Statement on Mental Health

Student National Medical Association
Health Policy and Legislative Affairs Committee
Statement on Mental Health

First Revision

Revised and prepared for the Winter 2020 National Leadership Institute BOD Session
January 24-26, 2020
San Diego, CA
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INTRODUCTION

Established in 1964, the Student National Medical Association (SNMA) has resolved to focus on the needs of medical students of color, as well as provide exceptional healthcare to underserved communities and communities of color. The SNMA’s focus on healthcare extends into the realm of supporting quality mental health practices both for medical professionals and the communities we aim to serve. A report released by the Institute of Medicine (IOM) showed growing evidence of numerous issues concerning access to healthcare services, quality of care received, and improvement in health outcomes among different groups continues to build. Over a decade has passed since that report, during which time the manner that we deliver care has changed to meet the new demands and change in dynamic of illness. Unfortunately, discrepancies still exist in the delivery of that care as well as health outcomes for minorities. SNMA is determined to develop promising methods to reduce and eventually eliminate disparities in health, including mental health.

BACKGROUND

Culture refers to a group’s shared set of beliefs, norms, and values. This includes attitudes towards mental health and mental illness. Cultural perceptions of mental health may play an important role in the larger burden of mental illness seen in underserved communities. It dictates whether people seek treatment, their ability to cope with symptoms, the amount of support they receive in the community and from their families, where they seek services, and how well they fare in treatment. These observations are most apparent in underserved communities, especially those primarily comprised of racial and ethnic minorities.

Multiple analyses of different racial/ethnic groups have shown distinct patterns in which different cultures express, experience, and cope with feelings of distress. While making generalized statements regarding cultural characteristics can invite stereotypes, these culturally common symptoms deserve recognition as they run the risk of being misinterpreted by clinicians. Patients from various communities may express their distress in ways that are deemed culturally acceptable to avoid describing the emotional component of their symptoms. By ignoring cultural perspectives of mental health among the underserved, clinicians may miss an opportunity to remove communication barriers that hinder treatment. Additionally, racial minorities within the
medical profession often face their own obstacles in terms of navigating the medical and basic science fields.\textsuperscript{5} Now more than ever, we need to change the dynamic of work and learning environments filled with racial microaggressions and lack of mentorship.

The Association of American Medical Colleges (AAMC) defines underrepresented in medicine (UIM) as “those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.”\textsuperscript{6} From a socioeconomic standpoint, we are often judged based on our race/ethnicity, gender, and class. These three categories directly impact institutional and personally mediated perceptions about UIM groups. Furthermore, these institutional and interpersonal perceptions adversely affect clinical experiences of minority medical students and faculty, as well as opportunities they are offered in professional development such as promotion and funding.\textsuperscript{7} By directly addressing these issues, we can affect change that will facilitate more people of color – both within the medical profession and community – seeking mental health care. The first step to doing so is to eliminate the stigma associated with mental health and illness.

Despite decades of research, recognition and treatment of mental illness and its comorbidities, it still remains a significant public health problem in the United States (US), accounting for a projected $280.5 billion a year by 2020.\textsuperscript{8} It is no secret that addressing the overall health and specific mental health needs in the minority population is a highly complex issue that warrants attention from physicians, public health workers, policy makers, and medical students. According to data from the National Institute of Health’s (NIH) National Institute of Mental Health (NIMH), approximately 47.6 million adults in the US suffer from a diagnosable mental disorder in 2018, suggesting that many people suffer from these disorders in their day-to-day lives such as in the workplace, church, home, etc.\textsuperscript{9} Collaborative effort between those in the medical and social service communities are integral to achieving the best care for those in minority communities with mental health disorders.

Depression is one of the most common mental health problems in the US, with 17.7 million adults having at least one major depressive episode in the past year in 2018.\textsuperscript{10} Racial/ethnic disparities exist in access to mental health services. A 2014 study showed that 36.8% of Hispanic/Latinos, 29.5% of Black/African Americans, and 26.8% of Asians reporting lifetime use of any mental health service, despite exhibiting one or more depressive symptoms, compared with 42.8% of Whites.\textsuperscript{11} In a mental illness surveillance report created by the Centers for Disease
Control (CDC), it was recommended that efforts to monitor mental illnesses and establish better coping approaches for those with mental disorders should be increased. This notion is further reinforced by Healthy People 2020’s goal to “improve mental health through prevention and by ensuring access to appropriate, quality mental health services” and initiatives elucidated in the 2008 NIMH strategic plan.

