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American Journal of
**PUBLIC
HEALTH**

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COVER: There is a need to recontextualize the root causes of health inequities including HIV and substance use, incorporating a greater understanding of intergenerational racialized trauma. Future mentorship and training for the next generation, as well as inclusion of diverse research approaches, are essential. Public health requires health equity for everyone.

Photo concept and selection by Aleisha Kropf. Photo by Klaus Vedfelt/Getty. Printed with permission.

Funding for the research and related work in this special issue was supported by a grant from the National Institute on Drug Abuse, R25 DA035692.



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
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Intergenerational Trauma and Structural Racism: New Mentorship Approaches to HIV and Substance Use Prevention and Treatment



This issue features a collection of articles under the umbrella of “HIV, Substance Use, and Trauma: Mentoring to Dismantle Structural Racism.” Historically, most research on racial discrimination and trauma and HIV and substance use has examined these issues primarily as individual-level processes. Echoing themes from Krieger’s ecosocial theory (<https://bit.ly/3MC6vIk>), the articles in this collection seek to advance knowledge about how structural racism and intergenerational trauma are embodied for racialized US communities, resulting in disproportionate rates of HIV and substance abuse.

Leveraging theoretical and empirical insights from the intergenerational trauma and structural racism literature, this collection seeks to contextualize racialized health inequities and pinpoint opportunities for multi-level (i.e., individual, community, and structural) intervention. These structural racism and intergenerational trauma contexts are vital because, as Resmaa Menakem writes in his book, *My Grandmother’s Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies* (Las Vegas, NV: Central Recovery; 2017),

Many African Americans know trauma intimately—from their own nervous systems, from the experiences of people they love, and most often, from both. But African Americans are not alone in this. A different but equally real form or racialized trauma lives in the bodies of most white Americans. And a third, often deeply toxic type of racialized trauma lives and breathes in the bodies of many of America’s law enforcement officers. All three types of trauma are routinely passed on from person to person and from generation to generation. (p. 9)

Understanding the link between structural racism and intergenerational trauma provides health equity researchers and mental health practitioners with a critically grounded lens to understand the structural and historical moorings of health inequities such as HIV

and substance use. Although there is a place and need for ameliorative solutions to mend, as Menakem writes, “our bodies . . . Black folks, white folks, and America’s police” (p. 10), the collection also spotlights an urgent need for transformative solutions to dismantle structural racism. Collectively, these articles suggest that the field cannot (and will not) clinically treat individuals and communities out of intergenerational trauma when the main source of that trauma—structural racism and interlocking structural heterosexism, sexism, cisgenderism (to name a few)—thrives unchecked.

This collection’s subtitle spotlights another important need: mentoring and training. George Floyd’s 2020 murder sparked widespread awareness about the deleterious health effects of structural racism. The fact that awareness of structural racism was novel for many White people in the United States has serious implications for mentorship of the next generation of health equity researchers and public health professionals. At a minimum, there is a need to expand the undergraduate and graduate curriculum to include education about topics such as intergenerational trauma and structural racism, and relevant critical frameworks such as ecosocial theory, critical race theory, and intersectionality. That such training will occur in a political climate in which these same topics have been weaponized highlights the precarious terrain that researchers and practitioners seeking to research and develop interventions on these topics must traverse. As such, this collection shows a bold and needed approach to recontextualize understanding about the root causes of health inequities such as HIV and substance use, and seeds the ground for future mentorship and training for the next generation. **AJPH**

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DOI: <https://doi.org/10.2105/AJPH.2023.307316>

11 Years Ago

Methods for the Scientific Study of Discrimination and Health: An Ecosocial Approach

[T]he ecosocial theory of disease distribution . . . concerns who and what drive social inequalities in health. . . . A central focus is on how we literally biologically embody exposures arising from our societal and ecological context, thereby producing population rates and distributions of health. . . . [E]cosocial theory posits that inequitable race relations simultaneously—and not sequentially—(1) benefit the groups who claim racial superiority at the expense of those whom they deem intrinsically inferior, (2) racialize biology to produce and justify the very categories used to demarcate racial/ethnic groups, and (3) generate inequitable living and working conditions that, via embodiment, result in the biological expression of racism—and hence racial/ethnic health inequities. . . . [D]iscrimination harms health [via] economic and social deprivation; excess exposure to toxins, hazards, and pathogens; social trauma; health-harming responses to discrimination; targeted marketing of harmful commodities; inadequate medical care; and, especially (but not only) for indigenous peoples, ecosystem degradation and alienation from the land. Moreover, as emphasized by ecosocial theory’s simultaneous focus on exposure, susceptibility, and resistance, how people resist injustice and its health-harming effects, individually and collectively, and the resilience that enables them to do so also must be examined.

From *AJPH*, May 2012, pp. 936–937

67 Years Ago

Segregation and Discrimination in Medical Care in the United States

Health agencies and organizations have a responsibility to go on record in favor of integrated facilities and the abolition of discriminatory practices, since the achievement of this will be translated in the reduction of morbidity and mortality and an increase in the average expectation of life of [Black Americans]. Segregation and discrimination are environmental factors and are just as damaging to health as water pollution, unpasteurized milk or smog. The American Public Health Association and certainly this Section have a responsibility in this area. Every public health worker, whether in the North or South, ought not to accept the patterns of his community as sacrosanct, but rather should help set the wheels in motion whereby responsible community leaders can come together and work out solutions for the improvement of the health of every single individual in that community.

From *AJPH*, September 1956, p. 1081

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Advancing Public Health and Social Equity Through Research, Training, and Action

Tamara Taggart, PhD, MPH, Sabrina L. Smiley, PhD, MPH, MCHES, and Tiarney D. Ritchwood, PhD

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Despite advances in prevention and treatment, people of color in the United States are at heightened risk for substance use and HIV because of underlying structural and social inequities. Although racism, stigma, and discrimination are known drivers of disparate substance abuse and HIV outcomes, public health efforts to advance research and support the systemic policy and programmatic changes needed to address racial and social inequities have been inconsistent in approach and implementation. In recent years, highly publicized miscarriages of justice and civil rights violations (e.g., murder of George Floyd and other national and international incidents of police brutality, disproportionate burden and impact of the COVID-19 pandemic on communities of color, and forced sterilization of women in immigrant and criminal detention facilities) have propelled systemic inequities and racial trauma to the forefront of public discourse, ushering in renewed attention to these long-standing issues.

