic plan to implement this item of the Position Statement in coordination with other components and SAMHSA, among other organizations.
4. Create a strategic plan in coordination with other components, organizations, and SAMHSA to design plans for community mental health.

APA efforts in stimulating research would include a strong recognition that the SDoMH, including structural racism, are central pathways generating mental illnesses, that there is a need to study disease mechanisms, and that these mechanisms have upstream determinants that are targets for prevention and early treatment studies. Life course exposures and intergenerational trauma need to be recognized as factors in mental health outcomes.

C. Policy Workgroup

Composition: Allan Tasman, M.D., Chair; Gary Belkin, M.D., Ph.D., M.P.H.; Lisa Fortuna, M.D.

Target Audience: APA Board of Trustees, APA members and all psychiatrists, and allied organizations, advocates, and policy networks and decision-makers.

Areas of Focus: An extensive commitment to internal APA capacity to participate in growing an ecosystem of policy and delivery system leaders, experts, and advocates to create the foundations for an SDoMH paradigm for the practice and purpose of psychiatry, mental health systems, and social policy.

Recommendations:

In recognition of the breadth of tasks enumerated in this report, APA should establish credible capacity to sustain and lead a public health- and policy-driven agenda for the profession and the APA. To do that, the APA Board of Trustees should authorize and establish a dedicated APA Center for the SDoMH. This Center (or other nationally expert group of designated individuals hired in permanent roles at APA) should, among other potential duties, complete and maintain an SDoMH Workplan and Policy Agenda (Workplan) that builds out an expansive SDoMH approach for the profession of psychiatry, and for social policy in the US more broadly.

This Workplan should be informed by and in consultation with the Councils of the APA. We recommend that the initial Workplan be completed within six months after hiring a director for the Center. That hiring should be completed within six months of Board approval for the Center (or similar new team). The Workplan should at a minimum include the following

1. Comprehensive input from an invited network of social policy organizations, foundations, think tanks, etc., across the areas that impact SDoMH (e.g., housing, poverty, health, equity, child and family support, community development, etc.) and a plan to formalize and continue such a network of allies, including consumer organizations that also capture this breadth of SDoMH as an ongoing, permanent input to APA policy framing and planning. This should include coalitions focused on resilience and healthy child attachment, especially for families facing adversity, and efforts to build on the science of nurturant communities and measurable population well-being (Biglan et al., 2020).
2. Specific priority policy advocacy objectives based on multistakeholder network input and evidence of mental health benefits from, and to, existing social policies and outcomes. Those objectives should include but not be limited to ways to end child poverty; universalize access to healthcare, childcare, pre-K, and secondary education; and establish a guaranteed income and living wage and a path to join other countries in adopting well-being budget tools and methods (New Zealand Treasury, 2019).

3. A path for APA to pursue with others the delivery system conditions, funding, and reimbursement codes and other policies that will enable providers to coach and join task-sharing partnerships with community-based organizations. As described by the Clinical Workgroup, task-sharing is a proven, evidence-based model where clinicians collaborate with, coach, and support skill adoption by community members to provide frontline mental healthcare, promotion, and prevention through community partnerships. This approach extends the reach of care overall, can position it closer to and integrate it within efforts to impact SDoMH, and similarly spreads and integrates clinicians more deeply into the work of mental health prevention and promotion and into a range of community settings. Such an approach has been shown feasible on a large scale, with lessons learned about the infrastructure (training capacity, funding models, technical supports) needed to do that, such as in New York City and Los Angeles, as well as globally (Belkin & McCray, 2019; Kohrt et al., 2015; Wennerstrom, 2011; Patel, 2018; Wells et al., 2013). There are therefore good foundations for policy advocacy and professional development to mainstream this approach.
4. Priorities that are informed by input from relevant Councils, especially for APA activities and responsibilities regarding professional development, training and curricula, clinical practice, research development, and other aspects of APA roles and program, to advance an SDoMH approach, including consideration of a specialty in Public Health Psychiatry and the adoption of the other recommendations of this report.
5. Short- and medium-term objectives for these efforts, and description of partnerships, grants, and funding opportunities needed to grow the staff, scope, resources, and capabilities of the Center/designee(s) to do this work.
6. A plan for the Center to continue managing a process for an iterative, ongoing, updated, indicator-tracked SDoMH Workplan and Policy Agenda moving forward beyond this initial six-month report, with updates no less than annually and reports on progress to the APA Board of Trustees. We recommend that this Workplan process be further solidified by being required in the bylaws as a part of APA governance.
7. Guidance for APA advocacy to:
 - a. Establish a CDC deputy director for community mental health and emotional well-being.
 - b. Peg NIMH funding to the relative contribution of social factors to mental health and bring parity to social factor-based and prevention/promotion-focused research.
 - c. Make permanent the Child Tax Credit (now expired) and establish a US-wide guaranteed income and ongoing raised minimum wage.
 - d. Support policies for reimbursement and incentivization of providers and health organizations to address SDoMH as an integral part of mental health.
 - e. In doing this work, the Committee also recommends pursuing opportunities to advance an SDoMH agenda as described here through efforts at the state and local levels since they offer the potential to serve as laboratories for new approaches, which could then be adopted nationwide.

A proposal for such a dedicated Center with this general scope of work was initially unanimously endorsed by the Task Force as its first recommendation in October 2021 in order for it to be considered for initial funding at the following December APA Board of Trustees meeting (the final Board meeting for 2021), so as to include its initial phase-in as part of 2022 budget (Appendix B, attached, is a lower-cost version requested as a backup consideration). However, initial assurances that this would be considered by the Board were not realized, and ongoing unclear guidance to the Task Force on how to pursue this and other recommendations and action items suggested for Board consideration continued for the remaining duration of our deliberations. We regret these issues did not get the hearing, debate, or consideration they more than deserved by the Board. Some of us were left with the impression that these disruptions were deliberate efforts to impede such prospects.

There was, though, no vote by the Board on any of these action items. While the entire Interim Task Force Report was “accepted” by the Board, such an action does not require any action from the APA or its components. We hope APA members will nonetheless engage these priorities, bring to bear the will and pressure to advance them through the organization, and in particular pursue the institutional commitment to dedicate APA expertise and staff to pursuing this long-overdue policy agenda, Workplan process, and paradigm shift toward SDoMH as described here.

D. Public Health Workgroup

Composition: Kenneth Thompson, M.D., Chair; Michael Compton, M.D., M.P.H.; Sanya Virani, M.D., M.P.H.

Focus: This workgroup focuses on the public health significance of SDoMH and why this Task Force is necessary and timely.

Target Audience: The profession itself, academia, foundations, and the world of public health, civic organizations, and government.

Areas of Focus: Psychiatry needs to develop primary prevention approaches to mental illnesses and well-being that marry public health and psychiatry. To accomplish this, we need to lay the groundwork for the creation, organization, and support of a cadre of public health psychiatrists. This will build on the organization of the conceptual basis for public health psychiatry. The approach is to identify the public health issues to be addressed, delineate the work to be undertaken, and outline the training and support they will need to be effective.

