Half of mental health conditions occur by the time patients turn 14 years old, while three-quarters begin by 24. Racial, gender and sexual minorities—this includes African Americans, Hispanics, Asian Americans and LGBTQ+ patient groups, among others—often suffer from worse mental health outcomes due to a variety of factors. Those include inaccessibility of health care services, cultural stigma around mental health, and discrimination, all of which have been exacerbated during the COVID-19 pandemic.

That is why AMA member Adrian Jacques H. Ambrose, MD, MPH—a child and adolescent psychiatrist, and medical director of youth and family services at Beth Israel Lahey Health Behavioral Services system in Danvers, Massachusetts—is working to help get children the right behavioral health care at the right time in the right setting.
During a recent interview, Dr. Ambrose discussed the impact of the pandemic and how it is providing opportunities to reconceive mental health care and mental health equity. He was most recently the AMA Young Physicians Section (YPS) representative on the AMA Advisory Committee on LGBTQ Issues and is currently the American Psychiatric Association Delegate to the YPS.

**AMA:** COVID-19 has, of course, been horrific in many ways. Yet it’s been said that one silver lining is that it placed a bigger spotlight on mental health. What’s your perspective?

**Dr. Ambrose:** When we think of psychiatry and psychiatric conditions, we too often think of that as something separate from us—as some foreign strangers or some homeless person that’s experiencing it. And I hope that this pandemic has at least bridged that it could happen to anyone. It really could happen to you. It could happen to your colleagues, your parents and your children. I hope it allows us to destigmatize that aspect of mental health and how to seek treatment, how to access care and actually address it—as you would with any other medical condition.

But the second part is the awareness that I’m not alone and I can do something about it. For a long time, within the field of psychiatry and certainly for youth, there’s been a misunderstanding that it’s somehow a moral shortcoming and that the person is not strong enough. With more understanding from biomedical sciences, we’re realizing that it’s the same as if you’re dealing with any other medical condition—you wouldn’t say to a child with asthma that your lungs are not strong enough for life. That’s the area of empathy and compassion that I hope that we can continue to cultivate and not regress.

The acuity of the cases of suicide or suicidal ideation among youth and young adults that I’ve been seeing in both ambulatory and emergency services have been higher. Regrettably, it’s a problem of decreased supply and increased demand. The—already limited—supply of higher level of care facilities was decreasing due to their limited capacity for infectious control. Concurrently, you have an increase in the (already very high) mental health demand of both youths and adults. Especially for some of the youths who receive mental health services at school (e.g., in-school counseling), their mental health care was likely interrupted or discontinued due to school closures.

**AMA:** Much has been said, by the AMA and others, about the pandemic’s inequitable impact among African Americans, Hispanics and LGBTQ+ patient groups, among others. How do you see that playing out on the mental health side during COVID-19?

**Dr. Ambrose:** Within the pandemic itself, we have a little bit of a luxury to assume that everyone has a relatively loving family. Unfortunately, that’s not the reality for a lot of people. When you’re considering that for a lot of these sexual and gender minority youths, they are stuck with parents who may not necessarily be supportive. All these kids who are struggling with their gender identity, they don’t necessarily have their support group that they normally would have either in a school setting or in a social setting. And now they’re...
potentially on their own managing this, with not really supportive or understanding parents.

On the ethnic and racial minority side, while the virus does not discriminate at all, the health outcomes that we're seeing are quite disparate. For a lot of different states, we're seeing ethnic and racial minorities being impacted by COVID the most.

And from a mental health standpoint, we are not connecting the dots. What I mean by that is the mental health consequences of potentially losing a parent and the grieving that comes with loss—loss of life, job, family members, communities, housing—during that time may be disproportionately higher in the ethnic and racial minority groups by the mere fact that they’re most impacted by COVID.

Then on top of that, what we have learned is that, unfortunately, this group is also less likely to access health care, less likely to access mental health care and have less resources to do so either by their occupation or their environment. This is where mental health equity has a lot of room to grow. Instead of waiting for patients to come to us to receive care, what if we go to them and meet them where they are in their home and community—to let them know that we haven’t forgotten about them?

AMA: Is reaching them where they are key to moving forward?