Still, research examining the ill effects of racism, stigma, and discrimination on HIV and substance use outcomes, as well as potential evidence-based solutions, remain limited in their capacity to sufficiently advance health equity. There remains an urgent need to clarify how harmful structural racism is to substance use and HIV outcomes and how it, along with intersectional stigma and discrimination, uniquely affects different populations. For this research to be responsive, relevant, and culturally grounded, greater community engagement, including the inclusion of research perspectives from Black people, Indigenous people, and other people of color (BIPOC), should be prioritized.

In this *AJPH* special issue, we highlight the work of early career investigators who completed the HIV/AIDS, Substance Abuse, and Trauma Training Program. This is a mentored research training program funded by the National Institute on Drug Abuse. It provides multidisciplinary, state-of-the-art training to better equip early career investigators to advance National Institutes of Health-funded

research that investigates and challenges practices in racialized systems (e.g., education, employment, health care, and criminal justice) that stymie public health efforts to achieve health equity. Central to this program is mentoring to support rigorous community-driven research with special attention to the challenges that new investigators, especially BIPOC, face that constrain opportunities and stifle creative approaches and solutions to our most pressing public health challenges.

The articles in this issue investigate a range of public health challenges, including community violence, racial trauma, HIV, substance use, and mental health problems, calling for a paradigm shift in the training, theoretical frameworks, methodological and intervention approaches, and policies used to achieve health equity.

REDUCING MENTAL HEALTH DISPARITIES

The historical and current manifestations of structural racism have had a long and lasting impact on the mental health of BIPOC in the United States. For example, Black youths are expected to progress through developmental milestones in racially antagonistic spaces that expose them to a number of systemic stressors, including community violence, racism, trauma, and poverty. These factors cause and exacerbate mental health problems and perpetuate growing inequities in access to and engagement in mental health treatment.

Hampton-Anderson et al. (p. S140) use the socioecological model to characterize multilevel influences on mental health outcomes among Black youths and focus on mental health provider training as a strategy to mitigate

Black youths' premature attrition from treatment. Specifically, they advocate a training model centering three innovative standards of practice that account for society-, community-, and individual-level influences on mental health. The public health implications of this model are vast and include directives for training and mentoring that attend to the social-structural and cultural needs of Black youths; balance mental health treatment with social justice advocacy; and develop evidence-based approaches that amplify the cultural strengths, values, and practices that are salient in Black communities.

Bernard (p. S133) extends the work of Hampton-Anderson et al. to draw attention to the mechanisms by which a lack of culturally responsive training and mentorship perpetuates mental health disparities for Black youths. In particular, Bernard suggests that systemic changes in access to mental health care services are necessary, but insufficient, to promote positive mental health outcomes among Black youths. Taken together, the articles by Hampton-Anderson et al. and Bernard elucidate a multipronged path toward addressing racial disparities in mental health care involving the training and mentoring of mental health professionals to eliminate inequitable treatment strategies. This strategy will also increase mental health professionals' knowledge of issues related to culture, racial inequity, and advocacy for systems-level changes that target structural racism, thereby reducing barriers to retention in mental health care.

STRUCTURAL RACISM AND DISCRIMINATION

Despite significant advances in HIV prevention and treatment, racial and

ethnic disparities in HIV-related outcomes persist. Burton et al. (p. S102) summarize evidence exploring the associations between structural racism and sexual risk. They propose four novel and impactful recommendations for the field that challenge traditional definitions of HIV risk and highlight the necessary research and practice advances needed to end racial and ethnic HIV disparities. Their work is particularly relevant to the editorial presented by Loeb et al. (p. S107), which describes how the care experiences of Black and Latinx people living with HIV could inform culturally relevant multilevel strategies for managing public health crises, such as the COVID-19 pandemic, in the context of structural racism. They emphasize the importance of developing policies and programs that address structural inequities and barriers to health care access with patient-centered behavioral strategies that mitigate health risks. They consider how the skills and challenges people of color living with HIV faced during the height of the COVID-19 pandemic should be better understood to improve health equity for people living with HIV in the face of current and emergent public health threats.

Transgender and nonbinary people face an egregious amount of violence, stigma, and discrimination. In the United States, several state and federal policies (on, e.g., health insurance, education, access to public restrooms) have undermined the rights of transgender and nonbinary people, affecting their mental health and physical well-being and thereby leading to further victimization. Berke et al. (p. S115) specify that victimization of transgender and nonbinary people must be understood in the larger context of discrimination at the intersection of interlocking systems of oppression. They propose

multilevel empowerment interventions as a strategy to address violence toward BIPOC transgender and nonbinary people and to disrupt structural contributions to their victimization. They discuss how the act of shifting power from researchers to community members leads to more innovative and effective strategies to reduce violence toward transgender and nonbinary communities and to achieve health equity.

Inequitable social-structural systems and experiences of trauma heighten vulnerability for commercial sexual exploitation, substance use, and HIV among BIPOC children and adolescents. Although much has been written on intergenerational transmission of trauma, less attention has been given to intergenerational transmission of resilience. Bounds et al. (p. S124) present findings, challenges, and lessons learned from their implementation of an adapted intervention called Support to Reunite, Involve, and Value Each Other. This intervention aids public health practitioners working with vulnerable minoritized adolescents and their families. Drawing on their work with young people with lived experience of homelessness, Bounds et al. focus on strengths-based approaches to implement family-based interventions to promote positive parenting, family resilience, and social cohesion. Their intervention offers a way for future researchers and practitioners to understand how to work with BIPOC adolescents and families to incorporate cultural values, family dynamics, and flexibility to effectively adapt evidence-based interventions to these populations.