Recommendations:

1. Ensure that all psychiatrists have some basic understanding of the SDoMH and the work this section of public health psychiatry will develop and grow. The time to move forward is now. The promotion of positive mental health, well-being, resilience, and prevention of illnesses is a critical element of public health. Public health practice by psychiatrists should include specifying a human ecological and population approach to health and well-being; advancing “nurturant and healthy groups, institutions, and communities built on place-based initiatives; promoting mental health literacy and resilience; and elaborating on physical and mental health in a “health in all policies” approach as a process for sustainable and inclusive societal development.
2. More public health psychiatrists are needed. It is necessary to specify how a public health, macro-social mental health, and SDoMH lens elevates public health aims and priorities within the profession and delineates the role and function of public health psychiatrists and their training and development. The APA should develop a catalog of programs members have helped develop locally and statewide as a resource for members to understand successes and failures of approach or implementation, which are likely unknown outside the locality because there has been no publication or publicity about them.
3. The development of specific residency training programs and fellowships that enable psychiatrists to develop public health capabilities must be explored. At least two or three such programs should be created in the United States.
4. The community psychiatry Gold Awards program in the APA should be re-engineered to include a focus on programs or initiatives that are targeted at reducing adverse effects of SDoMH.

5. A consultation with international leaders in the field of public health psychiatry is currently underway. A monograph collecting the comments will be developed as a roadmap for elaborating the future of a public health approach to psychiatry.
6. The Task Force is collaborating with the Public Mental Health Implementation Centre of the Royal College of Psychiatrists (RCP) to learn how the RCP is engaging in a public health approach and addressing the social determinants of health. See <https://www.rcpsych.ac.uk/improving-care/public-mental-health-implementation-centre>. Interested Board members are invited to attend the collaborative meetings.

VII. Recommendations and Conclusion

Task Force Recommended Actions for the Board of Trustees

First proposed for the December 2021 meeting

Action 1. Will the Board of Trustees vote to require the establishment of a Center for the SDoMH as defined and detailed in Appendix B?

First proposed for the March 2022 meeting

The APA needs both a short-term and a long-term commitment and capacity to anchor iterating and comprehensive strategies to build knowledge for an SDoMH-based paradigm. The Task Force requests that the Board of Trustees approve the below action items to begin implementing the APA Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health, which was approved by the APA Assembly in November 2018 and the APA Board of Trustees in December 2018. None of these recommendations require either a change in component membership or an increase in the short-term cadre of APA staff. The first two action items will implement several of the five sections of the 2018 Position Statement, and the following six action items will address specific sections of the text of the Position Statement from which it was derived.

Action 1. Will the Board of Trustees vote to recommend the Assembly Executive Committee establish a standing Workgroup on SDoMH within the Assembly to create a strategic plan to implement the Position Statement in coordination with the District Branches?

The strategic plan should be developed in coordination with the Council on Advocacy and Government Relations and other components to ensure monitoring of and advocacy for District Branch- and state-level issues concerning SDoMH.

Action 2. Will the Board of Trustees vote to approve a name and scope of work change of the “Division of Diversity and Health Equity (DDHE)” to “Division of Diversity, Health Equity, and SDoMH (DDHESD),” since SDoMH is a major driver of health inequities and inextricably linked to health equity?

Action 3. Will the Board of Trustees vote to require that the Council on Advocacy and Government Relations establish a standing Workgroup within the Council to create a strategic plan in coordination with the Division on Government Relations among other components and external organizations? The strategic plan should be developed in coordination with the Assembly and other components to ensure monitoring of and advocacy for District Branch- and state-level issues concerning SDoMH.

Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities.

Action 4. Will the Board of Trustees vote to require that the Council on Quality Care establish a standing Workgroup within the Council to create a strategic plan to implement this item of the Position Statement

in coordination with the Council on Children, Adolescents, and Their Families; Council on Minority Mental Health and Health Disparities; and Council on Geriatric Psychiatry, among other Councils and DDHESD?

Advocates for the dissemination of evidence-based interventions that improve both the social and the mental health needs of patients and their families.

Action 5. Will the Board of Trustees vote to require that the Council on Healthcare Systems and Financing establish a standing Workgroup within the Council to create a strategic plan to implement this item of the Position Statement in coordination with other components, SAMHSA, and other organizations outside the APA?

- a. Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities.
- b. Advocates for the dissemination of evidence-based interventions that improve both the social and the mental health needs of patients and their families.

Action 6. Will the Board of Trustees vote to require that the Council on Medical Education and Lifelong Learning establish a standing Workgroup within the Council to create a strategic plan to implement this item of the Position Statement in coordination with AADPRT, ADMSEP, the Psychiatry RRC, and ABPN, among other organizations?

- a. Supports medical and public education on structural and SDoMH, mental health equity, and related evidence-based interventions.
- b. Urges medical school and graduate medical education accrediting and professional bodies to emphasize educational competencies in SDoMH and mental health equity.
- c. Urges psychiatry residency training directors and other psychiatric educators to use systematic approaches to teach about structural and SDoMH.
- d. Supports the training of psychiatrists, in graduate and continuing medical education, in best practices to address the structural and SDoMH and promote health equity.

Action 7. Will the Board of Trustees vote to recommend that the screening process for future APA-appointed representatives to the Psychiatry RRC and ABPN include assessing all potential nominees' commitment to advocate for inclusion of SDoMH in the ACGME general psychiatry residency and fellowship competencies, ACGME milestones, and the ABPN examinations to better address the need to incorporate attitudes, knowledge, and skills related to SDoMH?

- a. Supports medical and public education on structural and SDoMH, mental health equity, and related evidence-based interventions.
- b. Urges medical school and graduate medical education accrediting and professional bodies to emphasize educational competencies in SDoMH and mental health equity.
- c. Urges psychiatry residency training directors and other psychiatric educators to use systematic approaches to teach about structural and SDoMH.
- d. Supports the training of psychiatrists, in graduate and continuing medical education, in best practices to address the structural and SDoMH and promote health equity.

Action 8. Will the Board of Trustees vote to require that the Council on Research establish a standing Workgroup within the Council to create a strategic plan to implement this item of the Position Statement in coordination with NIMH and SAMHSA, among other organizations?

Advocates for increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery.

Although the Board of Trustees voted at its March 2022 meeting to accept the Task Force Report, which included these eight action items, there were no specific votes on any of the items. Without such specific, positive votes to support these recommendations, there is no formal action by APA to implement any of

them, either centrally or through any of the component Councils or committees that were proposed via a submitted proposal for the December 2021 Board of Trustees meeting.

What has the APA done so far?

1. APA Staff—Environmental Scan and Website Updates:

- a. Ricardo Juarez coordinated input from members to implement and update the Task Force on the SDoMH webpage at <https://www.psychiatry.org/psychiatrists/social-determinants-of-mental-health-task-force>.
- b. APA staff compiled a list titled “APA Component Activities Relevant to Social Determinants of Health & Mental Health.” See Appendix E.
- c. The Division of Diversity and Health Equity issued in December 2021 a document titled “Social Determinants of Mental Health: Environmental Scan of APA Administration Activities.”

2. Assembly Committee on Social Determinants of Mental Health. The APA Assembly passed an action paper on May 22, 2022, establishing an Assembly Committee on Social Determinants of Mental Health: <https://americanpsychiatricassociation.app.box.com/s/bdpoatzykbuxp1i3qy0r5dytvq0cq3uo>.