Nationwide, attention has been focused on racial/ethnic disparities in mental health services and outcomes in the Surgeon General landmark supplemental report, “Mental Health: Culture, Race and Ethnicity.” This report documented that minorities receive lower quality mental health care in general than Whites and there are still wide disparities in mental health services for Black/African Americans, Hispanic/Latinos, Asians, and Native Americans. Moreover, Holden and Xanthos reported that Black/African Americans experience more mental health disadvantages relative to Whites with respect to financial barriers, barriers to help seeking, and poorer quality services. Barriers to seeking treatment for mental health disorders among low income Black/African Americans include poor access to care, stigma, and lack of awareness about mental illness. Additionally, ethnic minorities’ failure to perceive the need for medical care partially account for the low rates of treatment for depression among this population.

We can begin to relieve the burden of mental illness in these communities by inquiring about cultural influences during everyday patient care and delivering services that are responsive to the cultural concerns of the community. Cultural misunderstanding between the patient and the physician often leads to missed information and communication problems that prevent individuals from using services and receiving appropriate care.

The Cultural Formulation Interview, developed by the American Psychiatric Association and the DSM-5 Cross-Cultural Issues Subgroup, provides an example of a strategy for understanding how culture interacts with mental health for a particular patient and tailoring your interview and treatment based on the interaction. It involves a series of questionnaires that incorporate learning about the cultural identity of the individual, exploring the cultural explanation of their illness based on that identity, considering their psychosocial environment, examining how the clinician-patient relationship may be affected by their interpretation of cultural and social status, and finally creating a diagnosis and care plan that incorporates these strategies. This strategy allows determination of cultural meanings of illness and how the patient copes with distress. Both have major implications for (a) promoting mental health, (b) preventing mental illness, and (c)
most importantly, furthering the physician’s understanding of the complexities of mental health disparities in underserved communities. While the cultural formation interview is not the only strategy for assessing cultural influences; the methodology can serve as an outline for future strategies.

National statistics published by the Kaiser Family Foundation (KFF), which are based on data from the AAMC, indicate that in 2018 the total US medical school graduates by race and ethnicity were as follows: 10,909 White (56%); 4,101 Asian (21%); 1,119 Black/African American (6%); 1,059 Hispanic/Latino (5%); 59 American Indian/Alaska Native (< 1%); 9 Native Hawaiian/Pacific Islander (< 1%). Of the 19,553 graduates, 47% were female and 53% male. Race/ethnicity disparities, therefore, display the largest divide. A Mayo Clinic multicenter survey of over 1000 medical students demonstrated that though minority medical students experience similar symptoms of burnout and depression as nonminority students, UIM students are more likely to report lower sense of personal accomplishment, and a lower quality of life in many domains. “Imposter syndrome,” also known as perceived fraudulence, is defined as self-perception of fraudulence despite objective successes and a failure to internalize these successes. Black/African American students are known to experience higher levels of imposter syndrome leading to higher levels of anxiety and depression. Minority students were also significantly more likely to have experienced a significant personal life event or illness in a twelve-month time frame; however even when controlled for these factors, differences in quality of life persisted. A 2002 AAMC study of depressed medical students’ use of mental health services, cited lack of time, lack of confidentiality, and stigma associated with use as the three most significant barriers to access of mental health care. This 2002 study demonstrated that one quarter of medical students surveyed met criteria for depression, but a 2016 systemic review and metanalysis found that depressive symptoms were between 2.2 and 5.2 times higher among medical students that the general population of similar age in the US.

**SCOPE OF THE PROBLEM**

**Practitioner Bias**

In a landmark 2002 report, “Unequal Treatment,” the IOM identified bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers as important contributors to
racial and ethnic disparities in healthcare.\textsuperscript{25,26} Practitioners often have to make judgments about a patient’s condition and make decisions concerning treatment without adequate information. The added pressures of time and resource constraints can unfortunately invite the incorporation of stereotypes and bias into clinical decision-making. Practitioner bias, whether done knowingly or unknowingly, has been associated with disparate outcomes in a variety of clinical settings ranging from the management of chest pain to the manner of communication and information sharing during discussions with patients.\textsuperscript{27–29} It has garnered significant attention by health disparities researchers with the majority of literature attributing subconscious perceptions rather than overt prejudice as the predominant mechanism of practitioner bias.\textsuperscript{30} Regardless of the mechanism of bias, its effect on underserved communities' stems from a process whereby inappropriate thoughts and expectations lead to inappropriate decisions and actions.\textsuperscript{4}

