Social and Political Determinants of Health and Mental Health

Ruth S. Shim and Monica Taylor-Desir

Introduction

The rise of the Community Mental Health Movement in the early 1960s, bolstered by the Civil Rights Movement, brought the biopsychosocial model to the center of mental health care, resulting in a greater acknowledgment that biological, psychological, and social factors interact to create poor mental health outcomes. At the same time, deinstitutionalization, coupled with inadequate and underfunded community mental health services, led to an exacerbation of mental health inequities among marginalized populations with serious mental illness and substance use disorders. These marginalized populations were most susceptible to the damaging effects of the social and political determinants of health and mental health. The World Health Organization (WHO) defines the social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (World Health Organization 2020). The WHO goes on to implicate the social determinants of health as the major cause of health inequities worldwide. When considering community psychiatry in the modern era, one cannot begin to consider mental health disparities and inequities without accounting for the social determinants of mental health. While not distinctly different from the social determinants of health, the social determinants of *mental health* deserve special emphasis because they may lead more robustly to poor mental health outcomes and mental health inequities seen in society.

With increased attention to the social determinants of health and mental health over time, community psychiatrists have a greater understanding of its importance. Much awareness was gained with the release of the seminal report, *Closing the Gap in a Generation*, written by the WHO's Commission on Social Determinants of Health (2008). This report assembled the data on the role of the social determinants of health in perpetuating social injustice and inequities in health outcomes, leading to a significant increase in publications and initiatives focusing on these issues. Healthy People 2020 emphasized five social determinant areas: economic stability, education, social and community context, health and health care, and neighborhood and built environment. Healthy People 2030 builds on this work, identifying the social determinants of health as one of its five overarching goals (US Department of Health and Human Services 2020).

R. S. Shim (✉)
Department of Psychiatry & Behavioral Services, University of California, Davis School of Medicine, Sacramento, CA, USA
e-mail: rshim@ucdavis.edu

M. Taylor-Desir
Department of Psychiatry and Psychology, Mayo Clinic, Rochester, MN, USA
e-mail: taylor-desir.monica@mayo.edu

W. E. Sowers et al. (eds.), *Textbook of Community Psychiatry*,
https://doi.org/10.1007/978-3-031-10239-4_29

Additionally, over the years, there have been calls to action to address the social determinants of mental health within the behavioral health field (Shim and Compton 2018). This chapter discusses the importance of the social determinants of mental health, presents evidence highlighting specific social determinants, and identifies intervention points to illustrate how community psychiatrists can combat structural racism by addressing the social and political determinants of mental health, leading to more equitable and improved mental health outcomes.

Framework for the Social Determinants of Mental Health

In considering the social determinants of mental health, a conceptualization (see Fig. 1) is helpful to enhance understanding of multiple contextual factors (Shim and Compton 2020).

The top of the figure represents poor mental health outcomes (and mental health inequities). Moving down the figure, underlying poor mental health outcomes are risk factors for mental illnesses and substance use disorders. Risk factors are defined as characteristics that precede a disorder and are statistically associated with the development of the disorder. These include physiological stress responses, psychological stress, behavioral risk factors, "poor choices," and reduced options. Psychiatry places a great deal of emphasis on the identification and stratification of risk factors, especially when conducting suicide risk assessments. However, when considering the social determinants of mental health, it becomes increasingly clear that if one is intervening at the level of the risk factor (i.e., at the level that directly precedes the development of disease), the intervention may be too late. Rather, research on the social determinants of health advocates moving "upstream" to address "the causes of the causes" (Marmot 2007). Moving upstream (or down the figure) leads to the social determinants of mental health. These are grouped into four categories in Fig. 1: (1) *pervasive US societal problems* (adverse early life experiences, discrimination and racism, exposure to violence, and interaction with the criminal justice system), (2) *opportunities for accruing wealth* (low edu-