TITLE: Establishment of an Assembly Committee on Social Determinants of Mental Health

WHEREAS:

- The range of adverse Social Determinants of Mental Health contributes to and exacerbates existing mental health disorders and conditions.
- The Social Determinants of Mental Health that are currently codified under Z codes in the DSM-5-TR call for evaluation and care as part of accepted psychiatric practice, yet Z codes are not usually eligible for reimbursement.
- Our patients, healthcare providers, employers, insurance companies, lawyers, policymakers, and elected officials utilize DSM diagnoses in their decision-making.
- Enhanced identification of specific Social Determinants of Mental Health in the DSM would provide an opportunity to track and research the effects of various stressors affecting the mental health of individuals and communities, such as the effects of climate change.
- Such identification of Social Determinants of Mental Health will provide information useful for the development of appropriate clinical interventions and preventive strategies.
- In December 2018, the Board of Trustees approved “Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health” following approval by the Assembly in November 2018:

“The American Psychiatric Association:

- Supports legislation and policies that promote mental health equity and improve the social and structural determinants of mental health, and formally objects to legislation and policies that perpetuate structural inequities.
- Advocates for the dissemination of evidence-based interventions that improve both the social and mental health needs of patients and their families.
- Urges healthcare systems to assess and improve their capabilities to screen, understand and address the structural and social determinants of mental health.

- Supports medical and public education on the structural and social determinants of mental health, mental health equity, and related evidence-based interventions.
 - Urges medical school and graduate medical education accrediting and professional bodies to emphasize educational competencies in structural and social determinants of mental health and mental health equity.
 - Urges psychiatry residency training directors and other psychiatric educators to use systematic approaches to teaching about structural and social determinants of mental health.
 - Supports the training of psychiatrists, in graduate and continuing medical education, in best practices to address the structural and social determinants of mental health and promote health equity.
- Advocates for increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery and to develop new evidence-based interventions to promote mental health equity.”
- On March 1, 2022, President Biden outlined a strategy to address our national mental health crisis that called for the mobilization of a vast array of resources and innovative thinking to transform the nation’s capabilities.
- On March 12, 2022, the Board of Trustees accepted the interim report of the APA Presidential Task Force on the Social Determinants of Mental Health, which recommended that “the Assembly Executive Committee establish a standing Workgroup on SDoMH within the Assembly to create a strategic plan to implement the Position Statement in coordination with the District Branches.” [Since the Assembly does not have “standing Workgroup” as a defined structure, the term “Committee” is used in this Action Paper].

BE IT RESOLVED:

The Assembly Executive Committee will establish an Assembly Committee on Social Determinants of Mental Health to create a strategic plan to implement the 2018 “Position Statement on Mental Health Equity and the Social and Structural Determinants of Mental Health” in coordination with the District Branches.

The strategic plan should be developed in coordination with the Council on Advocacy and Government Relations and other appropriate components to ensure monitoring of and advocacy for District Branch-and state-level issues concerning Social Determinants of Mental Health.”

3. Joint Reference Committee. The Committee approved establishing a Caucus on Social Determinants of Mental Health in March 2022; it was approved by the APA Board of Trustees in July 2022.

Conclusion

Sorting out how the APA might address the SDoMH, given its history, was bound to be a fraught process, even without the current mental health crisis. The stakes are high, and the prize for fully engaging the field and the profession is great. Nonetheless, the barriers to change are significant. This request that the Board vote on action items and report on its votes is the result of efforts to thread through these challenges to launch a process whose momentum cannot be halted. Most Task Force members feel that the next few steps are not adequate for the challenges we face. They would be especially correct—to our shame—if these small actions were the only steps taken. But efforts to do more at this moment were unsuccessful. More will need to be done—much more, and soon. The members of this Task Force cannot understate this. This is a moment for our field and our profession to stand up. Will we?

Appendix A

APA/SAMHSA and Diversity Fellows Focus Group Report Results

The Workgroup on Education and Research also invited key RFMs to participate in a focus-group discussion to address all forms of SDoMH. We invited the APA/SAMHSA and Diversity fellows to participate in a two-hour focus-group discussion on the role of SDoMH in improving psychiatric care. Following the focus-group discussion, which included a group jamboard discussion for input on what RFMs deemed central today to equip them to advance SDoMH in their practice and clinical learning environments, the fellows were invited to complete a survey. The survey was also shared with all APA/APAF fellows.

Focus-Group Report Results from a Total of 32 Participants

We asked nine key questions:

1. Participants were asked to agree or disagree with the following statements:
 - a. I understand the concept of Social Determinants of Health (SDoH).
 - b. I understand the concept of Social Determinants of Mental Health (SDoMH).
 - c. I can identify the differences between SDoH and SDoMH.
 - d. To succeed in my profession, it is critical to learn about SDoMH.
 - e. It is valuable to examine and discuss the impacts of SDoMH in patient, policy, research and academic work.

Conclusion: Most participants either strongly agreed or agreed with each statement. There were few who remained neutral, and no one disagreed with any of the statements.

2. Participants were asked to agree or disagree with the following statements:
 - a. SDoMH is adequately covered through continuous medical education and training.
 - b. My training has fostered the knowledge, skills, and attitudes to address SDoMH.
 - c. My training has fostered a better understanding of the impact of Adverse Childhood Experiences (ACEs) on patients.
 - d. I support SDoMH be included as a core competency and not a subspecialized portion.
 - e. I believe that Diversity, Equity and Inclusion curriculum in my training makes a difference in addressing SDoMH issues.
 - f. I believe that after participating in the training and/or focus group on SDoMH, I can better intervene on behalf of patients and their families.

Conclusion: Most participants either strongly agreed or agreed with each statement. There were few who remained neutral, and only five people disagreed with statement c, while no one disagreed with any other statements.

3. In my training, the SDoMH course is currently offered as the following (check all that apply): The options given were Core Elective, Didactic, Seminar, Optional Elective, Journal Club, Occasional Mention, Other (Write-in), Not Sure.

Conclusion: The top three selections were Didactic, Occasional Mention, and Journal Club, respectively.

4. Participants were asked to agree or disagree with the following statements:
 - a. In my training, I have had adequate training on SDoMH key factors.
 - b. I know how to identify and evaluate Economic Factors (e.g., transportation access, food scarcity).
 - c. I know how to identify and evaluate Familial Factors (e.g., caregiver separation, abuse and neglect, family composition).
 - d. I know how to identify and evaluate Cultural Factors (e.g., linguistic barriers, cultural understanding of mental illness, immigrant/refugee issues).

- e. I know how to identify and evaluate Neighborhood Factors (e.g., housing instability, community violence exposure).
- f. I know how to identify and evaluate Climate Factors (e.g., covid pandemic, environmental toxins, climate change).
- g. I know how to identify and evaluate Vocational and Educational Factors (e.g., unmet educational need, job/vocational needs).
- h. I know how to identify and evaluate Structural and Historical Factors (e.g., institutionalized poverty and racism, community history).
- i. I know how to identify and evaluate Urban/Rural, Location/Population-Density Factors (e.g., regional differences).

Conclusion: Reports varied across the board with many of these statements, with most people agreeing but also a good number of people either remaining neutral or disagreeing.

- 5. I have used SDoMH to improve preventive and intervention strategies to address the well-being of patients.

Conclusion: Most of the participants reported yes, and few reported no or that they were not sure.

- 6. What activities are you engaged in regarding clinical and population-based actions to address the SDoMH? (Check all that apply.) The options given were:
 - a. Screening patients for SDoMH.
 - b. Referring patients to community-based resources to address SDoMH.
 - c. Capturing SDoMH data in EHRs.
 - d. Using community health workers to address patients' SDoMH.
 - e. Researching aspects of SDoMH.
 - f. Engaging in public policies aimed at addressing SDoMH.
 - g. Becoming involved in community health needs assessment.

