The Social Determinants of URBAN MENTAL HEALTH: Paving the Way Forward

CONFERENCE PROCEEDINGS

Hosted by the Adler School of Professional Psychology
Institute on Social Exclusion

Jointly sponsored by the University of Illinois at Chicago
College of Medicine and the Jane Addams College of Social Work
The Social Determinants of Urban Mental Health: Paving the Way Forward

Table of Contents

Introduction ................................................................. 3
1 Keynote Address: Michael Marmot ............................... 4
2 Plenary Address: Kwame McKenzie .............................. 9
3 Plenary Address: Sarah Curtis ................................. 11
4 Research Panel: Jennifer Ahern and Alex Richardson ........ 13
5 Research Panel: Frances Ming Kuo and Liam Downey ....... 16
6 Legislative Framework Panel: Marice Ashe and Mark Hatzenbuehler ........ 18
7 Public Agencies Panel: Bechara Choucair and Margaret Round .......... 21
8 Foundations Panel: Rachel Wick and Jane Lowe ............. 24
9 Post-Conference Workshop: Mental Health Impact Assessment .......... 27
Acknowledgements ....................................................... 29
Introduction

In Chicago on September 19-20, 2012, the Adler School of Professional Psychology’s Institute on Social Exclusion (ISE) brought together the world’s leading minds on the social determinants of mental health for “The Social Determinants of Urban Mental Health: Paving the Way Forward.” At this conference, they discussed the many ways in which city living can affect the mental well-being of urban residents, particularly those most vulnerable.

Experts and thought leaders called for researchers to pay more attention to how social conditions such as poverty, violence and isolation in urban areas can harm the mental health of underserved individuals and communities. They addressed half of the world’s population living in cities.

Professor Sir Michael G. Marmot’s opening words, a snapshot of his pioneering work over the last 35 years, encouraged attendees to think differently and recognize that the purpose of researching the social determinants of urban mental health is social justice, and the role of researchers is to provide practical steps to achieve it. Those practical steps come with groundbreaking work, and all of our conference speakers are doing just that. From Jane Isaacs Lowe’s extraordinary dedication working with vulnerable populations with the Robert Wood Johnson Foundation, to understanding how nutrition increases mental health risk from the pioneering work of Dr. Alex Richardson, powerful and multidisciplinary knowledge illuminated the conference.

ISE Executive Director Dr. Lynn Todman, Vice President for Leadership in Social Justice at the Adler School and a prominent U.S. expert on the link between public policies and the mental health of urban communities, closed the conference with a special workshop around her work with Mental Health Impact Assessment.

Exciting conversations took place in the room and online about the research, practice, and insights presented—and it is critical that they continue.

Of the many thought-provoking statements heard over the conference, Dr. Marmot’s opening address continues to resonate: "Our purpose must be one of social justice; our role is to provide practical steps."

In your own important work: How will you fulfill that role?

For more information about “The Social Determinants of Urban Mental Health: Paving the Way Forward” or the Adler School’s Institute on Social Exclusion and its MHIA project, visit adler.edu/ISE or email ISE@adler.edu.
Keynote Address

Professor Sir Michael G. Marmot, M.B.B.S., M.P.H., Ph.D.
Director, UCL Institute of Health Equity (Marmot Institute)
Chair, European Review on the Social Determinants of Health and the Health Divide

“Taking Action on Social Determinants to Improve Mental Health in Urban Settings”

“The Social Determinants of Urban Mental Health: Paving the Way Forward” conference commenced with an enlightening keynote address by Professor Sir Michael Marmot, Director of University of College London’s (UCL) Institute of Health Equity, and Chair of the European Review on the Social Determinants of Health and the Health Divide.

Professor Marmot’s presentation elucidated the important role of mental health in the construct of the social determinants of health.

In his opening remarks, Marmot gave three reasons mental health is important to the social determinants of health.

First, mental illness is a major cause of morbidity and mortality. In addition to causal mechanisms, mental health and illness are key outcomes when health disparities exist.

Moreover, Dr. Marmot maintained, mental health is not distinct from physical health; mental health is health. Second, as Marmot stated, “The mind plays a very important role in linking the social environment to physical disease.” Marmot used the analogy of a gateway to illustrate how the social environment influences the physical environment.

Third, Marmot challenged the audience by saying, “We treat people with mental illness...people with disability disgracefully.” Marmot suggested that by addressing mental health disparities, we have an opportunity to be inclusive of everyone, particularly those with mental illness.

During his presentation, Marmot focused on the effect of socioeconomic position and mental health disparities. This framing allowed him to enumerate action steps to address social determinants of health in his final remarks.

THE GRADIENT PHENOMENA

Citing from his work entitled “Social Determinants of Health Inequalities,” Marmot introduced the social gradient in health. Using a table to illustrate the level of income deprivation and life expectancy, Marmot stated, “the gap between 5% [the poor] and 95% [the rich] is 7 years... in smaller areas of the country...a 17 year gap in life expectancy.” Marmot critically challenged the use of the term “health inequalities” and suggested that the term assumes a categorical focus—studying the poor or those in poverty. His sloped graph illustrating life expectancy and socioeconomic position suggested a different conclusion. To better understand the nature of health inequalities, Marmot stressed the use of a gradient perspective. “It’s a gradient phenomenon from top to bottom and the implications of that are quite profound.” Marmot profoundly noted:

“If you focus on the poor, you’ve got to do something about poverty. If you focus on the gradient, you’ve got to do something about society. We are all involved! It means doing something about the nature of society, not just trying to do something about the poor.”
THE EVIDENCE

To further demonstrate the social gradient of health, Marmot supplied tables of research to support his claims. First, he provided a table demonstrating a steep gradient illustrating disability-free life expectancy relative to socioeconomic position. He argued with statistical support, “the most affluent live their lives with about 12 years of disability, and the least affluent live about 20 years of their shorter lives with disability.”

Marmot used economic reasoning to justify cost efficiency and effectiveness to taking action. To make his economic argument, Marmot used the British government’s recent push to increase the retirement age from 65 to 68. Utilizing the previous tables examining the effect of socioeconomic position and life expectancy and disability, Marmot argued, “Three-fourths of the population does not have disability-free life expectancy. If you want to advance retirement pension age to 68, you have to take action.” In other words, most of the population is likely to be disabled at 68 and therefore unable to work, having to rely on increased disability government funding.

Marmot continued to demonstrate the social gradient of health in his table examining gender inequity (as cited in the World Health Organization commission on Social Determinants of Health). He argued, “Very convincing evidence exists for gender inequity risk factors for depression, low socioeconomic position, low education, and unemployment and underemployment.” Additionally, “strong evidence exists for gender inequity risk factors for food insecurity and early nutrition deficiencies, gender inequity, and low income.” Examining lifespan data from European countries, Marmot noted how behavioral problems in children predict future outcomes and have important long-term consequences. Moreover, his analyses showed that adult deprivation correlated higher with depression compared to child deprivation.

SUMMARY OF THE EVIDENCE

Consistent with his role as researcher, Marmot referenced the World Health Organization (WHO), the Commission on Social Determinants of Health (CSDH), and the ‘Marmot Reviews’ (European Review, 2010 – 2012; English Review, 2008 – 2010; Global Review, 2005-2008). He recommended the audience review these documents to further appreciate the existing evidence.

DO WE HAVE THE WILL? UNFAIRNESS AND BLAMING

After citing the evidence, Marmot turned to discussing the barriers to action. He argued, “We have the knowledge, and the means to close the gap in a generation—the question is, do we have the will?” In spite of the major challenges that arise in energizing people to take action, Marmot proposed a simple solution:

“Put fairness at the heart of all policy making and health will improve and health inequalities will diminish.”

Marmot argued that one of the barriers to achieving fairness is the definition itself. Marmot suggested current governments (referring to England’s government specifically) do not use the word fairness with meaning:
“I use the word fairness in a particular way. As a doctor, I’m concerned with health outcomes. Systematic inequalities in health between social groups that are deemed to be avoidable by reasonable means are unfair. Hence, any action that retards progress toward reducing these avoidable health inequalities, are unfair. Quite simple.”

In addition to skewed definitions, Marmot provided reasons for what may hinder fairness. He pointed to blaming of the poor and the mentally ill as one such reason. Marmot used a “My Fair Lady” example and referenced the MIT-authored book, “Poor Economics,” in which socioeconomic position and need is highlighted. Marmot posited that socioeconomic position does not determine need: “The poor are no different from us. The fact that I’m poor doesn’t mean that I need any less than the next man.” He further contested the traditional blaming argument, which suggests that the poor are less active in finding work, by noting that in England there are 50 applicants for every job vacancy. He then highlighted the role of narrative, suggesting that society is prone to generalize rare examples to everyone in a given group.