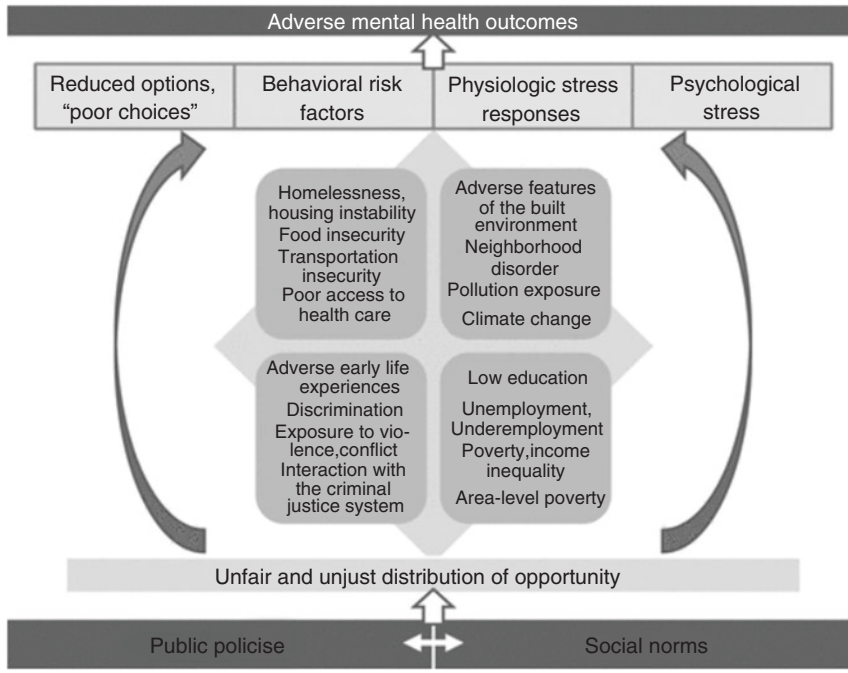

Fig. 1 A conceptualization of the social determinants of mental health

cation, unemployment and underemployment, poverty and income inequality, and area-level poverty), (3) *basic needs* (housing instability, food insecurity, transportation insecurity, and poor access to health care), and (4) *the physical environment* (adverse features of the built environment, neighborhood disorder, exposure to pollution, and climate change) (Compton and Shim 2020). This is not meant to be a complete list of social determinants of mental health, but it should serve as a starting point for considering the upstream "causes of the causes" of poor mental health outcomes.

In further examining the conceptualization, beneath these social determinants of mental health are the unfair and unjust distribution of opportunity – a concept defined as *social injustice*. The driving forces behind injustice in society are the public policies and social norms that govern that society. Public policies are the laws, policies, ordinances, and rules (both written and unwritten) that regulate institutions, communities, and governments. The political determinants of health describe these public policies which influence relationship structures, resource distribution, and the administration of power. These elements influence one another to tip the balance of health equity and health inequities (Dawes 2020). Social norms are the values that we intrinsically place on population groups – specifically, those groups we choose to value as a society and those groups we choose to diminish or devalue. Throughout history, people with serious mental illnesses and substance use disorders have been consistently stigmatized, devalued, and oppressed. Social norms include beliefs that people with mental health problems and substance use disorders are morally and spiritually deficient, make poor decisions, or are emotionally weak. As a result, society passes laws and creates policies to reflect these values. For example, the policy that creates a lack of insurance parity for mental health and substance use disorders ensures that people with mental illnesses and substance use disorders have less access to services compared to people with physical health conditions. Similarly, other damaging policies have led to people with mental health problems and substance use disorders being criminalized, resulting in disproportionate levels of interaction with the carceral system (Dvoskin et al. 2020).

The Social Determinants of Mental Health Evidence Base

Social determinants of mental health are important contributors to poor mental health outcomes and mental health inequities. This chapter will highlight evidence that demonstrates how the social determinants of mental health impact the lives of individuals and their communities. We will highlight the importance of addressing the social determinants of mental health in developing prevention, treatment, and research strategies.

Exposure to Violence

Violence is an expressed form of oppression, meaning that commonly oppressed groups (minoritized populations, people of lower socioeconomic status) are at risk for being victims of physical and structural violence (Young 1990). Recent studies have estimated the prevalence of US children's exposure to community violence ranging from a shocking level of 50–75%, and one study found that the number of indirect violence exposures was significantly associated with any adverse mental health outcome, especially posttraumatic stress disorder (PTSD) and depression (Gollub et al. 2019). The National Survey on Children's Exposure to Violence surveyed children of various races, gender, socioeconomic status, family structure, region, and developmental stage of the child, noting that most children in the United States have experienced direct or indirect exposure to violence within the previous year, with 10% reporting five or more violent exposures within the previous year (Finkelhor et al. 2013). Additionally, among North American Indigenous youth populations, Hautala and Sittner (2018) found an association between direct and indirect violence exposure and increased risk of substance use disorders.

