Educating Health Professionals to Address the Social Determinants of Mental Health: Proceedings of a Workshop (2020)

DETAILS

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The Social Determinants of Mental Health

Highlights

- The social determinants of mental health (SDMH) deserve equal attention to the social determinants of physical health because mental health conditions have high costs, prevalence, morbidity, and mortality, and they have been neglected in conversations about social determinants. (Shim)
- All policies have an impact on people's mental and physical health, and health professionals have a responsibility to advocate for policies that will improve health. (Shim)
- Contained in National Academies report A Framework for Educating Health Professionals to Address the Social Determinants of Health was the need to emphasize experiential learning that is interprofessional and cross-sectoral. (Fisher)
- Both learners and practitioners need to practice in such a way that acknowledges and addresses the SDMH, or the health professions will never get beyond where they are now. (Klink)
- One of the challenges [to using a team-based model of care] was trying to change the dynamics of a team of health professionals who are used to working parallel to each other in silos. Policy issues will have to be addressed if a sustainable interprofessional environment that bridges academia and practice is to be created. (Carter)
- As educators seek to bring the social determinants of mental health into the classroom, it is important that they examine their own biases, conscious and unconscious, in order to better guide their students toward addressing disparities that can increase joy in their patients' lives. (Crewe)

This list is the rapporteurs' summary of the main points made by individual speakers (noted in parentheses), and the statements have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine. They are not intended to reflect a consensus among workshop participants.

Social Determinants

Following the brief opening remarks, Kennita Carter then welcomed the first speaker, Ruth Shim, a professor in cultural psychiatry at the University of California, Davis, who co-authored a publication titled, "Addressing the Social Determinants of Mental Health: If Not Now, When? If Not Us, Who?" (Shim and Compton, 2018).

During her residency training, Shim said, she noticed something interesting about her patients. She rotated between Emory University Hospital, where many patients are financially well off, and Grady Hospital in downtown Atlanta, where there is a high percentage of homeless and low-income patients. Patients were admitted with the same mental health issues, and they received the same care and services. However, patients from Emory University Hospital tended to get better, while patients from Grady Hospital did not, and Shim "could not figure out what

was happening." This experience, Shim said, took her on a journey to understand this disparity and eventually led her to the social determinants of mental health (SDMH).

Before delving deeply into the SDMH, Shim wanted the workshop participants to understand the basic tenets of the social determinants of health (SDH). She defined SDH as "those factors that impact upon health and well-being: the circumstances into which we are born, grow up, live, work, and age, including the health system" (CSDH, 2008). She added that these factors are shaped by the distribution of money, power, and resources and that the distribution of these resources is influenced by policy choices that are made at global, national, and local levels.

The SDH, Shim said, are predominantly responsible for the health disparities and health inequities that are seen both within and between countries. These terms—disparities and inequities—are often confused, although they are distinct concepts:

> **Health disparities:** differences in health status among distinct segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities.
> **Health inequities:** disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity.

Health disparities, Shim said, are not associated with a value judgment; they are merely differences in health outcomes between groups. Health inequities, on the other hand, are unjust, avoidable, and due to systemic issues and policy choices. Shim illustrated health inequities with an example from Health Canada illustrating how a toddler's "Why?" questioning can illustrate the social determinants of health (see Box 2-1). This story, said Shim, shows how the boy's hospital visit has far more to do with social and economic circumstances—which are related to policies and practices—than physical or medical issues.

BOX 2-1
Social Determinants and Health Outcomes

Why is Jason in the hospital?
Because he has a bad infection in his leg.
But why does he have an infection?
He has a cut on his leg and it got infected.
But why does he have a cut on his leg?
He was playing in a junk yard next to his apartment building and fell on some sharp, jagged steel there.
But why was he playing in a junk yard?
His neighborhood is run down. Kids play there, and there is no one to supervise them.
But why does he live in that neighborhood?
His parents can't afford a nicer place to live.
But why can't his parents afford a nicer place to live?
His dad is unemployed, and his mom is sick.
But why is his dad unemployed?
Because he doesn't have much education, and he can't find a job.
But why….?

SOURCES: Presented by Ruth Shim on November 15, 2019; Government of Canada, 2013.

When considering how social determinants influence health, Shim said, the "ultimate marker of health" is mortality. There are a number of factors that influence a person's likelihood of premature mortality, including genetic predisposition, behavioral patterns, health care, environmental exposures, and social circumstances (see Figure 2-1). However, Shim said, nearly all of these factors are ultimately related to social determinants. Exposure to environmental toxins depends in large part on the neighborhood in which a person lives and on the availability and affordability of safe housing. Whether or not a person has access to high-quality health care depends on income, insurance, and proximity to high-quality facilities. Behavioral patterns—such as exercise, diet, and smoking—are influenced by such factors as the availability of healthy foods and access to a safe place to exercise. Even genetic predisposition can be influenced by social determinants; for example, trauma experienced by parents and grandparents may change

the genetic and epigenetic makeup of their descendants. While some of these determinants may be due in part to individual choices, Shim said, "the choices we make are based on the choices we have."[1] People who have limited options are less likely to be able to make good choices.

