**APA Resource Document**

# Social Determinants of Mental Health in Children and Youth

Approved by the Joint Reference Committee, 2022

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." — *APA Operations Manual*.

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## Introduction

The field of psychiatry is at a historic precipice in advancing a more equitable society and mental health care system. While the predominant medical model has given us many triumphs and advances, psychiatrists have an opportunity to catalyze change within the dynamic and complex process of social causation. A deeper understanding of the interplay between social determinants and mental health conditions is critical and is a core skill of structural competency. In their book *The Social Determinants of Mental Health*, which provided an extensive and detailed overview of the topic, Compton and Shim closed the final chapter with a "call to action" for behavioral health professions and highlighted specific action items.[1] This APA resource document responds to that "call to action" by giving additional practical tools for child- and youth-serving professionals, organizations, and institutions. The recommendations in this document also align with the Strengthening Families Protective Factors framework developed by The Center for the Study of Social Policy (CSSP), which identifies the following as key areas for focus in increasing child and family resilience: ensuring concrete supports are available, cultivating caregiver resilience, increasing caregiver knowledge of parenting and child development, strengthening family social connections, and supporting the social and emotional competence of the child so they can form positive relationships and regulate emotions.[2]

## Definitions

| Term | Definition |
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| **Social Determinants** | Nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.[3] |
| **Commercial Determinants** | Conditions, actions, and omissions by corporate actors that affect health. They can have beneficial or detrimental impacts on youth mental health because youth are influenced by advertisements and celebrity promotion of material. For example, the marketing of electronic nicotine delivery systems and cannabis to youth risks activating highly sensitive and still-developing pathways in teens' brains. There are also positive contributions to public health made by the private sector, e.g., ensuring |

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| | living wages, paid parental leave to improve child health outcomes, sick leave, and access to health insurance.[4] |
| **Environmental Determinants** | Global, regional, national, and local environmental factors that influence human health via physical, chemical, and biological elements external to a person, and all related behaviors. For example, exposure to toxic chemicals can lead to chronic and often irreversible health conditions such as neurodevelopmental problems. Climate change, and other natural and human-made stressors, influences health by disrupting physical, biological, and ecological systems.[5] |
| **Positive Youth Development** | An intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support they need to build their leadership strengths.[6] |
| **Adverse Childhood Experiences (ACEs)** | Potentially traumatic events that occur in childhood, including, but not limited to, experiencing violence, abuse, or neglect; witnessing violence in the home or community; and having a family member attempt to die or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance abuse problems, mental health problems, or instability due to parental separation or household members being in jail or prison.[7] |
| **Caregiver** | The primary person who meets the child's physical needs more than anyone else; the primary person who consistently assumes the role of providing direct care and support to the individual so the individual can live successfully in the community, and who does so without compensation for providing such care.[8] |
| **Structural Competency** | A set of skills for clinicians to recognize ways that institutions, neighborhood conditions, market forces, public policies, and health care delivery systems shape symptoms and diseases, and to mobilize for correction of inequalities in these as they manifest both in physician-patient interactions and beyond the clinic walls.[9] |
| **Downstream Interventions** | Downstream interventions occur at the micro and/or individual level and mitigate the impacts of more distal socio-ecological determinants through efforts to increase equitable access to health care services. These are interventions that occur at the individual level and/or at the point of care; most mental health interventions occur downstream.[10] |
| **Midstream Interventions** | Interventions that generally occur at the community or organizational level and seek to reduce risky behaviors or exposures to hazards by influencing health behaviors or psychosocial factors and/or by improving material working and living conditions.[10] |

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| **Upstream Interventions** | Typically involve structural and system-level changes including interventions that reform or target fundamental social and economic structures and involve mechanisms for the redistribution of wealth, power, opportunities, and decision-making capacities in order to improve the health and mental health of populations.[10] For example, state and federal legislation, court decisions, regulatory processes, executive orders, etc. |
| **Resilience** | The process of multiple biological, psychological, social, and ecological systems interacting in ways that help individuals to regain, sustain, or improve their mental well-being when challenged by one or more risk factors.[11] Policy and systems of care are important for supporting resilience and promoting optimal conditions and environments. |
| **Trauma-Informed Care Approach** | A strengths-based systematic approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."[12] |

## Topical Overview

Diverse social, environmental, and commercial factors influence collective life experiences and the individual mental health of children, youth, and their families. Children and youth must be guaranteed a healthy environment where they can grow, be active participants of their communities, and set and fulfill life goals that align with their uniqueness and dignity. This is no easy task, as basic needs such as safety, education, financial resources, healthy caregivers, and optimal life exposures are the base upon which health and resilience can be built.

This resource document will focus on several domains of social determinants important for the mental health of children and youth: (1) access to basic social needs for the family, (2) caregiver health and parenting behavior, and (3) life experiences in the home and the community (Figure 1). Resilience is developed and fostered by optimal conditions in each of these domains. Advancing the resilience of children, youth, families, and communities is accomplished through understanding and optimizing the social determinants that promote healthy development, along with physical and psychological health. This document argues for a structurally competent approach to resilience that does not emphasize individual factors, such as grit and determination, but includes evidence-based interventions that address social determinants.

This resource document will highlight important domains of social determinants of mental health in children and youth, provide screening tools and questions, and delineate practical actions at different levels: downstream, midstream, and upstream interventions (Figure 2). At the downstream point of care, a major emphasis in this resource document is on medical record coding for problems, or "conditions," linked to social determinants of mental health. Specifically, practitioners are strongly encouraged to utilize the DSM-5-TR[13] as a resource for identifying an appropriate ICD-10[14] Z code for purposes of tracking, billing, clinical documentation, and treatment planning (Table 1). While the Z codes do not address underlying causes of problems, they label problems in descriptive terms and remain one systematic way to have social issues reflected in the medical chart. This document will also highlight specific groups that are disproportionately

impacted by the stated social determinants, usually due to their being members of disenfranchised and/or minoritized communities. Vignettes will emphasize the clinical relevance and provide examples of downstream, midstream, and upstream interventions.

**Figure 1.** *The relationship between resilience and the social determinants of mental health in children and youth. Access to basic needs, caregiver health and parenting behaviors, and childhood experiences in the home and community are domains of social determinants that are not mutually exclusive. They are points of intervention to promote resilience and prevent poor mental health outcomes.*

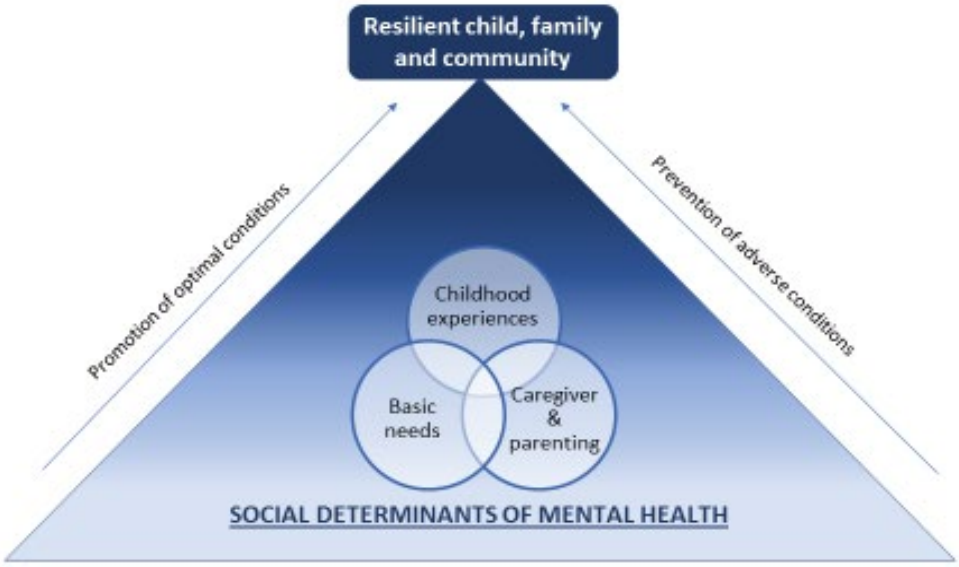


**Figure 2.** *The different levels of interventions. Upstream initiatives seek to create community-level impact and improve socioeconomic conditions through policy, laws, and regulations. Midstream initiatives seek to create individual-level impact by meeting individuals' social needs (screenings, referrals, protocols). Downstream efforts seek to create individual-level impact during clinical care.*