How can blaming and unfairness be remediated? Marmot argued mental health and mental illness should be considered at the global policy level in a similar fashion to the way public health and public illness is considered.

**SIX DOMAINS OF RECOMMENDATIONS**

In The Marmot Review Executive Summary: Fair Society, Healthy Lives (2010), Marmot addressed future recommendations within six different domains. In his keynote address, he discussed five in some detail. [He did not discuss education].

1. **Child development:** Once again, the gradient phenomenon is evident in examining data on child development. Marmot presented research to suggest that 56% of children in England are classified as having a good level of development by age five. Moreover, Marmot and colleagues found that reductions in inequalities based on income deprivation break the link between where you are on the social hierarchy and poor health outcomes. For the audience members still questioning, Marmot provided a success story from Birmingham, UK, where the city narrowed the health outcome inequality gap in three years. When Marmot asked the City of Birmingham how they accomplished this, they responded, “We just focused on it.” Marmot is currently working with Birmingham to develop concrete steps that other cities may seek to replicate.

2. **Employment or working conditions:** Marmot suggested unemployment causes ill health and emphasized it is the nature of the work that really matters (as evidenced in “Work, Stress and Health: The Whitehall II Study”). Marmot described the current sociopolitical environment and the employment policies in Europe, citing evidence for an association between increased unemployment with a rise in suicide and homicide. Marmot further stated, “I’ve argued that predictably these policies...of Europe will increase suicide.” Additionally, Marmot listed “lack of control, high demand, lack of support, effort reward imbalance...[and] low organization justice” as major predictors in explaining 1/3 of mental illness that occurs in the working population. He concluded, “employment is good for mental health but the nature of work really matters.”

3. **Gender equity:** As previously discussed, Marmot argued that a higher risk of depression exists among women and this is likely related to “multiple responsibilities, caring responsibilities, lack of support, gender-based violence, lack of access to healthcare, poor physical health, education, lack of autonomy, [and] migration.” Additionally, Marmot suggested that low control at home, particularly for women of low socioeconomic position, is associated with a “huge increase in depression.” Marmot further asserted low control at home for women of low socioeconomic position is more salient than low control at work.

4. **Healthy living places:** Marmot cited evidence of a gradient between deprivation and lack of social support. Additionally, a graph illustrated the correlation between the top 1% in socioeconomic position in the United States and the pattern of economic growth and recession. Marmot hypothesized when the top 1% held 23% of total household income (i.e., 1928 and 2007) the result was an economic recession. In comparison, during the USA’s greatest economic growth, the top 1% held 10% of total household income (i.e., late 1970s). To further illustrate his position, Marmot used an example of parent and adult children socioeco-
nomic position. Marmot found England to have less rigidity in class structure and more social mobility compared to the United States. In other words, “the bigger the inequalities—the greater the gap between the rungs of the ladder—the more difficult it is to get from one rung to the next.” Furthermore, Marmot suggested good urban design exercises green space, encourages social and group cohesion, and improves self-esteem and total mood disturbance.

**Ill health prevention:** Drawing on evidence from studies in alcohol, Marmot discussed the gradient in ill health. His research found a social gradient when alcohol consumption is compared to socioeconomic position (e.g. individuals occupying high socioeconomic positions are more likely to consume alcoholic beverages). Additionally, a gradient relationship exists between alcohol-associated harm (e.g. hospital admissions and mortality) and an individual’s socioeconomic position (e.g. individuals occupying low socioeconomic positions are more likely to experience alcohol-associated harm). In summary, Marmot hypothesized socioeconomic position may influence patterns of alcohol consumption and/or harm. Further, he suspected other social and psychological disparities might influence an individual’s susceptibility to the ill effects of alcohol. For example, when Marmot and Sir Harry Burns, Chief Medical Officer in Scotland, specifically examined the high mortality rate in the city of Glasgow (UK), they found evidence that people who find themselves in a subordinate position (i.e. low control, low self-efficacy and esteem) tend to suffer alcohol-related harm. Marmot and Burns concluded the causes of premature deaths in Glasgow are largely “psychosocially determined” with drug-related poisonings, alcohol, and suicide as the top three causes of death. Still, Marmot contended “Health inequalities are not inevitable or immutable.”

**FINAL REMARKS**

In closing, Professor Sir Michael Marmot asserted, “Our animating purpose has to be one of social justice. But it is important to get the evidence to show the practical steps we can take to achieve that end.”

During the question and answer period, Marmot suggested, “be a part of the debate and vote the rascals out” when asked by a participant how to address the political power differential in achieving change. Additionally he stated, “talk from the evidence.” Marmot suggested reducing health inequalities is a moral issue, and as a physician, he is genuinely interested in alleviating human suffering. A personal goal for Marmot when navigating the “political jungle” is to get the politics to be honest by using evidence.

Two participants asked for recommendations regarding the particular roles medical and mental health professionals can play in alleviating health inequities, improving healthcare delivery, and galvanizing action. Marmot began by commenting that advanced nations of the world should provide universal access to healthcare. Specifically, Marmot suggested that physicians can begin to take action by [1] “Putting [their] own house in order,” noting they can provide political support to government officials who are prepared to take action on the social determinants of health; [2] advocating for cross-sector partnerships; and [3] presenting research findings in ways that contribute to change. For example, Marmot cited a truly comprehensive primary care center in East London that has over 100 non-medical programs, including English classes, community and early childhood development courses, and an occupational skills agenda. Marmot stated, “They can’t help their patients remain healthy and prevent illness unless they are addressing [patients’] lives.”

One participant asked Marmot to share community examples of successful cross-disciplinary collaborations. Marmot cited progress in India, highlighted by the establishment of a commission that used 16 indicators to monitor the social determinants of health. In a second example, Marmot cited how 13 government departments in Norway are developing new ways to discuss the social determinants of health. In Denmark, Marmot pointed out that health and housing departments now emphasize use of the “Health Cities Movement” to promote well-being. In Sweden, Marmot noted that local governments are sending representatives to meetings that discuss health disparities. Finally, Marmot observed that Brazil’s “Cash Transfer” program also addresses health inequalities.
One participant expressed concern regarding the trend in the United States in which younger medical professionals are pursuing specialty degrees as opposed to less prestigious primary care positions. The participant believed cross-sector or partnership collaboration is more likely to occur in the primary care setting and less in the specialty clinics. In response, Marmot cited a rewarding experience in which he made a presentation to the International Federation of Medical Student Associations. Marmot noted the “palpable energy” in the young medical professionals who seemed to take to the social determinants of health with idealism and optimism.

Finally, one participant expressed the need for “difficult conversations” in the United States particularly regarding “unyielding” racism. She asked, “What examples have you had where there was breakthrough on these very important topics?” Marmot highlighted disempowerment in action and the caste system in India. Researchers tested children who were a part of India’s caste system. Experimenters created three sets of conditions. Under one condition, researchers did not draw attention to caste background. In the second condition the experimenters drew public attention to the caste background, and in the third condition, they drew attention privately. Under the first scenario, test results of the children were similar—e.g., comparable across caste systems. However, if attention was called to the caste, publicly or privately (e.g., conditions two and three), lower caste children did significantly worse on the testing compared to their higher caste peers. Marmot stated, “This is disempowerment in action.” This breakthrough yielded only two results, not the expected three—knowing or not knowing. In other words, the fact of knowing the caste is what made it the determinant and contributed to disempowerment, not the fact of being in a particular caste. In his final remarks, Marmot illustrated in a similar example how social exclusion can become a social determinant of the health of Romani (Gypsy), Aborigine, and Indigenous people of around the world.

**BIOGRAPHY**

Sir Michael Marmot has led a research group on health inequalities for 35 years. He is Principal Investigator of the Whitehall II Studies of British Civil Servants, investigating explanations for the striking inverse social gradient in morbidity and mortality. He leads the English Longitudinal Study of Ageing (ELSA) and is engaged in several international research efforts on the social determinants of health.

He was a member of the Royal Commission on Environmental Pollution for six years and served as President of the British Medical Association (BMA) in 2010–2011. He is a Fellow of the Academy of Medical Sciences, an Honorary Fellow of the British Academy, and an Honorary Fellow of the Faculty of Public Health of the Royal College of Physicians. In 2000 he was knighted by Her Majesty The Queen, for services to epidemiology and the understanding of health inequalities. Internationally acclaimed, Professor Marmot is a Foreign Associate Member of the Institute of Medicine (IOM), and a former Vice President of the Academia Europaea. He won the Balzan Prize for Epidemiology in 2004, gave the Harveian Oration in 2006, and won the William B. Graham Prize for Health Services Research in 2008.