Exposure to racism and racial trauma in K-12 schools negatively affects the academic achievement, emotion regulation, and socioemotional health and

well-being of students. Recent politicization of teaching about critical race theory, racism, and racial trauma in schools has exacerbated oppressive systems in higher education. As states continue to pass laws that limit education on the history of slavery, racism, and racial inequality, the need for collective action and racial healing is pressing. Racial healing is a process that rejects norms of White superiority, celebrates cultural heritage and identity, challenges privilege and White supremacy, and provides guidance on the introspective and interpersonal work needed to collectively heal from racial trauma and injustice. Tan et al. (p. S119) share an insightful process to develop and implement a racial-healing initiative to promote socioemotional wellness and address racism in K-12 schools. They describe their formative research; strategies for collaborating with youths, parents, and educators; and lessons learned for future school-based racial healing initiatives. They conclude with a call to action to remain hopeful in our efforts to achieve health equity and provide strategies to promote racial healing in schools based on their study findings.

Lastly, Wyatt et al. (p. S110) describe the development and implementation of the Women-Centered Program for Women of Color, a culturally congruent intervention to reduce sexual health risks for women of color in a low-income area of Los Angeles County, California. Guided by the principles of community-based participatory research, Wyatt et al. practiced cultural humility to develop this program for Black and Latina cisgender women, which combines increased information and skills about HIV and sexually transmitted infection prevention with reproductive health. Wyatt et al. describe an innovative and

powerful intervention conducted during the COVID-19 pandemic for women of color who, because of poverty, trauma, and gendered racism, are at heightened vulnerability for HIV and unintended pregnancy. Lessons learned from this intervention provide a way forward for engaging this often forgotten yet highly vulnerable group in HIV prevention.

INTERPERSONAL VIOLENCE

At the onset of the COVID-19 pandemic, reports of interpersonal violence increased in the United States. Public health measures designed to curtail the spread of COVID-19 along with heightened social-structural stressors associated with the pandemic resulted in an increase in interpersonal violence, mental health problems, and substance use. Marginalized communities experience disproportionate amounts of interpersonal violence, with Black and Latina women being particularly affected. Smith-Clapham et al. (p. S149) assessed the effects the COVID-19 pandemic had on women of color experiencing interpersonal violence and provide recommendations for training law enforcement, mental health clinicians, and public health care professionals to implement and manage prevention and intervention efforts targeting interpersonal violence. They conclude with robust policy recommendations to disrupt systems that isolate and stigmatize survivors of interpersonal violence.

MEASURING EXPOSURE TO RACISM

It is well established that physical and social environments contribute to disparities in substance use across the life course, particularly for BIPOC

adolescents and young adults. The articles presented by Zhen-Duan et al. (p. S129) and Taggart et al. (p. S136) underscore the need to refine traditional measures of social and physical neighborhood environments to better assess the contributions of structural racism to adolescent and young adult substance use. Zhen-Duan et al. summarize the limitations of the Adverse Childhood Experiences Questionnaire in research on racial and ethnic disparities in substance use, arguing that the conceptualization of adverse childhood experiences cannot be separated from the social environment or intergenerational impacts of structural racism. They suggest that the Adverse Childhood Experiences Questionnaire be expanded to enable an examination of the mechanisms through which racism and inequality affect substance use outcomes for BIPOC youths. They also posit that nuanced methodological approaches that model complexity and interactions between individuals and their environment are needed to advance health equity.

Relevant to the work of Zhen-Duan et al., Taggart et al. propose a novel methodological approach to assess neighborhood influences on substance use that centers the lived experiences of Black youths in their social and physical neighborhood environments. Taggart et al. integrate components of activity space assessments, racialized risk environment models, and models of community violence to investigate the cooccurrence of racism-related stress and substance use among young Black men. Their study findings elucidate the community- and structural-level strategies needed to increase health-promotive neighborhood contexts and reduce racism-related stressors.

FINAL THOUGHTS

The articles in this supplement show that eliminating structural racism and achieving health equity requires that we first acknowledge structural racism as a fundamental cause of health inequities. Next, we must advance training, policies, clinical practices, and methodologies that propose radical shifts in traditional public health approaches. For this research to be effective, it is essential that greater inclusion of—and research perspectives from—BIPOC investigators be prioritized. These articles highlight the work of highly skilled early career investigators who are poised to lead efforts aimed at dismantling structural racism and who have been supported by the National Institutes of Health-funded initiatives intended to increase diversity and facilitate equitable and inclusive practices that are necessary to advance health equity. [AJPH](#)

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PUBLICATION INFORMATION

Full Citation: Taggart T, Smiley SL, Ritchwood TD. Advancing public health and social equity through research, training, and action. *Am J Public Health*. 2023;113(S2):S98–S101.

Acceptance Date: May 14, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307340>

CONTRIBUTORS

T. Taggart and T. D. Ritchwood conceptualized, drafted, revised, and provided substantive feedback on the editorial. S. L. Smiley conceptualized and contributed to earlier drafts of the editorial. All authors reviewed revisions of the editorial.

ACKNOWLEDGMENTS

T. Taggart's effort was supported by the National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH) award R01DA056264 and the

National Institute of Allergy and Infectious Disease, NIH (award UG3AI169655). S. L. Smiley's effort was supported by the California Tobacco-Related Disease Research Program (awards T31P5502, T32SR5041) and the California HIV Research Program (award H21PC3601). T. D. Ritchwood's effort was supported by a career development award from the National Institute of Mental Health, NIH (K08MH118965). This work was supported by an award from the NIDA (award R25DA035692).

We thank Marleen Castaneda for supporting this special issue.

Note. The content of this editorial is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.



SOFTCOVER, 100 PAGES, 2021
ISBN 978-0-87553-312-6

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Structural Racism and Racial Trauma Among African Americans at Elevated Risk for HIV Infection

Kelsey L. Burton, PhD, Tiarney D. Ritchwood, PhD, and Isha W. Metzger, PhD

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Forty years into the HIV epidemic, we have witnessed remarkable achievements. People living with HIV (PLWH) can thrive because of the availability of antiretroviral therapy (ART), with a lifespan like those without HIV. We learned that “U = U”; that is, we now know that PLWH whose HIV cannot be detected by laboratory testing cannot sexually transmit the virus to their partners. The advent of preexposure prophylaxis (PrEP) expanded biomedical HIV prevention tools, enabling people without HIV to protect themselves from infection. While we have the necessary HIV prevention and treatment tools to end the HIV epidemic, such a goal remains elusive. Unfortunately, these great achievements in research and practice have been accompanied by profound failures, including inequitable access to new HIV prevention and treatment options among African Americans.