Conclusion: The top three activities selected were "referring patients to community-based resources to address SDoMH," "screening patients for SDoMH," and "capturing SDoMH data in EHRs."

- 7. In the following statements, please use the scale to indicate if you agree or disagree:
 - a. I feel confident to interview a patient around SDoMH and apply it in my clinical practice and treatment planning.
 - b. I am aware that SDoMH can influence my clinical practice with post-traumatic stress (PTS).

Conclusion: Most participants either agreed with or remained neutral on each statement. There were few who disagreed with either of the statements.

- 8. What are the perceived barriers to addressing the SDoMH? Please check all that apply. The options given were:
 - a. Education or training on SDoMH
 - b. Discomfort with the topic
 - c. Time
 - d. Financial incentives
 - e. Ability to provide solutions
 - f. Staffing
 - g. Community resources
 - h. Other – Write in

Conclusion: The top three perceived barriers selected were "Education or training on SDoMH," "Time," and "Community resources."

- 9. In the following statements, please use the scale to indicate if you agree or disagree:
 - a. I would like to become more active in advancing SDoMH.

- b. I believe APA is committed to addressing SDoMH.
- c. I feel confident that APA's response to SDoMH is adequate to address the concerns of its members.

Conclusion: Most participants either agreed or remained neutral, with few disagreeing. There is clearly enthusiasm for developing the SDoMH for our early members.

Embracing the Social: A Permanent APA Office for Social Determinants of Mental Health

Our profession is a privileged body in society that, by addressing the social determinants of health and mental health, can do even more to advance equity in health, mental health, and well-being, and in doing so strengthen the social ties, resilience, and human capital essential to the health of the nation and our democracy. The mental capacity of the people of the nation is our greatest asset.

Social factors drive both opportunities for mental health and well-being and the risks and severity of mental illness. In recent decades, research has made clear the outsize role of these factors in producing enormous inequities in health and mental health. Psychiatry has untapped capacity to contribute to addressing these factors and to continue to grow and flourish as a profession. It is particularly critical that psychiatry address those social determinants of health and mental health that have a distinct psychiatric component. The profession's potential to act at the social level is often obscured by a prevailing clinical paradigm that focuses on individual psychiatric treatment of people with mental illness. Engaging the social factors opens a range of new paths: expanded areas of research, enhanced training, broadened clinical focus, roles as skill- and capacity-builders for nonprofessionals working in communities through what is called "task-sharing," significant contributions to public health practice, and other public policy making that is often the best route to primary prevention and to the promotion and protection of health, mental health, and well-being.

The APA has an opportunity and an obligation to correct this marked mismatch between the massive impact of social factors and opportunities to address them, and current training and practice. The APA is well positioned to join with and help lead the array of allies, advocates, institutions, policy makers, and professionals needed to establish and apply an SDoMH approach to individuals, communities, and the population at large. We can lead and serve as a model among medical specialties to include primary prevention and mental health promotion as important aspects of our professional roles, training future psychiatrists to include a deep appreciation and an approach to addressing the social determinants of mental health. If we do not travel down this road now, psychiatry will be left behind at this transitional moment of attention to the social aspects of development and disease prevention and to efforts to secure health equity and social justice.

The APA Presidential Task Force on SDoMH White Paper generated a list of potential steps toward this future—from creating new curricula and trainings that reengineer medical education to implementing reimbursement that supports task-share roles to advancing public health practice and policy making that integrate our expertise. A structural change in the APA is needed to turn these ideas, and much more, into action. The prevailing clinical focus in psychiatry did not emerge overnight. It has deep roots in our institutions, knowledge base and tools, career paths and cultures, business models, and political and other alliances and networks. Responding to SDoMH honestly, effectively, and comprehensively requires the APA and its members to take on long-term commitment, engagement, and dedicated resources to grow similar, deep roots for a social determinants-based paradigm for psychiatry. It is time to allocate resources specifically to jump-start and continue the work the SDoMH task force is starting. In doing so, the APA will be joining others, such as US pediatricians and family practitioners and the Royal College of Psychiatry, in similar efforts.

We therefore propose that a key objective of the Task Force be to establish a permanent APA Office on the SDoMH. An initial multidisciplinary core office team of nationally recruited, experienced experts and implementers will establish a multiyear Workplan of initiatives and fundraising to build out an expansive

SDoMH approach for psychiatry. This office would be positioned in the Division of Diversity and Health Equity, which could be renamed the Division of Diversity, Health Equity, and the Social Determinants of Mental Health. The director for SDoMH will report to the chief of the division and have responsibility for working in collaboration with staff of other APA Councils and committees, the Assembly, etc., as is currently the model in use in that division, to develop and implement initiatives related to education, clinical practice, research, public affairs, coalition building, and advocacy.

Initial office Workplan priorities should be completed within six months of the hiring of a director and then become an ongoing, minimally annually updated and Board-reviewed Workplan that at a minimum includes:

1. Comprehensive input from an invited network of social policy organizations, foundations, think tanks, etc., across the areas that impact SDoMH (e.g., housing, poverty, health, equity, child and family support, community development) and a plan to formalize and continue such a network of allies, including consumer organizations that also capture this breadth of SDoMH, as an ongoing, permanent input to APA policy framing and planning. This should include coalitions focused on resilience and healthy child attachment, especially for adversity-facing families, and efforts to build on the science of nurturant communities and measurable population well-being (Biglan et al., 2020).
2. Specific priority policy advocacy objectives based on multistakeholder network input and evidence of mental health benefits from, and to, existing social policies and outcomes. Those objectives should include but not be limited to ways to end child poverty; to universalize access to healthcare, childcare, pre-K, and secondary education; and to establish a guaranteed income and living wage and a path to join other countries in adopting well-being budget tools and methods (Treasury, New Zealand, 2019).
3. A path for APA to pursue with others the delivery system conditions, funding, and reimbursement codes and other policies that will enable providers to coach and join task-sharing partnerships with community-based organizations. As described by the Clinical Workgroup, task-sharing is a proven, evidence-based model where clinicians collaborate with, coach, and support skill adoption by community members to provide frontline mental healthcare, promotion, and prevention through community partnerships. This approach extends the reach of care overall, can position it closer to and integrated within efforts to impact SDoMH, and similarly spreads and integrates clinicians more deeply into the work of mental health prevention and promotion and into a range of community settings. Such an approach has been shown feasible on a large scale, with lessons learned about the infrastructure (training capacity, funding models, technical supports) needed to do that, such as in New York City and Los Angeles, as well as globally (Belkin & McCray, 2019; Kohrt et al., 2015; Wennerstrom, 2011; Patel, 2018; Wells et al., 2013; Singla et al., 2018). There are therefore good foundations for policy advocacy and professional development to mainstream this approach.
4. Priorities that are informed by input from relevant Councils, especially for APA activities and responsibilities regarding professional development, training and curricula, clinical practice, research development, and other aspects of APA roles and program, to advance an SDoMH approach, including consideration of a specialty in Public Health Psychiatry and the adoption of the other recommendations of this report.
5. Short- and medium-term objectives for these efforts, and descriptions of partnerships, grants, and funding opportunities needed to grow the staff, scope, resources, and capabilities of the Center/designee(s) to do this work.
6. This Center will continue to manage a process for an iterative, ongoing, updated, indicator-tracked SDoMH Workplan and Policy Agenda moving forward beyond this initial six-month report, with updates no less than annually and reports on progress to the APA Board of Trustees. We recommend

that this Workplan process be further solidified by being required in the bylaws as a feature of APA governance.