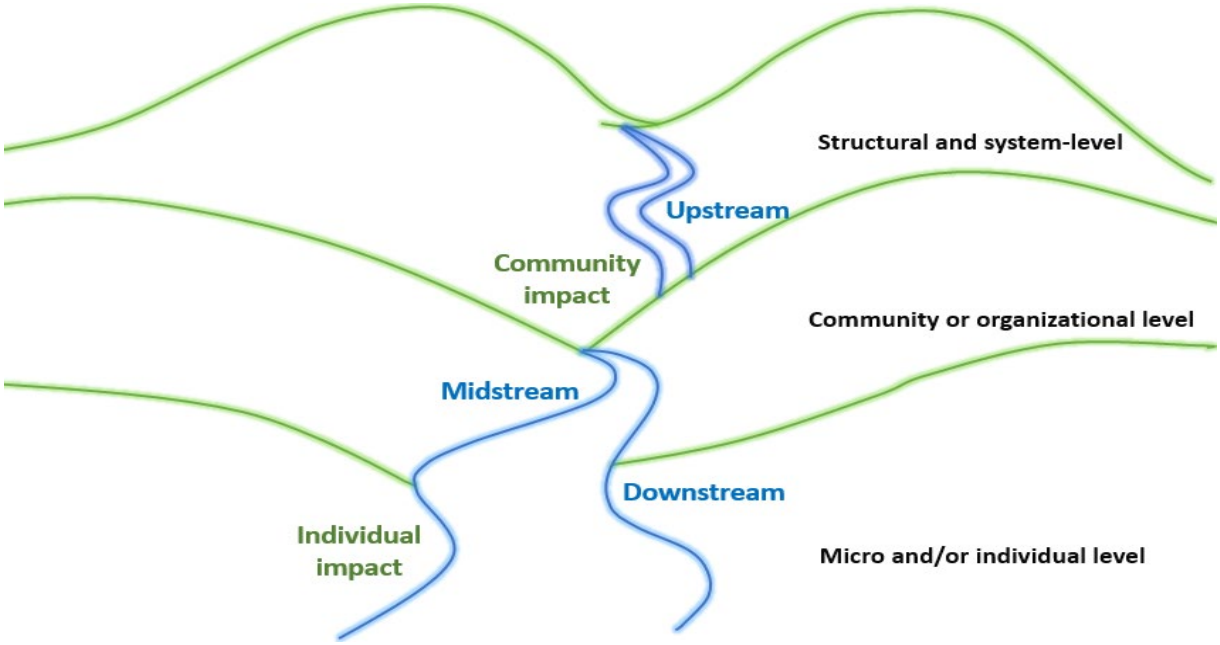


**Table 1.** *Medical record ICD-10 coding of conditions relevant to social determinants using DSM-5-TR section "Other Conditions that may be a Focus of Clinical Attention." Note: DSM-5-TR conditions from the section that are not included here are the adult maltreatment conditions, suicidal behavior and self-injury, and any non-Z codes, in addition to selected conditions in the category of "additional problems" that may not have direct application to children and youth.*

| DSM-5-TR Category | Z Codes for Selected Conditions Relevant to Social Determinants of Mental Health in Children and Youth |
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| **Educational Problems** | Z55.0 Illiteracy and Low-Level Literacy<br>Z55.1 Schooling Unavailable and Unattainable<br>Z55.2 Failed School Examinations<br>Z55.3 Underachievement in School<br>Z55.4 Educational Maladjustment and Discord With Teachers and Classmates<br>Z55.8 Problems Related to Inadequate Teaching<br>Z55.9 Other Problems Related to Education and Literacy |
| **Housing Problems** | Z59.01 Sheltered Homelessness<br>Z59.02 Unsheltered Homelessness<br>Z59.1 Inadequate Housing<br>Z59.2 Discord With Neighbor, Lodger, or Landlord<br>Z59.3 Problem Related to Living in a Residential Institution<br>Z59.9 Other Housing Problem |
| **Economic Problems** | Z59.41 Food Insecurity<br>Z58.6 Lack of Safe Drinking Water<br>Z59.5 Extreme Poverty<br>Z59.6 Low Income<br>Z59.7 Insufficient Social or Health Insurance or Welfare Support<br>Z59.9 Other Economic Problem |
| **Occupational Problems** | Z56.82 Problem Related to Current Military Deployment Status (830)<br>Z56.0 Unemployment |

| DSM-5-TR Category | Z Codes for Selected Conditions Relevant to Social Determinants of Mental Health in Children and Youth |
|---|---|
| | Z56.1 Change of Job<br>Z56.2 Threat of Job Loss<br>Z56.3 Stressful Work Schedule<br>Z56.4 Discord With Boss and Workmates<br>Z56.5 Uncongenial Work Environment<br>Z56.6 Other Physical and Mental Strain Related to Work<br>Z56.81 Sexual Harassment on the Job<br>Z56.9 Other Problem Related to Employment |
| **Problems Related to the Social Environment** | Z60.2 Problem Related to Living Alone<br>Z60.3 Acculturation Difficulty<br>Z60.4 Social Exclusion or Rejection<br>Z60.5 Target of (Perceived) Adverse Discrimination or Persecution<br>Z60.9 Other Problem Related to Social Environment |
| **Problems Related to the Family Environment** | Z62.29 Upbringing Away From Parents<br>Z62.898 Child Affected by Parental Relationship Distress<br>Z63.5 Disruption of Family by Separation or Divorce<br>Z63.8 High Expressed Emotion Level Within Family<br>*Z62.0 Inadequate parental supervision and control***<br>*Z62.1 Parental overprotection***<br>*Z62.21 Child in welfare custody***<br>*Z62.22 Institutional upbringing***<br>*Z62.3 Hostility towards and scapegoating of child***<br>*Z62.6 Inappropriate (excessive) parental pressure***<br>*Z63.3 Absence of family member***<br>*Z63.4 Disappearance and death of family member***<br>*Z63.6 Dependent relative needing care at home***<br>*Z63.7 Other stressful life events affecting family and household***<br>*Z63.72 Alcoholism and drug addiction in family*** |
| **Relational Problems** | <u>Parent--Child Relational Problem</u><br>Z62.820 Parent–Biological Child<br>Z62.821 Parent–Adopted Child<br>Z62.822 Parent–Foster Child<br>Z62.898 Other Caregiver–Child<br><br>Z62.891 Sibling Relational Problem<br>Z63.0 Relationship Distress With Spouse or Intimate Partner |
| **Problems Related to Other Psychosocial, Personal, and Environmental Circumstances** | Z72.9 Problem Related to Lifestyle<br>Z64.0 Problems Related to Unwanted Pregnancy<br>Z64.1 Problems Related to Multiparity<br>Z64.4 Discord With Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker<br>Z65.4 Victim of Crime<br>Z65.4 Victim of Terrorism or Torture<br>Z65.5 Exposure to Disaster, War, or Other Hostilities<br>*Z65.8 Other specified problems related to psychosocial circumstances***<br>*Z58.9 Problem related to physical environment, unspecified*** |
| **Problems Related to Interaction With the Legal** | Z65.0 Conviction in Criminal Proceedings Without Imprisonment<br>Z65.1 Imprisonment or Other Incarceration |