Despite accounting for only 13% of the US population, African Americans comprise 42% of all new HIV diagnoses.¹ For members of key subpopulations, the situation is even more dire;

approximately half of African American men who have sex with men (MSM) are expected to contract HIV in their lifetime.¹ Among all cisgender women, African Americans identifying as cisgender comprise 54% of new diagnoses, and African American transgender women comprise 46% of new diagnoses among all women.¹ Compared with their peers from other racial/ethnic backgrounds, African Americans have lower rates of engagement in the HIV treatment continuum.¹ In 2019 alone, for every 100 African Americans diagnosed with HIV, 74 received some HIV care, 56 were retained in care, and 61 were virally suppressed, indicating lower engagement than their White and Hispanic/Latino peers.¹ While individual and social factors (e.g., HIV-related stigma, HIV knowledge, poverty, sexual risk) are frequently cited as the primary contributors to low engagement in the HIV prevention and treatment continuum, the spotlight on such factors masks the broader social, political, and economic conditions that generate and maintain observed racial disparities in

HIV infections and related outcomes, such as structural racism and repeated exposures to racial trauma.^{2,3}

In this article, we discuss the influence of structural racism (i.e., the way in which society promotes and sustains racial discrimination through larger systems and macro-level conditions that limit the opportunities, resources, power, and well-being of racial minorities) and racial trauma (i.e., the emotional injury resulting from exposure to various forms of racism, racial discrimination, and racial bias) on HIV-related outcomes among African Americans. We conclude with recommendations aimed at addressing these factors to end racial disparities observed in the HIV epidemic.

STRUCTURAL RACISM AND HIV

Structural racism is a key source of racial disparities in HIV-related outcomes^{2,4} and can occur in various social domains, including schools, corporations, legal systems, and health care. One of the most blatant and impactful examples of the influence of structural racism on HIV-related outcomes among African Americans was drug policy concerning controlled or illicit substances—policies that disproportionately targeted people of color.⁵ In 1971, led by then-President Richard Nixon, the US federal government declared drug abuse “public enemy number one,” launching the War on Drugs—a federal campaign that sought to end the illicit drug trade in the United States, wherein the federal government budgeted billions for drug-control agencies, established harsh penalties for drug possession, and increased police presence in predominately ethnic minority communities.

Biases in the US drug policies and policing and sentencing practices led to

harsher legal penalties for people of color who bought or sold drugs compared with their White peers; despite the similarities in illicit drug use between African Americans and White Americans,⁵ law enforcement agencies and state prosecutors inequitably targeted people of color for investigation and incarceration.^{5,6} Decades of failed policies and practices led to the mass incarceration of people of color, with incarceration of African American men skyrocketing. By 1980, the African American arrest rate for drug possession and drug sale was three times higher than for their White counterparts. Unfortunately, racial disparities in incarceration rates have worsened, with African American arrest rates being up to five times higher than for White Americans.⁷

The impact of the mass incarceration of African Americans on racial disparities in HIV-related outcomes is multi-level. At the individual and community levels, higher incarceration rates among African Americans disturbed sexual networks within the African American communities, limiting the pool of available sexual partners and increasing the likelihood of overlapping sexual partnerships, thereby increasing HIV risk.⁵ Moreover, stigma and employment practices limited opportunities for those who were formerly incarcerated, including access to health insurance, leading to social and financial stressors, all of which had generational impacts on families and entire communities.^{4,6,8} Together, these policies contributed to the rise in HIV infection and transmission in African American communities.⁹

The impact of structural racism on HIV risk and transmission extends to the health care system. Previous research, for example, has linked poor health care quality to provider and systemic biases,

including HIV-related stigma.¹⁰ Personal or vicarious experiences of racism, discrimination, and stigma within such systems has been linked to health care disengagement, including with preventive and HIV care.^{11,12} A study among African American women living with HIV, for example, found that perceptions of structural racism and discrimination in HIV care settings contributed to skepticism or distrust of medical advice and mistrust in the health care system.¹³

Taken together, structural racism operates through various social systems, including policy and health care provision, and has harmed generations of people of color by limiting access to HIV prevention and treatment resources, and exacerbating personal and communal experiences of racism and discrimination, leading to experiences of racial trauma.¹⁴

RACIAL TRAUMA AND HIV

Racial trauma can result from both direct and vicarious experiences of racism¹² and has been linked to psychological distress.¹⁴ To our knowledge, there are no studies exploring the effects of racial trauma on HIV risk behaviors. However, exposure to racial discrimination has been linked to poor HIV-related outcomes.¹⁵ One study, for example, linked more experiences with racial discrimination to greater engagement in risky sexual behaviors among heterosexual African American men.¹⁵

In addition to affecting engagement in risky sexual behaviors, racial trauma may also have an impact on engagement in HIV care. One study among African American MSM living with HIV, for example, found that participants reporting greater experiences of discrimination because of their HIV status, race, and sexual orientation were less likely than their peers with fewer reports of

discrimination to adhere to their ART regimens over six months.¹⁶ In a recent study among older African Americans, experiences of HIV-related stigma and discrimination were linked to greater odds of medication nonadherence.¹⁷ Moreover, a recent meta-analysis found increased odds of ART nonadherence among PLWH with trauma-related histories than their peers without trauma histories.¹⁸

Although such studies are unable to infer causation, they do suggest that experiences of racial discrimination could have an impact on sexual behavior, though the nature of this link requires further investigation. As interest in the effect of structural racism and racial trauma on HIV outcomes continues to grow, more research is also needed to understand the impact of racial trauma on HIV outcomes among people of color.