Unemployment and Job Insecurity

The mental health impacts associated with employment have been exposed in the wake of the coronavirus disease 2019 (COVID-19) pandemic, in which a significant portion of the US population has lost their jobs or have been deemed "essential workers," requiring them to take significant risks to their health to maintain employment. During the COVID-19 pandemic, job insecurity was associated with an increase in anxiety symptoms (Wilson et al. 2020). Unemployment is associated with poor mental health, and, in Norway, one study found a direct association with increased prescriptions of psychotropic drugs at times of unemployment compared to times when individuals were employed (Kaspersen et al. 2016; Øverland 2016).

Homelessness and Housing Instability

Housing instability and homelessness is a major contributor to poor health outcomes for children, adults, and families. While it is difficult at times to determine causality, data suggests that serious mental illness is not the main contributor to homelessness in the United States (Substance Abuse and Mental Health Services Administration 2011). The United States Conference of Mayors conducts an annual survey of hunger and homelessness which has consistently showed the dearth of affordable housing is the leading cause of homelessness. The other top contributors to homelessness include unemployment, poverty, and low wages (National Law Center on Homelessness and Poverty, 2018). However, evidence does support that being homeless does contribute to worse mental health outcomes, including suicidal ideation, trauma, and substance misuse (Padgett 2020). Similarly, a systematic review of people under threat of eviction found associated poor mental health outcomes, including depression, anxiety, and psychological distress (Vásquez-Vera et al. 2017).

Climate Change

The most recent United Nations (UN) Climate Report sounded the alarm for a concerted global effort to address climate change. The UN noted that a rise in global temperatures of 1.5 °C could lead to the displacement of millions of people, rising sea levels, decreased production of critical crops, forest fires, and pandemics (World Meteorological Organization 2020). Nevertheless, it is challenging to attribute climate change to adverse mental health outcomes for several reasons, including lack of data on premorbid mental health problems, associated transient stress responses associated with weather-related disasters, and interaction with various other social determinants of mental health (Hayes et al. 2018). That said, data on the aftermath of Hurricane Katrina found sustained, elevated rates of PTSD over time. These findings have persisted across many other extreme weather events, including floods and drought (Rataj et al. 2016). The impact of climate change as a social determinant of mental health is still an emerging area of research and investigation (see chapter "Climate Change: Impact on Community Mental Health").

Points of Intervention to Address the Social Determinants of Mental Health

Discrimination and Racism

The Aspen Institute defines structural racism as "a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity" (The Aspen Institute 2016). These racial group inequities are often expressed in actions as discrimination. Structural racism contributes to the unjust and unfair distribution of opportunity in society, which leads to the creation of the various social determinants of mental health. As racial inequities are baked into the structures of society (through policies and institutional practices),

they cannot be easily undone by changing individual interpersonal interactions. Dismantling structural racism involves ending old, racist policies and creating new, anti-racist policies. For example, in 2018, the majority of Black (69%) and Latinx (67%) people with mental illnesses reported not receiving treatment, compared to 51% of White people (Substance Abuse and Mental Health Services Administration 2019). For people with serious mental illnesses, the numbers were equally concerning, with 42% of Black and 44% of Latinx people not receiving treatment, compared to 33% of White people with serious mental illnesses (Substance Abuse and Mental Health Services Administration 2019). If these numbers are considered through the lens of patient-level factors, it is easy to conclude that Black and Latinx people do not access or receive treatment due to stigma, lack of insight about illness, and poor adherence to treatment recommendations (Nadeem et al. 2007). However, recent studies have determined that cost and lack of insurance are the most common cause given for those that report unmet need, almost twice as often as minimization of symptoms and nearly five times as often as perceived stigma (Alang 2019; Walker et al. 2015). Thus, structural forces, not individual patient preference, are the main drivers of poor access to mental health care.