| DSM-5-TR Category | Z Codes for Selected Conditions Relevant to Social Determinants of Mental Health in Children and Youth |
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| **System** | Z65.2 Problems Related to Release From Prison<br>Z65.3 Problems Related to Other Legal Circumstances |
| **Abuse and Neglect**<br><br>*Child Maltreatment and Neglect Problems* | Other Circumstances Related to Child Physical Abuse<br>Z69.010 Encounter for mental health services for victim of child physical abuse by parent<br>Z69.020 Encounter for mental health services for victim of nonparental child physical abuse<br>Z62.810 Personal history (past history) of physical abuse in childhood<br><br>Other Circumstances Related to Child Sexual Abuse<br>Z69.010 Encounter for mental health services for victim of child sexual abuse by parent<br>Z69.020 Encounter for mental health services for victim of nonparental child sexual abuse<br>Z62.810 Personal history (past history) of sexual abuse in childhood<br><br>Other Circumstances Related to Child Neglect<br>Z69.010 Encounter for mental health services for victim of child neglect by parent<br>Z69.020<br>Encounter for Mental Health Services for Victim of Nonparental Child Neglect<br>Z62.812 Personal history (past history) of neglect in childhood<br><br>Other Circumstances Related to Child Psychological Abuse<br>Z69.010 Encounter for mental health services for victim of child psychological abuse by parent<br>Z69.020 Encounter for mental health services for victim of nonparental child psychological abuse<br>Z62.811 Personal history (past history) of psychological abuse in childhood |
| **Problems Related to Access to Medical and Other Health Care** | Z75.3 Unavailability or Inaccessibility of Health Care Facilities<br>Z75.4 Unavailability or Inaccessibility of Other Helping Agencies |
| **Additional Conditions or Problems That May Be a Focus of Clinical Attention** | Z65.8 Religious or Spiritual Problem<br>Z72.81 Child or Adolescent Antisocial Behavior<br>Z91.19 Nonadherence to Medical Treatment<br>Z63.4 Uncomplicated Bereavement |

*** ICD Codes (Italicized Description) in the ICD-10 that are not specified in the DSM-5-TR.*

## I. Basic Needs: Family and Youth Socioeconomic Environment

The basic social needs of youth and their families include access to income, appropriate education, employment, nutritious food, safe and stable housing, and access to health care services of decent quality including mental health services. These resources serve as the bedrock for optimal physical and emotional development.

**Adversity in This Domain:**

Poverty and limited access to basic needs impact the development and long-term mental health of youth and their families, manifesting as malnutrition or overweight/obesity, family stress, lack of access to needed services, and increased exposure to adverse childhood life experiences.[15] Unfortunately, according to national data, in 2019, 14.4% of children under age 6 lived in poverty, with a disproportionate impact on children of color. Among these 10 million children living in poverty-stricken homes, approximately half lived in extreme poverty, where households made 50% of the federal poverty level.[16] These numbers are certainly an undercount; they are based on annual income, but some families experience episodic poverty of 1–2 months at a time. Food insecurity, as an example, impacts approximately 10% of US households and is linked to poor mental health outcomes in a multitude of research studies.[17] Additionally, approximately 1.3 million (2.5%) US students did not have stable housing, based on data from the school year 2019–2020 (NCES 2021). Poverty has a multidimensional impact on youth mental and physical health through individual, familial, and environmental impacts that are too extensive to explore in this resource document but are extensively discussed in the literature.[18] Efforts to reduce childhood poverty, food insecurity, and family homelessness are critical to addressing this domain of the social determinants of mental health.

Additionally, health care, including mental health care, whether in school, specialty settings, or collaborative care settings, is a basic need. The majority of youth needing specialty psychiatric services are unable to access them due to the limited size of the mental health workforce, limited access to integrated care settings, and insurance coverage issues related to payment for mental health services. These challenges are greater in underserved and rural areas.[19]

**Resources to assess/screen for basic needs:**

In child and adolescent clinical psychiatry settings, social needs assessments or core psychosocial evaluations are conducted as part of the initial evaluation. During such evaluations, it is critical that deficits in basic needs, such as family income and benefits, food insecurity, transportation, health insurance coverage, educational concerns for the child, and employment and housing concerns for the caregiver and family, are assessed and integrated into the treatment plan collaboratively with families.

Tools that can help gather this information include:

- **Health Leads**[21]
- **Accountable Health Communities (AHC) Health Related Social Needs Screening Tool**[22]

**Interventions**

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| **Downstream** | *At the point of care, after screening, mental health providers and other health care professionals can ensure:*<br><br>● Medical record coding: Mental health providers and caseworkers are encouraged to document relevant Z codes from categories in Table 1.<br>  ● Educational Problems<br>  ● Economic Problems<br>  ● Housing Problems<br>  ● Occupational Problems<br>● Social referral to case management to coordinate access to identified housing, benefits, employment, and transportation needs.<br>● Referral for food prescription programs to address the family's food insecurity and nutritional needs.<br>● Families are educated about the Individuals with Disabilities Education Act and their rights to request assessments and in-school support.<br>● 504 Plans are written according to Section 504 of the Federal Rehabilitation Act of 1973 to improve supports in the classroom.[23]<br>● Communication with schools and educators to identify optimal learning environments and educational advocacy to ensure individualized educational plans (IEPs) are established as needed. |
| **Midstream** | *Organizations and Communities can ensure:*<br><br>● Care coordination services are available through care managers to enable rapid access to needed services, advocacy for social benefits, and promotion of general engagement with service providers.<br>● Food prescription programs are established in collaboration with local farmers markets to provide ease of access to healthy food.<br>● Advocacy: Integrated medical-legal supports (immigration, tenant rights) are made available in the clinical setting or through established partnerships. |
| **Upstream** | *Advocacy at the state and federal levels for policy changes to support:*<br><br>● Anti-poverty initiatives<br>● Youth employment opportunities<br>● Child health insurance coverage<br>● Caregiver-directed programs that integrate economic development, education, and family well-being with policy<br>● Investment in school-based services, community clinic services, intensive outpatient services, and day programs for youth to decrease dependence on highly restrictive settings such as inpatient hospitalization and residential facilities, and investment in various levels of mental health care for high-need youth with mental illness to enhance community functioning<br>● Investment in integrated care initiatives that promote increased access to clinical services |

## II. Caregiver Health and Parenting Behaviors

Youth and their experiences do not exist in a silo but rather exist in the context of a relationship with caregivers and others. The child's socio-developmental environment begins to be shaped at conception and even before, given the inheritance of stress-influenced epigenetic modifications. Later, behavioral modeling,

social learning, and relational skills are imparted in the family and community.[24] Considerations for prevention and for promoting mental health, well-being, and development should therefore begin during the prenatal period. In utero environment is affected by a broad range of maternal factors, including substances the mother may be exposed to ranging from environmental pollutants to illicit substances, stress hormones such as cortisol, nutrition the mother is able to access, and health care quality and availability.

Furthermore, postnatally, the caregiver's awareness of normal development and their developmentally appropriate and positive interactions with the child foster healthy interpersonal functioning and development in the child. Parenting behaviors that promote optimal youth development include affirmation/validation, responsiveness, modeling, emotion regulation, and parent as secure base for the growing child.

