

THINK **BIGGER** DO **GOOD**  
POLICY SERIES

# **COVID-19, Structural Racism, and Mental Health Inequities: Policy Implications for an Emerging Syndemic**

Ruth S. Shim, M.D., M.P.H., and Steven M. Starks, M.D.

Winter 2021



Dear Reader,

Now is the time to solve the growing behavioral health needs in our country by advancing public policies that transform the delivery of mental health and substance use disorder services and address outdated funding mechanisms.

This paper is part of Think Bigger Do Good, a series of papers launched in 2017 through the support and leadership of the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation. While the paper topics continue to evolve, our goal to develop a policy agenda to improve health outcomes for all remains constant.

In partnership with national experts in behavioral health, including our editors, Howard Goldman and Constance Gartner, we identified seven critical topics for this third series of papers. Each paper identifies the problem and provides clear, actionable solutions.

We hope you join us in advocating for stronger behavioral health policies by sharing this paper with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters. To learn more about Think Bigger Do Good and to access the other papers in the series, visit **[www.thinkbiggerdogood.org](http://www.thinkbiggerdogood.org)**.

Sincerely,

**Joseph Pyle, M.A.**

President  
Scattergood Foundation  
Founding Partner of Series

**Rick Kellar, M.B.A.**

President  
Peg's Foundation  
Founding Partner of Series

**Jane Mogavero, Esq.**

Executive Director  
Patrick P. Lee Foundation

**Tracy A. Sawicki**

Executive Director  
Peter & Elizabeth Tower Foundation

**We would like to acknowledge the following individuals for their participation in the meeting that led to the conceptualization of the paper series.**

**Colleen L. Barry, Ph.D., M.P.P.**

John Hopkins Bloomberg School of Public Health

**Cynthia Baum-Baicker, Ph.D.**

The Scattergood Foundation

**Anita Burgos, Ph.D.**

Bipartisan Policy Center

**Thom Craig, M.P.A.**

Peg's Foundation

**Rebecca David, M.P.H.**

National Council for Behavioral Health

**Kelly Davis**

Mental Health America

**Lisa Dixon, M.D., M.P.H.**

Columbia University, NY State Psychiatric Institute, and Psychiatric Services

**Sara Dugan, Pharm.D., B.C.P.P., B.C.P.S.**

Northeast Ohio Medical University

**Peter Earley**

Author & Journalist

**Alyson Ferguson, M.P.H.**

The Scattergood Foundation

**Richard Frank, Ph.D.**

Harvard Medical School

**Rachel Garfield, Ph.D., M.H.S.**

The Henry J. Kaiser Family Foundation

**Mary Giliberti, J.D.**

Mental Health America

**Aaron Glickman, B.A.**

Perelman School of Medicine, University of Pennsylvania

**Sherry Glied, Ph.D.**

NYU Wagner School of Public Service

**Howard Goldman, M.D., Ph.D.**

University of Maryland School of Medicine

**Pamela Greenberg, M.P.P.**

Association for Behavioral Health and Wellness

**Kimberly Hoagwood, Ph.D.**

New York University School of Medicine

**Michael F. Hogan, Ph.D.**

Hogan Health Solutions

**Chuck Ingoglia, M.S.W.**

National Council for Behavioral Health

**Rick Kellar, M.B.A.**

Peg's Foundation

**Kelly Kelleher, M.D., M.P.H.**

The Research Institute at Nationwide Children's Hospital

**Jennifer Mathis, J.D.**

Bazelton Center for Mental Health Law

**Donald Matteson, M.A.**

Peter & Elizabeth Tower Foundation

**Brian McGregor, Ph.D.**

Satcher Health Leadership Institute, Morehouse College

**Erik Messamore, M.D.**

Northeast Ohio Medical University

**Ben Miller, PsyD**

Well Being Trust

**Jane Mogavero, Esq.**

Patrick P. Lee Foundation

**Mark R. Munetz, M.D.**

Northeast Ohio Medical University

**Sandra Newman, Ph.D.**

John Hopkins Bloomberg School of Public Health

**Joseph Pyle, M.A.**

The Scattergood Foundation

**Barbara Ricci**

Center for High Impact Philanthropy

**Cheryl Roberts, Esq.**

Greenberger Center

**Victoria Romanda**

Peg's Foundation

**Tracy A. Sawicki**

Peter & Elizabeth Tower Foundation

**Lloyd Sederer, M.D.**

NYS Office of Mental Health/Mailman School of Public Health

**Dominic Sisti, Ph.D.**

Scattergood Program for Applied Ethics in Behavioral Health Care & Perelman School of Medicine at the University of Pennsylvania

**Andrew Sperling, J.D.**

NAMI

**Kate Williams, J.D.**

The Scattergood Foundation

**Glenda L. Wrenn, M.D., M.S.H.P.**

180 Health Partners

## Titles in the Paper Series

**Editors** Howard Goldman, M.D., Ph.D., and Constance Gartner, M.S.W.

### **America's Opioid Epidemic**

Lloyd I. Sederer, M.D.