7. In addition to pursuit of detailing the policy areas above, the Policy Workgroup also recommends this Workplan include APA advocacy to:

- a. Establish a CDC deputy director for community mental health and emotional well-being.
- b. Peg NIMH funding to the relative contribution of social factors to mental health and bring parity to social factor-based and prevention/promotion-focused research.
- c. Make permanent the Child Tax Credit (now expired) and establish a US-wide guaranteed income and ongoing raised minimum wage.
- d. Support policies for reimbursement and incentivization of providers and health organizations to address SDoMH as an integral part of mental health.
- e. In doing this work, the Committee also recommends pursuing opportunities to advance an SDoMH agenda as described here through efforts at the state and local levels since they offer the potential to serve as laboratories for new approaches, which could then be adopted nationwide.

Proposed Budget and Organization

Initial funding to establish the core office team can come from a combination of existing budget reallocation, APA Foundation endowment, and membership and/or external crowd funding to strengthen this purpose and its authenticity. This office will be staffed and equipped with the leadership and expertise needed to establish and then implement such a Workplan and coordinate these efforts with related executive and other division activities.

Director: A doctoral-level, nationally recognized expert with a track record in policy development and organizational change to address the social determinants of health and/or mental health. A psychiatrist or other physician with pertinent specialty training will be considered. Provides overall management, strategic leadership, and growth trajectory for the office and its impact, including identifying policy, research and social change advocacy for APA that will advance SDoMH. Will lead in identifying opportunities for the APA to advance professional skills and roles for impacting SDoMH in clinical practice, and for psychiatrists to take on new roles in partnering with community efforts to task-share mental healthcare, prevention, and promotion; for assuming public health and public policy leadership; and for advancing medical school and residency training opportunities in these areas.

Associate Director of Partnerships, Policy, and Research: A senior leader and recognized expert in SDoMH who will support the office to translate its objectives and purpose into partnerships, policies, and research. A doctoral-level candidate with research experience in SDoMH is preferred. This position will support subject matter expertise in SDoMH within the office and engage and maintain collaborations with other organizations for APA to pursue work on addressing SDoMH and promoting population well-being equity. Given the priority areas of focus of the initial Workplan, these activities could include pursuit of payment models that support task-sharing and other psychiatrist roles that impact SDoMH, efforts to shape NIMH priorities, adapt training and accreditation standards, and promote advocacy and movement-building for social policies and equity priorities that impact SDoMH and improve and protect population health.

The proposed budget (below) assumes these positions will be sequenced with initial recruitment of a director to be in place by approximately no later than six months from APA Board authorization of this proposal. The associate director will be recruited no later than approximately four months later. These scopes of work and recruitments may be sequenced and shaped as strategy and resources evolve, but the initial intention is to include all areas of work described above and secure budget commitments to support initial roles on which to build and expand the impact, staff capacity, and external resources for the office.

Based on information from APA CFO Kevin Madden, the initial budget assumptions over five years are as follows:

Proposed Five-Year Budget to Support the APA Social Determinants Initiative

Salary Expenses (Account # 5000)

	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>
DIRECTOR M.D.	150,000	310,000	320,000	330,000	340,000
ASSOC DIRECTOR Ph.D. preferred	40,000	160,000	165,000	170,000	180,000
Total Salary *	190,000	470,000	485,000	500,000	520,000

* Total salary assumes all positions filled at target six- and four-month timelines as described.

In addition to salary, costs include annual fringe benefits at 28%; annual travel per employee at \$1,500 per trip; annual meeting expenses at \$2,000 per attendee.

Appendix C

Social Determinants of Mental Health/Health (SDoMH/H) Resources

Francis Lu, M.D., DLFAPA
Kim Professor in Cultural Psychiatry, Emeritus
UC Davis
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Robert C. Like, M.D., M.S.
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The SDoMH/H resources we have compiled are clustered into the following sections below:

- I. Professional Organizations
- II. Federal Government
- III. State Government
- IV. Foundation and Other Resources Websites
- V. UME/GME/CME and Online Training and Articles
- VI. Specific SDoMH
- VII. Measurement/Coding of SDoMH/H
- VIII. Funding for Addressing SDoMH/H
- IX. SDoMH/H: Cost/Outcome Benefits
- X. Curated Book and Film Lists on Cultural Psychiatry and Related Topics

This resource list touches on other topics, including the biopsychosocial model, diversity, inclusion, equity/disparities, social justice, and cultural and structural competency.

I. Professional Organizations

1. American Psychiatric Association (APA)

- a. Position Statements [Policy Finder](#) (official APA positions)
[Mental Health Equity and the Social and Structural Determinants of Mental Health](#), 2018
- b. [Resource Documents](#)
[Social Determinants of Health](#), 2020
- c. [Diversity and Health Equity](#)
Section 1: Education: CME webinars, toolkits, fact sheets, and other educational content specifically on diverse and vulnerable communities.

Section 2: Engagement Opportunities: APA components and caucuses, awards, resident/fellow fellowships, and networking opportunities aimed at supporting and increasing diversity within APA and psychiatry.

Section 3: Advocacy and News: Relevant press releases, position statements, and advocacy resources to help psychiatrists advocate for the needs of diverse and underserved populations.

2. World Health Organization

a. [Social Determinants of Mental Health](#)

b. [Social Determinants of Health – Teams](#); [Social Determinants of Health – Health Topics](#)

3. American Public Health Association

a. [Racism and health](#)

b. [Health equity](#)

c. [Social determinants of health](#)

d. [Mental health](#)

4. Association of American Medical Colleges

a. Achieving Health Equity: [How Academic Medicine Is Addressing the Social Determinants of Health](#)

b. [Teaching Hospitals’ Commitment to Addressing the Social Determinants of Health](#)

c. [Merging Social Determinants Data into EHRs to Improve Patient Outcomes](#)

d. AAMC Submits Comments on [Additional ICD-10 Codes for Social Determinants of Health. 2019.](#)

e. AAMC Comments on [PhenX Toolkit Proposals for Social Determinants of Health. 2020.](#)

g. AAMC Submits Comments on [NIMHD’s Proposed Social Determinants of Health Measures.” 2020.](#)

h. AAMC Center for Health Justice [Responds to Social Determinants of Health Caucus. 2021.](#)

i. AAMC Submits [Letter to Congressional Social Determinants of Health Caucus. 2021.](#)

j. AAMC Participates in [Briefing on Social Determinants of Health and Health Equity. 2021.](#)

5. Accreditation Council for Graduate Medical Education

[Clinical Learning Environment Review \(CLER\) Pathways to Excellence, Version 2.0](#) (see especially HQ Pathways 5-7)

6. American Medical Association

[“All-hands-on-deck approach” needed on social determinants of health](#)

7. American Academy of Family Physicians

a. [Advancing Health Equity by Addressing the Social Determinants of Health](#) in Family Medicine (Position Paper)

b. [The EveryONE Project™](#)

c. [Health Equity, Diversity, and Social Determinants of Health](#)

8. American Academy of Pediatrics

a. [Social Determinants of Health Resources](#)

b. [Screening Tools](#)

9. American College of Physicians

Position Paper: [Addressing Social Determinants to Improve Patient Care and Promote Health Equity](#)

10. American College of Surgeons

[Social determinants of health and surgery: An overview](#)

11. Aligning for Health

A membership association advocating for more integrated and coordinated programs to improve health outcomes for Americans.