He was Chair of the Commission on Social Determinants of Health (CSDH), which was set up by the World Health Organization in 2005, and produced the report titled *Closing the Gap in a Generation* in August 2008. At the request of the British Government, he conducted Strategic Review of Health Inequalities in England post 2010, which published its report “Fair Society, Healthy Lives” in February 2010. He has now been invited by the Regional Director of WHO Euro to conduct the European Review of Social Determinants of Health and the Health Divide, which reported in September 2012. He has agreed to chair the Breast Screening Review for the NHS National Cancer Action Team. He is a member of The Lancet-University of Oslo Commission on Global Governance for Health.
Kwame McKenzie, M.D.
Medical Director
Centre for Addiction and Mental Health, Toronto, Canada

“How Do Cities Cause Mental Illness?”

Kwame McKenzie, M.D., Medical Director at the Centre for Addiction and Mental Health in Toronto, Canada, is an internationally recognized expert on the social causes of mental illness, suicide, and the development of effective equitable health systems. His presentation detailed known risk factors of psychosis and examined reasons why severe mental illness is more prevalent in large urban cities than other environments. Dr. McKenzie discussed the evolution of biological and social perspectives on the development of psychosis. He suggested that both viewpoints reflect an incomplete knowledge of the cause of psychosis. The distinction between risk factors and causes is important, as there is no clear cause of schizophrenia. Dr. McKenzie argued the clearest and most advanced understanding of psychosis lies in the study of their interactions across multiple dimensions of functioning.

The biological perspective on psychosis is the most widely known and researched throughout psychiatry and psychology. Decades of research have revealed a high genetic heritability and multiple genes involved in the development of schizophrenia. For example, having an identical twin with schizophrenia is the highest genetic risk factor of developing the disease. Obstetrics research discovered that children who experienced a lack of oxygen or infections during pregnancy were more likely to develop schizophrenia in adulthood. Such increased risk is believed to reflect changes in brain structure and functions such as dopamine pathways.

In contrast to biological risk factors, social risk factors concern aspects of the environment that impact childhood development. Research has shown that bullying and separation from parents before age 16 results in a higher risk of psychosis. Perhaps most interesting, the highest known social risk factor for developing psychosis is being born and raised in a large city. In fact, the longer one lives in a city during childhood, the greater the risk for developing psychosis. Living in a stressful city neighborhood, people face numerous daily hassles. Many of these daily stressors are not major traumas, but minor emotional injuries that accumulate over time. Both racism and the ethnic minority immigration experience also account for increased risk, which impart increased stress in daily life. The more one fears racism, the higher the risk. However, this risk holds true with any experience of discrimination, not solely on ethnic minorities. Dr. McKenzie asserted that several years of daily stress such as discrimination and poverty can impact a child or adult’s basic functioning and eventually lead to a breakdown of psychological resources.

As neither biological nor social risk factors alone can explain the onset of psychosis, Dr. McKenzie turned his attention to the evolution of models of causation throughout the history of science. Theories of causation have mirrored the technological and scientific eras in which they were created. For example, germ theory as a mono-causal approach emphasized the environment and factors outside the individual. Epidemiological and ecological approaches began to understand psychosis as a complex set of interactions that form interlocking chains of events.

In following models of causation throughout time, Dr. McKenzie noted that explanations continue to build on each other. The current public health perspective incorporates a four-dimensional model of causation. The four dimensions include individual factors, ecological or group-level factors, the interaction of those factors, and time. Dr. McKenzie emphasized that the most important aspect of the model is to look at the interactions of all four dimensions. For example, the urban environment changes the exposure to risk factors such as malnutrition and infection during pregnancy. There is also an interaction between ethnic minority group status and social cohesion. Social factors become more important with increased levels of stress, and an increasing list of factors are shown to have an impact on the developing mind during sensitive periods, such as using cannabis before age 16.
What current research and models of causation suggest is that social and biological risks are not solitary, but create interactions between genes and the environment. “Psychosis is not about the brain,” argued Dr. McKenzie. “It’s about bits of the brain trying to adapt... It is the mechanisms that we use to adapt to the environment.” The development of the brain and mind depends on environmental stimulation, which generates neuronal connectivity. Dr. McKenzie drew a comparison of the brain and emotions as muscles; to develop properly, one must have environmental information—the right ones at the right times.

Specific interactional effects impact the development of psychosis. Epigenetics refers to the reversible regulation of various genomic functions, which occurs independent of DNA sequencing. In other words, the specific environment directly impacts brain development. Early chronic stress impacts one’s stress signaling system and causes impaired neuronal responsiveness and symptoms of prefrontal cortical dysfunction. Repeated exposure to environmental risk factors may cause persistent and more severe symptoms over time.

Dr. McKenzie argued that the interaction of dopamine dysregulation and a cognitive schema attempting to grapple with stressful experiences and give them meaning leads to the development of psychotic symptoms.

The four-dimensional and interactional model points to a new way of thinking about psychosis. Rather than focusing on biology or the social environment, it is most pressing to understand the mechanisms linking the two. In stating this point, Dr. McKenzie made an important distinction between mind and brain. Whereas brain is a biological organ, the mind is the felt experience of the brain interacting with the environment.

Childhood environment is the context for which the developing mind adapts to the world, socially and biologically. Maintaining a focus on the interactions and mechanisms linking biology and the environment within the context of time will help re-orient our understanding of psychosis as a multi-level process. These problems lie in the mind, not the brain. The future of our understanding of psychosis lies in a science of interaction between the mind and the brain. This holistic and multi-level perspective will allow us to build biological and psychological treatments, along with providing better protective environments to help prevent the onset of psychosis.

BIOGRAPHY

Dr. McKenzie joined the Centre for Addiction and Mental Health and the University of Toronto in 2007.

He is an internationally recognized expert on the social causes of mental illness, suicide, and the development of effective, equitable health systems. As a physician, psychiatrist, researcher, and policy advisor, Dr. McKenzie has worked to identify the causes of mental illness and in cross-cultural health for over two decades. His research includes social, community, clinical and applied policy studies. He has international experience in Africa, Europe, the Caribbean, and United States.

Dr. McKenzie has set up award-winning services and has more than 100 academic publications including four books. He has trained countless clinicians and researchers and developed health policy for national governments in Europe and Canada. His clinical practice is in Toronto.

Trained in medicine at the University of Southampton, Dr. McKenzie’s psychiatric training was at the Maudlsey Hospital and Institute of Psychiatry (United Kingdom) and Harvard University (United States).

He is a past Member of the Council, Royal College of Psychiatrists (UK) and currently Medical Director, Centre for Addiction and Mental Health; Professor of Psychiatry, University of Toronto; and President, Canadian Mental Health Association, Toronto.
Sarah Curtis, D.Phil.
Professor of Health and Risk
University of Durham, United Kingdom

“Space, Place and Mental Health”

Professor Sarah Curtis addressed the conference via satellite relay from her office at Durham University in the United Kingdom (UK). An internationally recognized specialist in health geography, she discussed the numerous ways geographical settings influence mental health.

Dr. Curtis began her provocative presentation by asking the audience to participate in a “thought experiment” in which attendees imagined a comfortable and happy “special place” that promoted relaxation and recuperation. Embedded within the exercise was the request that participants visualize the answers to questions like: What kind of place is it? What are the features of the landscape? Are there people there? If so, who are they? Using this technique, she demonstrated that “places” are not merely locations but instead that places matter for health as Wil Gesler’s notion of therapeutic landscape suggests.

Indeed, places may constitute symbolic physical environments that embody civic pride or other emotional attachments. Places can be sacred places and conjure deep religious or secular feelings, social environments that give rise to a sense of community, or salutogenic properties like social capital and social cohesion. Most especially, Dr. Curtis observed settings and the social processes that occur within environments do matter for mental health because they promote or are detrimental to individual and collective well-being.

Dr. Curtis punctuated her comments by calling attention to the World Health Organization’s definition of health: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Noting the distinctions between individual and population health, she concluded that when one combines the individual with an ecological approach, a comprehensive model of social determinants of health emerges.

Dr. Curtis showed that researchers often join geographic information with human health data to examine the complex issues arising from social fragmentation, and to explore public policy remedies that promote the level of cohesion required to support good psychological health. Mortality information (e.g., suicide data), morbidity reports (e.g., data generated by physicians, nurses, and hospitals within clinical settings), and self-reports on illness and surveys provide useful measures of population-level well-being.

Describing research conducted by Townley et al. (2009), Dr. Curtis noted that 40 individuals who suffered from mental illness had drawn maps of their communities and participated in walking interviews. Townley’s research group then used GIS technology (i.e., “Geographic Information System”) to plot all of the places that appeared to be important to the interviewees. Quantitative and qualitative data derived from this inquiry permitted researchers to comment upon how particular places—many of which were scattered across an urban area and were not near interviewees’ homes—reduce social fragmentation and increase social cohesion and social integration, thereby facilitating and sustaining mental health.
Plenary Speaker: Sarah Curtis (continued)

BIOGRAPHY

Professor Sarah Curtis is an internationally recognized specialist in the geography of health, focusing on the geographical dimensions of inequalities of health and health care. Her scholarship elucidates how varying geographical settings relate to human health inequalities. Dr. Curtis was appointed as Professor of Health and Risk at the University of Durham in September 2006. Based in the Department of Geography, she also works closely with colleagues in other disciplines through the Institute of Hazard, Risk and Resilience and the Wolfson Institute.