Another factor contributing to the significant lack of access to mental health services of minoritized populations includes the low numbers of psychiatrists that accept insurance compared with physicians in other specialties (Bishop et al. 2014). In 2009–2010, only 55% of psychiatrists accepted private, noncapitated insurance, and only 43% accepted Medicaid (compared to 88% and 73% of physicians in other specialties). There are many explanations for this inequity in insurance acceptance, including lower reimbursement rates, coupled with longer visits needed to provide psychotherapy. However, the shortage of psychiatrists and general high demand for mental health care services mean that psychiatrists have the power to dictate how they interface with the mental health care system. For those psychiatrists without a background or interest in community psychiatry, the desire to provide psychotherapy to patients of a higher socioeconomic status (patients that are of similar backgrounds and experiences) may be very strong. Similarly, psychiatrists who have implicit bias and discriminatory beliefs toward Black, Indigenous, and other People of Color, operating a solo private practice that takes cash only can ensure less interaction with these populations.

Lack of equitable insurance access is the result of discrimination and structural racism – policies that promoted desegregation of the health care system in the United States were often coupled with pushes for universal health care coverage (Hoffman 2008). During these efforts, the American Medical Association was strongly opposed to expanding health care coverage to all Americans, leading to widening gaps in access. Efforts to expand Medicaid and decrease uninsurance rates in the United States (including the Affordable Care Act) continue to be met with significant opposition that ensures the persistence of racial and other inequities in health care coverage (Lantz and Rosenbaum 2020).

Thus, in considering improving mental health treatment outcomes and closing the gap of mental health inequities, greater attention should be paid to ensuring that everyone has access to health insurance at rates that cover mental health and substance use disorders at the same level as physical health conditions. Further, policies must ensure that mental health professionals can provide services to all sectors of the population, not just those people with access to insurance or with income levels that enable people to pay out-of-pocket for treatment services.

The point of intervention involves changing existing policies and laws that regulate mental health care insurance access. This requires electing public officials with a commitment to advocate for more racially equitable policies that support greater access to mental health services and incentivize training mental health workers with an interest in providing services in community settings. Thus, laws and policies that impede or suppress voting result in perpetuating the status quo. Because of policies and laws that have criminalized mental illness, many people with

substance use disorders and mental illnesses access mental health services after they have been arrested or served time in criminal justice settings. As a result, some of the very people who could vote to improve policies for people with serious mental illnesses and substance use disorders (people with lived experiences of substance use disorders and serious mental illnesses) have been marginalized in society and unable to vote. Thus, policies need to focus on improving community power and political voice for oppressed and marginalized communities.

Adverse Early Life Experiences

Childhood trauma is a powerful social determinant of mental health. Previous studies (utilizing the Adverse Childhood Experience [ACE] study) have found correlations between early childhood trauma and a host of poor health and mental health outcomes, including increased behavioral risk factors (e.g., early age of initiation of sexual activity and cigarette smoking), increased suicide attempts, and early mortality (Felitti et al. 1998). These findings are remarkably consistent, but also made more concerning in light of newer findings that show that the original ACE study did not include many common traumatic experiences that are more often experienced by children of color, including interaction with the foster care system, experiencing racism, and witnessing violence in neighborhoods (Cronholm et al. 2015). Additionally, the concept of complex posttraumatic stress disorder (C-PTSD), recognized as a mental illness internationally, but not in the United States, highlights the unique risk that children and adolescents who are unable to remove themselves from traumatic circumstances face when they have the potential to be re-traumatized in their social environments (Kazlauskas et al. 2020). Thus, unfair and unjust distribution of opportunity is a major contributor to differential experiences of childhood trauma that exist in society. Public policies and social norms drive these differential and inequitable opportunities. Children of lower socioeconomic status or of minoritized groups are often not valued (or given the same opportunities to achieve healthy lives) as children from higher socioeconomic status. As a result, these children often experience greater incidence and prevalence of adverse childhood experiences.

The intervention point for addressing the social determinant of adverse childhood experiences involves taking action to change public policies and social norms. If the societal norms dictate that some children are not worthy of the same legal protections and support as other children, then policies are implemented to support this claim – as evidenced by higher rates of discipline of Black, Latinx, and Indigenous children in school compared to White children (Welsh and Little 2018). Therefore, the intervention involves undoing inequitable policies that disadvantage students of color. Investments in early childhood education programs (e.g., those programs modeled after Head Start) demonstrate significantly improved outcomes and lower societal costs due to less criminal activity and less reliance on social welfare programs (Belfield et al. 2006). Similarly, the Nurse-Family Partnership program, which sends nurses out on home visits to pregnant mothers, has shown significantly lower rates of child mistreatment compared to usual care over the long term (Eckenrode et al. 2017). These interventions require monetary and human capital investments in children and families of color in order to reap rewards 10–20 years in the future, far beyond a standard election cycle.

