UC San Diego
UC San Diego Previously Published Works

Title
Social Determinants of Mental Health

Permalink
https://escholarship.org/uc/item/7h70m6zd

Journal
JAMA Psychiatry, 79(4)

ISSN
2168-622X

Authors
Jeste, Dilip V
Pender, Vivian B

Publication Date
2022-04-01

DOI
10.1001/jamapsychiatry.2021.4385

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

VIEWPOINT

Social Determinants of Mental Health
Recommendations for Research, Training, Practice, and Policy

Dilip V. Jeste, MD
Department of Psychiatry, University of California, San Diego, San Diego; and Sam and Rose Stein Institute for Research on Aging, University of California, San Diego, San Diego.

Vivian B. Pender, MD
Department of Psychiatry, Weill-Cornell Medical College, New York, New York.

Defining the Concept of Social Determinants of Health

The notion that social factors have a major effect on human health goes back to ancient Greece. However, the first formal document about social determinants of health (SDoHs) with a global impact was not published until 1998.[1] It defined SDoHs as conditions in the environments where people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality-of-life outcomes. It listed several SDoHs: early childhood development; education, job opportunities, and income; racial and ethnic and other forms of discrimination; housing, transportation, and neighborhoods; and access to clean air and water and to quality affordable health care. The recent COVID-19 pandemic has exposed a critical need to refocus on SDoHs as health care disparities have worsened in populations where racism is endemic.

SDoHs affect people with serious mental illnesses (SMIs) and substance use disorders (SUDs) too.[2] However, there are also some unique issues that concern persons with SMIs and SUDs. Half of all lifetime cases of SMIs and SUDs start by the age of 14 years, and three-fourths by the age of 24 years,[3] although treatment may not occur until years later. The median age of onset for anxiety disorders and impulse-control disorders is 11 years, with a range of 7 to 15 years.[3] Ninety percent of adults with SUDs begin substance use during early adolescence. Childhood emergence of psychopathology severely impacts, among various factors, the quality of education received, thereby reducing subsequent job opportunities and income, leading to worse health care access and outcomes than people with later-onset illnesses.

There are also other specific issues affecting persons with SMIs and SUDs. For example, in the US, there are more individuals with SMIs and SUDs in prisons and jails than in hospitals.[4] Furthermore, people with SMIs have a 15- to 20-year shorter life span than the general population, and this mortality gap has increased in recent decades, likely owing to patients with SMIs not benefitting from modern health care advances.[5] These facts suggest additional social determinants of mental health (SDoMHs) that are distinct from the general SDoHs.

Expanding the Concept of SDoHs to Include Mental Health

The SDoMHs that affect patients with SMIs and SUDs uniquely or disproportionately include (1) a pervasive stigma against SMIs and SUDs; (2) a lack of parity in reimbursement for mental health care; (3) a seriously flawed criminal justice system that ignores the contributions of poorly treated SMIs and SUDs to criminal behaviors; (4) homelessness; (5) social isolation with associated loneliness; (6) social media, with hurtful communication leading to high stress and suicides, especially among youth; and (7) positive social determinants, including positive childhood experiences,[6] social connections, and community-level resilience, social engagement, and social support, exemplified by movements like the Compassionate Communities.

Coexisting SDoMHs act synergistically. Thus, individuals with SMIs from racially and ethnically marginalized communities may face worse health outcomes than White individuals with SMIs or people from racially and ethnically marginalized communities without SMIs.

Recommendations for Research, Training, and Practice

Mental health professionals need to be trained in recognizing and addressing SDoMHs at individual and community levels.

Individual-Level Health Care

Research | Reliable and valid measures of the effects of each SDoMH on the well-being of patients across the life span need to be developed and tested in rigorous studies. Longitudinal studies should assess the associations of specific SDoMHs with mental, physical, and cognitive function, after controlling for relevant confounders. Investigations should also address the potential underlying biopsychosocial mechanisms involved. Finally, evidence-based interventions to reduce the adverse health effects of specific SDoMHs are warranted.

Training | Courses to increase SDoMH competency among trainees and practitioners are necessary. The effect of this training on the clinicians' knowledge base and, subsequently, on their patients' well-being should be examined.

Clinical Practice | A short battery of pragmatic but validated assessments of SDoMHs is critical. Identification of the social causes of health inequities in individual patients is necessary to use targeted personalized interventions. "Social prescribing" is needed to link patients to social services to promote access to social supports within their communities, such as caregiver groups.

Community-Level Health Care

Research | The rise of public health as a distinct field has galvanized interest in prevention. *Primary prevention* refers to treating risk factors to prevent diseases, whereas *primordial prevention* refers to preventing the risk fac-

Corresponding Author: Dilip V. Jeste, MD, Sam and Rose Stein Institute for Research on Aging, University of California, San Diego, 9500 Gilman Dr, Ste 0664, La Jolla, CA 92023-0664 (djeste@health.ucsd.edu).

© 2022 American Medical Association. All rights reserved.

Downloaded From: https://jamanetwork.com/ by a University of California - San Diego User on 02/28/2022

tors themselves. Thus, enhancing maternal (including reproductive) health, preventing child abuse and neglect, and treating parental mental illness may lower the incidence of problem behaviors in youths, which behaviors predispose individuals to psychiatric disorders and SUDs in later life.[7]

Studies of such prevention strategies are warranted at national and international levels. Funding agencies should support research targeting place-based, community-led (not just community-participatory) research and prioritize collaborative learning practices and community capacity building.