The mental health field may be especially susceptible to bias given the cultural differences in perceptions and presentations that may go unrecognized by providers. Confusion and misunderstanding regarding symptoms of mental illness from specific patient groups is often put forward as a potential cause of overdiagnosis and mistreatment of certain mental health conditions.\textsuperscript{31,32} Black/African Americans, regardless of the type and severity of their mental illness, are more likely than their White counterparts to be involuntarily committed.\textsuperscript{26} Even with similar rates of overall mental illness across racial and ethnic backgrounds, Black/African Americans have higher than expected rates of diagnosed schizophrenia.\textsuperscript{31,32} This evidence suggests a more negative perception of mental illness among racial ethnic minorities that ultimately leads to poor treatment.

Misdiagnosis and under-treatment are the unfortunate consequence of inappropriate clinician bias. Affective disorders such as depression, anxiety and bipolar disorder often go unrecognized among individuals from underserved communities and communities of color.\textsuperscript{1,33} These vulnerable populations are also less likely to receive appropriate care for some more common mental illnesses.\textsuperscript{14} While these trends are likely attributable to a myriad of factors such as socioeconomic status, mental health insurance status, and mistrust, subconscious practitioner bias that goes unrecognized and unaddressed will only perpetuate these trends.

\textit{Access to Mental Health Services}

People of color are disproportionately concentrated in health professional shortage areas and medically underserved areas. A report by the KFF indicates that in 2018, 21\%
Hispanic/Latinos, 19% Native American, and 17% Black/African Americans went without seeing a doctor due to cost, compared to only 13% of Whites. In parallel, 26% Hispanic/Latinos, 10% Native American, 20% Black/African Americans, and 14% Whites reported having no regular source of healthcare. These structural barriers, which directly impact access disparities and quality metrics, are displayed by the healthcare system.

People of color receive lower quality of care and have higher uninsured rates compared to their White counterparts. The Affordable Care Act (ACA) helped begin to close the gap by requiring public reporting and monitoring healthcare access and quality; however, expansion is required to ensure accountability through reporting. In addition, elimination of quality gaps as part of payment reform is also needed. Although under federal law each state’s insurance company is required to provide to the public justification for raising rates higher than 10%, due to supply and demand, premium and deductible prices available to consumers by insurance companies are inflated. This puts an additional strain on underserved communities. According to the KFF, most of those who are uninsured are low-income, working families of color. In 2017, nearly half (47%) of these groups lived below 200% of the federal poverty level (FPL).

It is important to mention that the CDC emphasizes differences between populations with respect to their accessibility, quality, and outcomes of mental healthcare as a major component of disparities. The supplement to the Surgeon General report on mental health brought much needed attention to the role of cultural factors in mental health disparities. In the supplemental report and in the research literature, Black/African Americans are identified as a population that is vulnerable to mental health disparities and faces unique challenges pertaining to mental health care. In particular, some ethnic minorities are disadvantaged in a number of areas that impact their interaction with mental healthcare systems. This is why it is important for us to bridge the gap between minority population and health care providers who they desperately need right now more than ever. Previous research has found that the mental healthcare system provides less care to Black/African Americans than to Whites, even when mental health status was adjusted to compensate for this. In addition, relative to specific mental illnesses such as major depression, Underrepresented in Medicine students are more likely to experience higher degrees of functional limitation compared to the White population.

With regard to seeking help for their mental illness, research suggests that Black/African Americans are less likely to seek mental health care compared to the White population. If we
change this aspect of this complex mental health crisis, we will create a new wave of positive change that will eradicate the current stigma so minorities can be motivated to seek high quality care for their mental illness.

Two major expansions under the ACA have the ability to ignite change. Thirty-seven states, including Washington, DC, have expanded Medicaid services to non-elderly adults without dependent children with incomes at or below the 133% FPL. More importantly, all health insurance policies cover mental health and substance abuse services. These mental health services include, but are not limited to, rehabilitation facilities and habilitative services for people with any behavioral health illnesses/disorders/concerns. In addition, all state Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries have access to similar counseling, medication, social work, and therapy services. Though each state is responsible for providing children with essential services, determination of services covered for adult consumers varies.

