

# Inequity and the Disproportionate Impact of COVID-19 on Communities of Color in the United States: The Need for a Trauma-Informed Social Justice Response

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COVID-19 has had disproportionate contagion and fatality in Black, Latino, and Native American communities and among the poor in the United States. Toxic stress resulting from racial and social inequities have been magnified during the pandemic, with implications for poor physical and mental health and socioeconomic outcomes. It is imperative that our country focus and invest in addressing health inequities and work across sectors to build self-efficacy and long-term capacity within communities and systems of care serving the most disenfranchised, now and in the aftermath of the COVID-19 epidemic.

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Disasters, such as recent hurricanes, and public health emergencies, such as the COVID-19 epidemic, lead to significant community-wide disruptions in all sectors of public and private life. What we see repeatedly across national crises and disasters is that the most disenfranchised among the U.S. population are disproportionately harmed physically, emotionally, economically, and educationally. These are the same communities already experiencing the toxic stress of poverty, crime, unemployment, racism, and discrimination, now increasing in targeting Asians and Asian Americans, who then additionally bear the burdens and traumatic stress brought on by a crisis. These systemic, social determinants of health are not considered risk factors for COVID-19 in the same way as cardiovascular disease, diabetes, respiratory disease, hypertension, or cancer (Adams, Katz, & Grandpre, 2020), although

they are mediators of toxic stress. The sociopolitical, racial, and environmental stresses that communities of color already experience are unimaginably magnified during the COVID-19 pandemic.

In April 2020, the Centers for Disease Control and Prevention (CDC) reported national data on confirmed coronavirus cases by race and ethnicity (National Center for Immunization and Respiratory Diseases & the Division of Viral Diseases, 2020). The available data suggest that the virus is having disproportionate effects on communities of color, with Black Americans accounting for 34% of confirmed cases even though Black Americans account for only 13% of the total U.S. population. Latinos and Hispanics have seen similar statistics nationwide, and here at Zuckerberg San Francisco General Hospital, Latinos constituted 25%–20% of COVID-19-related hospitalizations and 80% of intensive care unit admissions in the same month. However, nationally, race and ethnicity are missing or unspecified in most CDC-reported cases, and when Native Americans are counted, they are included in the “other” category (Nagle, 2020), so the health impact on communities of color is likely worse than is currently known. As a result, a growing number of states have started reporting racial and ethnic data for all cases and fatalities. In the Mission District of San Francisco, California, an epidemiological study involving community-wide testing is under way to better identify patterns of transmission and vulnerability for this traditionally Latino neighborhood, which has been heavily hit by the epidemic (Chávez & Mark, 2020). These types of data will provide further insight into the public health impact of COVID-19 on communities of color across the country (Resnick, Galea, & Sivashanker, 2020; Thebault, Tran, & Williams, 2020).



It is highly likely that preexisting inequities are at the root of the disproportionate impact of the COVID-19 epidemic on racial-ethnic minorities in the United States, including

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1. Inequity in health care access and quality and limited health care coverage for uninsured and underinsured families;
2. Health care disparities, such as lower rates of vaccination or cancer screening in communities of color, adding to predisposing factors;
3. Preexisting social determinants of health and related chronic illnesses that lead to vulnerability to developing severe COVID-19-related complications and illness;
4. Low wage employment that does not allow work from home or adequate implementation of physical distancing and that lacks sick leave benefits;
5. Digital divide in access to sustained Internet and Wi-Fi and insufficient technology hardware and/or comfort with technology use (which has become essential for telehealth services and remote education for children);
6. Unaffordable childcare and poorly resourced schools where children are unable to thrive;
7. Overrepresentation in correctional and immigration detention facilities, where the risk of rapid viral spread is high, along with disruptions in accessing social services due to immigration-related fears; and
8. Concentration of minority populations in urban areas, with higher likelihood of living in crowded or multifamily homes.