**Adversity in This Domain:**

Untreated mental health disorder in pregnancy carries risks of harm including maternal depression, suicide, and poor fetal and child growth.[25,26] Throughout the rest of the life span, the caregiver's mental health continues to be a priority, as the available data suggest that approximately 20% of children live in a home with a parent with a mental health condition and approximately 5% live with a caregiver with a seriously impairing disorder.[27] Without adequate support, caregivers with mental illness may struggle with meeting their own basic needs such as health care, education, food, and shelter.[26] Children in homes with caregivers affected by untreated mental illness require attention and support to reduce risk of neglect, unintentional injuries, suicide, and violence, among other exposures.[27]

Parenting behaviors during development that are tied to poor mental health outcomes include insensitive, unresponsive, and rejecting approaches to the child, which may be evidenced by invalidation, criticism, lack of consistency, and lack of parental warmth. With regard to the level of parental responsiveness and level of parental control in the relationship, parenting styles that are well studied are categorized as authoritative (high responsiveness, high control),[28] authoritarian (low responsiveness, high control), and permissive styles (low responsiveness, low control). High levels of parental responsiveness, as seen in the authoritative style, lead to optimal mental health and academic outcomes.[28]

**Resources to assess/screen for caregiver mental health and parenting behaviors:**

In venues such as the obstetrics and gynecology, pediatrics, internal medicine, and mental health settings, there are opportunities to screen caregivers with the following tools and questions:

- **Edinburgh Postpartum Depression Scale**[29]
- **Patient Health Questionnaire (PHQ-9)**[30]
- **Parenting Style Questionnaire**[31]

- *How do you respond when your child refuses to follow your instructions? What discipline strategies do you use to teach appropriate behaviors? Can you describe your parenting style?*

**Interventions**

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| **Downstream** | *At the point of care, after screening, mental health providers and other health professionals can ensure:*<br><br>● Medical record coding: Mental health providers and caseworkers are encouraged to document relevant Z codes from categories in Table 1.<br>  ● Problems Related to Family Environment<br>  ● Relational Problems<br>● Referral to parent-focused/early childhood interventions such as Triple P Parenting[32] and Healthy Start.[33]<br>● Caregivers receive referrals as needed for social and professional support; if concerns about neglect or abuse are apparent, appropriate notification of family services to ensure appropriate follow-up. |
| **Midstream** | *Organizations and communities can ensure:*<br><br>● Evidence-based preventive interventions to support new mothers and at-risk caregiver-child dyads and families with significant adversity.<br>● Integrated care within the pediatric and adult internal medicine departments for early identification of children with emotional and behavioral dysregulation.<br>● Integrated behavioral health care and stepped models in primary care. |
| **Upstream** | *Advocacy at the state and federal levels to support:*<br><br>● Parent-focused interventions such as paid parental leave (0-5) or new parent pay programs.<br>● Community-oriented behavioral health care programs serving children and families.<br>● Policy, funding, and/or reimbursement for integrated behavioral health care programs, such as:<br>  ● Collaborative care programs to increase maternal access to psychiatric consultation in the obstetric setting (e.g., Massachusetts Child Psychiatry Access Program (MCPAP)[34] for moms to target maternal depression—an approach that is well studied.<br>  ● Children's Behavioral Health Initiative (CBHI),[35] helping MassHealth children with behavioral, emotional, and mental health needs and their families with integrated behavioral health services through a comprehensive, community-based system of care.<br>  ● Collaborative models among child-serving systems of care. |

## III. Childhood Experiences: Home and Community

No discussion of optimal childhood environments is complete without a discussion of children's rights, which is a lens through which we can understand positive youth development.[36] Positive youth development involves engaging youth as active participants in their schools and communities, as future leaders who will thrive and whose strengths should be validated and developed for their future roles as members of society. As such, societal structures that promote positive youth development serve as critical social determinants of youth physical and mental health. Youth who are "thriving" are more likely to have optimal outcomes and greater individual resilience. Relevant sections of the United Nations Children's Rights Convention (UNCRC - 2009b)[37] include the child's right to participation, to expression, to thought and religion, to association, to

assembly, and to play. Experiences in optimal environments facilitate healthy developmental trajectories in the areas of physical, emotional, cognitive, and social development.

**Adversity in This Domain:**

## A. Exposure to Abuse or Neglect

Adverse childhood experiences (ACEs) create stress and developmental insults. Their long-term impact on physical and mental health were initially studied by Filetti et al., in 1998.[38] This study was the first to document the dose-dependent increase in risk of adverse outcome for adults who had ACEs. Since then, research on adverse childhood experiences has expanded to include experiences outside the home such as exposure to community violence, adverse foster care placements, peer victimization or bullying, and forced migration/displacement. These encompass the range of exposures that impact long-term mental and physical well-being. There is consistent evidence demonstrating the graded association between ACEs and mental health outcomes for youth. It has been documented that youth with multiple ACEs were more likely to also self-report suicidality, substance abuse, violence, and traumatic stress.[39,40] Exposure to abuse and/or neglect is one example we will focus on here.

The child's environment is unsafe if there is physical, sexual, or emotional abuse or neglect of their needs. Neglect may result from factors such as parental mental illness or substance abuse. Such exposures create high-stress situations that can overwhelm the child's ability to cope, potentially impacting every domain of their development, including physical, cognitive, social, emotional, and psychological. The US Department of Health and Human Services reports that 3.9 million children had a child maltreatment report in 2020, with the highest rate of child abuse occurring in children under age 1 (25.1 per 1,000). In over 90% of confirmed cases, youth are maltreated by one or both parents as opposed to other adults. Sixty-eight percent of youth fatalities were children under age 3.[41]

**Resources to assess/screen for adverse childhood experiences:**

- Thorough psychosocial and trauma screening to identify risks in the environment:
  - **The Pediatric Adverse Childhood Experiences and Related Life-events Screener (PEARLS)**[42]
  - The UCLA PTSD Scale, a thorough review of childhood traumatic exposures[43]

### Interventions

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| **Downstream** | *At the point of care, after screening, mental health providers and other health professionals can ensure:*<br>● Medical record coding: Mental health providers and caseworkers are encouraged to document relevant Z codes from categories in Table 1.<br>  ● Child Maltreatment and Neglect Problems<br>● Provision of trauma-informed therapy.<br>● Enrollment of child, or encouragement to enroll, in pro-social community activities including afterschool programs and sports programs. |

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| | • Rapid and appropriate referrals for preventive services; protective services in cases of active neglect or abuse. |
| **Midstream** | *Organizations and communities can ensure:*<br><br>• Organizational policies supporting trauma-informed care.<br>• Social-emotional learning curricula in schools and pediatric health venues to promote emotional expression.<br>• Education of community regarding trauma, impact, and availability of treatments. |
| **Upstream** | *Advocacy at the state and federal levels for policy change to support:*<br><br>Policies supporting trauma-informed care and prevention of adverse experiences:<br><br>• Early childhood programs such as the 0-5 Early Childhood Mental Health Initiative, which provides children in the preschool years with preventive interventions embedded in school, clinics, and other community settings.[44]<br>• Life skills programs, such as 4-H, which is operated by the Cooperative Extensions and promotes youth skills development, engagement, leadership, and mentorship.[45] |

## B. Exposure to Bullying

Bullying is defined as repeated aggressive behavior toward another student where the balance of power is such that the student being bullied cannot effectively defend themselves. In the digital space, bullying takes the form of repeated aggressive behavior toward another student using computers, cell phones, or other electronic devices.[46] According to the 2019 Youth Risk Behavior Survey, a self-report survey of youth ages 12–18, 22% reported being bullied in school, mostly in locations such as classrooms, stairwells, cafeterias, and outside on school grounds. An additional 15.7% reported being bullied electronically. In both settings, female identifying students were more likely than males to be bullied.[47] Youth who are bullied and those who bully are more likely to suffer significant mental health consequences. Youth in the community need protection from bullying and its adverse effects. It is important that school environments are safe, respectful, and inclusive. Environments that turn a blind eye to bullying do not serve the needs of youth.

**Resources to assess/screen for bullying:**

- PEARLS Part 2 Question 1: *Has your child ever seen, heard, or been a victim of violence in your neighborhood, community, or school? (for example, targeted bullying, assault or other violent actions, war or terrorism)*[42]
- Massachusetts Aggression Reduction Center (MARC)[48]
- Questions during evaluations:
    - *Do you know anyone who has been bullied?*
    - *Have you ever been bullied?*
    - *Have you ever bullied another?*

**Interventions**

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| **Downstream** | *At the point of care, after screening, mental health providers and other health professionals can ensure:*<br>● Medical record coding: Mental health providers and caseworkers are encouraged to document relevant Z codes from categories in Table 1.<br>● Z60.4 Social Exclusion or Rejection<br>● Use of appropriate language in clinical care (NCTSN): avoid use of bully and victim. Utilize language such as person who bullied and person who is bullied.<br>● Psychotherapy or referral for psychotherapy is provided to address identified emotional needs.<br>● Collaboration with caregivers and schools to promote safety. |
| **Midstream** | *Organizations and communities can ensure:*<br>● Promotion of strict anti-bullying policies in youth-serving environments and teacher education about bullying and its consequences. |
| **Upstream** | *Advocacy at the state and federal levels for policy change to support:*<br>● Anti-bullying legislation requiring schools to promptly investigate bullying. |

## C. Exposure to Digital Media/Social Media Use

The digital and cyber environment is of significance to youth, with the average young person spending 7.7 hours daily in this environment.[49] As such, understanding how these environments impact youth mental health and how unregulated online/internet/digital spaces act as social determinants of youth mental health will help us aptly target interventions to protect/support.