**Structural Racism, Implicit Bias, and Health**

Discrimination is a major form of injustice and plays an important role in health outcomes, especially amongst UIM communities. The eco-social theory models the realities of how oppressive societal situations impact life choices over historical generations. Since the start of the century, the CDC, NIH, and IOM have acknowledged through scientific study the relationship between racial discrimination and health care. A central focal point rests within societal and environmental exposure patterns to harm that link the distribution of health to physiological manifestations and gene expression. For example, evidence has shown that chronic stress contributes to preterm birth and other adverse pregnancy outcomes and both higher chronic stress and higher rates of poor pregnancy outcomes are consistently seen in people of color compared to White people. It is thus crucial to consider how social inequities play a comparable role.

The eco-social theory requires constant consideration of the relationship between levels of exposure, the environmental and historical context, and susceptibility and resistance to exposure from the micro to the macro level. Therefore, the distribution of health, disease, and both psychological and physical well-being across a community is complex and compounded by many variables. In this light, it is vital to understand the superiority and inferiority complex created amongst individuals. Internalizing these concepts allows these ideas to circulate amongst all populations and generates acceptance of inequitable living, working, and educational conditions for UIM groups.
A few challenges to understanding the health impact and structural determinants of racial inequality include: laws, institutional policies and practices, national, regional, state and local economic and political infrastructures and neighborhood, school, and workplace conditions. Though the federal government abolished legal racial discrimination in the 1960s, present day *de facto* discriminatory policies and practices presented by the healthcare system, residential, educational, and occupational segregation creates an unwanted gap for UIM individuals and communities. In order to overcome such inequality and health diminishing effects, people must not only display elements of resilience, self-efficacy, and self-worth, but there must be change within the federal to local levels of government.

**Disparity in Medical Education and Basic Science Research**

It has been proven that racial/ethnic disparities in successful completion of a career in medicine occur as a result of multifactorial and systematic inequalities. “Initiatives targeting underrepresented minorities at an early stage to enhance health care career interest and provide academic support and mentorship will be required to address the racial disparity that exists in the US medical schools and ultimately the physician workforce.” Many applicants have limited resources, financial burdens, and other social and cultural influences that may decrease the feasibility of pursuing a career in medicine. In particular, recent studies show that the number of Black/African American males applying to medical school has improved in recent years, yet the number of matriculants have continued to decline. It is hypothesized that this is reasons that include an lack of mentors or role models of color in medicine, public stereotypes, lack of resources, mass incarceration, and unequal educational resources.

The National Science Foundation reported in 2018 that Black/African Americans (5%), Hispanic/Latinos (6%), and Native Americans (< 1%) continue to lag behind Whites (67%) and Asians (21%) in their rates of participation in science, technology, engineering, and mathematics (STEM) fields. Studies done by the Higher Education Research Institute at the University of California Los Angeles demonstrated that both social and academic adjustment to college affect participation and success in STEM fields. UIM groups were shown to be more affected by concerns about their abilities to finance college, which made those students less likely to socially adjust and participate in STEM majors and health science research.
It has been suggested that an enhancement of racial diversity within medicine may reduce health disparities by enhancing care for diverse patient populations. In order to address the issues of health disparities, it is important that we widen our focus to include many causative factors in the low number of UIM students. Diversity strategies that not only target recruitment of underrepresented minority students, but also provide a strong pipeline of mentorship, camaraderie, and guidance are imperative to ensure the successful retention of students. Additionally, resources to aid students in managing the social difficulties they may encounter can enhance their well-being and allow them to focus on the arduous task of learning how to heal patients.

**STATEMENT OF POSITION AND RECOMMENDATIONS**

The Student National Medical Association acknowledges that mental health instability plagues underserved communities, making it a growing public health concern. However, in order to maximize services provided by the healthcare system to address the psychological well-being of ethnic and minority populations, we must first establish lasting and trusting relationships at the individual level. Addressing social determinants of health, systems of power, and education can provide mechanisms to overcome the aforementioned barriers. For this reason, SNMA supports the following recommendations:

1. **Address gaps in cultural understanding among the health workforce.**
   a. Medical Schools should employ an evidence-based approach in cultural competency education and training for physician educators and develop initiatives to emphasize the importance of mentoring minority students and encouraging their participation.
   b. Enhanced exposure for trainees to practices in cultural competency and implicit bias (pre-service and in-service) is key in ensuring the healthcare workforce is adequately informed

2. **Encourage increased collaboration between community mental health partners and local organizations.**
   a. Communities of color often find comfort and refuge among faith communities, local advocacy groups, and social gatherings. It's imperative for mental health
affiliates and service providers to be connected with the communities they intend to serve.

b. Collaboration also involves active engagement and inclusion of community members within service-providing entities. For example, establishing community advisory boards or giving space for community voices in systems-level decision making.