Dr. Curtis holds a B.A. Hons. in Geography from Oxford University and D.Phil. in Urban and Regional Studies from the University of Kent. Before joining Durham University she worked as Professor in Geography at Queen Mary, University of London.

Dr. Curtis has been the Senior Editor for the leading international journal Social Science and Medicine (2003-2012), and she undertakes work for national Research Council committees and evaluation panels in the United Kingdom and abroad. She is a Member of the Society of Social Medicine, a Fellow, and a Chartered Geographer (Founding Member), of the Royal Geographical Society/Institute of British Geographers. She is also an Academician of the Academy of Social Sciences and a Registered Practitioner of the Academy for Higher Education.
Jennifer Ahern, Ph.D., M.P.H.
Assistant Professor of Epidemiology, School of Public Health
University of California-Berkeley, USA

“The Neighborhood Social Environment Shapes Mental Health and Health Behavior”

In recent years, research on the community characteristics that shape health has been an area of particular interest for social epidemiologists. Using New York as a model for the center of this research, Dr. Ahern indicated a body of evidence linking specific neighborhoods to health behaviors such as smoking and drinking. Individuals may question whether the specific place or the people living in that area caused the concentration of particular health behaviors. Dr. Ahern introduced the different geographic levels that people are exposed to like nations, states, and communities or neighborhoods. She explained there are certain factors that affect community level exposures including social interactions, availability of goods and services, and land use.

Dr. Ahern’s presentation focused how the social environment of individuals can impact mental and physical health behaviors. These behaviors can manifest through violence, depression, and smoking. While researching the relationship of these three factors to collective efficacy, Dr. Ahern controlled for individual perception of the community, which can confound the studies.

Research on community factors that shape violence began in Chicago, where there has been an historical process of marginalizing and isolating certain communities. This produces conditions of structural disadvantage that is evident in concentration of poverty for racial and ethnic minorities. Collective efficacy, an important concept that derives from this research, comprises social cohesion and informal social control. The former signifies mutual trust and shared values while the latter represents willingness to intervene for the common good of a community. Collective efficacy captures the social capacity that deteriorates in marginalized communities. Deterioration of collective efficacy may ultimately lead to violence in these communities. In Chicago, research has found a relationship between collective efficacy, youth firearm possession, dating violence, and adolescent suicide attempts. In New York City, efforts to recreate this study found strong relationships between collective efficacy and violence.

Dr. Ahern suggested low collective efficacy influences poor mental health. The informal social control flowing from positive collective efficacy may reduce stressful events within a community. If high levels of social cohesion are experienced, individuals can provide social support to residents within the community. This has a buffering effect on stressful events when they do occur. Although current studies in the United States show that lower collective efficacy is linked to more depression or depressive symptoms, similar results have been obtained in other countries. This may be a result of the less egalitarian nature of the United States as compared to other countries. Dr. Ahern found that, although there did appear to be a strong relationship between collective efficacy and depression, the correlations were strongest for those 65 years and older.

A persistent challenge for researchers is the ability to disentangle social selection from social causation. Researchers must ask whether one’s past health influences his or her current health status or whether one’s current place of residence affects health. There has been limited longitudinal or intervention data to help unravel this issue. Dr. Ahern recommended that interventions target interpersonal interactions like communal activities that increase collective efficacy. Those interventions should be aimed at reducing marginalization and providing access to needed resources and services.
Dr. Alex Richardson
Senior Research Fellow, Department of Social Policy and Intervention, University of Oxford
Founder/Director, Food and Behaviour Research, Inverness, Scotland, United Kingdom

“The Importance of Nutrition for Mental Health”

Dr. Richardson opened her presentation by introducing a photo depicting humankind. This familiar photo portrays the typical ape slowly progressing to the image of an evolved man. However, there was one startling aspect of this photo: the last evolutionary change shows an obese man carrying a supersized soda cup, mocking America’s diet. Through her research on nutrition and mental health outcomes, Dr. Richardson found nutrition to be a principal factor that society continues to ignore.

People generally acknowledge that nutritionally poor diets pose physical risks to children; however, they do not always acknowledge that poor nutrition may also result in poor mental health outcomes. Nutrition also has been linked with antisocial behavior in the youth population. For example, researchers conducted a study on inmates at a high security youth prison in the UK, giving a daily multi-vitamin and fatty acid supplements to youth offenders. A decrease in the rate of disciplinary incidents in those who were treated compared to those who were given a placebo treatment was found. Hence, simply changing youths’ diets appeared to lessen aggressiveness.

Foods containing large amounts of sugar can affect mood, behavior, and cognition by creating a cycle of rapid increases in the blood sugar level followed by rapid decreases. Individuals optimally function and perform when blood sugar levels are stable. Studies show that sugar has opiate-like effect on gene expression in reward areas of the brain in rats. As a result, high-sugared foods may be addictive, causing the typical consumer to overload on foods high in sugar.

A diet that consists of high amounts of altered fatty acid, or fat, can also be detrimental to mental and physical health. However, Dr. Richardson argued that consuming the right fats is vital to our diets. Some fats, like Omega-3 and Omega-6 fatty acids, are essential. She believes that proper nutrition is necessary for brain development as it is composed of 60 percent fat. Foods popular in this culture contain high levels of hydrogenated and trans-fat, which have no known nutritional benefits and many health risks. In 2009, the World Health Organization (WHO) declared that trans-fat is toxic and raises the risks for inflammation, obesity, Type II diabetes, and cardiovascular disease. Trans-fat is also associated with depression, anxiety, memory problems, irritability, and aggression. Despite the significance on mental and physical health, people continue to consume foods high in trans-fat.

The American Psychiatric Association has generated several recommendations for improved nutrition. First, all adults should eat fish at least twice a week. Second, patients with mood, impulse control, or psychotic disorders should consume 1g/day of eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA), which are Omega-3 essential fatty acids found in fish oil. Lastly, supplements, such as vitamins, may be useful in patients with mood disorders. Proper nutrition, specifically Omega-3, is vital in young children. Evidence from randomized control trials has shown significant benefits for children with dyslexia, dyspraxia, and/or attention deficit/hyperactivity disorder (ADHD).

To conclude, Dr. Richardson reemphasized the importance of nutrition, not just for our brains, but for our bodies as well. Controlled trials have shown benefits for mood, behavior, and cognition from dietary interventions, such as supplementation with long-chain Omega-3 fatty acids and withdrawal from artificial food colorings. She also believes that modern, Western-type diets are unhealthy, and that they are affecting the way our brains develop and function. The concern is not just about obesity, but the effect on mental health and performance throughout life.
BIographies

Jennifer Ahern, Ph.D., M.P.H.

Dr. Jennifer Ahern is a social epidemiologist who has published extensively on neighborhood-level determinants of health and health behaviors. As part of this body of research she has focused on mental health, substance use, women’s health, and birth outcomes. She has also conducted research on the health effects of traumatic events. Dr. Ahern’s work is methodologically focused, including the application of causal inference methods to the study of social factors.

Dr. Alex Richardson

Alex Richardson is best known for her research into how nutrition (and particularly fatty acids) can affect behavior, learning and mood; although her work also involves several large-scale collaborative programs that include studies of epidemiology, genetics, brain imaging, biochemistry and nutrition as well as physiological and psychological functioning. Her primary research interests include a) the role of nutrition in brain development and function, and its implications for behavior, learning and mood, and b) the biology of individual differences in personality, perception and cognition, particularly in relation to developmental and psychiatric disorders.

Her current research examines on the role of fatty acids in relation to both normal individual differences and developmental and psychiatric disorders such as dyslexia, dyspraxia, ADHD, autism, depression and schizophrenia. Recent and ongoing work includes controlled treatment trials to investigate the effects of dietary supplementation with fatty acids in relation to features of these conditions, experimental studies of possible underlying mechanisms, and collaborative investigations of the epidemiology and genetics of neurodevelopment disorders.

Dr. Richardson’s research has always been aimed at developing new methods of identification and management that will have real practical benefit. She therefore works closely with a range of education and health practitioners as well as local and national support groups and charities. In addition to her role as a founder director of FAB Research, she also helped to found the Dyslexia Research Trust, was a co-opted Trustee and Scientific Advisor to the Dyspraxia Foundation, serves on the Biomedical Research Committee of Autism Unravelled and the Autism Treatment Trust, and liaises closely with the Hyperactive Children’s Support Group among others.