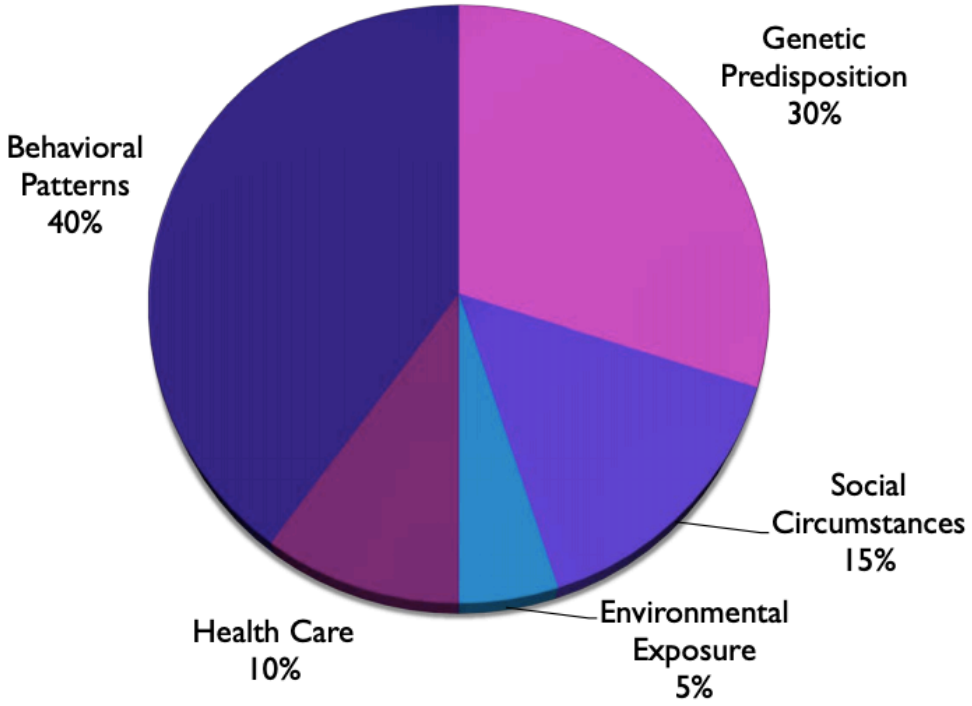

FIGURE 2-1 Determinants of health and their contributions to premature death.
SOURCES: Presented by Shim on November 14, 2019; created from data in McGinnis et al., 2002.

This influence of the SDH on mortality, Shim said, can be starkly seen in the different life expectancies of people living in the Washington, DC metro area (see Figure 2-2). People who live in Montgomery, Fairfax, and Arlington counties—only a few miles away from the city center—have an average life expectancy of 84 to 86 years, while people living in the District of Columbia and in Prince George's County can expect to live to only 78 years, on average (RWJF, 2016). This demonstrates, Shim said, that even small differences in social determinants such as geography can reflect large differences in health outcomes.

[1] Quote originally attributed to David Williams, M.D.