Many youth have positive experiences with the digital environment, as it can be a place to stay connected with others, form new relationships, express creativity and individuality, and find support—especially related to mental health. However, significant risks also exist.[50] With social media, youth have access to a greater number of people, with the opportunity for negative social interactions that are frequent and immediate. For example, being bullied in real life can be continued and amplified on the internet. Being a victim of cyberbullying has been associated with self-harm and suicidal behaviors. Other harmful interactions in the digital environment include unwanted sexual solicitations, exploitative sexting, and other forms of sexual violence.[50]

In addition to risky social interactions, there is also the risk of exposure to harmful content, which can be detrimental to youth mental health. The internet has a plethora of material promoting and instructing youth on methods of suicide and self-injurious behaviors, harmful substance use, and disordered eating behaviors. General social media use has been associated with difficulties with body image and disordered eating, as well as with depression and anxiety. This may be a result of social media serving as a space to promote one's best self or even perfection, creating a skewed narrative.[50]

**Resources to assess/screen for problematic internet use:**

- Problematic and Risky Internet Use Screening Scale (PRIUSS): https://www.ncbi.nlm.nih.gov/pmc/articles/instance/4035908/bin/nihms562198f3.jpg[51]

**Interventions**

| | |
|---|---|
| **Downstream** | *At the point of care, after screening, mental health providers and other health professionals can ensure:*<br>● Medical record coding: Mental health providers and caseworkers are encouraged to document relevant Z codes from categories in Table 1.<br>  ● Z72.9 Problem Related to Lifestyle, Unspecified<br>● Brief motivational interviewing intervention.<br>● Psychoeducation of the patient regarding safe and healthy internet use.<br>● Parent education about family digital media use contracts (e.g., American Academy of Pediatrics' Family Media Plan). |
| **Midstream** | *Organizations and communities can ensure:*<br>● Access to educational programs related to internet safety, how to have a healthy relationship with social media, etc.<br>● Education of teachers and parents about cyberbullying and the KnowBullying app by SAMHSA.[52]<br>● Parent education about the American Academy of Pediatrics Family Media Plan.[53] |
| **Upstream** | *Advocacy at the state and federal levels for policy change to support:*<br>● Policies requiring technology companies to incorporate internet safety guidelines for youth. |

## D. Exposure to Community Violence and Interactions With Law Enforcement

Youth with high levels of exposure to community violence are at elevated risk of mental health sequelae such as traumatic stress responses, anxiety, and substance use, among others.[54] Community violence includes all deliberate acts to harm another member of the community, and exposure can be as a victim or an observer. Children growing up in communities with high rates of community violence may struggle with fears about safely attending school and traversing their communities independently, even in absence of directly being a victim or observer. This fear can also leave them vulnerable to early gang recruitment as gang prevalence increases in the United States. These adolescent recruits are then at elevated risk for poly-traumatization during a formative time in their development through their higher exposure to weapons, drug use, and illegal activities.

On the other hand, interactions with law enforcement and the juvenile justice system also impact the mental health of youth. Incarcerated youth are a significant and highly vulnerable population in the United States, which has the highest proportion of incarcerated youth of any developed country. There are notable racialized and class disparities in the youth that interact with law enforcement and the juvenile justice system. Census information shows that African American adolescents are five times more likely to be

incarcerated than white adolescents. Additionally, Latino and Native American adolescents are three times more likely to be incarcerated than their white counterparts.[55]

Youth with interactions with law enforcement and the juvenile justice system also tend to have higher rates of trauma and mental health burden than other youth. About 70% of those in the juvenile justice system report having experienced at least one traumatic event, with juvenile offenders being four times as likely to have experienced four or more ACEs in their lifetime. This is particularly alarming as childhood trauma research has shown that an individual with a history of four or more ACEs is 4.5 times more likely to experience depression and 15 times more likely to attempt suicide.[56] Thus, unsurprisingly, rates of mental health problems are also higher among youth in the juvenile justice system than among non-incarcerated youth. Studies estimate that about 40–70% of adolescents in the justice system have current mental health disorders and 19–32% of incarcerated youth report suicidal ideation, with 12–16% reporting a previous suicide attempt.[56,57]

**Resources to assess/screen for exposure to community violence, gangs, and guns:**

Tools:

- UCLA PTSD Screening Tool[43]
- Pediatric PEARLS (Part 2 Question 1)*:*[42]
    - *Has your child ever seen, heard, or been a victim of violence in your neighborhood, community, or school?*

Questions

- *Inquire about gang exposure and/or involvement:*
    - *Are there gangs active in the community?*
    - *Do you know anyone who is involved in a gang?*
    - *Have you ever been approached to join a gang? How did you respond?*
- *Inquire about gun access (as indicated):*
    - *Do you know anyone who has a gun or weapon?*

**Interventions**

| | |
|---|---|
| Downstream | *At the point of care, after screening, mental health providers and other health professionals can ensure:*<br><br>● Medical record coding: Mental health providers and caseworkers are encouraged to document relevant Z codes from categories in Table 1.<br>  ● Z65.3 Problems Related to Other Legal Circumstances<br>  ● Z65.4 Victim of Crime<br>  ● Z65.8 Other specified problems related to psychosocial circumstances<br>  ● Z72.81 Child or Adolescent Antisocial Behavior (truancy, delinquency, offenses in form of gang membership)<br>● Treatment of psychiatric illnesses as indicated including PTSD, anxiety, and depression.<br>● Referral to local Big Brothers/Big Sisters programs. |
| Midstream | *Organizations and communities can ensure:*<br><br>● Education and gun buyback programs in the community. |

| | |
|---|---|
| | • Robust law enforcement accountability measures.<br>• Community-based alternatives to addressing harms and preventing trauma. |
| Upstream | *Advocacy at the state and federal levels for policy change to support:*<br><br>• Eliminating policies and practices that facilitate disproportionate violence against specific populations.<br>• Juvenile justice system reforms that may include:<br>  • Support for diversion programs.<br>  • Reduction of juvenile detention and investment in community-based and neighborhood programming/capacity for mental health and youth development. |

## E. Exposure to Substances

Early exposure to substances during pregnancy can have short-term and long-term consequences in children. Maternal screening that avoids discriminatory practices and criminalization and incudes post-discharge care is essential to prevent and promote child and maternal well-being. The prevalence of substance use involving illicit drugs is 3.4% in ages 13 to 14 and 16.5% in ages 17 to 18.[58] Risk factors include the family and community characteristics that are potential targets for intervention, including intrauterine exposure to drugs/alcohol, marital conflict, disturbed family environment, negative life events, social adversity, laws and norms favorable toward alcohol and drug use, availability of and access to alcohol, targeted marketing of alcohol and cigarettes, poverty, and community/school violence.[59] A good example of the way social determinants influence substance use is the current "vaping" epidemic.