Dr. Richardson is also the author of They Are What You Feed Them, a widely-acclaimed book written for parents and professionals that explains how and why children’s diets can affect their behavior, learning and mood, and offers easy-to-follow practical advice based on the latest scientific evidence. All author proceeds from this book are dedicated to the FAB Research charity.
Frances E. (Ming) Kuo, Ph.D.
Associate Professor and Director, Landscape and Human Health Laboratory
University of Illinois at Urbana-Champaign, Urbana, Illinois USA

“Nature in the City: An ‘Overlooked’ Factor in Urban Mental Health”

Liam C. Downey, Ph.D.
Associate Professor, Environmental Studies Program Institute of Behavioral Science
University of Colorado, Boulder, Colorado, USA

“The Mental Health Impacts of Living Near Industrial Activity”

Associate Professor of Sociology and a member of the research faculty at University of Colorado Boulder’s Institute of Behavioral Research, Dr. Liam Downey discussed his expertise in environmental inequality. He discussed his and others’ research over the past 20 years demonstrating associations between neighborhood diversity composition (i.e. race, ethnicity, socioeconomic status) with pollution levels and with the presence of other environmental hazards. His research specifically examined the mental health effects of living in industrial neighborhoods or in those with extensive environmental hazards.

Dr. Downey’s research found that living in close proximity to industrial activity has a direct and positive association with perceptions of neighborhood disorder, feelings of personal powerlessness, and depression. His research specifically found that these effects were more severe for lower-income versus higher-income individuals as well as higher among Hispanic and African American respondents than White respondents. This effect is likely exacerbated among ethnic minorities and low-income individuals for multiple reasons. First, they are more likely to live in polluted or highly industrialized neighborhoods. Secondly, people who make decisions regarding acceptable pollution levels often do not live within the communities housing industrial facilities, and policies are often created without consulting the local communities. Furthermore, residents of polluted or highly industrial areas often lack the resources to escape their neighborhoods. Like noise, vandalism, and drug use, Dr. Downey and colleagues’ research suggests that living in close proximity to industrialized areas increases psychological distress by constantly reminding residents that they live in unsafe, unhealthy, and socially undesirable neighborhoods.

Dr. Downey’s research found that living in close proximity to industrial activity has a direct and positive association with perceptions of neighborhood disorder, feelings of personal powerlessness, and depression. His research specifically found that these effects were more severe for lower-income versus higher-income individuals as well as higher among Hispanic and African American respondents than White respondents. This effect is likely exacerbated among ethnic minorities and low-income individuals for multiple reasons. First, they are more likely to live in polluted or highly industrialized neighborhoods. Secondly, people who make decisions regarding acceptable pollution levels often do not live within the communities housing industrial facilities, and policies are often created without consulting the local communities. Furthermore, residents of polluted or highly industrial areas often lack the resources to escape their neighborhoods. Like noise, vandalism, and drug use, Dr. Downey and colleagues’ research suggests that living in close proximity to industrialized areas increases psychological distress by constantly reminding residents that they live in unsafe, unhealthy, and socially undesirable neighborhoods.

Dr. Francis Kuo is Associate Professor at the University of Illinois at Urbana-Champaign and Director of the multidisciplinary Landscape and Human Health Laboratory. Her current research examines how the presence of trees, grass, and other natural elements within the immediate physical environment supports health in individuals and communities. Research consistently found links between mental and physical well-being with the presence of nature. She discussed her research that found living in an environment with trees or greenery substantially lowers the risk of developing clinical depression, anxiety disorders, and physiological stress levels. Other studies she mentioned found significant links with urban ecosystems and neighborhood safety, reduced ADHD symptoms, reduced verbal and physical aggression, and improved cognitive performance. This body of research, she concluded, may partially explain income-related mental-health disparities. For example, some percentage of negative psychological outcomes is likely related to the differential access to green spaces.

Dr. Kuo argued her research suggests greenery and natural elements around our living environments deserve the attention of city dwellers and policy makers. Improving green spaces may have a legitimate capacity to improve population-level mental health in a cost-effective manner. This is a relatively easy investment and powerful intervention that would foster feelings of tranquility, connectedness to nature, increased subjective well-being, and a decrease in clinical disorders.

Both Dr. Downey and Dr. Kuo’s research examine how different environmental mechanisms directly lead to psychological outcomes. The audience discussed differences between urban and rural environments, as the speakers primarily focused on urban environments. Additionally, Dr. Kuo highlighted how her research influenced the City of Chicago to implement a multi-million dollar initiative to plant trees across the city, demonstrating the effect such research can have on helpful public
Adler School of Professional Psychology

Research Panel: Frances Ming Kuo and Liam Downey (continued)

Policy. The panel discussion concluded with acknowledging the research lacks people's perceptions of what particular buildings or contexts mean, which may differ across class or ethnic lines. The panels' take-home message was clear: Urban landscape and environmental context largely affect residential mental health, and policy makers would do well to more fully consider population psychological welfare in decision-making.

BIOGRAPHIES

Frances E. (Ming) Kuo, Ph.D.
Associate Professor and Director, Landscape and Human Health Laboratory
University of Illinois at Urbana-Champaign, Urbana, Illinois USA

Frances E. (Ming) Kuo is a nationally and internationally recognized scientist examining the impacts of urban landscapes on human health. Her research focuses on how the presence of trees, grass, and other natural elements within the settings of daily life supports healthy human functioning in both individuals and communities. Starting in 1993, she led a series of studies on the impacts of green residential spaces on human functioning in inner city Chicago, for which she and her collaborators received the Environmental Design Research Association’s Achievement Award. Subsequently, she and her former student, Dr. Andrea Faber Taylor, began examining the impacts of green spaces on Attention Deficit/Hyperactivity Disorder (AD/HD). Their investigation has yielded evidence of a cause-and-effect relationship between physical environments and AD/HD symptoms, as well as a national study documenting the generalizability of this relationship.

In addition to her AD/HD work, Dr. Kuo is investigating positive impacts of schoolyard environments on students’ academic achievement (as measured by standardized test scores), as well as how residential environments can support active living among older adults. Dr. Kuo’s work has convincingly linked healthy urban ecosystems to stronger, safer neighborhoods, lower crime, reduced AD/HD symptoms, reduced aggression, and an array of mental health indicators. Dr. Kuo recently completed a review of the scientific evidence for the role of green environments in a healthy human habitat for the National Recreation and Parks Association.

Dr. Kuo is a faculty member at the University of Illinois at Urbana-Champaign, where she directs the multidisciplinary Landscape and Human Health Laboratory. She holds appointments in both the Department of Natural Resources and Environmental Sciences and in the Department of Psychology.

Her background is in cognitive psychology and environmental psychology, with degrees from the University of California, Berkeley [M.A.] and the University of Michigan [Ph.D.].

Liam C. Downey, Ph.D.
Associate Professor, Environmental Studies Program Institute of Behavioral Science
University of Colorado, Boulder, Colorado, USA

Dr. Downey’s primary sociological interests include race and class inequality in the political, environmental, and economic realms. He is currently studying environmental inequality in metropolitan America, the mental and physical health impacts of residential proximity to polluting manufacturing facilities, and the impact that residential segregation has on residential proximity to manufacturing jobs and pollution. He is also conducting research that seeks to discover whether female-headed families are more likely than male-headed families and married couple families to live near polluting manufacturing facilities.

In addition to conducting research, he has devoted considerable energy to demonstrating the potentially important role Geographic Information Systems (GIS), a form of mapping software, can play in advancing sociological thinking and research. He is also conducting a new research project that examines the relationship between economic inequality, democracy, and environmental degradation at the national and global levels.
The Social Determinants of Urban Mental Health: Paving the Way Forward

Marice Ashe, J.D., M.P.H.
Founder and CEO
ChangeLab Solutions, Oakland, California, USA

“What's Law Got to Do with It?”

Mark L. Hatzenbuehler, Ph.D.
Assistant Professor of Sociomedical Sciences, Mailman School of Public Health
Columbia University, New York, New York, USA

“Social Determinants of Mental Health Disparities in Lesbian, Gay, and Bisexual Populations”

The second day of the conference commenced with an informative panel discussion by Marice Ashe, J.D., Founder and CEO of ChangeLab Solutions in Oakland, California and founder and Executive Director of Public Health Law & Policy and Dr. Mark L. Hatzenbuehler, Assistant Professor of Sociomedical Sciences at the Mailman School of Public Health, New York, New York. The panelists described the legislative framework for social determinants work, and provided examples of current initiatives to improve public mental health outcomes through the use of law, public policy, and cross-professional collaborations.