The Moral Determinants of Mental Health

Berwick (2020) calls on health professionals to embrace the *moral determinants of health,* in which investment in human well-being takes precedent, and solidarity and shared responsibility are embraced above other values. Berwick lists several recommendations to take action to address the moral determinants of health, which equally apply to determinants of mental health, including ratification of human rights treaties and conventions, ensuring universal health care, leadership in reversing climate change, reforming the

US carceral system, reforming immigration laws to protect families and reduce trauma, ending food and housing insecurity/homelessness in the United States, and resisting voter suppression tactics so that all voters have a voice in political institutions. These goals are simultaneously lofty, but also achievable with a clear plan of action that is bolstered by community empowerment and leadership that enacts policies that promote creating equitable opportunities for people to achieve health.

As previously discussed, action on the moral determinants of health involves interventions in public policies and social norms. From a public policy perspective, both global and local interventions are necessary. Psychiatrists and other mental health professionals must advocate for people with serious mental illnesses and substance use disorders, both by working to empower oppressed communities and by leveraging privilege to effect change with those political actors that hold power. Many examples of organizations that develop and sustain community power exist across sectors. To address multiple social determinants, including housing insecurity, area-level poverty, exposure to violence, and poor education, Purpose Built Communities has redesigned and transformed neighborhoods, leading to increased employment, decreased violent crime, and dramatically increased school performance (Franklin and Edwards 2012). To tackle the social determinants of discrimination, unemployment, and poverty, the National Domestic Workers Alliance has organized domestic workers and helped to pass bills of rights in various states and cities, guaranteeing basic employment rights to minimum wage and overtime pay (National Domestic Workers Alliance 2020). Color of Change has worked to empower communities to address multiple social determinants of health, including, but not limited to, discrimination, interaction with the carceral system, unemployment, poverty, and neighborhood disorder (Color of Change 2020). These examples demonstrate how effective organization to build community power can lead to lasting changes in outcomes. The main question becomes, "How do community psychiatrists and other mental health professionals contribute to this work?" These organizations are just some examples of community-based organizations that are making positive change in addressing social determinants of mental health. Community psychiatrists must partner with these and other organizations in their communities to implement and effect change in their local communities. Additionally, community psychiatrists must also develop strategic relationships with lawmakers. This simultaneous top-down and bottom-up approach can lead to lasting improvements in addressing the social, political, and moral determinants of health.

To address the social norms that lead to harmful policies, community psychiatrists and other community mental health professionals have a responsibility to increase their knowledge of the above noted inequities that are often not incorporated in medical or professional school curricula. Scholarly work informed by critical race theory, feminist theory, and queer theory, to name a few, helps to increase understanding of how systems of oppression and structural violence are perpetuated in the assessment, diagnosis, and treatment of serious mental illnesses and substance use disorders. Once armed with additional information, community psychiatrists and other mental health professionals have a moral responsibility to speak up when witnessing and observing injustice occurring. Existing social norms have made it acceptable to express discriminatory or exclusionary thoughts, in the form of off-color jokes, microaggressions, and racial abuse. This cannot be tolerated in backrooms where power is being expressed, and it cannot be allowed to invade policies that occur in the open. Thus, racial equity impact assessments must be conducted on all proposed policies to address the social determinants of mental health.

There are challenges and threats to taking action to address the social determinants of mental health. First, many community psychiatrists and other mental health professionals have made sacrifices (monetary, geographic, etc.) to work in the public sector. Often, their schedules are overloaded due to the demand for providers. Committing to additional work is challenging and working with communities is

time-consuming. Furthermore, this work is far outside of most providers' level of expertise, and a lack of mastery in this space might lead to frustration or disillusionment for those providers that are used to appearing competent and fully knowledgeable. Finally, the scope of work to be done may seem insurmountable as there is much injustice in the world and people with serious mental illness and substance use disorders are suffering. For all of these valid concerns, it is important to consider the words of Nobel Laureate Elie Wiesel, who said:

> But where was I to start? The world is so vast, I shall start with the country I know best, my own. But my country is so very large. I had better start with my town. But my town too, is large. I had best start with my street. No: my home. No: my family. Never mind, I shall start with myself! (Weisel 1982, p. 135)

Community psychiatrists and community mental health professionals must begin with a deep self-inventory and then translate that investment outward into their communities and work settings.