Electronic nicotine delivery systems (ENDS) are popular vaping devices among nicotine-naïve youth, with use reaching epidemic proportions in some areas. In 2019, 27.5% of high school students in the US reported their use.[60] Youth-targeted marketing and social media promotion are some of the main influencers of this. Young individuals with mental illness may be attracted to ENDS due to beliefs that ENDS may help modify their psychiatric symptoms or offset side effects of psychotropic medications, or due to common underlying risk factors for mental illness and substance use (e.g., executive function deficits).[60] In a recent systematic review of vaping and mental health comorbidities in youth, vaping has been consistently associated with depression, suicidality, attention-deficit/hyperactivity disorder (ADHD), and conduct disorder in adolescents.[60]

**Resources to assess/screen for caregiver and youth substance use:**

- National Curriculum on Reproductive Psychiatry[62]
- CRAFFT – Substance Abuse Screen for Adolescents and Young Adults [63]

Question:

- *Is anyone in the household using drugs or alcohol?*

**Interventions**

| | |
|---|---|
| Downstream | *At the point of care, after screening, mental health providers and other health professionals can ensure:*<br>• Medical record coding of relevant Z codes: |

| | |
|---|---|
| | ○ Z72.9 Problem Related to Lifestyle, Unspecified<br>○ Z63.72 Alcoholism and Drug Addiction in Family<br>● The impact of substance use on the individual's functioning is identified.<br>● Motivational interviewing techniques are utilized to promote optimal decision-making about substance use. |
| Midstream | *Organizations and communities can ensure:*<br>● Clinical services for youth include substance use education and treatment.<br>● Youth services are enhanced at the community level to keep youth occupied through after-school educational, recreational, and vocational activities. |
| Upstream | *Advocacy at the state and federal levels to support:*<br>● Enforcement of age limits on access to substances and marketing that targets youth. |

# IV. Subgroup at Elevated Risk: Minoritized Youth and Communities of Color

## a. Minoritized Youth and Communities of Color

Race and ethnicity are not social determinants of health. However, disproportionate exposure to social determinants of poor mental health among minoritized and disenfranchised communities of color is well documented. Many children and youth experience poor mental health outcomes based on their socioeconomic disadvantage, ethnic or racial minoritized status, and/or immigrant status. Experiences of racism and discrimination, and witnessing of racial violence targeted at one's group, have been associated with depression, anxiety, and posttraumatic symptoms and act as social determinants of mental health.[64] Social media can serve as a vehicle for further transmitting these images of violence and societal inequities.[65] Compounding these challenges for minoritized children and youth are low levels of mental health service utilization, impediments to accessing care, and care that is not culturally responsive or does not conform to evidence-based guidelines.[66] The consequences are reflected in elevated risk for stress-related mental health and physical health problems and poor outcomes. Addressing social determinants of mental health early includes inquiring about experiences of discrimination (e.g., in the community, at school) or other social stressors and whether these are present and meaningfully affecting a youth's well-being, how the youth and family can access supportive resources, and what they identify as needs and priorities. Racialized injustices have long contributed to mental health disparities for minority and underserved populations.

**APA Resources:**

- Advocating for Anti-Racist Mental Health Policies with a Focus on Dismantling Anti-Black Racism[67]

## b. Gender and Sexual Minority Youth

There is a constant battle, not only in the political arena but even in religious and academic settings, for the creation of universal policies to protect the basic rights of the LGBTQ+ community. However, in the meantime, children and youth are vulnerable targets of discrimination (either in person or via social media,

through cyberbullying). The lack of acceptance and the violence toward sexual and gender minorities, not only by society but even from their own families, put this group at high risk for depression, substance use problems, PTSD, and suicide. Additionally, they are at risk of becoming homeless, losing their job, and losing meaningful relationships. For many years, this group has experienced discrimination and lack of trust in the health care system, which has created a barrier to accessing prevention, diagnosis, and treatment of mental health illnesses. There is a need for medical providers that are prepared to address the health needs of gender and sexual minorities in a caring and empathic way. Social determinants affecting the mental health of LGBTQ+ individuals and families largely relate to oppression and discrimination, and include legal discrimination in access to health services, employment, housing, marriage, and adoption; lack of laws protecting against bullying in schools; and lack of equal participation in sports and other activities healthy for development. Disproportionate experiences of homelessness disrupt the lives and development of these young people and can lead to significant negative outcomes in mental and physical health, lower educational attainment, and economic instability. Living without shelter and adult protection leaves these children and young adults vulnerable to exploitation and abuse. Affirmative care is an approach to care that embraces a positive view of LGBTQ+ identities and relationships and addresses the negative influences that homophobia, transphobia, and heterosexism have on the lives of LGBTQ+ youth and their families, and that considers their medical, mental health, and social needs. Policy issues of importance to consider include ones that prevent and respond to bullying and harassment, homelessness, and discrimination in health care, education, and employment.

**APA Resources:**

- LGBTQ Youth Face Mental Health Challenges: Social Support and Safe Spaces Make a Difference[68]

### c. Immigrants/Refugee Youth

Traumatic migration, family separation, and displacement place immigrant and refugee youth at high risk for mental illness. Lower access to resources, xenophobia, unsupportive policies, and lack of socio-political power predispose immigrant/refugee youth and their families to the development of stress-related and other mental health disorders. Immigration is often associated with traumatic experiences that in turn are highly related to social determinants of mental health. These include experiences of violence, poverty, political oppression, threats, and disasters. Post-migration, stressors can include limited resources given status, low income, poor employment, unsafe housing, discrimination, intra- and interpersonal conflict, stress from adjusting to a new environment, exploitation, and fear of deportation. Inadequate educational opportunities and language barriers to services are faced due to a lack of bilingual and bicultural providers. Anti-immigrant climate, discriminatory social policies, and heightened immigration enforcement create and perpetuate unprecedented challenges for young immigrants, resulting in short- and long-term negative developmental outcomes. These include disruptions in education and to ethnic identity formation, poor physical health, and emotional distress that can begin in infancy and last into young adulthood. From a clinical perspective, using a socio-cultural ecological framework that considers the complex interplay among individual, relationship, community, cultural, and societal factors that influence mental health is central to providing appropriate and effective care for immigrant and refugee children.[69] Addressing social determinants of health from a policy and societal perspective includes:

- Protecting the health of children of immigrants by reducing disparities in federal, state, and local policies.
- Supporting immigrant parents and reducing stress in mixed-status families (families where some individuals are undocumented and some are citizens).
- Supporting and training teachers and schools in how to support children of immigrant families.

- Investing in neighborhoods and immigrant communities and resources.

**APA Resources:**

- Stress & Trauma Toolkit for Treating Undocumented Immigrants in a Changing Political and Social Environment[70]
- Position Statement on Immigration, Children, Adolescents, and Their Families[71]

Case Vignettes:

## Screening, Diagnosis, and Interventions Vignettes

| Access to Basic Needs as a Social Determinant of Mental Health |
|---|
| **Case:** Michael, a 6-year-old child, presents to a psychiatric clinic with his mother for an evaluation for disruptive behavior at school and at home. His mother reports that he has difficulty sitting still and following directions. She describes him as very energetic and "off the walls." This has become particularly troublesome as the family is living in a shelter, and the mother fears they will be asked to leave if Michael cannot calm down. His mother also reports that she has been getting feedback from teachers saying that he is not focusing at school and will often get into fights with other students. In the interview alone, Michael is easily engaged and observed to move quickly from toy to toy in the room. He says he does not have a lot of toys at home and wants to "play with everything." He admits to getting into fights at school, but only when other kids make fun of him for being "smelly" or "homeless." He says that before moving to the shelter, his family moved between hotels and friends' homes frequently. |
| **Discussion:** In this case, Michael has symptoms that are red flags for the diagnosis of ADHD (high energy, poor focus, and impulsive behavior), and should be properly screened for this condition with a more complete history supplemented with Teacher and Parent Vanderbilts or equivalent screening tools.<br>However, there appears to be more to his presentation than a potential ADHD diagnosis. There is significant familial stress, as they have been moving frequently, most recently living in a shelter. Some of these factors are contributing to the patient's behaviors, serving as social determinants of his current clinical picture.<br>For example, Michael does not have a lot of toys at home, perhaps implying a lack of stimulating home environment. His aggression at school appears to be in response to being ridiculed for poor hygiene. While ADHD should remain on the differential and the patient should receive necessary treatment if indicated, addressing his familial stressors is a necessary component to understanding this case. |
| Screening |
| • Basic needs screening with the PRAPARE tool to identify concerns such as housing and food insecurity, among others. |
| Interventions |
| Downstream interventions: |

- Interventions: If determined to have ADHD, patients should be treated appropriately with first-line interventions of medications and behavioral training. The school should be included in treatment through the formation of an IEP and necessary behavioral interventions depending on the severity of illness.
- Medical record coding of Z codes:
    - Z59.01 Sheltered Homelessness
    - Z59.7 Insufficient Social or Health Insurance or Welfare Support

Midstream interventions:

- Community and school programs to assist this family. While available resources differ in each area of the country, there are often familial housing programs and local food banks that can assist.
- Many shelters also have programs to work with the local government to find temporary housing while families look for more long-term solutions.
- Public school systems have food programs to provide kids with food at school, ensuring they receive several meals daily. Thus, it is critical to get a social worker involved, if available, in order to link the families with these available resources.