3. **Increase diversity among providers to reflect the patient population served.**
   a. Diversity within the workforce is a focused method of helping reduce implicit cultural biases and provide comfort for patients of diverse backgrounds. Of note, diversity includes but is not limited to race, ethnicity, sexual orientation, gender identification, primary language spoken, disability (or lack thereof) and country of origin.

4. **Leverage community involvement in mental health initiatives to normalize mental health and facilitate conversations around the use of mental health services.**
   a. Societal stigma and associated imposter syndrome as described above is best addressed through community norming work.

5. **Conduct frequent community needs assessments to increase an understanding of the population and depict a clear picture of barriers.**
   a. Community needs assessments done with and alongside communities are key in illuminating inequities in resource allocation, health care delivery, and community need.

6. **Develop strategies for implementing frequent mental health assessments.**
   a. Strategies may include creating new or amending existing institutional policies within academic institutions, clinical settings or other health-focused workplaces to designate the type and frequency by which patients and communities are assessed.
   b. Another strategy would be developing a survey that is given every time a patient establishes care within a primary care setting that elucidates both their current status and how they feel about mental health in general. Giving space for a patient to decide what is most important to them enhances the treatment relationship and encourages their input and action within their own recovery.
7. **Designate incentives to align mental health care resources with community needs.**
   
   a. Under a behavioral economics framework, financial incentives through insurance benefits or penalties for lack of action may help in this alignment. For example, full coverage under public insurance (Medicaid and Medicare) for mental health care services and incorporation of mental health care into existing federally qualified health centers.

8. **Establish proven pipeline programs such as Opportunity Program, Aspiring Docs, and Summer Medical and Dental Education Program within every medical institution to address the lack of diversity within the health workforce.**
   
   a. As recommended by the AMA and within the AAMCs report, *Altering the Course: Black Males in Medicine*, we must advocate for increased representation of underrepresented minorities in medicine nationwide to encourage more applicants to apply and become accepted. In order to for students to thrive, we must provide more examples, above, below, and at peer level, of students of minority background with common experiences and common goals.

   b. Medical institutions should work with the community and partner with highly diverse schools to adopt strategies that have exhibited success.

9. **Advocate for Medical Schools to build and enhance a pipeline of resident and attending mentorship.**
   
   a. Mentorship is critical to success in populations that are broadly underexposed to careers in the field of medicine. In addition, establishing a sense of community, and decreasing isolation enhances the mental health of students.

   b. Additionally, medical minority organizations should collaborate with admissions offices to establish recruitment plans and serve as a resource to maximize the number of UIM medical students graduating from US Medical Schools.\(^\text{54}\) It must be noted that a holistic review of one’s application be considered when admitting applicants: an UIM should not be excluded based on one standardized exam or predetermined cutoff.\(^\text{7}\)

10. **Continue the discussion around free, encouraged/mandatory counseling sessions for all medical students.**
a. This effort seeks to end the stigma associated with seeking and using mental health assistance programs on academic campuses. Reducing stigma gives students an opportunity to voice any concerns that may arise throughout their educational career and possibly inhibit the successful completion of their degree.

b. Several schools have partnered with third party clinics to provide additional confidentiality for students. Holding outside counsel sessions independent of school affiliated hospitals/clinics helps ensure anonymity. In tandem, if treatment must be provided by attending physicians, residents, and student peers at their respective schools, no electronic medical records should be maintained. Likewise, any notation placed on academic records must remain confidential and have no bearing on administrative decisions associated with the student’s career.

c. In addition, by taking cost out of the equation, students may feel more at ease to seek treatment and talk about their mental issues.

11. Specialized counseling should be offered for dual degree students.

   a. Graduate students (e.g., MD/PhD, MD/MBA, MD/MPA, etc.) constantly express the need for more mental health supports in their programs due to the length of programs and uncertainties associated with degree completion.
REFERENCES


20. The Henry J. Kaiser Family Foundation. Distribution of Allopathic Medical School Graduates by Gender.