Unlike many European countries, the United States does not have a policy of universal health care. Instead, we have safety-net hospitals with the legal and values-based mission to provide health care for individuals regardless of their insurance status. Safety-net hospitals then by definition are usually public hospitals that serve lower income communities, immigrants, and others who are publicly insured or uninsured. The need for a rapid COVID-19 response, including the creation and deployment of telehealth, was challenging for many public hospitals and community health organizations. In our experience, the task was made more possible by the receipt of technology donations, rapid training of clinicians, and relaxed telehealth regulations that allowed for a broader selection of video and audio platforms that could be used. What would have typically taken us years to build in telepsychiatry capacity was completed in a matter of weeks. However, the ability to provide care for the most vulnerable adults and children with acute needs, especially during what is anticipated to be a long COVID-19 public health recovery period, is still concerning.

Children from disenfranchised communities are the same children whose families are at increased risk for illness, unemployment, and community exposure to COVID-19 (Belmonte, 2020). Their parents are unable to work from home, do not have work-leave benefits, or simply lost their jobs or work hours. Traumatic loss, combined with inequities in resources, is a risk factor for posttraumatic stress disorder (PTSD) and long-term mental and physical health consequences (Anda, Porter, & Brown, 2020; Felitti et al., 1998) and a particularly fragile circumstance for

children's development (Shonkoff et al., 2012). Exposure to multiple traumatic experiences and social inequities are well-established mental health and medical liabilities for low-income communities and people of color, already persistently contributing to disruption in educational attainment (Porche, Fortuna, Lin, & Alegria, 2011), the school to prison pipeline (Barnes & Motz, 2018; Mallett, 2017), and disproportionate representation in juvenile justice and chronic poverty (Robles-Ramamurthy & Watson, 2019). The ongoing loss of a generation of elders due to COVID-19 is another painful source of grief and a profound loss for families. These are all multigenerational stressors that challenge parents' ability to maintain emotional regulation (Gavidia-Payne, Denny, Davis, Francis, & Jackson, 2015), which is a necessary buffer for children who are already at elevated risk of PTSD- and trauma-related disorders compared to adults (Herring, 2017). Given the relationship between trauma exposure and toxic stress and risk for pervasive mental health consequences into adulthood, a focused response to COVID-19 is needed for youth of color already facing heightened risks. Unfortunately, most schools and communities are generally unprepared to fully address mental health needs, and schools serving lower income communities are particularly underresourced. Although many are dedicated mission-driven schools, filled with compassionate teachers who seek to best serve students, the cultivation of solutions requires a societal investment.

In this COVID-19 crisis and what is predicted to be ongoing long-term public and mental health repercussions of this first COVID-19 wave, academic institutions like ours have demonstrated that they have the infrastructure, heightened knowledge, and resources to rapidly deploy telehealth access to disenfranchised patients in the community. However, the behavioral health community-based organizations (CBOs) and other related systems (e.g., child welfare, juvenile justice) do not, and they are struggling. Academic institutions need to rapidly partner to provide practice guidance, teaching, and telehealth consultation support to these CBOs and other systems to truly build self-efficacy in providers for delivery and overall, long-term capacity for providing telehealth access to much-needed child behavioral health care.

Community and cross-sector collaborations will be important for mounting an effective response to the COVID-19 crisis by

1. Moving away from practices and regulations that further silo clinical and social services and instead promoting their integration. Health care regulations and reimbursement strategies should help structure collaborative care and prevention strategies across sectors—taking advantage of technological advances that can support these cross-sector partnerships;
2. Emphasizing respectful, thoughtful, and consistent leadership to empower community stakeholders to act accordingly to address their specific communities' needs;
3. Building capacity around community-academic telehealth partnerships;
4. Creating environments and relationships in schools and other community settings (even if virtual) that help children develop and sustain self-regulation skills, relational

skills, problem-solving skills, and involvement in positive activities; and

5. Promoting parenting competencies, positive peers, caring adults, positive community environments (including elimination of racist and xenophobic experiences), and economic opportunities for families.

COVID-19 has highlighted existing disparities and risks for children, families, and communities of color and those living in poverty. In the United States, we currently have an opportunity to refocus and act on addressing health inequities that have only been worsened by this pandemic.

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