Upstream interventions:

- On a systems level, continued work needs to be done to improve mental health treatment availability and coverage for low-income families. Although the patient in this vignette was able to present to a psychiatrist, many similar kids are unable to find a low-cost provider or their families are unable to take time off to get them to appointments. Thus, such kids are at risk for misdiagnosis and inappropriate treatment.
- Legislative changes addressing health care reform, parental leave policies, improved labor wages, and more equitable access to housing can be avenues for greater changes in preventing such scenarios.

## Caregiver Mental Health as a Social Determinant of Mental Health

**Case:** Sophia, an 11-year-old residing with her parents and a 1-month-old sibling, presents for evaluation with her father due to increased irritability with her family members. Sophia has no prior mental health history but has been noted by her father to be increasingly sullen over the past three months and not sleeping well, and experienced weight loss of 5 lbs. According to the father, Sophia's irritable mood is concerning, especially after two recent incidents of lashing out at her 1-month-old infant sibling, causing concern about harm to the infant. During the interview with Sophia, she reports that since the start of her mother's pregnancy, she feels her parents no longer love her. Her father works many hours at his business and her mother is always in bed. She expected things to improve after the baby was born, but over the past month, her mother is more tired and busy, and is unable to spend time with her. Previously, her mother would pack her lunches and cook meals, but now Sophia makes her own breakfast and packs a protein bar for lunch, and her father brings fast food after his shift for dinner. Daily, her father appears angry when he arrives home because the house is messy and the baby cries a lot. Recently, when Sophia

comes home from school, she cleans and helps with her sibling instead of doing homework, resulting in poor grades.

Sophia feels sad most days, worthless, irritable, tired, helpless, angry, and hopeless. She denies suicidal ideation. She is eating less and at night she can't sleep because she is scared about what will happen after her mother returns to work next week. She thinks she will be completely alone after that. She is convinced this is all her fault.

**Discussion:** This case illustrates a child who may meet criteria for major depressive disorder, single episode, mild. A significant factor contributing to Sophia's condition is the change in family dynamics during her mother's pregnancy. As a result of these changes, Sophia is *losing her parental support/attachment points* in the home. Her mother may be experiencing postpartum depression or other medical sequelae of pregnancy evidenced by her increased absence and fatigue. Her mother's symptoms make her emotionally and physically unavailable, with decreased ability to perform parental duties such as ensuring Sophia has adequate nutrition. Her father may be experiencing his own mood changes related to the increased stress. His angry mood is decreasing the patient's self-worth and overall sense of safety and support.

Together, these stressors act as social determinants of the child's mental health and their impact is to erode Sophia's sense of self, prevent attainment of her basic needs, and push her into a parental role, leading to increased stress and manifestation of the symptoms you are asked to assess. In addition to standard of care to accurately diagnose Sophia and potentially recommend therapy and medication, the following steps are indicated:

Screening for Caregiver Mental Health and Family Basic Needs

- Schedule an appointment with caregivers to assess their emotional health and the family's access to basic needs.
- Screen the mother with Patient Health Questionnaire-9 (general screening tool for depression) or Edinburgh Postnatal Depression Scale (screening for postpartum depression). Screen the father utilizing the PHQ9.
- Utilize screening aids such as the Health Leads screening toolkit to help you assess if other factors, such as health care literacy, housing, and financial concerns, are increasing the burden at home.

Interventions

Downstream interventions:

- Once the burdens are assessed, various resources could be provided that may help decrease those burdens on Sophia and her family. For example, postpartum depression can be addressed through psychoeducation, referral for psychiatric/psychological evaluation, use of online support groups, therapy, or short courses.[61,62]
- Basic needs identified through the Health Leads screening tool should be addressed through social referral for case management services or direct assistance, which may be available for financial concerns.
- Clinician approach to the family, particularly the clinicians' interest alone, may be helpful to the family. Validation and connection can be powerful tools against isolation and maladaptive responses. It is important to validate the stress the family is under and acknowledge that they are having difficulty.
- Medical record coding of Z codes:
    - Z62.82 Parent Child Relational Problem: Parent-Bio Child
    - Z63.7 Other stressful life events affecting family and household

Midstream interventions:

- Your organization or local mental health service should have programs that can be accessed to support Sophia and her family. These may require a referral from you or your organization so that the family can participate.
- Case management: Involvement of case management services can identify resources geared to the nonmedical insecurities or "basic needs" that need to be addressed. It may also facilitate access to programs such as respite care, after-school activities, or child care.
- Community-level programs: There may be programs in the community that help provide assistance (church groups, volunteer organizations), including a range of services from meal assistance to child care, so that the parents have time to rest.
- School-based services: There may also be school-based interventions such as breakfast and lunch programs, counseling services, and so on that could be beneficial.

Upstream interventions:

- Paid parental leave: Without paid parental leave, neither of Sophia's parents are able to take time to adjust to the new family dynamic, including the physical, emotional, and structural changes expected within each individual and within the family unit. In the absence of this, Sophia's family may need to consider options for time off such as FMLA, and, if indicated, the doctor may need to support such a petition. Alternatively, the doctor should understand the importance of supporting them in lobbying/petitioning for these types of policies.
- Health insurance coverage: There is also the question of the parents' health care coverage or literacy. Many mothers will lose health insurance gained for the pregnancy a month after birth; so although the mother may acknowledge her need for care, she may not think she will have access to it. The patient's father may not have health insurance at all. These situations may be addressed by local government or donation-sponsored clinics or programs or indicate a reason to be involved in policy changes that may increase care for future patients.

- Collaborative care models: While Sophia is the identified patient in this vignette, collaborative care models can help expedite her mother's access to mental health care through the maternal health system. Support for collaborative care models for new mothers could impact the duration of untreated depression experienced by Sophia's parents.
- Upstream factors are often difficult if not impossible to address as a direct care provider due to policies and regulations that are out of the provider's control. Nonetheless, understanding these factors is critical in understanding the constraints on Sophia and her family.

## Adverse Childhood Experiences as a Social Determinant of Mental Health

**Case:** John, a 16-year-old adolescent patient residing with his adoptive parents, presents for irritable and depressed mood over the past three months, referred by his school for skipping school. He is at risk of truancy.

According to his father, John lost interest and motivation to engage in school and has been isolated in his room, only playing video games for the past three months and avoiding friends and family events. Academically, his grades dropped and he is failing his classes. According to John, he has been sad since his girlfriend ended their relationship earlier in the year. John felt abandoned and rejected by his girlfriend and shared, "I am useless. No one loves me." In his interview, John had poor eye contact and was minimally engaged. He endorsed irritability, amotivation, and feelings of worthlessness and helplessness, with lack of concentration and passive suicidal thoughts. He hasn't been able to sleep well because of nightmares with a recurrent theme of being abandoned. Despite John's adoptive father being a constant figure for him, he has always struggled with trusting others in relationships due to his fear of abandonment and rejection.

On review of his social and developmental history, you see that John had a difficult childhood. His biological mother struggled with substance use disorder when John was an infant. He was neglected and usually noted to be uncared for/unkempt. Child Protective Services was involved and John was placed in various foster care placements in early childhood. At age 5, he was reunited with his biological mother, who had been working on substance recovery but struggled with her own depression. One evening, he found his mother unresponsive after she died from an opioid overdose. He was placed back into foster care until he was adopted at age 10. His adoptive parents separated when he was 13 and he has been with his adoptive father since then.