### **Behavioral Health and the Individual Health Insurance Market: Preserving Key Elements of Reform**

Richard G. Frank, Ph.D., and Sherry A. Glied, Ph.D., M.A.

### **Bringing Treatment Parity to Jail Inmates with Schizophrenia**

Mark R. Munetz, M.D., Erik Messamore, M.D., Ph.D., and Sara E. Dugan, Pharm.D., B.C.P.P., B.C.P.S.

### **Coordinated Specialty Care for First-Episode Psychosis: An Example of Financing for Specialty Programs**

Lisa B. Dixon, M.D., M.P.H.

### **Employing People with Mental Illness in the 21st Century: Labor Market Changes and Policy Challenges**

Richard G. Frank, Ph.D., and Sherry A. Glied, Ph.D., M.A.

### **Fentanyl and the Evolving Opioid Epidemic: What Strategies Should Policymakers Consider?**

Colleen L. Barry, Ph.D., M.P.P.

### **Housing Is Mental Health Care: A Call for Medicaid Demonstration Waivers Covering Housing**

Jennifer Mathis, J.D.

### **Improving Outcomes for People with Serious Mental Illness and Co-Occurring Substance Use Disorders in Contact with the Criminal Justice System**

Glenda L. Wrenn, M.D., M.S.H.P., Brian McGregor, Ph.D., and Mark R. Munetz, M.D.

### **Informed Consent: A Policy Prescription for Communicating Benefit and Risk in State Medical Marijuana Program**

Erik Messamore, M.D., Ph.D., and Sara E. Dugan, Pharm.D., B.C.P.P., B.C.P.S.

### **Integrating Mental Health and Addiction Treatment in General Medical Care: The Role of Policy**

Emma B. McGinty, Ph.D., M.S., and Gail L. Daumit, M.D., M.H.S.

### **Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate**

Jennifer Mathis, J.D., Dominic A. Sisti, Ph.D., and Aaron Glickman, B.A.

### **Meeting the Needs of Justice-Involved People with Serious Mental Illness within Community Behavioral Health Systems**

Natalie Bonfine, Ph.D., Amy Blank Wilson, Ph.D., L.S.W., and Mark R. Munetz, M.D.

### **New Opportunities to Improve Mental Health Crisis Systems**

Michael F. Hogan, Ph.D., and Mathew L. Goldman, M.D., M.S.

**Redesigning Federal Health Insurance Policies to Promote Children's Mental Health**

Kimberly Hoagwood, Ph.D., Kelly Kelleher, M.D., M.P.H., and Michael F. Hogan, Ph.D.

**Policy and Practice Innovations to Improve Prescribing of Psychoactive Medications for Children**

Kelly J. Kelleher, M.D., M.P.H., David Rubin, M.D., M.S.C.E., and Kimberly Hoagwood, Ph.D.

**Preventing Suicide Through Better Firearm Safety Policy in the United States**

Jeffrey W. Swanson, Ph.D.

**Suicide Is a Significant Health Problem**

Michael F. Hogan, Ph.D.

**The Current Medicaid Policy Debate and Implications for Behavioral Healthcare in the United States**

Rachel Garfield, Ph.D., M.H.S., and Julia Zur, Ph.D.

**Youth Suicide Is Increasing: Modest Actions Taken Now Can Save Lives**

Michael F. Hogan, Ph.D.

Find the papers online at [www.thinkbiggerdogood.org](http://www.thinkbiggerdogood.org)



We are grateful for the partnership that allows this paper and others to appear in *Psychiatric Services*, a peer-reviewed monthly journal of the American Psychiatric Association. Content can be viewed at [ps.psychiatryonline.org](http://ps.psychiatryonline.org).