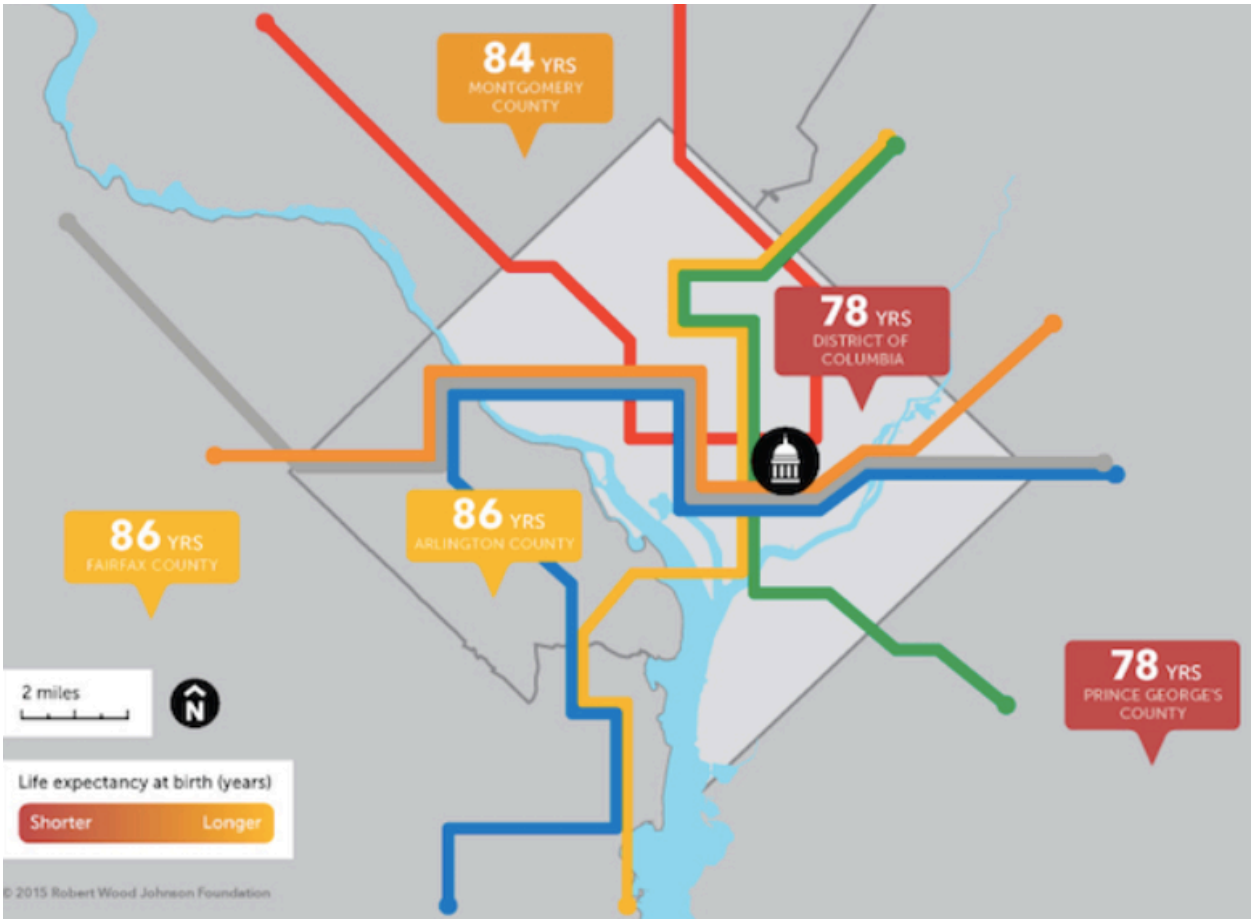

FIGURE 2-2 Life expectancies in the DC metro area.
SOURCES: Presented by Shim on November 14, 2019. RWJF (2016). Copyright 2016. Robert Wood Johnson Foundation. Used with permission from the Robert Wood Johnson Foundation.

Understanding how social determinants lead to health inequities, Shim said, requires attention to the concept of intersectionality. Intersectionality, a term coined by Kimberle Crenshaw in 1989 to explain the oppression of African-American women, refers to the way in which people have multiple overlapping and interacting identities and specifically to the fact that individuals who are members of multiple disadvantaged groups have unique and often compounded disadvantages. For example, a person with mental illness who is also African-American and female may face unique challenges that are not addressed by efforts to address the singular issues of mental illness, racism, or sexism (Crenshaw, 1990). Shim said that medical students are often taught to "reduce somebody down to one individual, one concept, or one idea," but it is critical to acknowledge the complexities of people and the intersectionality of their various identities.

Mental Health

The social determinants of mental health are not distinctly different from the social determinants of health in general, Shim said. However, Shim noted that they deserve special emphasis for three reasons. First, mental illnesses and substance use disorders are highly prevalent and highly disabling. Second, mental health conditions are high-cost, high-morbidity,

and high-mortality illnesses. Third, mental health conditions have been largely neglected in conversations and interventions relating to the SDH.

As discussed above, social determinants—such as geography, access to health care, and environmental conditions—are highly influential on health, Shim said, and even seemingly small differences can result in major differences in outcomes. Mental health is influenced by these same social determinants, and the outcomes can be even more severe, she said. People with serious mental illness, Shim said, die on average up to 25 years earlier than the general population. These deaths are not necessarily due to suicide or violence, she said; people with serious mental illness often die of the same causes as everyone else, just earlier. This burden is particularly heavy on people of racial and ethnic minority groups. According to a Surgeon General report, these groups have less access to and availability of care, they receive generally poorer-quality mental health services, and they experience a greater disability burden from unmet mental health needs (HHS, 2001). Poor mental health outcomes, Shim said, have been associated with multiple social determinants, including adverse childhood experiences, discrimination, poverty, unemployment, income inequality, food insecurity, and the built environment.

Mental health disorders are particularly difficult to separate from social determinants, Shim said, because conditions are "filtered through the lens of society" and diagnoses are, in large part, based on observations and interpretations of behavior. Behaviors may have different underlying reasons, but these reasons are often not considered when making a diagnosis. For example, Shim said, a child who is hyperactive and disruptive in class may be diagnosed with attention deficit hyperactivity disorder (ADHD). However, for some children these behaviors may be more readily explained by the fact that the child is hungry. Social determinants such as food insecurity may not only be associated with mental health disorders, but may in fact be confounded with them. Sandra Lane, a professor of anthropology and public health at Syracuse University, added a similar observation about diagnoses of behavioral disabilities in children in Syracuse, New York. Syracuse has high rates of violence, and school days are sometimes interrupted by active shooter situations. The schools that have the highest rates of gunshots nearby are also the schools with the highest rates of diagnosed behavioral disabilities, Lane said. However, Lane and her colleagues believe that many of these behavioral disabilities—often diagnosed as ADHD—are actually diagnoses of posttraumatic stress disorders that are due to the violent environment in which the children live and study. Shim concurred and stressed that psychiatric disorders are defined and diagnosed through the lens of experts and their experiences, and these experts may not be familiar with the day-to-day lived experiences of the people who receive these diagnoses.