While there is no singular solution for eliminating the racial disparities observed in HIV infections, efforts to end the HIV epidemic must include multi-level approaches aimed at dismantling structural racism and addressing racial trauma. We make the following recommendations for public health practice and research:

1. Provide HIV prevention services in correctional settings,
2. Address implicit bias and discrimination in health care,
3. Prioritize health equity and community engagement, and
4. Incorporate racial trauma healing into interventions.

PROVIDE HIV PREVENTION SERVICES IN CORRECTIONAL SETTINGS

Federal and state policies related to drug possession have led to higher

rates of incarceration among African Americans. With correctional facilities being recognized as potential entry points for HIV prevention and treatment strategies,^{19,20} greater efforts are needed to ensure equitable access to biomedical prevention and treatment tools both during and after incarceration. Although condoms are widely known as effective HIV-prevention tools, they are often inaccessible because of concerns about encouraging sexual activity, a myth that has been repeatedly debunked. Providing condoms in correctional facilities could reduce HIV transmission in those settings²⁰ and prepare individuals who are released to adopt such practices while in the community. Like condom distribution, offering PrEP in correctional facilities could also reduce HIV transmission risk.

HIV testing and screening practices within correctional facilities vary from state to state. Some facilities only offer testing at the request of an inmate or during the intake process. Public health practitioners and scholars have advocated universal HIV testing and screening procedures, which could increase early detection of HIV and improve linkage to HIV care within correctional systems.¹⁹ One policy, opt-out HIV testing, has been linked to increased rates of HIV testing among incarcerated populations compared with opt-in approaches.²⁰

In addition to obtaining resources within correctional facilities, access to resources in the community must also be addressed. Decarceration, which involves releasing incarcerated persons with nonviolent offenses, is a strategy for reducing racial inequities in incarceration. Although this strategy could reduce racial disparities in disproportionate rates of incarceration, we need to concurrently implement strategies

that also reduce HIV transmission risk. While access to HIV treatment within prisons is often required by federal or state policies or both, formerly incarcerated people often lose access to HIV treatment upon release, as they often face challenges with securing follow-up care because of economic and employment instability.^{9,21} These challenges create barriers for continuing HIV care and accessing ART. Legislation focused on criminal justice reform and decarceration should address systematic factors that interrupt HIV care, such as affordable housing, under- or unemployment, and failure to expand Medicaid access. As such, criminal justice reform could improve access to re-entry programs, which assist formerly incarcerated populations with linkage to support services, including mental health treatment, employment and housing, and health care.

ADDRESS IMPLICIT BIAS AND DISCRIMINATION IN HEALTH CARE

Implicit bias—a form of bias that occurs automatically and unintentionally that affects judgments, decisions, and behaviors—is common among health care providers and threatens equitable access to HIV prevention and treatment services. Previous research observing PrEP uptake among African Americans, for example, linked health care provider decision-making regarding the appropriateness of PrEP to racism and both implicit and explicit biases against patients.²²

While there are ongoing efforts to address implicit bias in health care, including revisions to the curricula in training programs, statewide mandates requiring implicit bias training to meet continuing education requirements for

some health care professionals, and the implementation of structural competency training, which seeks to educate providers on the role of structural racism on racial health disparities, the long-term effectiveness of such programs is unknown. Moreover, there are often unclear metrics applied toward measuring the effectiveness of such programs, as the field is still evolving in this area; we need validated tools and standardized constructs to enable cross-comparisons and evaluation.

PRIORITIZE HEALTH EQUITY AND COMMUNITY ENGAGEMENT

Health communication campaigns aimed at increasing engagement in the HIV prevention and treatment continuum can impact one's attitudes, beliefs, willingness to change, and behavioral intentions.²³ HIV prevention and treatment messaging should not only address individual behaviors but also reach further, challenging social and cultural norms that lead to high-risk behaviors.²³ To do so, we must engage key populations in the research, development, implementation, and dissemination of novel interventions that could lead to structural changes, including economic and housing development. Engaging affected populations in HIV research could facilitate the development of culturally relevant messages with a higher likelihood of community buy-in and acceptance,²⁴ which could provide evidence for the need for policy changes that could have an impact on social and cultural norms.

In addition to engaging members of key populations in public health practice and research, increasing representation of African Americans within HIV care and research can also improve

HIV outcomes. Previous research, for example, has shown that patients receiving care from providers with the same racial identity reported a more positive experience in health care and more effective communication with their health care provider. However, structural racism within academic admissions affects diversity in this field, with many scholars advocating structural change by establishing pipeline programs for people of color, implementing antiracism curricula, utilizing more holistic approaches to application review for academic admissions, and developing initiatives aimed at mentoring and supporting trainees of color within professional health programs.

INCORPORATE RACIAL TRAUMA HEALING INTO INTERVENTIONS

For many African Americans, experiences of racism, discrimination, and bias are unavoidable facets of life. These experiences, however, are linked to poor health outcomes, including trauma and psychological distress.²⁵ Among African Americans living with HIV, experiences of racism and trauma can intersect with stigma and discrimination associated with their HIV status and sexual orientation, among other socio-structural determinants.³ Completely eliminating all forms of racism from our society, however unlikely, will take time. As such, we must ensure that African Americans are able to cope with these unfortunate and unjust burdens. Within mental health treatment interventions, incorporating racial trauma healing into HIV prevention and treatment interventions may be a necessary step toward supporting African Americans at elevated risk of contracting HIV or currently living with the virus.

Racial trauma healing describes a therapeutic process that implements strategies aimed at helping people of color heal from traumatic racial experiences. For example, Metzger et al. shared several approaches for addressing racial trauma among African Americans receiving mental health treatment, including integrating racial socialization—the process of transmitting cultural attitudes, behaviors, perceptions, and values to help African American adolescents manage racial discrimination and racism—into evidence-based psychotherapies.²⁵ Specifically, the researchers proposed adaptations to trauma-focused cognitive behavior therapy that would include racial socialization and suggested that clinicians use culturally relevant communication approaches (e.g., poetry and music) rather than the general storytelling that is recommended to encourage youth to share their experiences with racism and discrimination, exploring how they contribute to current challenges and ways to overcome them. Among African Americans living with HIV, incorporating racial trauma healing into mental health treatment may support retention in HIV care and ART adherence by providing strategies for coping with intersecting trauma and stressors that could disrupt health care engagement.