# COVID-19, Structural Racism, and Mental Health Inequities: Policy Implications for an Emerging Syndemic

**Ruth S. Shim, M.D., M.P.H.**

Department of Psychiatry and Behavioral Sciences  
University of California, Davis  
rshim@ucdavis.edu

**Steven M. Starks, M.D.**

Department of Clinical Sciences  
University of Houston College of Medicine  
sstarks@central.uh.edu



# 1 / Introduction

Syndemics, or synergistic epidemics, were first described in the literature in the early 1990s, specifically highlighting the convergence of substance use disorders, violence, and AIDS (1). Syndemic theory helps to provide a framework for how diseases and social conditions form, interact, and cluster to produce worse outcomes for certain populations (2, 3). The 2019 coronavirus disease (COVID-19) pandemic, racial injustice, and health inequities have recently been posited as a new syndemic, globally and particularly in the United States (3, 4). Here, we consider the syndemic of COVID-19, mental health inequities, and structural racism.

---

**Syndemic theory helps to provide a framework for how diseases and social conditions form, interact, and cluster to produce worse outcomes for certain populations.**

---

Although COVID-19 has led to significant morbidity and mortality, it is particularly important to consider its impact on people with mental illnesses and substance use disorders (5). COVID-19 has been associated with increased mental health problems, including depression, suicide, anxiety disorders, and substance use disorders (6). Furthermore, because of a confluence of social determinants of mental health and structural vulnerabilities, people with serious mental illnesses and substance use disorders are at greater risk of contracting COVID-19 (5). Additionally, other oppressed and marginalized communities, including Black, Latinx, and Indigenous people, have higher rates of infection, hospitalization, and mortality, compared with white people (7).

Similarly, although it is well known that racial and ethnic inequities are pervasive in the behavioral health system, recent highly publicized killings of unarmed Black people (at a critical time when the United States was economically and socially slowed enough to take closer notice) have served to sharpen the focus on structural racism and social injustice as a driver of poor health and health inequities.



Thus the deadly manifestations of structural racism in the context of COVID-19 have shone a light on inequities in mental and substance use disorders for oppressed and marginalized populations, revealing a second pandemic of social injustice in the United States (8). Taken together, the concentration and interaction between racial injustice, COVID-19, and mental health inequities have led to devastating health consequences (3, 4). The intersection of these three conditions, and the resulting syndemic, presents numerous policy challenges—and opportunities. Addressing these issues in a unified manner, using a syndemic theory approach, can lead to significant progress and effective solutions for otherwise intransigent problems in society.

To date, the federal response to the COVID-19 pandemic has not adopted a syndemic theory approach. Initial legislation provided emergency funding for federal agencies and expansion of telehealth services (9) and covered paid sick leave, free COVID-19 testing and cost-sharing, unemployment assistance, nutrition assistance, and Medicaid funding support (10). A third bill addressed economic growth and public health responses, supports for state and local government, and financial supports for individuals and businesses (11). These legislative agenda items, all signed into law in March 2020, preceded national alarm about COVID-19's disproportionate impact on oppressed and marginalized communities.

In May 2020, companion bills were introduced that would establish a racial and ethnic disparities task force within the Department of Health and Human Services (HHS) to report outcomes data and federal spending (12, 13). In July 2020, the Senate introduced a companion bill focused on mental health equity in suicide prevention and mental health services for youths from minority groups (14, 15). With the current lack of congressional consensus and ongoing negotiations on a Biden-led coronavirus relief plan, communities of color continue to suffer as they await a federal plan, although the recently passed Consolidated Appropriations Act of 2021 has provided additional individual benefits in the form of direct payments, extended unemployment benefits, and rental and nutrition assistance (16).

For a more effective response, syndemic theory can help guide policy recommendations (at local, state, and federal levels) to effectively tackle all three synergistic conditions—COVID-19, structural racism, and mental health inequities. Several critical policy recommendations that account for syndemic theory are presented.

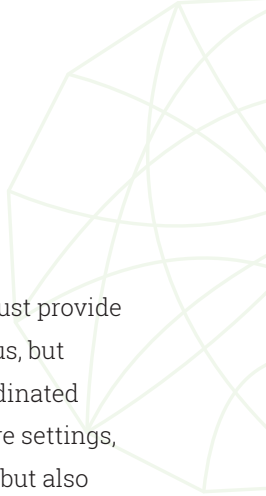
## 2 / Protect “Essential Workers” and Other “Vulnerable” Populations

The spotlight on “essential workers” during the COVID-19 pandemic has exposed risks of exploitation of U.S. workers. Workers deemed “essential” have responsibility for maintaining the infrastructure and functioning of the U.S. economy during the pandemic. These essential, frontline workers are more likely to have lower educational attainment, identify as members of racial and ethnic minority groups, be socioeconomically disadvantaged, and identify as immigrants (17). Essential workers, who are often in jobs with “low decision latitude” and “high job demands” are also more likely to be granted fewer labor protections and, on the basis of the seminal Whitehall II study (18), are more likely to have associated psychiatric disorders.