Social Justice, Public Policy, and Social Norms

Addressing health inequities due to social determinants requires addressing the underlying policies, structures, and resource allocation that create and perpetuate the social determinants. Shim said that mental health inequities are driven by unjust economic policies and practices and that these policies and practices are based on society's collective judgment about "which people are worth advantages and . . . which people are worth being disadvantaged." The concept of social justice relates to how resources (i.e., advantages and disadvantages) are distributed in society and attempting to ensure that resources are allocated equally and fairly among all members. Shim provided two ways to think about the concept of social justice. First,

David Miller (2003) described it as the distribution of advantages and disadvantages in society and the ways that resources are allocated to people by social institutions. John Rawls (2003) focused on assuring the protection of equal access to liberties, rights, and opportunities and on taking care of the least advantaged members of society.

Shim cautioned, however, that ensuring equal distribution of resources and opportunities is not as straightforward as it may seem. Rather than striving for equality, in which all people receive the same resources or care, we should strive for equity, in which people get the "specific thing that they need to be successful." Shim showed a figure to demonstrate the difference between equality and equity, noting that the people in the illustrations have different needs from one another and therefore require different resources to be successful (see Figure 2-3).

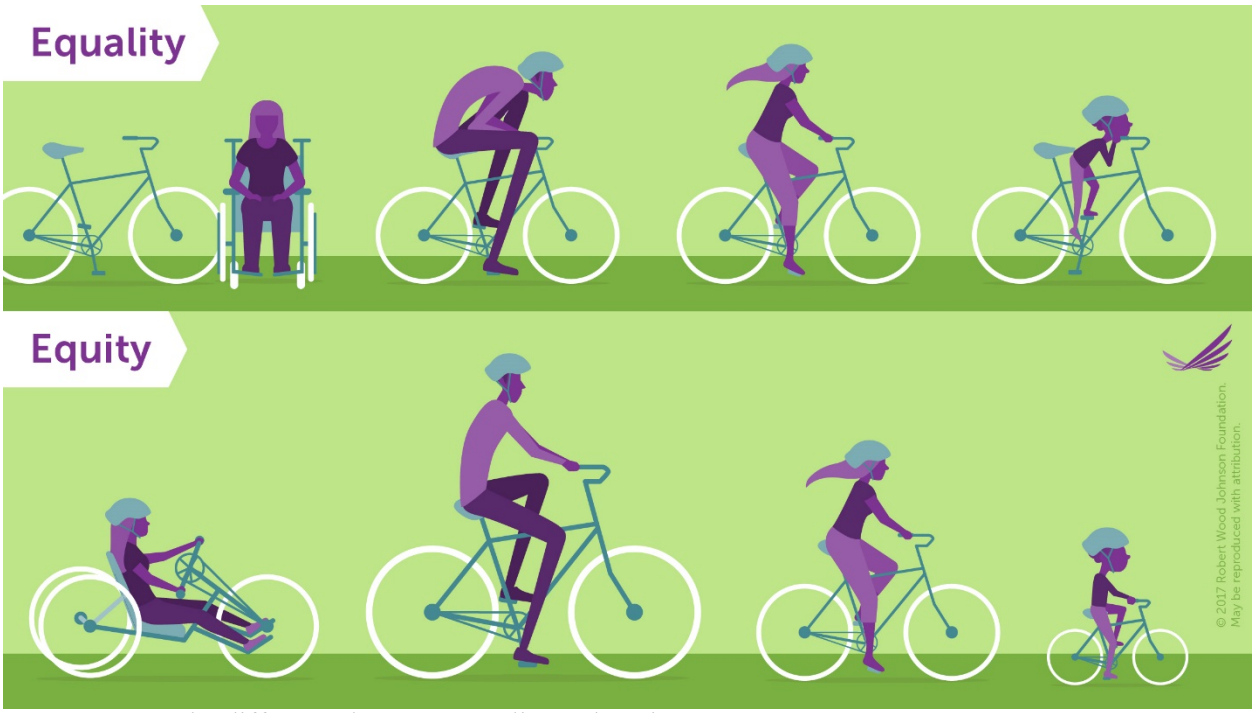

FIGURE 2-3 The difference between equality and equity.
SOURCES: Presented by Shim on November 14, 2019. RWJF (2017). Copyright 2017. Robert Wood Johnson Foundation. Used with permission from the Robert Wood Johnson Foundation.