Conclusion

The social and political determinants of mental health are primarily responsible for the vast differences in mental health outcomes that are observed among gender, race and ethnicity, and other demographic groups. Prior tendencies toward individuation have led us to attribute personal responsibility and choices to these differences in outcomes, rather than examine the unjust and unfair policies and practices that set the context for the social determinants of mental health. When community psychiatrists are better able to understand the driving factors that create mental health inequities, they are better able to design and execute effective interventions to begin to address the social determinants of mental health and improve outcomes for people with mental illness and substance use disorders. By intervening upstream at the level of social norms and public policies, community psychiatrists can effectively prevent a host of poor outcomes that routinely and characteristically occur downstream. Effective models exist that can help guide our efforts. There are many barriers to action, but everyone must start somewhere if we are to make lasting and sustainable change.

References

Alang, S. M. (2019). Mental health care among blacks in America: Confronting racism and constructing solutions. *Health Services Research*, *54*(2), 346–355.

Belfield, C. R., Nores, M., Barnett, S., & Schweinhart, L. (2006). The High/Scope Perry Preschool Program Cost–Benefit Analysis Using Data from the Age-40 Followup. *Journal of Human Resources*, *XLI*(1), 162–190.

Berwick, D. M. (2020). The Moral Determinants of Health. *JAMA*, *324*(3), 225.

Bishop, T. F., Press, M. J., Keyhani, S., & Pincus, H. A. (2014). Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. *JAMA Psychiatry*, *71*(2), 176.

Color of Change. (2020). About Color of Change. Retrieved on 1 November, 2020 at https://colorofchange.org/about/

Commission on Social Determinants of Health. (2008). Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health. World Health Organization.

Compton, M. T., & Shim, R. S. (2020). Why Employers Must Focus on the Social Determinants of Mental Health. *American Journal of Health Promotion*, *34*(2), 215–219.

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M., Pachter, L. M., & Fein, J. A. (2015). Adverse Childhood Experiences: Expanding the Concept of Adversity. *American Journal of Preventive Medicine*, *49*(3), 354–361.

Dawes, D. (2020). *The Political Determinants of Health.* Baltimore: Johns Hopkins University Press.

Dvoskin, J. A., Knoll, J. L., & Silva, M. (2020). A brief history of the criminalization of mental illness. *CNS Spectrums*, *25*(5), 638–650.

Eckenrode, J., Campa, M. I., Morris, P. A., Henderson, C. R., Bolger, K. E., Kitzman, H., & Olds, D. L. (2017). The Prevention of Child Maltreatment Through the Nurse Family Partnership Program: Mediating Effects in a Long-Term Follow-Up Study. *Child Maltreatment*, *22*(2), 92–99.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading

Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258.

Finkelhor, D., Turner, H.A., Shattuck, A., & Hanby, S. L. (2013). Violence, Crime, and Abuse Exposure in a National Sample of Children and Youth. An Update. *Journal of American Medical Association Pediatrics,* 167(7), 614–621.

Franklin, S., & Edwards, D. (2012). It takes a neighborhood: Purpose built communities and neighborhood transformation. Investing in What Works for America's Communities, 170–183.

Gollub, E. L., Green, J., Richardson, L., Kaplan, I., & Shervington, D. (2019). Indirect violence exposure and mental health symptoms among an urban public-school population: Prevalence and correlates. *PLOS ONE*, *14*(11), e0224499.

Hautala, D., & Sittner, K. (2018). Moderators of the Association Between Exposure to Violence in Community, Family, and Dating Contexts and Substance Use Disorder Risk Among North American Indigenous Adolescents. *Journal of Interpersonal Violence*, 0886260518792255.

Hayes, K., Blashki, G., Wiseman, J., Burke, S., & Reifels, L. (2018). Climate change and mental health: Risks, impacts and priority actions. *International Journal of Mental Health Systems*, *12*(1), 28.

Hoffman, B. (2008). Health Care Reform and Social Movements in the United States. *American Journal of Public Health*, *98*(Supplement_1), S69–S79.