CONCLUSION

Ending racial disparities observed in HIV-related outcomes requires us to focus our efforts on addressing structural racism and reducing the impact of racial trauma on populations affected by HIV. Incorporating racial socialization and healing into HIV prevention and treatment efforts may provide tools for coping with stressors, thereby improving HIV outcomes. This could also reduce

mistrust among African Americans living with HIV and medical providers and reduce interruptions of HIV care thereby improving ART uptake and adherence. Still, efforts are needed to diversify the field of HIV prevention and treatment, enabling more scholars of color to be leaders in addressing the racial HIV disparity. We posit that addressing structural racism in these suggested ways will allow us to combat disparities in HIV outcomes that disproportionately impact African Americans. [AJPH](#)

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PUBLICATION INFORMATION

Full Citation: Burton KL, Ritchwood TD, Metzger IW. Structural racism and racial trauma among African Americans at elevated risk for HIV infection. *Am J Public Health*. 2023;113(S2):S102–S106. Acceptance Date: January 2, 2023. DOI: <https://doi.org/10.2105/AJPH.2023.307223>

CONTRIBUTORS

K. L. Burton and T. D. Ritchwood drafted the article. All authors reviewed revisions of the article and provided substantive edits and feedback.

ACKNOWLEDGMENTS

T. D. Ritchwood's effort was supported by (1) career development awards from the National Institute of Mental Health (K08MH118965) and the Duke Center for Research to Advance Healthcare Equity, which is supported by the National Institute on Minority Health and Health Disparities under award U54MD012530, and (2) other support from the Duke University Center for AIDS Research, a National Institutes of Health (NIH)-funded program (5P30 AI064518).

Note. The content of this article is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

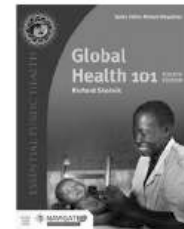
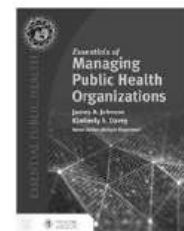
CONFLICTS OF INTEREST

The authors have no conflicts to declare.

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Achieving Health Equity and Continuity of Care for Black and Latinx People Living With HIV

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The COVID-19 outbreak and public health response have exacerbated racial health inequities, including those related to HIV. Black and Latinx communities are disproportionately impacted by morbidity and mortality associated with the intersecting pandemics of HIV and COVID-19. Structural racism has manifested in race-related social determinants of health (SDOH) that underlie these health inequities.¹

Black and Latinx people living with HIV (PLWH) are disproportionately exposed to poverty, barriers to health care access, and trauma, all of which increase the risk of substance use and mental health symptoms that interact with SDOH and compromise treatment adherence.² In addition, PLWH are more likely to experience medical comorbidities, including cardiovascular disease, the leading cause of mortality

in the United States and an independent risk factor for poor COVID-19–related outcomes.³ As these underlying risk factors increase Black and Latinx PLWH's vulnerability to morbidity related to both HIV and COVID-19, understanding their health strategies during these intersecting health crises could reveal important strength-based approaches for mitigating the impact of SDOH among these populations.

In this editorial, we consider how the care experiences of Black and Latinx PLWH could inform culturally relevant, multilevel strategies for managing public health crises like COVID-19 in the context of structural racism and bolster care for PLWH facing new health threats. We focus on two conditions of the COVID-19 pandemic: (1) disease prevention and management and (2) in-person care

disruptions and the rapid uptake of telehealth.

TRANSLATING PUBLIC HEALTH STRATEGIES FOR HIV TO COVID-19

Public health efforts to mitigate COVID-19 risks have relied on behavioral and social change strategies, many stemming from lessons learned from the HIV pandemic.⁴ Accordingly, research has called for expansions of investments in HIV infrastructure, policies, and research, as well as the engagement of PLWH communities, to develop effective COVID-19 public health responses.⁵ While there are obvious differences between HIV and COVID-19 (e.g., mode of transmission),⁵ individual-level mitigation efforts have failed to identify and leverage PLWH's use of patient-centered strategies to minimize COVID-19 risks. This is a missed opportunity.

Identifying attitudes and skills that PLWH may have transferred from their management of HIV to the mitigation of COVID-19 risk could inform prevention efforts aimed at minimizing new public health threats. For example, health care professionals could be empowered to foster self-efficacy among patients living with chronic illness (and, thus, at risk for emerging public health crises) by building on known care strategies and highlighting similarities in risk management approaches across varying health threats. In addition, public health messages for inevitable, emerging health crises could be improved by understanding whether HIV-specific self-management strategies are translatable to manage COVID-19 risks and whether they vary as a function of common health comorbidities and SDOH that affect PLWH.

Like responses to HIV, COVID-19 responses must address race-related inequities in SDOH that confer disease

risk and decrease service utilization.⁵ While structural-level interventions are necessary to achieve racial health equity, novel patient-centered approaches to navigating inequities should not be overlooked. Among Black and Latinx PLWH specifically, experiences navigating a racialized and chronic health condition like HIV could be translated to other public health crises as they intersect with structural racism. For instance, while living with HIV may have heightened perceptions of COVID-19 risk and engagement in protective health coping strategies for some patients, it may have increased medical mistrust, compromising ongoing HIV self-management and new COVID-19 risk management for others from minoritized racial/ethnic groups.

Approaches like these could be applied not only to health equity interventions for future public health crises but also to those for PLWH. Public health responses could incorporate culturally relevant interventions that empower racialized PLWH to apply their management of previous health and social challenges to new problems. For example, resilience and critical race consciousness have been identified as facilitators of HIV care and predictors of improved immune function among Black PLWH.^{6,7}

Interventions incorporating critical consciousness that promote awareness of and adaptive action against structural racism and other forces of oppression may increase self-efficacy and reduce HIV risk behavior and other risks associated with racialized public health crises (e.g., the opioid overdose crisis).⁸ Such interventions should be developed in collaboration with Black and Latinx PLWH to ensure their cultural and clinical relevance. These patient-centered strategies are an important component of risk-reduction efforts in the context of enduring race-related

SDOH; however, to achieve health equity, the onus remains on institutions and policymakers to dismantle policies that maintain structural inequities perpetuating health disparities.