---

**The spotlight on “essential workers” during the COVID-19 pandemic has exposed risks of exploitation of U.S. workers.**

---



Because this vital community is at high risk, policy interventions must provide protections for these workers. These interventions may seem obvious, but organizing appropriate protections has been difficult without a coordinated strategy. Because some essential workers staff behavioral health care settings, if they become infected, they might affect not only other employees but also patients receiving services in these behavioral health institutions. Thus essential workers in these institutional settings must be prioritized for personal protective equipment (PPE), be given generous leave for recovery from illness, and should have appropriate insurance coverage to receive treatment for COVID-19–related illnesses and any sequelae, including depression, anxiety, and posttraumatic stress disorder, as well as being given priority for COVID-19 vaccines.

Similarly, institutionalized populations are also at higher risk—structural racism dictates that “vulnerable” populations (often “vulnerable” as the result of chronic oppression) are also commonly marginalized—isolated from other populations in nursing homes, long-term care facilities, and jails and prisons. For example, a higher proportion of Black, Latinx, and Indigenous populations are held in jails and prisons, compared with white populations in the United States (19, 20). Because many people with serious mental illnesses and substance use disorders are incarcerated or held in long-term care facilities, it is imperative that these vulnerable populations be given appropriate protections, including PPE, adequate space to practice social and physical distancing, access to appropriate testing and treatment protocols for tracing COVID-19 infections, and prioritized access to COVID-19 vaccines.

# 3 / Engage and Empower Communities

Often, marginalized and oppressed communities lack power and agency in their local county and municipal governing bodies, as well as at the state or federal level. This is the result of numerous structurally racist policies of exclusion that have prevented these communities from holding or sharing power. Often, disinvestment in these communities leads to higher rates of violence and trauma, creating an increased risk of mental health inequities, compared with wealthier communities with greater political power and agency. These marginalized communities are often less likely to have safety nets in place for morbidity, mortality, job loss, and financial insecurity brought on by COVID-19. Policy initiatives that serve to build a sense of community and encourage greater civic engagement within these communities are key (21). This work is often led by community organizers.

---

## **Engagement at the community level also includes bolstering community health interventions.**

---

Engagement at the community level also includes bolstering community health interventions. Counties have community health centers and community mental health centers that utilize a model in which people with lived experience and community members are asked to provide representative leadership. Often, the members with lived experience are not fully representative of the community in a real way—local policy interventions to restructure board composition may ensure that the most marginalized citizens have a true voice in creating policy on these community health boards. Traditionally oppressed and marginalized populations must have a role in decision making, not only when COVID-19 contact tracing and testing are being considered but also when ensuring that vaccine dissemination includes all members of the community to most effectively promote equity. Similarly, state and federal policy interventions must invest in these often-overlooked communities by infusing supports for small-business owners and implementing effective aid packages that help support people in the face of food insecurity, financial hardship, and unemployment.

However, communities are often unable to advocate for needed policy interventions because of oppression in the form of voter suppression (22). Populations that are most likely to be oppressed, including Black, Latinx, and Indigenous people, as well as people with substance use disorders and mental health problems, often encounter systems-level barriers to adequate representation. Ultimately, the downstream effects of lack of representation are inequitable resource allocation, which can be manifest by blatant voter suppression or by more covert tactics, including long voting lines in oppressed and marginalized communities (23). With regard to the COVID-19 pandemic, lack of equitable resource allocation exacerbates the morbidity and mortality associated with the disease. Local policies must protect and support individuals in voting, including loosening voter restrictions (particularly those restrictions for formerly incarcerated individuals) and adequately staffing polling sites (especially in minority communities). Amid the COVID-19 pandemic, additional voting precautions must be taken, including ensuring that poll workers have access to PPE and that voting stations are arranged to observe social distancing guidelines to most effectively support voter participation while protecting the health of voters who are from marginalized communities. Also, voting by mail should be encouraged, and community health and behavioral health centers can assist with voter registration for patients. At the federal level, legislation to strengthen the Voting Rights Act can help to end voter suppression and other structurally racist policies that prevent effective representation for marginalized communities.