Dr. Ashe initiated the discussion by addressing the impact law has on social structures and public mental health. Laws can create or limit the conditions in which people become healthy; she emphasized the needs of disenfranchised and under-resourced communities. She presented statistics addressing the health disparities between individuals from low-income and high-income neighborhoods. The data indicated that individuals from areas of high concentrated poverty and low income are at higher risks of experiencing adverse health outcomes and lower life expectancy, and the health risks for this population are expected to worsen over the life span. Mental health disparities among this population include lack of social capital and solidarity.

Dr. Ashe presented a pyramid on intervention strategies from the U.S. Centers for Disease Control and Prevention emphasizing that most impact can be seen in public health when working at the level of socioeconomic factors such as poverty and racism. However, in terms of public policy intervention, she suggested that most impact can be seen when working one step from the bottom aimed at changing the context in which people live in order to make the individual’s default decisions easier. She suggested that public policy makers must address how the law should be used to change the context in which people live to improve overall health outcomes.

She invited audience members to mentally place themselves in the context of concentrated poverty through displaying a series of photos characteristic of high-poverty neighborhoods. The pictures showcased food deserts; the lack of healthy food options; the overabundance of liquor and corner stores; streets with no sidewalks, bike lanes, or accessibility for the elderly or disabled; decrepit and vacant housing; lack of public facilities; and the disruption of these neighborhoods by freeways. Dr. Ashe explained how these social determinants can directly impact depression, anxiety, substance abuse, lead poisoning, asthma, heart disease, obesity and decreases in intellectual functioning.

Ashe used a study from Health Affairs (2011) as an example of how intervention strategies can address morbidity rates brought on by extreme poverty. The study asked how many deaths could be prevented if access to care, quality of care, and prevention efforts were improved over a 25-year period. Findings indicated that if the status quo is maintained, more than 64 million preventable deaths will occur. Dr. Ashe argued that only with public policy prevention efforts will the cost of care plummet, and the quality and accessibility of health improve.

She concluded her presentation with examples of public health strategies aimed at improving health by addressing the context in which people live. These strategies included building complete streets, improving the pedestrian...
environment and streetscape, building affordable housing, creating public gathering places, improving parks and open spaces, and improving food choices at corner stores, farmers markets, mobile markets, and urban agriculture. Dr. Ashe stated, “Health in all policies, or mental health in all policies, must be the goal. As mental health professionals, it is our job to join with policy makers and community partners to enact regulations for the common good.”

Dr. Mark Hatzenbuehler contributed to the panel discussion by addressing how structural forms of stigma increase the risks for adverse mental health outcomes among members of socially disadvantaged populations. Presenting a legislative framework for social determinants work, the goal of his research is aimed at developing evidence-based policies to improve overall health and well-being for the lesbian, gay, bisexual (LGB) and other socially disadvantaged communities.

Dr. Hatzenbuehler explained social policies that differentially target the lives of LGB individuals and how these policies contribute to sexual orientation-related disparities in mental health. He discussed constitutional amendments banning same-sex marriage, anti-bullying policies, and state-level policies that address hate crimes and employment discrimination. Mental health data corresponding to these policies were taken from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). Dr. Hatzenbuehler and colleagues found that LGB individuals have higher rates of psychiatric disorders in states with no protective policies against hate crimes and discrimination. Similarly, in states with laws banning same-sex marriage, there was shown to be a significant increase in mood disorders among LGB respondents.

So, are there health benefits with reducing structural stigma? Do these benefits translate into reduced health care use and costs? According to Dr. Hatzenbuehler, the answer is yes. In Massachusetts after the legalization of same-sex marriage in 2003, there was a 13% reduction in mental health care utilization and a 14% reduction in mental health care costs for LGB individuals in the 12 months following same-sex marriage. Dr. Hatzenbuehler indicated that counties in Oregon with schools that have inclusive anti-bullying policies are associated with reduced risk of suicide attempts, in terms of LGB youth.

**BIOGRAPHIES**

**Marice Ashe, J.D., M.P.H.**

Founder and CEO
ChangeLab Solutions, Oakland, California, USA

As Founder and Executive Director of Public Health Law & Policy (PHLP), Marice Ashe launched and directs multiple pioneering efforts to improve public health outcomes through the use of law and policy. Under her leadership, PHLP builds the capacity of leaders across the nation to use practical public policy solutions as they address a range of chronic diseases. PHLP’s team of lawyers, city planners, architects, and policy specialists develop model laws and policies, consult on tough policy questions, and provide training and technical assistance to ensure strong policy initiatives that create sustainable solutions.

She is a frequent speaker at public health conferences throughout the nation, and she consults with federal and state agencies on how best to incorporate legal and policy tools into groundbreaking public health strategies. She is a graduate of the University of Notre Dame and received her M.P.H. and J.D. from the University of California at Berkeley.
Mark L. Hatzenbuehler, Ph.D.
Assistant Professor of Sociomedical Sciences, Mailman School of Public Health
Columbia University, New York, New York, USA

Mark Hatzenbuehler’s research examines how structural forms of stigma increase risk for adverse mental health outcomes among members of socially disadvantaged populations, with a particular focus on lesbian, gay, and bisexual (LGB) individuals. His research has been published in several leading journals including the *American Journal of Public Health, Psychological Bulletin*, and *Pediatrics*.

Dr. Hatzenbuehler’s research has received multiple awards from the American Psychological Association and the American Public Health Association, and his work has been cited in court cases on sexual orientation-related discrimination, including *Perry vs. Schwarzenegger*.

The goal of his research is to develop evidence-based policies and structural interventions that improve the health and well-being of members of socially disadvantaged groups. He has received grants and awards from the American Public Health Association, the National Institute of Mental Health, the American Psychological Association, and the Williams Institute at the UCLA School of Law. His recent research on the impact of social policies on mental health disparities in LGB populations was cited in an amicus brief for the California Supreme Court’s decision on Proposition 8. He completed his doctoral degree in clinical psychology at Yale University.
Dr. Bechara Choucair and Ms. Margaret Round explained how public agencies are operationalizing and applying the social determinants framework at the conference’s “Applying What We Know” panel session.

The session commenced with Dr. Choucair, Commissioner of the Chicago Department of Public Health. His presentation titled “Health Equity for a Healthy Chicago” outlined a public health framework for Chicago from a preventative approach. He suggested that responsibilities in public health departments involve fundamental tasks to assess health disparities and the need to develop policies that manage community health.

He explained the goal of the health equity objective is to engage social and physical environments to promote good health within Chicago neighborhoods, and to examine factors that influence these neighborhoods to improve health. Prevailing research suggests that behavioral choices and genetics influence 70% of our health, while social circumstances, environmental conditions, and medical care contribute to the remaining 30% of factors. It is imperative to take the aforementioned factors into consideration, as current literature indicates that to increase the impact on the population requires efforts at the individual level.

Dr. Choucair spoke to the agenda of the Department of Public Health as to how the City is dedicated to transform the health of Chicago. He described efforts of a commitment to health equity and the elimination of disparities. Developing a strong social fabric and sense of community in Chicago will affect progress toward spreading awareness of health disparities such as obesity, adolescent health, access to healthcare, prenatal care, violence prevention, and healthier homes affecting community mental health.

Dr. Choucair noted that forming healthy environments are key aspects to promoting health equity and making healthy choices more accessible to underserved communities.

In Illinois, “breastfeeding initiation rates are lowest for non-Hispanics, Blacks, those with high school education or less, Medicaid recipients, and WIC (Women, Infants, and Children) recipients.” Equipped with knowledge about health disparities, progress toward health equity is working to reduce these risks in maternal and child health.

Dr. Choucair explained the findings from the research have led Chicago to initiate a Baby-Friendly Hospital Initiative in 13 Chicago hospitals to support breastfeeding and to increase breastfeeding rates.

Another priority item for the health objective is tobacco use, which has been cited by the American Cancer Society as the “most preventable cause of death and its use is associated with many illnesses.” Chicago proposed interventions in favor of smoke-free policies in over 1,600 units of public housing, and tobacco-free policies on four hospital campuses, three higher education campuses, and six substance abuse and mental health service agencies. This is consistent with the need for supportive environments in the breastfeeding initiative.

Dr. Choucair stated, “Socioeconomic factors must be a core focus... guiding principles involve looking at multiple complex interrelated factors that contribute to social in-
equity and engage diverse populations... to alleviate health disparities." Further active strategies have stemmed from identifying health disparities through an urban agriculture ordinance. For example, strategies are at play to build Chicago obesity prevention programs and increase access to healthy foods in Chicago neighborhoods. Partnership action across diverse sectors and communities has been instrumental in reaching stakeholders. During the question and answer session, Dr. Choucair noted the importance of continued partnership development to provide structural changes and improve community health.