Equity in the distribution of resources and opportunities—and by extension, health equity—cannot be achieved, Shim said, without shifts in social norms and public policy. While politics and medicine may seem distinct, Shim said, they are anything but. As pathologist Rudolph Virchow famously said, "Medicine is a social science, and politics is nothing else but medicine on a large scale." The mechanism by which political choices affect health outcomes, Shim said, can be seen in Figure 2-4. Social norms and public policy influence one another, and both together affect how society chooses to distribute resources. This distribution of resources affects social determinants such as housing and food security, access to health care, environmental exposures, education, employment, and interaction with the criminal justice system. These determinants, in turn, affect behavioral risk factors, physical and mental stress, and the options that people have at their disposal. These factors then affect mental and physical health outcomes.

FIGURE 2-4 Types of social determinants of mental health and their causes and consequences.
SOURCES: Presented by Shim on November 14, 2019; created by Ruth Shim, M.D., M.P.H., and Michael T. Compton, M.D., M.P.H.

Given the intimate relationship between politics and health, Shim said, health professionals have a responsibility to advocate for policies that improve the SDH. "All policies are health policies,"[2] Shim said. All policies have an impact on people's health and mental health, yet "we don't always consider what that impact is before we enact laws." Moving the needle on social determinants of mental health will require health professionals to step outside of their professions and to collaborate across sectors in order to influence and form relationships with elected officials. Shim said that in her profession of psychiatry, many psychiatrists want to stay within the field and only work with other psychiatrists. But to have a true impact, they really need to work with groups outside of the health professions such as police officers, teachers, lawyers and city planners. In addition to working on the local level to affect policy, health professionals need to work on the federal level to increase spending for social care programs. The United States, Shim said, is the only developed country that spends more money on health care than on social care, yet it has poorer health outcomes than other developed countries (APHA, 2020).

[2] Widely used quote; not original to Shim.

In concert with political advocacy, Shim said, there is a need to change the social norms concerning mental health, inclusion, and mutual respect. "We need to create social norms of tolerance, acceptance, and inclusion," she said, and speak up when these norms are not being respected. When people are being "exclusionary, racist, sexist, homophobic, transphobic," she said, "it's on all of us to be the person that speaks up in those situations." Shim closed with a quote from American writer Audre Lorde: "When we speak, we are afraid our words will not be heard or welcomed. But when we are silent, we are still afraid. So it is better to speak."

From Knowledge to Action

In the opening workshop remarks made by Carl Sheperis, the dean of the College of Education and Human Development at Texas A&M University–San Antonio, he acknowledged that to guide current and future health professionals concerning their roles in influencing policy-level conversations on the SDMH, health professions educators must first have foundational knowledge concerning the SDH and mental health and on a plan for implementing the educational activity (meso level). To this end, the workshop participants engaged in two sessions targeted at faculty and other health professional educators to explore effective educational methods based on the National Academies consensus study *A Framework for Educating Health Professionals to Address the Social Determinants of Health* (NASEM, 2016).

Julian Fisher, a research associate at the Peter L. Reichertz Institute for Medical Informatics at Hannover Medical School in Germany, presented the framework that was developed by the 2016 consensus study committee and published in that report. The National Academies report also referred to the need to emphasize experiential learning that is interprofessional and cross-sectoral. The next set of workshop speakers addressed this issue. Kathleen Klink, a senior advisor in the Office of Academic Affiliations at the Department of Veterans Affairs (VA), and Sandra Crewe, the dean of the School of Social Work at Howard University, led participants in a discussion to identify existing and potential opportunities for interprofessional, experiential education on the social determinants of health. More specifically, their focus was on educating the educator on an interprofessional approach to addressing the SDMH through education and action.

FRAMEWORK FOR SDMH EDUCATION

Social determinants of mental health, Fisher said, can be compared to the slope of a hill. Achieving good health outcomes requires pushing a rock up the hill, but the steeper the slope, the harder it is to push (see Figure 2-5). For individuals who have a good income, stable employment, higher education qualifications, secure housing, and good access to food, the slope is shallow, and it is fairly easy to push the rock. For individuals who face greater challenges because of poverty, lack of education and employment opportunities, and lack of access to healthy options, the slope is steep, and it is difficult or nearly impossible to hold the rock steady or push it up the slope. When health professionals ask individuals to make behavioral changes for better health (e.g., eat better food or exercise regularly), people who are already struggling to push the rock will have a much harder time making these changes. In order to truly care for their patients and promote their well-being, health professionals must seek to understand and address the "hills" that their patients are facing. Jody Frost, the president of the National Academies of Practice, noted, however, that many of these factors are interrelated and interdependent like cogs

in a system and that changing one could have unintended and unforeseen consequences. For example, she said, if a person moves due to poor housing in his neighborhood, the problem of environmental exposures in housing will likely be fixed. However, if as a result of moving the person ends up far from his family, community, and support structures, other problems have been created. Addressing the SDH and health disparities requires a nuanced and holistic view of an individual's social determinants, including how positive and negative social determinants may be intertwined and interdependent, as well as their resources.