State lawmakers should seek to stabilize Black, Latinx, and Indigenous families and communities through income and housing supports. When the social determinants of mental health are addressed, these families are not destined to fall into the safety net, worsening health outcomes and increasing overall societal costs. Additionally, the intersection of racial injustice and mental health inequities means that many state-level policies disproportionately penalize minority communities. For example, even though rates of substance use disorders are similar among all populations, Black, Latinx, and Indigenous people (especially men) are more likely to be incarcerated for substance use (24). Because fines and incarceration destabilize family units, contribute to adverse childhood experiences, and place employment and economic barriers on individuals with drug-related offenses, reforming policies to reclassify drug possession penalties from felonies to misdemeanors and supporting a public health approach to treating substance use disorders can promote equity (25).



## 4 / Optimize Community-Led Crisis Response Interventions

As a result of the COVID-19 pandemic, mental health crisis services (including the use of suicide hotlines and rapid response to substance overdoses) are on the rise (26). These crisis services are disproportionately accessed by minority communities. In considering racial injustice as it relates to policing, there is a new emphasis on examining the response to mental health crises—because crisis response is often closely associated with law enforcement. Crisis Intervention Team (CIT) training, which aims to educate officers to effectively interact with people experiencing mental health crises, operates under the assumption that the structural inequities within the system are static, but policy interventions can shift the response to people experiencing mental health and substance use disorder crises (27). Several examples of community-driven mobile crisis response teams (e.g., the Eugene, Oregon, Crisis Assistance Helping Out On The Streets [CAHOOTS] model) exist because local community members have organized and launched such programs. Data on mobile crisis response services demonstrate that people in mental health crises have fewer interactions with law enforcement and greater utilization of mental health care services, and cost savings can be achieved (28). Financial support is needed at the local, state, and federal levels to effectively execute community-driven crisis response. Ultimately, a coordinated, national policy plan to increase access to mental health care services in the United States is necessary.

---

**These crisis services are disproportionately accessed by minority communities. In considering racial injustice as it relates to policing, there is a new emphasis on examining the response to mental health crises—because crisis response is often closely associated with law enforcement.**

---

# 5 / Improve Data Collection and Dissemination

The COVID-19 pandemic has shown the importance of data in quantifying inequities and in directing resources to defined populations. As has been done with the COVID-19 Racial Data Tracker, counties and states should develop public health strategies for their mental health data and surveillance programs to monitor COVID-19 risks by race and ethnicity for people with mental health conditions (29). State departments of health should utilize offices and task forces aimed at eliminating health disparities and inequities to develop action plans for the pandemic-associated mental health response. Local, state, and national COVID-19 case and hospital data should inform targeted mental health awareness campaigns and screening initiatives, with special emphasis on health care workers, who have experienced excess trauma and burnout in their work.

---

**State departments of health should utilize offices and task forces aimed at eliminating health disparities and inequities to develop action plans for the pandemic-associated mental health response.**

---



## 6 / Support School-Based Interventions

It is not yet clear how distance learning is affecting the mental health of students, although some preliminary data indicate that it has slowed the school-to-prison pipeline that exists in the United States, whereas other data suggest a widening of educational inequities (30, 31). Trauma and adverse childhood experiences lead to worse mental health outcomes for adults, and COVID-19 and interpersonal racism are two main sources of trauma, although not all adverse childhood experience questionnaires have previously incorporated the experience of discrimination as an adverse childhood experience (32). Thus schools must be redesigned with supports in place for students experiencing racism and trauma and to promote mental health in the face of loss associated with inequitable outcomes resulting from COVID-19. Prioritizing these efforts with policy interventions at the local and state levels could lead to better outcomes and prevention of more serious mental illness.

---

**Trauma and adverse childhood experiences lead to worse mental health outcomes for adults, and COVID-19 and interpersonal racism are two main sources of trauma, although not all adverse childhood experience questionnaires have previously incorporated the experience of discrimination as an adverse childhood experience.**

---



# 7 / **Expand Financial Supports for Mental Health Service Delivery**

Although local and state governments may be financially constrained with economic downturns, increased unemployment rates, increased numbers of uninsured individuals, revenue declines, and budget shortfalls, the COVID-19 pandemic underscores the urgency to maintain progress delivered by state mental health authorities. Programs, services, and supports available through traditional means of service delivery in hospital and community-based settings should be realigned with innovation and technology to increase access through telehealth and home-based solutions. Reducing payment rates for Medicaid providers who offer mental health and substance use disorder treatments or removing behavioral health services and benefits from state plans would worsen inequities and outcomes for Black, Latinx, and Indigenous populations.