[Social determinants of health](#)

12. American Psychological Association

- [Calling for more resources to address the social determinants of health](#). 2021.
- [Advising Congress on Social Determinants of Health](#) Caucus. 2021.
- [Report to Congressional Social Determinants of Health Caucus](#)

13. Coalition for Health Funding

[Social Determinants of Health and Health Equity: A CHF Member Perspective](#). 2021.

II. Federal Government

1. Centers for Disease Control and Prevention, DHHS

a. [Social Determinants of Health at CDC](#)

b. [CDC/ATSDR Social Vulnerability Index](#)

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health.

c. [CDC and OMH Minority Social Vulnerability Index](#)

- [Minority Social Vulnerability Index Fact Sheet](#)
- [Minority Social Vulnerability Index Explorer](#)

d. [Improving Social Determinants of Health—Getting Further Faster](#). (1/22) A collaboration by ASTHO and NACCHO that assessing advancement of health equity by addressing social determinants of health.

2. Office of Disease Prevention and Health Promotion, DHHS

- a. [Healthy People 2020's Social Determinants of Health](#)
- b. [Healthy People 2030 - Social Determinants of Health](#)
- c. [Social Determinants of Health Workgroup](#)

3. Substance Abuse and Mental Health Administration (SAMHSA), DHHS

- a. [Behavioral Health Equity](#)
- b. [Minority Fellowship Program](#)
- c. [National Network to Eliminate Disparities in Behavioral Health](#) (NNED)

4. Agency for Healthcare Research and Quality (AHRQ), DHHS

a. [Social Determinants of Health \(SDOH\)](#)

- [About SDOH in Healthcare](#)
- [Health Systems Research](#)
- [Practice Improvement](#)
- [Data and Analytics](#)
- [Resources](#)
- [What's New](#)
- [Identifying and Addressing Social Needs in Primary Care Settings](#) is located in the [EvidenceNOW Tools for Change](#) curated collection of tools and resources that help practices implement the best evidence-based practices.

b. [National Healthcare and Disparities Reports](#)

5. Centers for Medicare & Medicaid Services (CMS), DHHS

a. [CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies | CMS](#)

b. [Minority Health: The Difference a Decade Makes](#)

c. [Accountable Health Communities Model](#) that addresses SDoH

d. [Health Equity Technical Assistance](#)

- Personalized coaching and resources to help you embed health equity into your strategic plan
- Resources on improving care for racial and ethnic minorities, people with disabilities, individuals with limited English proficiency, sexual and gender minorities, and rural populations
- Data collection and analysis
- Help developing a language access plan and ensuring effective communication with those you serve
- [Building an Organizational Response to Health Disparities \(PDF\)](#)
- [Disparities Impact Statement \(PDF\)](#)
- [A Practical Guide to Implementing the National CLAS Standards \(PDF\)](#)
- [Using Z Codes: The Social Determinants of Health \(SDOH\) Data Journey to Better Outcomes \(PDF\)](#)

e. [Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries](#) (in Data Highlight No. 24, September 2021). [ICD-10-CM Official Guidelines for Coding and Reporting FY 2022](#).

f. [A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool](#): Promising Practices and Key Insights.

6. NIH National Institute on Minority Health and Health Disparities, DHHS

- [PhenX Social Determinants of Health \(SDOH\) Assessments Collection](#)
- [PhenX Toolkit](#)
- [Mental Health Research Collections](#)
- [Substance Abuse and Addiction Collections](#)
- [Social Determinants of Health Collections](#)

7. DDHS NIH National Center for Complementary and Integrative Health

[Whole Person Health: What You Need To Know](#)

8. Office of the National Coordinator for Health Information Technology (ONC)

- [Social Determinants of Health](#)
- ONC [Health IT Framework for Advancing SDOH Data Use and Interoperability](#) (6/17/2021)

9. [Congressional Social Determinants of Health Caucus](#)

10. **U.S. Senate**

[Senators Tina Smith, Chris Murphy Introduce Bill to Study, Address How Social Inequities Impact Health in Communities of Color](#)

III. State Government

1. **Colorado Department of Public Health and Environment**

[Strategic Plan on SDoH](#)

2. **New York State Office of Mental Health**

- [The SDoMH](#)
- [Addressing the SDoMH](#)

IV. Foundation and Other Resources Websites

1. **Hogg Foundation for Mental Health**

[Three Things to Know: Social Determinants of \(Mental\) Health](#)

2. **[National Collaborative for Health Equity](#)**

[The HOPE Initiative](#) tracking social determinants of health

3. **Robert Wood Johnson Foundation**

- [Social Determinants of Health](#)
- [A New Way to Talk about the Social Determinants of Health](#)

4. **National Alliance on Mental Illness**

[Ways We Can Address the Social Determinants of Mental Health](#)

5. **Victorian Health Promotion Foundation**

[Addressing the Social Determinants of Inequities in Mental Wellbeing of Children and Adolescents](#)

6. **National Collaborating Centre for Determinants of Health (NCCDH)**

[Social Determinants, Health Equity, and Mental Health: A Curated List](#)

7. **National Rural Health Resource Center**

[Social Determinants of Health Resources](#)

8. **National Health Law Program**

[Social Determinants of Health Legislation: Opportunities for a New Future](#)

9. **Reed Smith Health Industry Washington Watch**

[Consensus among HHS agencies on addressing social determinants of health through better data capture, interoperability](#)

V. UME/GME/CME and Online Training and Articles

1. **[Structural Competency: New Medicine for Inequalities That Are Making Us Sick](#)**
2. **American Medical Association** [What Are Social Determinants of Health?](#) (Training module)
3. **Office of Minority Health, DHHS**
[Improving Cultural Competency for Behavioral Health Professionals](#) (Online course)
4. **National Academy of Medicine**
[Educating Health Professionals to Address the Social Determinants of Mental Health: A Workshop](#)
5. **National Association of County and City Public Health Officials (NACCHO)**
[Roots of Health Inequity](#) course
6. **JAMA Network Open**
Denizard-Thompson N, Palakshappa D, Vallevand A, et al. Association of a Health Equity Curriculum With Medical Students' Knowledge of Social Determinants of Health and Confidence in Working With Underserved Populations. *JAMA Netw Open*. 2021;4(3):e210297.
<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776804>
7. **Journal of Ethics**
Alden M. Landry. Integrating Health Equity Content Into Health Professions Education, AMA Journal of Ethics, March 2021. https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2021-02/medu2-peer-2103_0.pdf
8. **American Association of Family Physicians**
Edgoose J. (ed). *Health Equity Curricular Toolkit*. Parkway Leawood, KS: Health Equity Team for Family Medicine for America's Health; 2018. URL.
https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/health-equity-toolkit/hops19-he-guidebook.pdf
9. **Advances in Medical Education and Practice**
Lewis JH, Lage OG, Grant K, Rajasekaran SK, Gameda M, Like RC, Santen S, Dekhtyar M. Addressing the Social Determinants of Health in Undergraduate Medical Education Curricula: A Survey Report. *Advances in Medical Education and Practice* 2020; 11:369-377.
https://www.dovepress.com/articles.php?article_id=54029
10. **Rhode Island Medical Journal**
Health Disparity Curriculum at The Warren Alpert Medical School of Brown University, 2014.
<http://www.rimed.org/rimedicaljournal/2014/09/2014-09-22-meded-erlich.pdf>
11. **Academic Medicine**
Social Determinants of Health Training in U.S. Primary Care Residency Programs: A Scoping Review, 2019.
https://journals.lww.com/academicmedicine/fulltext/2019/01000/social_determinants_of_health_training_in_u_s_34.aspx
12. **BMC Medical Education**
Identifying and addressing social determinants of health in outpatient practice: results of a program-wide survey of internal and family medicine residents, 2020.
<https://bmcmmededuc.biomedcentral.com/articles/10.1186/s12909-020-1931-1>

13. Annals of Family Medicine

Social determinants of health in family medicine residency education, 2018.