Kaspersen, S. L., Pape, K., Ose, S. O., Gunnell, D., & Bjørngaard, J. H. (2016). Unemployment and initiation of psychotropic medication: A case-crossover study of 2 348 552 Norwegian employees. *Occupational and Environmental Medicine*, *73*(11), 719–726.

Kazlauskas, E., Zelviene, P., Daniunaite, I., Hyland, P., Kvedaraite, M., Shevlin, M., & Cloitre, M. (2020). The structure of ICD-11 PTSD and Complex PTSD in adolescents exposed to potentially traumatic experiences. *Journal of Affective Disorders*, *265*, 169–174.

Lantz, P. M., & Rosenbaum, S. (2020). The Potential and Realized Impact of the Affordable Care Act on Health Equity. *Journal of Health Politics, Policy and Law*, *45*(5), 831–845.

Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *The Lancet*, *370*(9593), 1153–1163.

Nadeem, E., Lange, J. M., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does Stigma Keep Poor Young Immigrant and U.S.-Born Black and Latina Women From Seeking Mental Health Care? *Psychiatric Services*, *58*(12), 8.

National Domestic Workers Alliance. (2020). Raising Standards. Retrieved 1 November, 2020 from https://www.domesticworkers.org/raising-standards

National Law Center on Homelessness and Poverty. (2018). Homelessness in America: Overview of Data and Causes. Retrieved 2 February, 2021 from https://nlchp.org/wp-content/uploads/2018/10/Homeless_Stats_Fact_Sheet.pdf

Øverland, S. (2016). Unemployment and mental health. *Occupational and Environmental Medicine*, *73*(11), 717–718.

Padgett, D. K. (2020). Homelessness, housing instability and mental health: Making the connections. *BJPsych Bulletin*, *44*(5), 197–201.

Rataj, E., Kunzweiler, K., & Garthus-Niegel, S. (2016). Extreme weather events in developing countries and related injuries and mental health disorders—A systematic review. *BMC Public Health*, *16*(1), 1020.

Shim, R. S., & Compton, M. T. (2018). Addressing the Social Determinants of Mental Health: If Not Now, When? If Not Us, Who? *Psychiatric Services*, *69*(8), 844–846.

Shim, R. S., & Compton, M. T. (2020). The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity. *FOCUS*, *18*(1), 25–30.

Substance Abuse and Mental Health Services Administration. (2011). Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States. Retrieved on 1 November, 2020 from https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf

Substance Abuse and Mental Health Services Administration. (2019). Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health.

The Aspen Institute. (2016). 11 Terms You Should Know to Better Understand Structural Racism. Retrieved 1 November, 2020 from https://www.aspeninstitute.org/blog-posts/structural-racism-definition/

U.S. Department of Health and Human Services. (2020). Healthy People 2030. Retrieved 1 November, 2020 from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Vásquez-Vera, H., Palència, L., Magna, I., Mena, C., Neira, J., & Borrell, C. (2017). The threat of home eviction and its effects on health through the equity lens: A systematic review. *Social Science & Medicine*, *175*, 199–208.

Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2015). Insurance Status, Use of Mental Health Services, and Unmet Need for Mental Health Care in the United States. *Psychiatric Services*, *66*(6), 578–584.

Weisel, E. (1982). Souls on Fire: Portraits of Legends of Hasidic Masters. New York, Simon & Schuster.

Welsh, R. O., & Little, S. (2018). The School Discipline Dilemma: A Comprehensive Review of Disparities and Alternative Approaches. *Review of Educational Research*, *88*(5), 752–794.

Wilson, J. M., Lee, J., Fitzgerald, H. N., Oosterhoff, B., Sevi, B., & Shook, N. J. (2020). Job Insecurity and Financial Concern During the COVID-19 Pandemic Are Associated With Worse Mental Health. *Journal of Occupational and Environmental Medicine*, *62*(9), 686–691.

World Health Organization. (2020). The Social Determinants of Health. Retrieved 1 November, 2020 from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

World Meteorological Organization. (2020). WMO Statement on the State of the Global Climate in 2019. Retrieved 2 February, 2021 from https://library.wmo.int/doc_num.php?explnum_id=10211

Young, I. M. (1990). Five Faces of Oppression, in Justice and the Politics of Different. Princeton, Princeton University Press, pp. 39–65.