In the second portion of the session, Margaret Round, an environmental analyst from the Massachusetts Department of Public Health (MDPH), discussed “Public Health and Transportation Planning in Massachusetts.” Ms. Round is Chief of the Air Toxics program in the MDPH Environmental Toxicology Program. The program is aimed to evaluate health impacts associated with contaminants that may be present in some consumer products and the environment (e.g. air, water, soil).

Ms. Round explained the impact of the Massachusetts’ Transportation Reform Law and the benefits of consolidating transportation agencies in order to reduce duplicate efforts and enhance transportation planning. She described a range of health implications that are not homogeneously considered in transportation planning projects. As an example, she introduced the transportation Health Impact Assessment (HIA) that MDPH has developed to assess health implications. As a result from the HIA, collaborating members from environmental and transportation agencies integrated a team to evaluate the implications.

Ms. Round indicated the project served as a vehicle for community representatives to invest in restoring a major highway structure in Massachusetts. The restoration would impact a highway dividing diverse communities and dense areas of Massachusetts. To determine transportation concerns with regard to the pre-highway restoration, collaborating members generated considerations. Consideration included mobility for vehicles and pedestrians, access to goods via land use and economic development, air quality of roadways, public safety, and noise impact from elevation levels of roadways. From these concerns, the members drafted the pathway of proximate effects and health outcomes on populations living near and around the highway. Collaborating members used the HIA pathway drafts to demonstrate how proposed project and policy affect population health outcomes.

Consistent with Dr. Choucair’s arguments on health determinants, Ms. Round cited the need to mitigate risks of disparate environmental conditions in order to promote optimal health benefits. She recommended interagency consultation and planning could effectively work toward fundamental changes in the ways that communities are designed. In discussion, Ms. Round stated, “I believe health impact assessment is the future.” She emphasized the usefulness of an HIA as an instrument to comprehensively address social determinants of health and implement strategies for action.
BIOGRAPHIES

Bechara Choucair, M.D.
Commissioner, Chicago Department of Public Health
Chicago, Illinois, USA

Dr. Bechara Choucair is Commissioner of the Chicago Department of Public Health. Appointed by Mayor Richard M. Daley in November 2009, Dr. Choucair is re-shaping the department to meet the public health challenges of the 21st century. Born in Beirut, Lebanon, Dr. Choucair earned a bachelor of science degree in chemistry (with distinction) and a medical diploma from American University of Beirut. From 1997-2000 he completed his family practice residency at the Baylor College of Medicine in Houston, Texas. In 2009 he earned a master’s degree in health care management from the University of Texas at Dallas.

From 2001-2005, Dr. Choucair served as Medical Director of Crusader Community Health in Rockford, Illinois. From 2005-09, he was Executive Director of Heartland International Health Center. He has served as Vice Chair of Community Medicine, Department of Family & Community Medicine, Feinberg School of Medicine, and Northwestern University. Awards he has earned include the Loretta Lacey Maternal and Child Health Advocacy Award, Illinois Maternal and Child Health Coalition, 2009; the Health Professions Training and Education Award, National Association of Community Health Centers, 2008; the American Academy of Family Physicians Foundation, Pfizer Teacher Development Award, 2007; and the Forrest Riordan Humanitarian Award, 2005.

Margaret M. Round
Environmental Analyst
Massachusetts Department of Public Health, Boston, Massachusetts, USA

Margaret Round is Chief of the Air Toxics program in the Massachusetts Department of Public Health/Bureau of Environmental Health’s (MDPH/BEH) Environmental Toxicology Program (ETP). The ETP evaluates acute and chronic health impacts associated with chemical contaminants that may be present in a variety of environmental media including air, water, soil, fish, and some consumer products.

Ms. Round has extensive experience working on potential public health impacts and regulatory issues associated with ambient air quality and air toxics.

Since 2004, Ms. Round has been the project manager of a large-scale MDPH health study of Logan Airport in Boston. She is also actively involved in the department’s implementation of a public health surveillance network and on a project that is supporting local public health capacity to reduce health effects of climate change in Massachusetts.

Prior to working at MDPH/BEH, Ms. Round worked for 15 years at Northeast States Coordinated Air Use Management (NESCAUM) on various regional and national regulatory issues related to the implementation of the 1990 federal air toxics program. During this period, Ms. Round was responsible for the development of a bi-national framework involving the Northeast states and Eastern Canadian Provinces for reducing mercury emissions and coordinating related research activities in the region. Ms. Round has a bachelor of science degree in toxicology from Northeastern University (1984).
Dr. Rachel Wick, the Director of Policy, Planning and Special Projects at the Consumer Health Foundation (CDF), explained how CDF links the academic and grassroots non-profit communities by providing support to help build their capacities to address challenges in their communities. Initiating coalitions and networks to share knowledge and information to advance change, acting as catalysts for change and new ideas and working in the community, and trying to use endowment through mission-related investing are their primary methods of action.

Dr. Wick stated that her organization’s interest in health equity began seven or eight years ago. The organization was fueled by the research on social determinants of health, increases in seemingly intractable and unconscionable disparities in health by race and ethnicity, and a series of community speak-outs in the Washington, D.C. area. This motivated her organization to increase knowledge of the social determinants of health via multiple pathways including speakers, movie screenings, and plays, and extend this knowledge to their organizational function through internal assessments of their grant-making and communications policies. Additionally, Consumer Health Foundation constructed a new vision for the foundation’s work and clarified its values to include advocating for social change, equity and social justice, healthcare for all, partnership innovation and learning, and foundation accountability.

Consumer Health Foundation then added novel projects to address where communities are working at the intersection of health and other social and economic factors. Some campaigns relevant to this goal include paid sick leave for low-income workers, working conditions as a key part of health and locus of control issues, mental health and criminal justice, immigrant civil rights organizing and advocacy groups. Consumer Health Foundation also attempted to build communities’ capacity for understanding race and racism, and address diversity and inclusion with work of non-profits by conducting “Racial Equity 101” trainings, supporting racial dialogues with youth, and pursuing new partnerships and collaborations.

Dr. Wick shared the lessons learned such as staying calm and realizing the complexity of ending poverty and starting with partnerships within different circles. She closed by stating that the conversation on race and racism needed to continue in order to make real progress for health equity. New methods of research need to capture the dynamic interactions occurring at the individual and community level. She stated a need to ask the right questions in research and view the issue from a holistic viewpoint. Finally, she stated that we must stay grounded in the lived experience of families and communities because health equity is intuitive to those in the community.
Next, Dr. Lowe, Senior Program Officer at the Robert Wood Johnson Foundation (RWJF) and Team Director for the Vulnerable Populations Portfolio, stated that the mission of the RWJF is to help people live healthier, more productive lives, working to reverse the epidemic of childhood obesity, as well as addressing quality of care and expanding health insurance for all Americans. She stated that the RWJF is interested in creating opportunities for good health among society’s most vulnerable members and taking on issues that many feel are intractable and resistant to change.

RWJF has recently changed its focus from medical care and access to the social determinants of health (SDOH). The foundation created a commission for a healthier America that includes interest in the social determinants of health. It seeks to address two questions: “Why do some Americans have better health?” and “Why are some Americans not as healthy as they could be?”

In order to answer these questions, the commission set out to determine the appropriate language for social determinants of health. The commission listened to discussions on health at the highest level of policy-making, and found that solutions were only being directed within the medical care system. As a result, the commission raised awareness for factors beyond medical care and recommended viable and practical non-medical evidence-based strategies that would impact change in overall health.

Through its research, the commission found that people, including most policy makers, have difficulty understanding the social determinants of health. The foundation decided on the following statement to outline the social determinants of health: “Health begins, is sustained or not, where we live, learn, work, and play. Taken together, complex social factors such as poverty, education, and housing have greater impacts on health than medical care.” The RWJF summarized the research with a document titled “A New Way to Talk about Social Determinants.” Information crucial to communicating the social determinants of health includes understanding that the United States is one of the wealthiest nations in the world, but not the healthiest. We are raising a generation of children that will live sicker and shorter lives than their parents, and our zip code may be more important to our health than our genetic code. They also found that three points were integral to conveying the SDOH: “Health starts in our families, and is nurtured by our schools and workplaces, and playgrounds in our neighborhoods.” “How healthy we are and how long we live depends on many factors, namely education, income, smoking status, activity level, and diet.” “To improve America’s health we need solutions that look at where people live, learn, work, and play to get at the factors that shape health even more profoundly than healthcare.” She summarized the research, stating that improving America’s health requires leadership and action from every sector including people who work in public health and healthcare, education, transportation, community planning, corrections, private business, and so forth.

According to Dr. Lowe, RWJF’s messaging campaign altered its grant-making choices and programming by reframing its search for new solutions and pathways to improve health. The foundation began assessing areas previously neglected, and partnerships needed to change the culture and search for connections between health and other fields.