<https://www.annfammed.org/content/16/2/178>

14. MedEdPortal

An Experiential Resident Module for Understanding Social Determinants of Health at an Academic Safety-Net Hospital, 2017. https://www.mededportal.org/doi/full/10.15766/mep_2374-8265.10647

15. Health Affairs

- [Racism and Health](#)
- [Health Equity](#)
- [Social Determinants of Health](#)

VI. Specific SDoMH

1. *Physical environment*: Adverse built environment, neighborhood disorder, environmental pollution, climate change
2. *Social factors*: Discrimination and social inequality, exposure to violence, criminal justice involvement, ACEs
[The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity](#) (Shim and Compton, 2020)
3. *Basic needs*: Housing instability or homelessness, food insecurity, poor access to healthcare, difficulty with transportation
 - a. [The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity](#) (Shim and Compton, 2020)
 - b. [Food Accessibility, Insecurity and Health Outcomes](#)
 - c. [Housing and Services Resource Center](#)
4. *Socioeconomic status*: Low educational attainment, unemployment or job insecurity, poverty and income inequality, community poverty
 - a. University of Minnesota, [Interactions Between Poverty and Mental Health](#)
 - b. [Poverty and Mental Health](#)
5. Additional possible SDoMH: Political Determinants of Health, Daniel Dawes
 - a. [Prioritizing Equity video series: Political Determinants of Health | American Medical Association \(ama-assn.org\)](#) (Daniel Dawes, et al.)
 - b. [The Political Determinants of Health | Johns Hopkins University Press Books \(jhu.edu\)](#) Daniel Dawes.
 - c. [Health Equity Panel with Daniel Dawes and David Satcher, Sponsored by AARP – YouTube](#)

Also see [Healthy People 2020's Social Determinants of Health](#) and [Healthy People 2030 Social Determinants of Health](#)

VII. Measurement/Coding of SDoMH/H

1. CDC, DHHS

- [Three tools for screening for social determinants of health – FPM \(aafp.org\)](#)
- [Tools to Assess and Measure Social Determinants of Health – RHlhub Toolkit \(ruralhealthinfo.org\)](#)

- [Tools for Putting SDOH into Action | Social Determinants of Health | CDC](#)
 - [Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations – Center for Health Care Strategies \(chcs.org\)](#)
 - [Standardizing Social Determinants Of Health Assessments | Health Affairs](#)
2. **[National Collaborative for Health Equity](#)**
[The HOPE Initiative](#)
 3. **[American Academy of Family Physicians](#)**
 - [Social Determinants of Health: Guide to social needs screening](#) [Clinician tool]
 - [The Feasibility of Screening for Social Determinants of Health: Seven Lessons Learned](#)
 4. **American Hospital Association**
[Resources on Social Determinants of Health](#) and ICD-10-CM Coding for Social Determinants of Health
 5. **AACP [Account for Social Determinants of Health When Coding Office Visits](#)**
 6. **[Kaiser Permanente Structural Vulnerability Assessment Tool](#)**

VIII. Funding for Addressing SDoMH/H

1. **Deloitte**
[Addressing the social determinants of health for Medicare and Medicaid enrollees: Leading Strategies for Health Plans](#)
2. **Kaiser Permanente**
 - [Kaiser Unveils Health Equity Award to Recognize SDOH Achievements](#)
 - [Kaiser Takes Aim at Food Access, Social Determinants of Health](#)
 - [Kaiser Pairs with Data Analytics Team to Address Housing, SDOH](#)
 - [How Health Orgs Can Use Community Health to Pursue Health Equity](#)
 - [3 Steps for Building Your SDOH Business Case](#)
3. **AMA Evaluation and Management (E/M) Services Guidelines**
 - [New Clinical Coding Guidelines Account For Patients’ Social Risk](#): We Should Do More To Ensure They Advance Health Care Quality And Equity
 - [CPT® Evaluation and Management \(E/M\): Office or Other Outpatient and Prolonged Services Code and Guideline Changes](#)
4. **Physician-Focused Payment Model Technical Advisory Committee (PTAC)**
[Report to the Secretary of Health and Human Services](#): Addressing Social Determinants of Health and Equity in Alternative Payment Models and Physician-Focused Payment Models

IX. SDoMH/H: Cost/Outcome Benefits

- [CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies | CMS](#)
- [Quantifying Health Systems’ Investment in Social Determinants of Health, by Sector, 2017–19 | Health Affairs](#)
- [Addressing the Root Cause: Rising Healthcare Costs and Social Determinants of Health – PubMed \(nih.gov\)](#)

- [Costs Fell by 11% When Payer Addressed Social Determinants of Health \(healthitanalytics.com\)](https://healthitanalytics.com/news/costs-fell-by-11-percent-when-payers-addressed-social-determinants-of-health)
- [How Addressing Social Determinants of Health Cuts Healthcare Costs \(revcycleintelligence.com\)](https://revcycleintelligence.com/news/how-addressing-social-determinants-of-health-cuts-healthcare-costs)

X. Curated Book and Film List on Cultural Psychiatry and Related Topics at Amazon

by Francis Lu, M.D., Kim Professor in Cultural Psychiatry, Emeritus, UC Davis.

- [#10 Racism, anti-racism, race and related topics](#)
- [#11 Diversity/inclusion, health equity/disparities, social justice](#)
- [#12 Social Determinants of Mental Health / Health](#)

APA Component Activities Relevant to Social Determinants of Health and Mental Health (2021-22)

The following summary of APA component activities relevant to social determinants of health and mental health was compiled by APA Administration and shared with the APA Presidential Task Force on Social Determinants of Mental Health and updated as necessary.

COUNCILS

- **Council on Addiction Psychiatry**

The Council recommended a “Position Statement on the Impact of Structural Racism on Substance Use and Substance Disorders” at the October 2021 Joint Reference Committee (JRC) meeting. The JRC referred the position statement to the Council on Addiction Psychiatry and the Structural Racism and Accountability Committee, providing suggested edits for the Council to consider.

- **Council on Advocacy and Government Relations**

The Council recommended a “Resource Document on Advocating for Anti-Racist Mental Health Policies,” which is focused on dismantling anti-Black racism, at the October 2021 JRC meeting. The JRC approved the resource document, and it is now available on the APA website. The JRC referred the “Action Paper Addressing Bias in Law Enforcement Personnel and Correctional Staff” to the Council on Advocacy and Government Relations, with support from the APA Foundation. The JRC asked the APA Foundation to provide the Council with a list of existing APA Foundation programs and resources. In addition, the JRC requested that Council, with the assistance of the APA Department of Government Relations, identify where there might be policy gaps in terms of advocacy and look at potential near-term resources for DBs/SAs, with a separate parallel process to pull together information from the APA Foundation.

