AMERICAN PSYCHOLOGICAL ASSOCIATION

December 11, 2020

To: National Institute of Mental Health
nimhodwd@nih.gov

Re: Request for Information (RFI): Fostering Innovative Research to Improve Mental Health Outcomes Among Minority and Health Disparities Populations (NOT-MH-20-073)

Dear Colleagues:

On behalf of the American Psychological Association, the leading scientific and professional organization representing psychology in the United States, with more than 121,000 researchers, educators, clinicians, consultants and students as its members, I am pleased to provide these comments in response to this RFI. The suggestions come from several APA divisions, boards, and committees whose members have expertise in mental health and underserved populations—including APA's Division of Health Psychology (Div. 38), the APA Board for the Advancement of Psychology in the Public Interest, and the APA Committee on Children, Youth, and Families. We are grateful for the National Institute of Mental Health's increased focus on these important issues and appreciate the work the institute has already done in this space, including its investment in the RADX-UP initiative.

Our experiences with COVID-19 have laid bare the longstanding racial and ethnic inequalities that contribute to excess mortality for non-white and non-Asian Americans in the pandemic. But it is important to remember that even aside from the pandemic, racial and ethnic minority populations are severely and disproportionately impacted by many health problems and conditions. For White mortality in 2020 to reach levels that Blacks experience outside of pandemics, current COVID-19 mortality levels would need to increase by a factor of nearly 6. (Wrigley-Field, 2020)

The RFI asks for input on novel ways in which research on factors such as social determinants, cultural traditions, religion and spirituality, and historical trauma, etc. can be used to understand, prevent, and treat mental illnesses among minority and health disparities populations. That is such a critical lens through which disparities in mental health outcomes should be seen and addressed.

In collaboration with key informants and community health workers and *promotor/as* serving the needs of marginalized communities in medically underserved areas, Garcini and colleagues (under review) identified specific stressors related to social determinants that are affecting the physical health, mental health, and wellbeing of underserved communities. The identified

stressors are essential to address in order to reduce health risks among these underserved communities and to prevent further widening of existing health disparities. These stressors may offer insights into key areas of social determinants of health research, for this and other hidden or hard-to-reach populations Stressors identified pertained to the following social determinants of health that are ripe for continuing and new forms of intervention research:

a. **Discrimination/stigmatization:** Pertains to unjust or prejudicial treatment. Experiences of discrimination are associated with detriments in health and mental health. This is perhaps the most critical area to address in order to understand existing health disparities (Major, Mendes, & Dovidio, 2013).

b. **Access to technology:** COVID-19 has changed the way people interface with healthcare providers and with social support networks. Consequently, telehealth or other technological strategies may provide unique opportunities to improve health equity in communities where it was previously limited. However, many underserved communities do not have access to home computers, WiFi, and technology that they may need to fully access needed information channels and the changes in healthcare that have come as a result of COVID-19. Identifying ways to facilitate access and use of technology among underserved communities is essential. Nonetheless, this will require the building of trusting networks that would facilitate such access.

c. **Financial stability**: Pertains to job and income loss, which is associated with increased food and housing insecurity, inability to access needed health services and resources (i.e., technology, purchasing of protective equipment, health services), and for those of immigrant backgrounds, an inability to provide remittances for the healthcare of families in their home countries.

d. **Interface with law and/or immigration enforcement**: Pertains to interactions with law or immigration enforcement, as well as fear of having an interface with law or immigration enforcement. Native Americans have the highest rates of deaths during police encounters (Harvey, 2020). However, there have been several recent high-profile deaths of African-Americans during encounters with law enforcement. The resultant discussion highlights a long-standing community concern about mistrust and fear of law enforcement among marginalized communities. J. Bor and colleagues showed a connection between exposure to police killings and degradation in mental health. (Bor, Venkataramani, Williams, Tsai, 2018) Moreover, recent escalation in anti-immigrant policies, actions, and hate crimes has impacted many Latinx communities, and have increased mistrust and fear, as well as exposure to discrimination, stigmatization, and difficulties in communication. Of particular concern is that Latinx immigrants often face challenges in accessing and navigating needed physical health and mental health care. Also, among Latinx immigrants with temporary or undocumented immigration legal status, the threat of deportation or family separation in the midst of this pandemic due to loss of their protected immigration status, detention, or deportation is leading to considerable distress and worsening mental health.