Dr. Ambrose: I am optimistically hoping that that would be a space where we could bridge that divide a little bit. In mental health, it's certainly really interesting that the pandemic has also created this opportunity where a lot of times—if you think about the logistics of going into a clinic—it requires driving into the city, finding parking, going out to the clinic, paying the copay for the appointment, having the clinical encounter and then driving back and doing all those things. But telehealth has really bridged that and now has really become a very common way in which people have been accessing mental health.

My hope is that we can continue to build on that as a platform. And what I mean by meeting people where they are is instead of expecting that the typical clinical care is going to occur in the clinic, I hope that we can shift some of that baseline towards somewhere in the middle.

I’m looking into exploring a potential hybrid model or even more patient-centered model of care that we could integrate during this time that would allow us to miss fewer patients. Because the patients who drop out of care are often those who have fewer resources, are often minorities with multiple minority statuses and don't necessarily have the knowledge to navigate the health care system. Bridging that gap would be a beautiful dream of mine—kind of like the next frontier of mental health equity.

AMA: What does bridging that gap in mental health equity look like?

Dr. Ambrose: Let’s say that a child has a really bad behavioral regulation at school. Instead of the
school calling 911 and bringing that child into the ED, oftentimes by handcuffs, what if we can create a system of where there’s a mobile crisis social worker or clinician who’s able to either Zoom in or telehealth visit into the school and treat that in real time?

It’s about working with the child to figure out the root cause of their behavioral dysregulation and then potentially even referring him or her into an outpatient level service and in working with the school to devise a behavioral plan to mitigate future episodes. How wonderful would that be—to have that kind of immediate, real-time impact? And think about the amount of costs that we can save for the system. It’s a brainchild of mine to deliver value-based mental health care for youths that I’m hoping to explore more in the future.

AMA: Is it about finding that underlying cause to potentially prevent further harm and damage?

Dr. Ambrose: The way in which we have created the health system in the U.S.—at least for mental health care—is often not an ideal situation. Most kids, when they are accessing mental health, they’re not doing it in a space that’s most productive for them. It's often in the ED or in spaces where they're having a behavioral dysregulation. So they're not able to actually grasp that what they’re doing—the dysregulated behavior—is not helpful to them. Having someone trained in mental health to be able to guide them is a lot more productive. It's a lot more clinically sound and more evidence-based than having the police or people who are not trained in mental health deal with this.

We know that minority children are more likely to be disciplined for the same behavioral dysregulation at school settings in comparison to their white colleagues. This is one of those self-fulfilling prophecies. If you're telling someone that they're bad and you're calling the cops on them and you're putting them in detention, we're also sending a message to that child that: Hey, you're not a good person. We don't think that you can do this.

Whereas if we approach it as: You're having a hard time right now. These are medical conditions—ADHD, anxiety, panic disorder, autism, whatever it is—that we can treat. We can help you so that you can do whatever it is that you want to do. That’s why I think we need to explore critically the involvement of the justice system when it comes to ethnic minorities, especially youth, and their mental health.

If we hear them and let them know that they’re being heard and try to understand what they are going through, it can make a huge difference because we aren’t brushing them off on someone else or sending them away—we’re here to help.

It’s unfortunate that we don’t necessarily have the infrastructure to do so. The way in which we get reimbursed and paid for the services in a very structured environment—like in the ED, the clinic, hospital or residential program—and I hope that we can be a little bit more nimble in creating programs that center the care around the patient, especially in mental health. The pandemic has
taught us that health systems can be much more flexible in adapting to changes.

With this pandemic, whatever small silver lining that it might be, I hope that we could use that as an impetus for positive changes moving forward. I certainly want to try to move the needle. I want to continue learning about different opportunities within the AMA and the collaboration within the AMA across different services about what are some of the ways that we could connect the dots a little bit more and meet all patients where they are.

And if I could leave one last note, it is that I really hope that with the health justice piece and the health equity piece, that we don't conceptualize it as an add on, but rather one of the fundamental pillars of health care. We can't just provide clinical care and then just sprinkle on top a little of health justice and health equity. We need to conceptualize it as a core aspect of health care.