Dr. Lowe concluded her talk stating that across its body of work, the RWJF has tried to impact change in three major ways: making health, not just healthcare, matter to the public and to policy makers; seeking out levers of change outside the healthcare system to improve health; and establishing that leadership matters for large-scale change regarding health disparities. In the future, she stated that exciting work from the field of neuroscience will help inform social determinants work by highlighting the critical connections between body, mind, and environment. She felt it would be essential to thoughtfully integrate findings from neuroscience into the complex social backdrop in which the interventions will play out. Finally, she stated that the RWJF is committed to building the evidence base, and doing its part to impact significant change to promote the message that health lives in our homes, schools, neighborhoods, jobs, and relationships.
Foundations Panel: Rachel Wick and Jane Lowe (continued)

BIOGRAPHIES

Rachel Wick, M.P.H.
Director of Policy, Planning and Special Projects
Consumer Health Foundation

Rachel Wick is the Director of Policy, Planning and Special Projects at the Consumer Health Foundation, a private nonprofit grant-making organization whose mission is to achieve health justice in the Washington, D.C. region whose activities advance the health and well-being of historically underserved communities. She oversees the foundation’s health policy work and the implementation and evaluation of its strategic plan.

She also provides in-depth assistance to the president and CEO on a variety of issues including mission-related investing. She currently serves as chair of the Health Working Group of Washington Grantmakers, and is a member of the Working Group on Aging and the Regional Primary Care Coalition. She holds a bachelor’s degree in philosophy from the College of St. Benedict, and an M.P.H. in health management and policy from the University of Michigan.

Jane Isaacs Lowe, Ph.D.
Senior Program Officer and Team Director, Vulnerable Populations Portfolio
Robert Wood Johnson Foundation, Princeton, New Jersey, USA

Jane Isaacs Lowe, Ph.D., is a Senior Program Officer at the Robert Wood Johnson Foundation and Team Director for the Vulnerable Populations Portfolio, which creates new opportunities for better health for society’s most vulnerable members by investing in health where it starts—where we live, learn, work, and play. In this role, Dr. Lowe directs the portfolio’s strategy and investments in social innovations that promote lasting change and demonstrate the potential for widespread replication and national impact. She observes that the Vulnerable Populations team “works at the intersection of health and social problems, thinking holistically about what can be done to create successful, lasting programs.” She views the team’s role as one of catalyzing new ways of addressing urgent social issues such as preventing intimate partner and community violence, improving health and educational outcomes for young men of color, promoting social and emotional learning in children, and ensuring services for those with severe mental illness.

Drawn to the Foundation by its “ability to drive significant social change in the health of communities,” Dr. Lowe also oversees grants in the areas of community health, mental health, and long-term care.

Dr. Lowe came to the Foundation from the University of Pennsylvania School of Social Work, where she served as member of the faculty from 1989 through 1998, publishing and teaching in the areas of health practice, administration, and planning. She was the recipient of the Outstanding Teaching Award in 1992 and 1997. From 1976-1989, she worked at the Mt. Sinai Medical Center in New York City, where she served as a faculty member in the medical school’s Department of Community Medicine and as a hospital social work administrator. She views her experience as a clinical social worker as unique. Her work has led to greater insight into the human spirit and reinforced her passion for making a difference in the health and well-being of individuals and families by addressing the social determinants of health.

Dr. Lowe earned a doctorate in social welfare policy and planning from Rutgers University, a master’s in social work from Columbia University, and a bachelor’s degree in sociology and education from Cedar Crest College in Allentown, PA, where she is a member of the Board of Trustees. She is a current fellow at the New York Academy of Medicine.
In this post-conference workshop, staff members of the Institute on Social Exclusion (ISE) at the Adler School of Professional Psychology described the theory and practice involved in a Mental Health Impact Assessment (MHIA), which addressed important mental health issues in Chicago’s Englewood community. A preventative practice, MHIA enables mental health professionals to engage in socially responsible practice by working to ensure that legislative and public policy decision-making promotes the mental health of vulnerable communities. The MHIA process springs from basic Health Impact Assessment (HIA) procedures that include screening, scoping, assessment, recommendations, reporting, and monitoring and evaluation.

The initial step is screening, marked by determining the need and value of conducting an MHIA. During the conference workshop, team members explained to the assembled audience the details associated with each step that has been completed to-date. With regard to the screening phase, they noted that to select the MHIA project, the ISE screened more than 60 potential national, state, and local public policies – e.g., proposed amendments to the Fair Labor Standards Act, proposals to raise the minimum wage in the State of Illinois, and suggested amendments to municipal ordinances concerning how the city should address the growing number of foreclosed and vacant buildings in Chicago. After months of careful consideration, the team chose the EEOC’s Policy Guidance on the Consideration of Arrest Records in Employment Decisions [No. 915.061 (9/7/90)] for study.

Discussing each step in succession, the ISE reviewed the second step, which is scoping. Scoping involves determining which mental health impacts to evaluate, which methods are to be employed for analysis, and establishing a work plan. The third step, assessment, consists of a two-step process that first establishes the baseline health status of the affected population and subsequently assesses potential health impacts. The fourth step is recommendations and reporting, whereby a MHIA report that highlights the impact of the decision on the social determinants of mental health is developed. The report communicates findings and recommendations to stakeholders and community members. The final step is monitoring and evaluation, an important follow-up activity to the MHIA process.

In addition to integrating mental health considerations into HIA practice, the Mental Health Impact Assessment will result in a more rigorous and comprehensive analysis of the mental health implications of public decisions. It will also help to shift the focus in mental health research and practice from the traditional emphasis on risk and illness to promotion and wellness. This orientation should be welcomed within the emerging discourse and practice surrounding population mental health and be highly relevant to the emerging “Health in All Policies” agenda.

The MHIA team concluded the workshop with a brief description of the specific results from the assessment in the Englewood neighborhood, took questions from the audience, and invited participants to maintain contact with the Adler School of Professional Psychology to remain part of the long-term discussion on this topic.
BIOGRAPHY

Lynn Todman, Ph.D.
Executive Director, Institute on Social Exclusion
Vice President for Leadership in Social Justice
Adler School of Professional Psychology

Dr. Todman’s work focuses on the ways in which social, political, economic and cultural structures systematically marginalize urban populations. Her work is multidisciplinary and draws from the fields of economics, political science, sociology, public health, psychology, anthropology, and systems’ dynamics.

Dr. Todman lived and worked outside the United States for 14 years (in Sweden, Belgium, the United Kingdom, and Italy) during which time she collaborated with academics and practitioners on issues such as the social welfare implications of privatization policy; the role of community participation in urban development processes; and the relationship between urban transport policy and social exclusion and resulting implications for social welfare. Her work at the Adler School focuses on identifying ways in which laws, public policies and institutional practices prohibit urban populations’ access to normatively available rights, resources and opportunities. Her most recent work involves examination of the social determinants of mental health, its role in mediating the relationship between the social environment and physical health outcomes, and the development of tools, such a Health Impact Assessment, as a means of ensuring that social environments promote the mental and physical health of urban populations.

Dr. Todman is a Community Development Commissioner for the city of Chicago; a member of the state of Illinois’ Racial and Ethnic Impact Research Taskforce; vice chair of the Heartland Alliance for Human Needs and Human Right International Board of Directors; co-chair of the Benton Harbor Promise Zone; a member of the board of the Sargent Shriver National Center on Poverty Law Center; and a member of the Corporation Visiting Committee for the Department of Social Sciences at Massachusetts Institute of Technology (MIT). She earned her doctorate in urban and regional planning, and a master’s in city planning from MIT, and a B.A. from Wellesley College.
Acknowledgements

Conference Proceedings – ISE Staff & Student Contributors
Jared Berger, M.A. BSc (Hons)
Aaron Ceresnie, M.A.
Brittany Coleman
Rachel Eddy, M.A.
Hien Luu
Jason Reynolds, M.A.
Erin C. Watson, M.A.
Stacey Willard, M.A.
Sherri Boyle, ISE
J. Sherrod Taylor, (Ret.) Faculty Fellow

Conference Co-Sponsors
The conference was hosted by the Adler School of Professional Psychology Institute on Social Exclusion and jointly sponsored by the University of Illinois at Chicago College of Medicine and the Jane Addams College of Social Work

Institute on Social Exclusion Presenters
Lynn Todman, Ph.D.
J. Sherrod Taylor, J.D.
Christopher Holliday, Ph.D., M.P.H.
Tiffany McDowell, Ph.D., M.F.T.
Mark Driscoll, Ph.D.

Conference Location
Chicago Marriott Downtown Magnificent Mile
540 N. Michigan Avenue
Chicago, IL 60611

For more information about “The Social Determinants of Urban Mental Health: Paving the Way Forward” or the Adler School’s Institute on Social Exclusion and its MHIA project, visit adler.edu/ISE or email ISE@adler.edu.