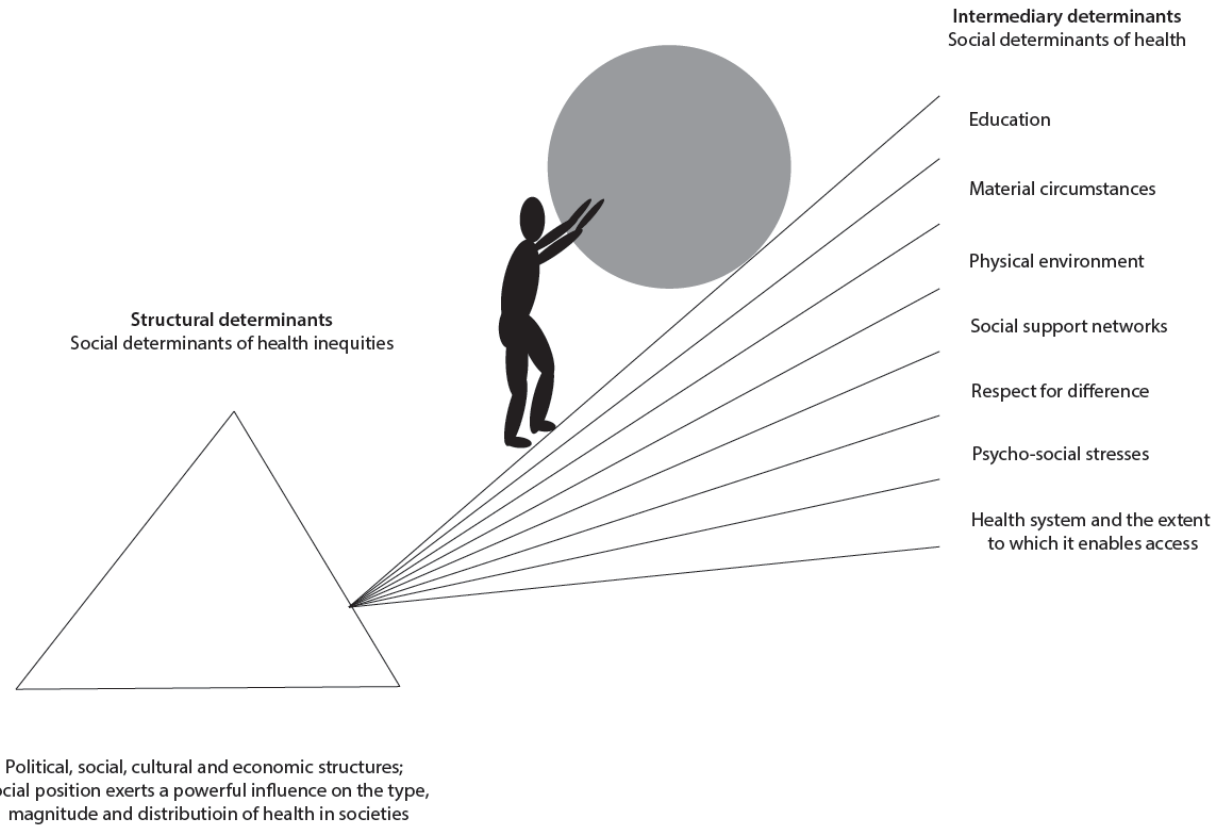

FIGURE 2-5 The impact of social determinants.
NOTE: Intermediary determinants listed (environmental hazards, food/nutrition, housing, employment, education, poverty) based on the World Health Organization Commission on the Social Determinants of Mental Health.
SOURCE: Presented by Fisher on November 14, 2019.

Ruth Shim's presentation, Fisher said, clearly demonstrated that it is not sufficient to treat people's illnesses without changing the conditions that made them sick in the first place. This suggests an obvious corollary, he added. Like during treatment, it is also not sufficient to educate and train health professionals without having them understand the underlying causes of illness, or the so called "causes of the causes." Unfortunately, educating health professionals to understand and act upon the social determinants of mental health is not as simple as adding a short module to the curriculum. If, as Shim explained, a large proportion of the contributors to morbidity and mortality are due to social determinants, not to health care, then health professions education must pay an equal amount of attention to the SDH. SDH education, Fisher underscored, must be "mainstreamed" into the curriculum.

Fisher then presented the National Academies committee's framework (see Figure 2-6). The framework is meant to map out a way to "mainstream" the SDH not just into curricula but also into the lifelong learning journey of a health professional. Zohray Talib, the senior associate dean for academic affairs and the chair of medical education at the California University of Science and Medicine, added to the conversation, saying that while the framework may be centered around the individual health professional's commitment to lifelong learning, it also is framed by the larger systems-level determinants of education, organization, and community. Incorporating SDH into the health professions will require commitment and restructuring of the educational system, collaboration and communication with the local community, and institutional support from organizations to incentivize and support the integration of the SDH into health professions education and practice, she said.