Behavioral vaccines refer to psychosocial strategies that can significantly reduce the risk of specific psychopathologies. Thus, the strong clinical-biological evidence for an inverse relationship between loneliness and wisdom suggests a potential for wisdom-focused interventions as vaccines to prevent loneliness-related disorders.[8]

Training | The Accreditation Council for Graduate Medical Education should include SDoMHs in the Accreditation for Psychiatry Residency and Fellowship training programs. Similarly, the American Board of Psychiatry and Neurology should do the same in the board certification process. Also, continuing education courses should incorporate SDoMHs in their materials.

Clinical Practice | All health professionals should receive an orientation in public health issues that involve advocacy with other disciplines and organizations to effect social changes. More public health psychiatrists are needed with emphasis on positive mental health and disease prevention. The science of task sharing describes a wide range of skills from acute care to prevention, promotion, and resilience building that can be adopted by lay persons with clinicians as cocreating partners.[9] These methods have started to scale in parts of the US and can connect direct care systems with community well-being.

Policy Implications

The US faces a serious mental health crisis. During the last 2 decades, there has been a behavioral pandemic of loneliness, social isolation, opioid abuse, and suicides.[10] This has contributed to a decrease in the average US longevity in the period from 2015 to 2017, for the first time since the mid-1950s. The COVID-19 pandemic and the necessary social distancing guidelines have worsened health and health care inequities in marginalized groups, such as persons with SMIs and SUDs, and in Black, Latinx, immigrant, and LGBTQ+ communities.

The systems of care for patients with SMIs and SUDs need to be reengineered to better recognize and respond to SDoMHs. Given the frequent co-occurrence of SMIs and SUDs, the silos of mental health services and substance use services must be broken and integrated with primary care. Models of care incorporating technology, peer support, and partnerships with faith-based and other community organizations are necessary.

Fortunately, there are now interventions that promote nurturing communities and environments.[9] Also, there is growing awareness of humanistic and global sustainable development goals. The recent US child tax credit, reducing child poverty by 50%, is a case in point. Making the credit permanent could significantly improve the physical and mental health of today's children through their lifetime. More such social policy developments should be fueled by psychiatric advocacy and advances in social epidemiology, trauma-informed policy and practice, school-based programming, and recovery-oriented practice and community partnering. In this emerging social context, we must explore new ways to address SDoMHs.

The time is ripe for our health care system to begin to incorporate SDoMHs in all parts of its operation. A well-planned, sustained effort with collaboration among all major stakeholders can transform today's broken mental health care system into a model for the rest of the world.

ARTICLE INFORMATION

Published Online: February 23, 2022. doi:10.1001/jamapsychiatry.2021.4385

Conflict of Interest Disclosures: None reported.

Additional Contributions: We acknowledge the work of the other members of the American Psychiatric Association (APA) Task Force on Social Determinants of Mental Health: Elie G. Aoun, MD, MRO, Gary S. Belkin, MD, PhD, MPH, Michael T. Compton, MD, MPH, Lisa R. Fortuna, MD, MPH, Tresha A. Gibbs, MD, Kimberly Gordon-Achebe, MD, Steve Koh, MD, MPH, MBA, Francis G. Lu, MD, Dolores Malaspina, MD, MS, MSPH, Allan Tasman, MD, Kenneth S. Thompson, MD, and Sanya Virani, MD, MPH. We also want to thank the members of staff of the Task Force: Yoshie Davison, MSW; Regina James, MD; Ricardo A. Juarez, MS; and Saul Levin, MD, MPA, FRCP-E, FRCPsych. These additional contributors were not financially compensated.

Additional Information: Dr Pender is the current President of the APA, and Dr Jeste is the Chair of the APA Task Force on Social Determinants of Mental Health.

REFERENCES

1. Wilkinson R, Marmot M. *Social Determinants of Health: The Solid Facts*. World Health Organization Regional Office for Europe; 1998.

2. Compton MT, Shim RS, eds. *The Social Determinants of Mental Health*. American Psychiatric Association Publishing; 2015.

3. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):593-602. doi:10.1001/archpsyc.62.6.593

4. Al-Rousan T, Rubenstein L, Sieleni B, Deol H, Wallace RB. Inside the nation's largest mental health institution: a prevalence study in a state prison system. *BMC Public Health*. 2017;17(1):342. doi:10.1186/s12889-017-4257-0

5. Lee EE, Liu J, Tu X, Palmer BW, Eyler LT, Jeste DV. A widening longevity gap between people with schizophrenia and general population: a literature review and call for action. *Schizophr Res*. 2018;196:9-13. doi:10.1016/j.schres.2017.09.005

6. Pender VB, ed. *The Status of Women: Violence, Identity, Activism.* Taylor & Francis; 2016. doi:10.4324/9780429483325

7. Jeste DV, Lee EE, Cacioppo S. Battling the modern behavioral epidemic of loneliness: suggestions for research and interventions. *JAMA Psychiatry*. 2020;77(6):553-554. doi:10.1001/jamapsychiatry.2020.0027

8. World Health Organization. Prevention of Mental Disorders: Effective Interventions and Policy Options; 2004. Accessed January 20, 2022. https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf.

9. Singla DR, Kohrt BA, Murray LK, Anand A, Chorpita BF, Patel V. Psychological treatments for the world: lessons from low- and middle-income countries. *Annu Rev Clin Psychol*. 2017;13:149-181. doi:10.1146/annurev-clinpsy-032816-045217

10. Lee EE, Bangen KJ, Avanzino JA, et al. Outcomes of randomized clinical trials of interventions to enhance social, emotional, and spiritual components of wisdom: a systematic review and meta-analysis. *JAMA Psychiatry*. 2020;77(9):925-935. doi:10.1001/jamapsychiatry.2020.0821

© 2022 American Medical Association. All rights reserved.

Downloaded From: https://jamanetwork.com/ by a University of California - San Diego User on 02/28/2022