e. **Family dynamics and structure**: This pertains to changes in family dynamics and home environment, such as having to perform multiple roles and share limited resources and

space (e.g., one computer for all members of the family; multiple family members sharing a room). Many underserved communities live in multigenerational homes and/or rely on care by elders. As COVID-19 is more likely fatal for older adults, allowing for continued interactions and care between generations has become a challenge. For economic and cultural reasons, many underserved families are more likely to reside in multi-generational homes with many people living in one house or apartment, which can make quarantining within the home challenging and increase risk to older family members. Changes in family dynamics are leading to distress affecting mental health and wellbeing of these underserved communities. Of note, the family stressors are magnified in households with a history of domestic violence, single parent households, families with shared custody, and families with caregiving responsibilities for older family members.

f. **Loss or changes in social support:** Older adults, those with limited English proficiency, and those with difficulties accessing technology are at increased risk of social isolation, which is associated with adverse physical and mental health consequences. The impacts may be especially great for people who are also dealing with immigration-related stress.

g. **Restricted access to reliable and valid sources of information**: This includes having limited access to information about resources and practices related to, for example, safety or where to seek health and mental health care, as well as reliance on misleading or unclear information. This in turn can lead to mistrust and misunderstanding that increases confusion, fear, uncertainty, and anxiety.

h. **Pre-existing health conditions**: The effects of compounded stressors during the COVID-19 pandemic are especially notable for individuals with pre-existing (health and/or mental health) conditions who are unable to access continuity of care or are afraid of seeking services. This is a primary concern for a large section of the racial/ethnic minority, marginalized, underserved population given the high prevalence of diabetes, respiratory illnesses, and cardiovascular diseases.

i. **Trauma**: There is a high prevalence of trauma in underserved communities for some of the reasons mentioned above (e.g., discrimination, interface with law or immigration enforcement). People are having to endure the negative physical health and mental health effects of trauma (i.e., re-traumatization) in the midst of the current health crises and a hostile socio-political climate that is targeting their communities. At the same time, they often have limited or no access to health services that are culturally and contextually sensitive to the trauma experiences in their communities,

j. **Quality of the work environment**: Racial/ethnic minorities comprised more than 50% of the essential workforce in the early stages of the pandemic (Economy Policy Institute, 2020). Additionally, many essential workers who are racial/ethnic minorities have continued to work in unsafe and harsh working conditions that are placing their physical and mental health at risk. For example, they may work long hours, have no or limited access to personal protective equipment or access to equipment that is inadequate and of poor quality, receive low wages, and suffer a loss or reduction in health and other benefits.

k. **Quality of the living and/or neighborhood environment**: Neighborhood composition and environments directly and indirectly impact physical health and mental health.

Among the stressors that have been identified in underserved neighborhoods are lack of access to: safe outdoor spaces for physical activity and respite from overcrowded living situations, grocery stores that carry quality food at affordable prices, and childcare for parents working outside of the home while schools are closed. The frequent presence of immigration enforcement (e.g., near COVID-19 testing sites and healthcare facilities) has been noted as a salient stressor for underserved Latinx communities that is affecting their health and wellbeing.

We recommend that NIMH and partner institutes undertake sponsorship of research on each of these social determinants of physical and mental health. Such research could also examine how multiple determinants interact and identify avenues to reduce immediate and long-term risks to health.

In addition, we offer the following suggestions on other areas of interest for which the RFI seeks input.

Regarding research that addresses racism and discrimination, either to test interventions or shed light on mechanisms of action, we encourage additional research on mental health stigma within underserved communities. For instance, identifying ways to overcome misconceptions and cultural dynamics (e.g., gender roles) that interfere with help-seeking behavior is much needed. Also, research on beliefs and attitudes about psychotherapy, psychiatric medication, and non-traditional healing practices will provide valuable information for understanding and overcoming existing disparities that stem from stigma.

The vaccine research of Janice Kiecolt-Glaser and colleagues at the Ohio State University raises interesting questions about the impact of stress on immune response in health disparity populations. Much of the toll of racism has been measured in terms of stress, either acute or compounded. Kiecolt-Glaser's research has demonstrated weaker and slower immune responses to vaccinations in populations experiencing great stress (see her work in caregivers (1996) and medical students (1998) in particular) compared to controls. Stress is almost certainly higher in racial and ethnic minority populations experiencing significant economic uncertainty, greater exposure to the coronavirus, and experiences of stigma and racism. Studying immune responses to the new coronavirus vaccines in health disparity populations would provide an opportunity to examine stress with an important biomarker.