CONTINUITY OF CARE AND DIGITAL INCLUSION

Continuity of care has been identified by PLWH as an important component of effective treatment.⁹ Preventing discontinuity of care is especially important for those living with chronic illness and who experience race-related inequities in access to SDOH as these patients' treatment adherence relies on maintenance of established relationships with trusted providers. COVID-19-related public health mandates forced changes in health service delivery, including clinic closures and scaling back or suspension of non-COVID-19-related health appointments.² Restricted in-person contact with providers led to fears of disruptions in patient health care utilization and adherence despite the rapid transition to digital platforms.

Transitioning health services to digital platforms has potential to increase the reach and frequency of care and may reduce concerns about continuity of care for those with chronic health conditions like HIV. However, it may also widen existing health disparities among those who experience digital barriers. Like many with chronic conditions, PLWH made the transition to remote health care during the pandemic. However, inequities in digital inclusion, including health literacy, digital skills, and access to technology, as well as limited English proficiency, greatly restricted the ability of some PLWH to participate in remote monitoring of clinical care and other telehealth services.^{2,10} Digital inclusion itself is an SDOH that interacts with others: older, racially/ethnically minoritized, and

low-income PLWH are more likely to experience lack of access to technology and low electronic health literacy, which, in turn, threaten continuity of care.¹¹

While many Black and Latinx people lack consistent access to digital technology,¹⁰ those that do have computer or smartphone access may not have the needed skills to effectively use their device to access telemedicine or telehealth services; indeed, these populations were less likely to use video platforms than other racial/ethnic groups early in the pandemic.¹² For Latinx PLWH, language barriers may further exacerbate these inequities.¹² Although the challenges and successes of the COVID-19-related growth of telemedicine have been well-documented, understanding the health care experiences of a population that requires consistent multidisciplinary care (i.e., PLWH) during this period could inform ongoing improvements to telemedicine and ensure continuity of care for those who need it most.

This information is particularly important as COVID-19 becomes endemic. Documented inequities in telehealth access as a function of race, socioeconomic status, and language must be addressed at multiple levels to prevent the exacerbation of current inequities in health care access. Provider solutions include offering preappointment sessions that could be scheduled to aid those with difficulties accessing or utilizing technology for telehealth visits and problem-solve barriers.¹³

Patient-related factors associated with the effectiveness of telemedicine must also be identified. For example, some patients report greater satisfaction with telemedicine than in-person appointments, particularly those engaged in behavioral health treatment or facing transportation barriers to treatment.¹⁴ However, without policy solutions to

increase access to and knowledge of digital technology solutions among people who are Black, Latinx, non-English speaking, and living in poverty, members of these groups will continue to be excluded from the benefits of telemedicine and experience discontinuity of care. Given the aforementioned intersectionality of Black and Latinx PLWH, this population is well-positioned to serve as key participants in the development of such solutions.

CONCLUSION

Mitigating public health crises requires multilevel intervention, including policies and programs to address structural inequities and barriers to health care access experienced by vulnerable subpopulations. In addition, patient-centered behavioral strategies can be leveraged to mitigate health risks among those disproportionately impacted by race-related SDOH. By understanding the adaptation of public health strategies for management and continuity of care in HIV, tailored public health messages can be used to lower the risks associated with COVID-19 and other public health crises as they intersect with race-related SDOH.

Because PLWH have an increased risk of future comorbidities and complications associated with COVID-19, the management of their HIV status could be adapted to reduce exposure and risk of COVID-19 and other public health problems. For example, these management strategies have potential translations to harm reduction and drug overdose prevention, which are increasingly and disproportionately affecting Black and Latinx people with and without HIV. In addition, the telemedicine experiences of Black and Latinx PLWH during the COVID-19 pandemic could inform programs and policies that increase digital inclusion and

reduce the impact of structural inequities on continuity of care in an increasingly digital health care space.

Given the enduring and pernicious nature of race-related SDOH, the skills and challenges of PLWH in morbidity prevention and care continuity should be better understood with the ultimate goal of improving health equity for Black and Latinx PLWH in the face of current and emergent health threats. *AJPH*

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PUBLICATION INFORMATION

Full Citation: Loeb TB, Banks D, Ramm K, et al. Achieving health equity and continuity of care for Black and Latinx people living with HIV. *Am J Public Health*. 2023;113(S2):S107–S109.

Acceptance Date: January 2, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307222>

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ACKNOWLEDGMENTS

Funding was provided by the UCLA David Geffen School of Medicine COVID-19 Research Award Program (HE-06); National Heart, Lung, and Blood Institute (U01HL142109, 3U01HL142109-04S3); and American Lung Association COVID-19 and Emerging Viruses Research Award (9230290). A. B. Hamilton is supported by a VA Health Services Research and Development Research Career Scientist Award (RCS 21-135).

CONFLICTS OF INTEREST

The authors are not aware of any conflicts of interest.

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Women-Centered Program for Women of Color (WC4WC): A Community-Based Participatory, Culturally Congruent Sexual Health Intervention in Los Angeles County, California

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The Women-Centered Program for Women of Color, a culturally congruent sexual health intervention, was implemented in 2018 in Los Angeles County, California, according to the principles of community-based participatory research: enhancing community capacity, establishing sustainable programs, and translating research findings to community settings. Participants exhibited significantly increased knowledge of and interest in preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) over time, but no significant change in condom use was evident. Booster sessions are needed to maintain interest in PrEP and PEP given concerns about reproductive and sexual health. (*Am J Public Health*. 2023; 113(S2):S110-S114. <https://doi.org/10.2105/AJPH.2023.307296>)

For nearly 17 years, the Center for Culture, Trauma and Mental Health Disparities at the University of California, Los Angeles, has specialized in community-based participatory approaches and trained public health professionals and clinic personnel to implement culturally congruent, evidence-based interventions. At-risk people of color are the focus of treatment programs across the United States, but few interventions are developed by women of color for women of color.