- **Council on Children, Adolescents, and Their Families**

The Council will support the work of the Task Force through its workgroups, including the Council’s workgroups on crisis response, immigration, suicide prevention in youth, and disparities. Council member Dr. Tresha Gibbs is also on the Task Force Clinical Workgroup, and Dr. Lisa Fortuna is on the Task Force Policy Workgroup. They are working with Council members to develop a “Resource Document on Social Determinants of Mental Health in Youth.” The Council developed a “Position Statement on Police Interactions with Children and Adolescents in Mental Health Crisis,” which was approved by the APA Assembly at its November 2021 meeting and referred to the JRC by the Board of Trustees at its December 2021 meeting. The Council also supported the consolidation of position statements on immigrant mental health with the Council on Quality Care.

Committee on Women’s Mental Health: The Committee plans to complement the Task Force on the Social Determinants of Mental Health through its work.

- **Council on Communications**

The JRC referred the *Action Paper Addressing Structural Racism in the APA Through Public Outreach* to the Structural Racism and Accountability Committee, Division of Diversity and Health Equity, Council on Communications, and the Department of Communications for input and to be made aware of the efforts that are being made to improve structural racism, and to communicate these efforts to the membership and the public.

- **Council on Geriatric Psychiatry**

The Council on Geriatric Psychiatry drafted an outline for a “Resource Document on the Impact of Racism in Older Adults” and submitted it to the Council on Minority Mental Health and Health Disparities for comments. The Council workgroup will now focus the resource on African Americans, with the title “The Impact of Racism in Older African American Adults.”

- **Council on Healthcare Systems and Financing**

The Council recommended a revised “Position Statement on the Role of Psychiatrists in Reducing Physician Health Disparities in Patients with Mental Illness” at the October 2021 JRC meeting. The JRC referred the position statement back to the Committee on Integrated Care by way of the Council on Healthcare Systems and Financing.

- **Integrated Care Committee:** The Committee wants to develop a two-page document on the evidence for how the Collaborative Care Model can address health inequities and highlight ways to address social determinants of health.

- **Council on International Psychiatry and Global Health**

Council members are developing a “Resource Document on the Mental Health Impact of Abuse of Power” that addresses the mental health effects of state-sanctioned violence, including political, economic, and religious examples and perspectives.

- **Chester Pierce Human Rights Award Nominating Committee:** At its December 2021 meeting, the Board of Trustees approved recommendations of the Committee and the Council to award the 2022 Chester M. Pierce Human Rights Award to Stacey Abrams, in recognition of her advocacy for social equity and equal voting rights, and Gregoire Ahongbonon, in recognition of his efforts to provide mental health services and social support to the mentally ill in West Africa.

- **Council on Minority Mental Health and Health Disparities**

The October 2021 JRC referred the “Action Paper Addressing Structural Racism in the APA Through District Branch Recognition” to the Council on Minority Mental Health and Health Disparities and Office of DB/SA Relations, and consultation from the Board Workgroup on APA-DB Relations for input and follow-up. The “Position Statement on Racism and Racial Discrimination in the Psychiatric Workplace,” developed by the Council in collaboration with multiple Councils and components, was approved by the APA Assembly at its November 2021 meeting. The Board of Trustees approved the position statement at their December 2021 meeting, and it is now available on the APA website.

- **Council on Psychiatry and Law**

The Council’s Racism, Social Determinants of Health, and Inequities Workgroup will develop a multiyear agenda intended to identify opportunities for psychiatrists to impact determinants of mental health that will reduce the risk of persons with behavioral health conditions being incarcerated or re-offending. The workgroup proposes to begin by working on a position statement on mass incarceration and a position statement on the transportation of civilly committed patients in the first year while developing the multiyear agenda.

- **Council on Quality Care**

The Council recommended to the JRC the “Position Statement on Mental Health Needs of Immigrants and People Affected by Forced Displacement” and the “Position Statement on Immigration, Children, Adolescents, and Their Families,” which are consolidations of previous APA position statements developed in collaboration with multiple Councils. The June 2021 JRC conditionally approved the position statements pending review by other Councils. The November 2021 APA Assembly approved the “Position Statement on Immigration, Children, Adolescents, and Their Families.” The Board of Trustees approved the position statement at its December 2021 meeting, and it is now available on the APA website. The Council is also

leading efforts to consolidate and update APA position statements addressing immigrant mental health.

OTHER COMPONENTS

- **Ethics Committee**

The APA Commentary on Ethics in Practice is intended to provide practical guidance for managing ethical dilemmas that come up in day-to-day practice. The Ethics Committee recently considered the issue of structural racism and determined that the commentary should reference the obligation of ethical psychiatrists to be aware of the issue and the detrimental effects that racism may have on the mental health of their patients.

APA FOUNDATION

APA Foundation funds numerous programs that focus on minority and under-represented mental health issues including health disparities, social determinants of mental health, and cultural literacy. The approximate budget for these programs is \$2.7 million per year, which is approximately 34% of the annual APAF budget.

- **[SAMHSA Minority Fellowship](#)**: 59 fellowships to provide training and education to residents and medical students about the cultural aspects of mental health in racial/ethnic and underserved patient populations and improve workforce diversity among American Indians/Alaskan Natives/Hawaiian Natives, African Americans, Asian Americans, and Hispanics. Dr. James serves as the project director.
- **[Diversity Leadership Fellowship](#)**: 30 fellowships to minority psychiatry residents or those interested in minority and vulnerable populations who, through the experiential and training opportunities of the fellowship, will become well equipped to teach, administer, and provide culturally competent, evidence-based mental health and substance abuse services to diverse minority groups and at-risk populations.
- **[Public Psychiatry Fellowship](#)**: 30 fellowships for outstanding residents interested in the field of public and community psychiatry.
- **[Valdiserri Correctional Psychiatry Fellowship](#)**: Two fellowships for residents affiliated with forensic psychiatry programs to receive additional experience, training, and mentorship in a correctional setting.
- **[Helping Hands Grants](#)**: This program was established in 2005 to encourage medical students to participate in community service activities, particularly those focused on underserved populations; raise awareness of mental illness and the importance of early recognition of illness; and build an interest among medical students in the psychiatric field. The Helping Hands Grants Program provides grants of up to \$5,000.
- **[Awards for Advancing Minority Mental Health](#)**: The Awards for Advancing Minority Mental Health were established in 2003 to recognize community organizations that have undertaken innovative and supportive efforts to:
 - a. Raise awareness in underserved minority communities about mental illness, including the need for early recognition, access to and the availability of treatment, and the cultural barriers to treatment.
 - b. Increase access to quality mental health services for underserved minorities.

- c. Improve the quality of care for underserved minorities, particularly those in the public health system or with severe mental illness.

The Awards include a financial contribution of \$5,000 given to the recipient organization.

- **APAF Awards:** These awards honor BIPOC members/leaders for lifetime service, outstanding research, and achievements that improve the lives of people with mental illness.
 - a. Solomon Carter Fuller Award
 - b. John Fryer Award
 - c. Kun Po Soo Award
 - d. Simon Bolivar Award
 - e. Alexandra Symonds Award
 - f. Jeanne Spurlock Award
- **Justice Initiatives:** Provide resources and training to police, judges and county officials to help them better understand, recognize, and address mental illness, with the goal of reducing the number of people with mental illness in jails.

Appendix V

References

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