FIGURE 2-6 Framework for lifelong learning for health professionals in understanding and addressing the social determinants of health.
SOURCES: Presented by Fisher on November 14, 2019; NASEM, 2016.

PUTTING EDUCATION INTO ACTION

There is a chicken and an egg issue with education and practice, Klink said. The educational system gives students the skills and knowledge they will bring into practice, but at the same time practice drives what students are learning, particularly in clinical education. Regarding the social determinants of health, Klink said, "without high-quality practice, clinical

education is not going to evolve." Both learners and practitioners need to "practice in such a way that [they are] acknowledging and addressing the social determinants of mental health," or the health professions will never get beyond where they are now, she said. Klink gave an example of an interprofessional practice model at the VA that was created in 2010 to address some of the issues discussed at the workshop and which required changes in both practice and education. The Patient Aligned Care Team (PACT) is a team-based model of care in which there are "teamlets" made up of a primary care provider and a nurse as well as an administrative staffer. A broader PACT unit—which includes providers such as pharmacists, social workers, and mental health specialists—provides support to the teamlets. Each teamlet is assigned a group of patients, and the entire PACT team works together to meet the patients' needs, from finding durable medical equipment to setting patients up in community living centers.[3]

In 2011 the VA established the Centers of Excellence in Primary Care Education; five of these centers were selected to teach the PACT model to learners. After a few years of using this model, the VA found that patient outcomes and measures of care were either the same as traditional care or slightly better. In addition, the learners were happy with their experience and felt they were very integrated into their teams. Carter worked in a PACT model and shared her experiences. One of the challenges, she said, was trying to change the dynamics of a team of health professionals who are used to working parallel to each other in silos. For example, it was challenging to convey the idea of dynamic leadership in which each member of the team makes important contributions and the leader of a decision-making process might be any member of the health care team, who could be, but does not need to be, the physician.

Klink and Carter asked workshop participants to share examples of educational models that are or could be useful for preparing learners to address the social determinants of mental health, particularly interprofessional models. In response, Fisher described a promising approach used at Hannover Medical School, Germany called The Patient University. This model uses patients with chronic disease as lifelong learning educators and resource experts on their own diseases and conditions, treatments, and social determinants. This "breaks up the power dynamic" by showing students with and from whom they can learn, and what they can learn from patients through a people-centered learning approach. Each intersection reinforces mutual learning and understanding, with the patients taking new co-created knowledge back out to the community and becoming health educators for others. This unique approach to interprofessional education for collaborative practice, Fisher said, expands the traditional interprofessional team to include the patient and centers the care discussion on the expressed needs of the patient.

Challenges

Workshop participants divided into small groups to further discuss innovative models with an emphasis on the challenges of implementing interprofessional education focused on social determinants. Caswell Evans, the associate dean for prevention and public health sciences at the University of Illinois at Chicago College of Dentistry, said that at his university, interprofessional teamwork and education are highly regarded and that leadership and the faculty have a sincere intent to bring this about. However, in actual practice, this commitment is manifested in just 1 day on the undergraduate health sciences campus, where students and faculty get together to discuss case studies in a multidisciplinary way. Evans explained that this

[3] For more explanation of interprofessional education, see Chapter 5 of the report.

day of interprofessional education is repeated annually but has not expanded into any broader efforts to regularly and intentionally bring together learners from different disciplines.

Sheperis reported that many participants at his table felt that many students are participating in a rich world of cross-disciplinary, integrated team training and applied practice opportunities in the academic environment. However, he said, once they move into the professional practice environment, there is a re-segregation of professions. A bridge between the academic and professional experiences is needed in order to continue the integrated team care approach initiated in academia, he said. Similarly, Frank Ascione, a professor of clinical and social and administrative sciences at the University of Michigan College of Pharmacy, said that his table discussed the fact that at the University of Michigan Medical School there is a longitudinal, multidisciplinary approach to education that brings together students from 14 different disciplines to share perspectives. However, when students go into the community, the multidisciplinary structure is no longer in place because of organizational, infrastructural, and funding barriers. For example, students are usually mentored or supervised by a practitioner from their own fields, rather than a team approach being used. Carter added some context to these two comments, noting that reimbursement is a major barrier to interprofessional practice. There are disparities in how much different professionals are paid; there are multiple types of reimbursement (e.g., Medicare and Medicaid, commercial insurance, private pay, etc.); there are often separate systems for physical, behavioral, and oral health; and coverage for services and providers varies state to state. These policy issues, Carter said, will have to be addressed if a sustainable interprofessional environment that bridges academia and practice is to be created (see Appendix D for the background paper presented at the planning meeting for bridging the education-to-practice divide in addressing the SDMH).