As a result of structural racism, poor access to health and mental health care—including lack of parity and insurance coverage—is a primary driver of mental health inequities. The ultimate fix will be universal access to health care for all U.S. residents; however, in the meantime, expanding access to services can be an important first step toward reducing inequities. As a result of the relaxation of state and federal restrictions, telepsychiatry services have expanded significantly during the COVID-19 pandemic (33). This increased access enables those who are unable to get transportation to appointments to connect for the first time. Telepsychiatry services, paid at a reasonable rate, need to be continued throughout the pandemic and afterward to address access problems for populations affected by service disparities.

# 8 / Expand Insurance Coverage and Increase Access

A critical component to ensuring health equity is access to health insurance. In states that did not opt to expand Medicaid under the Affordable Care Act, many families remain in the coverage gap, and several areas within these states are densely populated with Black, Indigenous, and Latinx communities. Additionally, many of these states have high per capita rates of COVID-19 cases (34). For these states, Medicaid expansion still offers a path to reducing mental health inequities in a manner that creates cost savings for states and protects oppressed and marginalized communities (35).

---

## **A critical component to ensuring health equity is access to health insurance.**

---

Although the immediate federal response considered prevention and treatment for the physical manifestations of COVID-19, it is critical to develop policies that address the emotional distress inequitably experienced by oppressed and marginalized communities. The federal government can eliminate cost-sharing (out-of-pocket costs) for mental health and substance use disorders services in the private health insurance market, in government health care programs, and for uninsured individuals who are survivors of COVID-19 or who are spouses or children of COVID-19 decedents.

Federal funding should support the broader range of community behavioral health organizations with prospective payment models and expand behavioral health integration services within Federally Qualified Health Centers and Rural Health Centers (which overwhelmingly provide care to communities of color). Given the expansion of telehealth services, the federal government should support the development of broadband infrastructure to close the technology and digital divide that currently exists, which can improve access to mental health and substance use disorder treatment for older adults, children, and adolescents.

# 9 / Promote Workforce Diversity

Policies should promote workforce leadership initiatives to ensure that culturally and linguistically appropriate mental health services are provided to oppressed and marginalized communities, those hit hardest by the COVID-19 pandemic. Federal workforce development programs should seek to eliminate the structural racism that persists in research institutions, education and training programs, and clinical mental health and substance use disorder settings that receive federal funding. Disparity impact statements are required for federal grant awards, and, similarly, grantees receiving grants for federal workforce development should be expected to report human resource management data or other plans on antiracism training, diversity and inclusion efforts, and implementation strategies. Organizations that receive federal workforce development grant awards should be required to report racial and ethnic demographic data and should be held accountable for ensuring Black, Latinx, and Indigenous representation at all levels of the organization, including leadership and executive staff. To further enhance the pipeline for mental health professionals, a federal student grant program should be developed to improve access to higher education for students from racial and ethnic backgrounds traditionally underrepresented in mental health care who are interested in mental health professions.

Federal agencies should receive specific funding and resources (beyond the funding traditionally earmarked for this work) to address inequities in mental health that have been exacerbated by COVID-19 and structural racism. The Substance Abuse and Mental Health Services Administration Office of Behavioral Health Equity, the HHS Office of Minority Health, the National Institute of Mental Health Office for Disparities Research and Workforce Diversity, the National Institute on Minority Health and Health Disparities, and other analogous federal agency offices should address the social determinants of mental health through direct action plans and policies that prioritize educating, training, and hiring a diverse workforce.



## 10 / Conclusion

The syndemic of COVID-19, mental health inequities, and structural racism has led to widespread protests and calls for change—in our public health system and in the structures that perpetuate racism. Social injustice has exposed certain weaknesses in the United States in terms of response to COVID-19, structural racism, and access to mental health services. However, it also presents a unique opportunity to correct course and set forth on a new path, one in which solutions take the synergistic effects of these social and health conditions into account.

For all policies, implementing racial equity action plans and impact assessments for policy decisions ensures that laws do not promote structural racism or inadvertently cause harm to Black, Latinx, and Indigenous populations (36). Emphasis on policy interventions that prioritize equity and justice and that focus on collective health and well-being will ultimately lead us on a more sustainable and equitable path.