There is a need to study mechanisms of risk and resilience in underserved populations using culturally and contextually appropriate frameworks. For example, in a patient-focused intervention, communications between African-American patients and racially discordant primary care providers were improved after the patients completed a values affirmation exercise (Havranek, 2012). It would also be helpful to understand the psychological and social mechanisms that underly various coping strategies (e.g., behavioral, cognitive, spiritual) that help people to build resilience. Innovative research methods will be valuable in this area, including use of mobile technologies to track behavior and psychological and physiological states in real time.

Regarding systems-level factors that may influence mental health outcomes among minority and health disparities groups, it is critical to conduct research to design and test training models for building a sustainable interdisciplinary workforce equipped to meet the mental health needs of

underserved communities. Garcini and colleagues (in preparation) identified nine core training areas for professionals and organizations working to address the mental health needs of these communities: (a) communication skills that facilitate active listening and validation; (b) symptom identification and screening, including suicide prevention and non-traditional symptoms; (c) trauma, including vicarious and racial trauma; (d) stress reduction strategies that are context sensitive; (e) strength-based approaches that foster resilience, motivation, sense of meaning, and purpose; (f) overcoming mental health stigma; (g) increasing cultural sensitivity, including learning how cultural factors may impact mental health and treatment attitudes; (h) information processing, including how to use technology and media in ways that are culturally sensitive; and (i) provider self-care when working with underserved communities. Also, a recent article by Cenat (2020), "How to provide anti-racist mental health care," offers guidelines for building trust between health care workers and systems and the minority patients they aim to serve, which might raise additional research questions. For example, studies to inform how such skills can be taught effectively would be useful.

Regarding new methods or tools for measuring mental health outcomes in minority and health disparities populations, we encourage NIMH to support research on how to recruit and retain members of underserved communities, particularly those from hidden and hard to reach populations, in mental health care and mental health research. This work could identify factors that inhibit or facilitate inclusion of marginalized populations in health efforts at all stages of prevention and treatment. Moreover, given that the web can be an effective platform for assessment and intervention (Fox et al., 2019; Larsen et al., 2020), it may be beneficial to study ways to increase access to technology within these communities (e.g., providing access to mobile phones with unlimited data, free WiFi).

There is a need for the development of culturally and contextually sensitive assessment measures and batteries that include consideration of non-traditional symptom presentation and mental health distress beyond the framework of DSM-5. These efforts also would take into account various cultures' concepts of distress and aim to capture the multiple ways in which trauma-related distress can be manifested, including among communities of non-western backgrounds. They might also aim to measure directly aspects of culture and context that can influence mental health conditions and treatment outcomes.

Regarding development of prevention interventions to address racism/discrimination to reduce risk for mental disorders and improve mental health, we are eager to see research that takes a lifespan developmental approach, including work that focuses on early development and the early impacts of social determinants of health, inequality, and racism. Interventions should operate within the contexts of pregnancy, parenting, and early childhood education. Ideally, research would follow the effects of such interventions longitudinally. We suggest too that the experiences and needs of sexual and gender minorities be considered in developing prevention interventions.

Other approaches that have been less widely studied, but that seem promising among underserved communities, might also be considered in developing prevention interventions. These include, for instance, life narrative approaches, existential therapies that facilitate meaning

making and life purpose, and faith-based approaches and spirituality. Interventions of these types could be integrated into more standard approaches.

Research on emergency responses to public health crises such as the current pandemic is needed. Disasters and emergencies create difficult conditions for those with mental health problems, and planning and preparation is essential. Research on how to build and deploy emergency response teams to effectively deliver information and resources to underserved communities in a timely manner could help reduce risk. These emergency response teams need to be embedded within underserved communities, as well as in relevant environments such as work sites and healthcare facilities. Risk communication and messaging in the context of emergencies is another area that would benefit from further research. Such work could lead to more effective strategies for message framing and overcoming false beliefs and could be especially useful when pursued in collaboration with media sources and channels that are preferred by underserved communities.

Finally, we encourage a focus on scientific workforce issues. It is critical to train and support researchers who come from the communities that our science aims to understand and engage with. Barriers to developing such researchers – whether they be educational, institutional, or related to research topic – need to be addressed and overcome.

Many thanks for the opportunity to share these ideas. We at APA are available to work with NIMH to further develop and implement them. Please contact me or Pat Kobor (pkobor@apa.org) with any questions or for further discussion.

Sincerely,

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Deputy Chief Executive Officer and
Acting Chief Science Officer

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