Potential and Existing Educational Activities

In the second half of the session, Crewe asked workshop participants to take a few minutes to discuss ideas for effective interprofessional educational activities specifically related to the SDH. Afterward, a spokesperson for each set of table discussants reported on the main messages that were discussed by participants in his or her group. General ideas were discussed first, and then specific existing programs were described. Participant Candance Willett said that health educators often use buzzwords like “community involvement” and “community engagement,” but “we are really not on the ground like we should be.” Doing hands-on work in the community—which means really getting to know the residents and developing a relationship with them—is invaluable to the educational experience, she said. Another spokesperson reported that his group discussed identifying natural opportunities for interdisciplinary learning. For example, instead of students from nursing, physical therapy, and occupational therapy all holding separate anatomy and physiology classes, “why not put them all in the same room?” This model could be effective if dialogue is purposefully encouraged among the health professions and could also be used for community learning opportunities—for example, by having a community member or organizational leader come in and discuss a topic of relevance to the community. As part of these interdisciplinary classes, students could debrief and discuss the material together, thus exposing each other to different perspectives, and perhaps could even discuss how they personally relate to the material. The spokesperson said interactions like these are “where we begin to change the culture.”

Refugee Health and Gun Violence

There are two existing programs at Syracuse University in New York that are interdisciplinary and community-based, Sandra Lane said. The first is a course on refugee health, which matches a refugee family with a student from Syracuse University and a health professions student from SUNY Upstate Medical University. The students, who come from a variety of health and non-health disciplines, work with the families for a semester and conduct home visits. The second program brings students from Syracuse University into the community to hear about gun violence and its impact on families and the community. Unfortunately, Lane said, there is very little support for these programs institutionally. The existence of the programs relies on the perseverance and hard work of community members and faculty members. See Chapter 5 for a further discussion of these programs.

Central Valley Bus Tours

The University of California (UC), Davis, Shim said, runs an activity called the Interprofessional Bus Tour of the Central Valley that was created by Jann Murray-García, M.D., M.P.H.. The tour is open to students and leaders from multiple health professions schools, including nursing, medicine, and public health. The tour takes participants into the Central Valley community, where they learn from community members and leaders about the history of the area and how health inequities have developed. One of the fears in such an activity, Shim said, is that it may exacerbate divisions between the students and the community and create a negative perspective about the community. Fortunately, Shim said, many of the students that attend the health professions schools at UC Davis are from the community itself and participate in the bus tours so that they can share their perspective and experiences. In the UC Davis environment, this model of education works primarily due to the commitment of the community leaders and the student advocates dedicated to enhancing the education of peers and colleagues.

Guided Assessments

Reamer Bushardt, a professor and senior associate dean in the George Washington University School of Medicine and Health Sciences, shared an example of a powerful interprofessional training experience that he had during a rural family medicine clerkship. The training involved teams of students from different health professions working with patients with mental illnesses and substance use disorders. As learners interviewed and conducted assessments with patients in an outpatient primary care setting, an experienced clinical psychologist was in a control room watching the assessment and could talk to the learner through a device in the learner's ear. This allowed the learner to have an authentic learning experience without "fumbling through" the clinical interaction, because the psychologist would help the learner to understand the nuances of assessment, interpret patient feedback, and probe beyond the clinical into social factors. Bushardt said, "This experience changed my clinical approach to individuals with mental illness, demonstrated the importance of discussing social determinants of health, and instilled a deep appreciation for the expertise of mental health counselors and therapists."

Camden Coalition Hotspotting

Jeffery Stewart, the senior vice president for interprofessional and global collaboration at the American Dental Education Association, said that his group discussed the Camden Coalition's hotspotting programs. These programs, which are now all over the country, are designed to help people and communities with both health issues and non-health issues. At the beginning of the development of a program, institutional representatives go out into the community and engage with various organizations and individuals about what the community needs and how the institution could help. Interprofessional teams of learners and other health professionals go into the community, learn from the community, and assist where they can. For example, Stewart said, a dental student might help a community member access housing assistance by getting in touch with the appropriate government agency. The community is put at the center of the program and guides its development and implementation.

Moving forward

There were several takeaways from this discussion, Crewe said. First, it is essential to invest in team approaches. "This is not a silo activity that we are engaged in," she said. Second, the diversity of the team matters because "new ideas emerge when there are individuals who don't just look like you." Health professional educators need to engage in interprofessional dialogue about the social determinants of health that allows for the voices of many different perspectives and communities. Third, "good things take time." Working on the social determinants of mental health is not a one-time endeavor; it is a process that takes time and effort and requires in-depth engagement among the community, academia, and practice. Finally, Crewe said, social determinants are relevant not only to patients, but also to educators and practitioners. As educators seek to bring the SDMH into the classroom, it is important that they examine their own biases, conscious and unconscious, in order to better guide their students toward addressing disparities that can increase joy in their patients' lives.

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