# References

- 1/ Singer M, Bulled N, Ostrach B: Whither syndemics?: Trends in syndemics research, a review 2015–2019. *Glob Public Health* 15:943–955, 2020.
- 2/ Singer M, Bulled N, Ostrach B, et al: Syndemics and the biosocial conception of health. *Lancet* 389:941–950, 2017.
- 3/ Gravlee CC: Systemic racism, chronic health inequities, and COVID-19: a syndemic in the making? *Am J Hum Biol* 32:e23482, 2020.
- 4/ Poteat T, Millett GA, Nelson LE, et al: Understanding COVID-19 risks and vulnerabilities among black communities in America: the lethal force of syndemics. *Ann Epidemiol* 47:1–3, 2020.
- 5/ Druss BG: Addressing the COVID-19 pandemic in populations with serious mental illness. *JAMA Psychiatry* 77:891–892, 2020.
- 6/ Ettman CK, Abdalla SM, Cohen GH, et al: Prevalence of depression symptoms in US adults before and during the COVID-19 pandemic. *JAMA Netw Open* 3:e2019686, 2020.
- 7/ Webb Hooper M, Nápoles AM, Pérez-Stable EJ: COVID-19 and racial/ethnic disparities. *JAMA* 323:2466–2467, 2020.
- 8/ Bailey ZD, Krieger N, Agénor M, et al: Structural racism and health inequities in the USA: evidence and interventions. *Lancet* 389:1453–1463, 2017.
- 9/ Coronavirus Preparedness and Response Supplemental Appropriations Act, Pub L No 116-123.
- 10/ Families First Coronavirus Response Act, Pub L No 116-127.
- 11/ Coronavirus Aid, Relief, and Economic Security Act, Pub L No 116-136.
- 12/ COVID-19 Racial and Ethnic Disparities Task Force Act of 2020, HR 6763, 116th Congress. May 8, 2020.
- 13/ COVID-19 Racial and Ethnic Disparities Task Force Act of 2020, S 3721, 116th Congress. May 13, 2020.
- 14/ Mental Health Equity Act of 2020, S 4388, 116th Congress.
- 15/ Pursuing Equity in Mental Health Act of 2019, HR 5469, 116th Congress.
- 16/ Here Is What's in the COVID-19 Relief Package. Washington, DC, National Public Radio, Dec 28, 2020. Available here <https://www.npr.org/2020/12/21/948744901/here-is-whats-in-congress-covid-19-relief-package>.
- 17/ Blau FD, Koebe J, Meyerhofer PA: Who Are the Essential and Frontline Workers? Working Paper 27791. Cambridge, MA, National Bureau of Economic Research, Sept 2020. Available here <https://www.nber.org/papers/w27791>.
- 18/ Stansfeld SA, Fuhrer R, Shipley MJ, et al: Work characteristics predict psychiatric disorder: prospective results from the Whitehall II Study. *Occup Environ Med* 56:302–307, 1999.

- 19/ Criminal Justice Facts. Washington, DC, The Sentencing Project, 2020. Available here <https://www.sentencingproject.org/criminal-justice-facts>.
- 20/ Daniel R: Since You Asked: What Data Exists About Native American People in the Criminal Justice System? Northampton, MA, Prison Policy Initiative, April 22, 2020. Available here <https://www.prisonpolicy.org/blog/2020/04/22/native>.
- 21/ Chandra A, Miller CE, Acosta JD, et al: Drivers of health as a shared value: mindset, expectations, sense of community, and civic engagement. *Health Aff* 35:1959–1963, 2016.
- 22/ Hing AK: The right to vote, the right to health: voter suppression as a determinant of racial health disparities. *J Health Dispar Res Pract* 12:48–62, 2018.
- 23/ Chen MK, Haggag K, Pope DG, et al: Racial Disparities in Voting Wait Times: Evidence from Smartphone Data. Working Paper 26487. Cambridge, MA, National Bureau of Economic Research, Nov 2019. Available here <https://www.nber.org/papers/w26487>.
- 24/ Hart CL, Hart MZ: Opioid crisis: another mechanism used to perpetuate American racism. *Cultur Divers Ethnic Minor Psychol* 25:6–11, 2019.
- 25/ Elderbroom B, Durnan J: Reclassified: State Drug Law Reforms to Reduce Felony Convictions and Increase Second Chances. Washington, DC, Urban Institute, Oct 2018. Available here [https://www.urban.org/sites/default/files/publication/99077/reclassified\\_state\\_drug\\_law\\_reforms\\_to\\_reduce\\_felony\\_convictions\\_and\\_increase\\_second\\_chances.pdf](https://www.urban.org/sites/default/files/publication/99077/reclassified_state_drug_law_reforms_to_reduce_felony_convictions_and_increase_second_chances.pdf).
- 26/ Warren JC, Smalley KB: The Long-Term Impact of COVID-19 on Mental Health. Washington, DC, Commonwealth Fund, 2020. Available here <https://www.commonwealthfund.org/blog/2020/long-term-impact-covid-19-mental-health>.
- 27/ Peterson J, Densley J: Is Crisis Intervention Team (CIT) training evidence-based practice? A systematic review. *J Crime Justice* 41:521–534, 2018.
- 28/ “Defunding the Police” and People with Mental Illness. Washington, DC, Bazelon Center for Mental Health Law, Aug 2020. Available here <http://www.bazelon.org/wp-content/uploads/2020/08/Defunding-the-Police-and-People-with-MI-81020.pdf>.
- 29/ The COVID Racial Data Tracker. Washington, DC, COVID Tracking Project, 2020. Available here <https://covidtracking.com/race>.
- 30/ Vinson SY, Waldman RJ: The pandemic paused the US school-to-prison pipeline: potential lessons learned. *Lancet Child Adolesc Health* 4:799–800, 2020.
- 31/ Masonbrink AR, Hurley E: Advocating for children during the COVID-19 school closures. *Pediatrics* 146:e20201440, 2020.