John gets flashbacks from the past when he found his mom dead. He always feels he cannot trust anyone and is hypervigilant and hypercritical of relationships he gets into. He avoids any medications that have a sedative component like the medication his mom overdosed on.

**Discussion:** This case illustrates a child who may have major depressive disorder complicated by chronic posttraumatic stress disorder. John's symptoms were exacerbated after his breakup with his girlfriend, a significant stressor because it reminded him of patterns of loss he has experienced throughout his life. At a young age, his mother had been in and out of his life and her care had been inconsistent, with prolonged periods of neglect when John was only an infant. John witnessed his mother's death when he was 5 years old. All those adverse childhood reactions resulted in chronic feelings of mistrust and worthlessness and

increased John's risk of major depressive disorder and PTSD.

Together, these adverse life experiences are social determinants of John's mental health, and their impact is to erode his self-confidence and his social functioning in close relationships, making it difficult for him to be resilient in the face of the current stressor.

John is at risk of serious adverse social and occupational outcomes given his risk factors and underlying vulnerabilities. Now that John is older, it is important to prioritize getting his needs met to avoid truancy and reduce risk of his involvement in the legal system. Societal policies that are harsh and punitive put John at risk for adverse outcomes. Without an understanding of his trauma, his service providers in mental health and society may misinterpret his behaviors and inadequate coping strategies, and that could lead him on a path of poor social function and outcome.

## Screening

- Meet with John alone for a comprehensive interview to help understand current sources of stress for him and how they relate to his past experiences.
- Consider a formalized screening tool for trauma and for adverse childhood experiences.
- A focus on his resiliency factors and strength will help John engage in treatment.

## Interventions

Downstream interventions:

- Trauma focus: Provide trauma-focused interventions and assessment. John would likely benefit from closer follow-ups and a longer-term relationship with a provider to help address his attachment anxiety, PTSD, and MDD. John would also benefit from interpersonal therapy with a focus on the attachment anxiety that is commonly seen in adolescents who have a history of adverse childhood experiences. His adoptive father can receive psychoeducation about the impact of John's trauma on his relationships and social functioning, and learn strategies that he can use to support John during this difficult time.
- Medical record coding of Z codes:
    - Z55.3 Underachievement in school
    - Z62.812 Personal history of neglect in childhood
    - Z63.4 Disappearance and death of family member

Midstream interventions:

- Case management: It would further be helpful to mobilize existing community resources, which would include more school support and intervention as well as higher-level outpatient clinical services:
    - Parental programs that support adoptive parents taking care of children of high needs and help them learn how to parent and manage behaviors, particularly when trauma is a big factor contributing to their presentation.

- Academically, given the poor grades due to his mental health condition, John may benefit from intensive outpatient services, perhaps in a partial program or an intensive day treatment where he can get clinical and educational support, even for 4–8 weeks.
- Providing his dad with support such as advising him about FMLA through his employer would be a priority, since Dad's involvement is highly significant in John's case and Dad may be concerned about job protections while attending to John's mental health needs.

- These may require a referral from your or your organization to support the care coordination for John and his caregiver.

Upstream interventions:

- Juvenile justice and diversion: Youth like John, at risk for truancy, may get involved with negative peer groups, even gangs. Advocacy for community-based approaches to prevent this outcome will help John avoid juvenile justice involvement.
- Permanency planning: While John was in the foster care system on and off over 10 years until his adoption, he missed the opportunity for stable permanent family placement. Efforts to expedite permanency planning are in the best interests of a child's development.
- Adversity due to addiction: Children living in homes with adults struggling with substance use disorders would benefit from policies that promote treatment of caregivers with substance use disorders. John's early exposures might have been avoided.

## Systems of Care Vignette

### Access to Care as a Social Determinant of Mental Health for Youth of Color/Minoritized Youth

**Case:** A pediatric clinic in a Federally Qualified Health Center (FQHC) in New England primarily serves children and youth of color and their families. The surrounding neighborhood includes families of Vietnamese, African American, and Latinx heritage, the latter primarily Puerto Rican, Dominican, Colombian, and Central American. Being within an FQHC, the clinic has a mission to serve lower-income families of diverse cultures who vary in their health care and psychosocial needs. The child and adolescent psychiatry and pediatrics teams created an integrated and collaborative care model to best address the behavioral health needs of families and to improve access to care. The collaborative care model is a systematic approach to addressing behavioral health through the integration of care managers or family partners and consultant psychiatrists, with primary care physician oversight, to more proactively manage mental health needs.

**Discussion:** The first step the team initiated was to identify the best behavioral health and psychosocial screening measures and workflows for conducting the screening and providing referrals. The goal of behavioral health screening was to identify previously unidentified children with behavioral health issues and provide timely treatment options. The outcomes of a Massachusetts policy mandating screening in primary care suggest that screening at preventive care visits has led to more behavioral health-related outpatient visits among vulnerable children. The collaborative team selected the Patient Health

Questionnaire-9 for Depression (for both adolescents and caregivers), the General Anxiety Disorder-7, and the Pediatric Symptom Checklist (PSC), a brief questionnaire that helps identify and assess changes in emotional and behavioral problems in children. These screening tools were made available in the languages most commonly spoken by families. In addition, the team worked with community member advisors to identify the best way to ask about trauma exposure and psychosocial needs. The community members identified the following question as helpful for identifying trauma: "Has your child or family experienced a stressful event in the past or recently that has affected your child's mood or behavior?" This question was meant to be asked by the pediatric provider and followed by a supportive discussion and referral to the behavioral health clinician (BHC), if needed. The BHC would then follow up with further assessment, brief intervention, and a referral for a higher level of care if appropriate.

Interventions

Downstream interventions:

- The integration of the BHCs was an important component of the collaborative model of integrated care, as was the addition of Family Navigators. Family Navigators are paraprofessionals, often with lived experience. Sometimes they are parents of children with disabilities or special health care needs who have navigated systems of care on behalf of their own children; they are empathetic and supportive because they have walked the walk. They help families find the resources they need for their children, listen, learn about the family's strengths and needs, connect them with appropriate resources, and answer any questions they may have. The Family Navigators in the program described in this vignette were from the community, culturally matched, and bilingual. They asked families about psychosocial needs while also helping to support caregivers in becoming informed advocates for their child's needs. Family Navigators used a cultural formulation and collaborative decision-making approach to understand caregivers' perspectives, explanatory models, and treatment preferences for child needs like ADHD, autism, or depression.

Midstream interventions:

- Addressing child and family needs can also include midstream social interventions like recreation and after-school programs, legal services, parent support, housing, nutrition and wellness programs, and transition to adulthood services. The team in the vignette has been successful in linking and engaging more families in care and social support early and prior to the onset of more severe symptoms. Caregivers have reported feeling more empowered and informed about how to access the care and/or resources they need and have felt respected and in partnership with the providers in prioritizing for their child's needs.

Upstream interventions:

- Continued advocacy is needed for supporting upstream interventions and initiatives that can enhance systems of care to serve families and address social determinants, including improved insurance coverage for children and families living in poverty, expanding reimbursement legislation to include case management and time spent addressing social determinants in primary care, funding for school-based prevention interventions, reimbursement for navigator services, funding of community health center prevention and treatment services, funding for training, and opportunities for diversifying the skilled behavioral health workforce.

## Closing Statements

In conclusion, understanding social determinants of health is paramount, as it provides a deeper understanding of the complexity of the societal structures and how they impact the lives of children, adolescents, and their families. This resource document provides a pragmatic approach to addressing social determinants downstream in clinical practice and through social referral, providing guidance on midstream and upstream interventions to meet the needs of patients and families. By optimizing optimal conditions and preventing adverse conditions in the social determinants of health, we can promote healthy development of children and adolescents. We recommend that structurally competent clinical care involve taking this practical model of downstream, midstream, and upstream interventions into daily practice and advocacy to achieve more resilient communities where children and youth not only survive but thrive.

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