- 32/ Cronholm PF, Forke CM, Wade R, et al: Adverse childhood experiences: expanding the concept of adversity. *Am J Prev Med* 49:354–361, 2015.
- 33/ Chen JA, Chung WJ, Young SK, et al: COVID-19 and telepsychiatry: early outpatient experiences and implications for the future. *Gen Hosp Psychiatry* 66:89–95, 2020.
- 34/ COVID in the US: latest map and case count. NY Times, 2020. Available here <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states>.
- 35/ Guth M, Garfield R, Rudowitz R: The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review. Washington, DC, Kaiser Family Foundation, March 17, 2020
- 36/ Bernabei E: Racial Equity: Getting to Results. New York, Government Alliance on Race and Equity, July 2017. Available here [https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE\\_GettingtoEquity\\_July2017\\_PUBLISH.pdf](https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf).

# How to use this paper to “Think Bigger” and “Do Good”

- 1 / **Send the paper to your local, state, and federal policy- and decision-makers**
- 2 / **Share the paper with mental health and substance use advocates and providers**
- 3 / **Endorse the paper on social media outlets**
- 4 / **Link to the paper on your organization’s website or blog**
- 5 / **Use the paper in group or classroom presentations**

As strictly nonpartisan organizations, we do not grant permission for reprints, links, citations, or other uses of our data, analysis, or papers in any way that implies the Scattergood Foundation, Peg’s Foundation, Peter & Elizabeth Tower Foundation, or Patrick P. Lee Foundation endorse a candidate, party, product, or business.

## SCATTERGOOD THINK | DO | SUPPORT

The Scattergood Foundation believes major disruption is needed to build a stronger, more effective, compassionate, and inclusive health care system – one that improves well-being and quality of life as much as it treats illness and disease. At the Foundation, we THINK, DO, and SUPPORT in order to establish a new paradigm for behavioral health, which values the unique spark and basic dignity in every human.

[www.scattergoodfoundation.org](http://www.scattergoodfoundation.org)



Peg’s Foundation believes in relevant and innovative, and at times disruptive ideas to improve access to care and treatment for the seriously mentally ill. We strive to promote the implementation of a stronger, more effective, compassionate, and inclusive health care system for all. Our Founder, Peg Morgan, guided us to “Think Bigger”, and to understand recovery from mental illness is the expectation, and mental wellness is integral to a healthy life.

[www.pegfoundation.org](http://www.pegfoundation.org)



The Patrick P. Lee Foundation is a family foundation with two core funding areas - Education and Mental Health. The Foundation’s primary investments in education are through its scholarship programs in science, technology, engineering, and math. In mental health, the Foundation’s investments focus on strengthening the mental health workforce, supporting community programs and services, advocating for increased public funding, and building the mental health literacy of the community.

[www.lee.foundation](http://www.lee.foundation)



PETER & ELIZABETH  
TOWER FOUNDATION

As grantmaker, partner, and advocate, the Tower Foundation strengthens organizations and works to change systems to improve the lives of young people with learning disabilities, mental illness, substance use disorders, and intellectual disabilities.

[www.thetowerfoundation.org](http://www.thetowerfoundation.org)