INTERVENTION AND IMPLEMENTATION

The objective of the Women-Centered Program for Women of Color (WC4WC) was to reduce sexual health risks

among women of color in a low-income area of Los Angeles County, California. The program was implemented according to community-based participatory research principles in a three-year collaboration with public health organizations. The goals of community-based participatory research are to enhance community capacity by supporting equal community participation in research leading to direct benefits, establish sustainable programs that improve health behaviors and health outcomes, and accelerate the translation of research findings to communities with health disparities through the design of effective and culturally tailored interventions.¹ The aims, procedures, and results of WC4WC align with these goals.

WC4WC incorporated concepts from *Eban*, a Yoruba word meaning fence that symbolizes good practices (e.g., self-protection and partner protection) and elimination of unhealthy ones.^{2,3} The intervention, which included sexual health facts provided on anatomical charts to increase condom and contraceptive use,² involved four sessions of two hours each with eight to 10 women per group. Pre-test, posttest, and one-month follow-up assessments were administered 30 days apart. Leaders of sessions with Spanish speakers were bilingual and bicultural.

Session 1: Preparing for the Journey

Participants learned the historical context of gender, race/ethnicity-based

trauma, oppression, and other systemic health barriers and shared their traumatic experiences with violence and discrimination. They calculated their index of risky partners and behaviors to build resilience (e.g., bodily autonomy, sobriety, resisting coercion and violence). Homework included journaling and initiating discussions of love and harm protection with partners.

Session 2: Tools for the Journey

Participants were provided information on male and female anatomy, how to use condoms and other contraceptives,⁴ and preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP). They were also offered a safer sex menu, a problem-solving mnemonic (FENCE) to teach self-protection strategies, and art by women of color for empowerment. Homework focused on “talk and listen” communication techniques.²

Session 3: It Takes a Village

Women redefined their racial/ethnic status and gender status as powerful tools to build self-esteem and shared what made them proud as women of color and as WC4WC “village” members.⁵ Homework focused on bonding with supportive, reliable individuals and defining personal and sexual safety with partners.

Session 4: Expanding the Village

Participants played sexual health games to reinforce knowledge and received prizes. *Ujima* (collective work and responsibility) was applied to inform community-based villages and

future goals. Women shared how they passed their knowledge on to others.

The team met monthly with community partners. With key aims established, each site took the lead in implementation with consultation and research team support.

PLACE, TIME, AND PERSONS

Three sites were located in a service planning area of South Los Angeles (SPA-6) severely affected by unintended pregnancies, HIV/AIDS, sexually transmitted infections (STIs), COVID-19, and limited health literacy and services. More than 60% of SPA-6 residents are people of color, 32% are not US citizens, 41.1% are unemployed, and 22.5% live in poverty.⁶ WC4WC was offered in person from September 2018 to March 20, 2020, and virtually after the COVID-19 shutdown (March 2020 to September 2021; Table 1). On-site project staff facilitated each session. All eligible, consenting women were accepted as similar programs were not available in SPA-6 (see the Appendix, available as a supplement to the online version of this article at <http://www.ajph.org>).

PURPOSE

Women in SPA-6 account for 11% of new infections in Los Angeles County.⁷ Efforts to provide sexual health services have been thwarted by restrictive state and federal funds. Services for pregnancy and disease transmission are separated from each other.⁸ Biomedical HIV strategies, including PrEP and PEP, are used only marginally among women of color at risk for HIV.⁹ Research in medical settings has shown that women are not asked about their sexual health to

the same degree as men.¹⁰ A history of racial/ethnic discrimination has sensitized women to be suspicious of studies that do not offer all services to everyone.¹¹

EVALUATION AND ADVERSE EFFECTS

The primary outcomes were condom use over the past 30 days, contraceptive use, STI and HIV knowledge, awareness of PrEP, and consideration of taking PrEP. Calculations for condom-protected intercourse acts in the past 30 days were adapted from an evidence-based intervention.² STI and HIV knowledge was assessed via 10 true or false statements.

Data and Statistical Analysis

Univariate and bivariate analyses were calculated for each measure and between predictors and outcomes at baseline, after program completion, and at a one-month follow-up. Using a repeated measures design with three data points, we fit mixed-effects linear models estimating fixed and random effects through SAS PROC MIXED (SAS Institute Inc, Cary, NC) for continuous outcomes (e.g., proportion of condom use) and PROC GLIMMIX (North Carolina State University, Raleigh, NC) with logit link for binary outcomes (e.g., awareness of PrEP).

Findings

Among the 379 women screened, 292 were enrolled. Attrition rates were 34.2% from pretest to posttest and 27.7% from posttest to the one-month follow-up; overall attrition was 46%. The primary reasons for dropping out were time constraints and privacy concerns. Those who dropped out after the assessment ($P = .035$) and at the

TABLE 1— Descriptive Characteristics for the Overall Sample and by Site: Women-Centered Program for Women of Color, Los Angeles, CA, 2018–2021

Characteristic	Overall Sample (n = 292), Mean ±SD or No. (%)	Black Women for Wellness (n = 100), Mean ±SD or No. (%)	To Help Everyone (n = 138), Mean ±SD or No. (%)	Watts Healthcare Corporation (n = 54), Mean ±SD or No. (%)	P
Age, y	39.9 ±12.9	41.2 ±12.5	40.4 ±13.0	35.9 ±12.7	.04
Race/ethnicity					.14
African American	257 (88.01)	92 (92.00)	116 (84.06)	49 (90.74)	
Latina	35 (11.99)	8 (8.00)	22 (15.94)	5 (9.26)	
Income ^a					.5
Below poverty level	169 (58.68)	55 (55.56)	80 (58.39)	34 (65.38)	
Above poverty level	119 (41.32)	44 (44.44)	57 (41.61)	18 (34.62)	
Education					.76
< high school	41 (14.04)	14 (14.00)	21 (15.22)	6 (11.11)	
High school	251 (85.96)	86 (86.00)	117 (84.78)	48 (88.89)	
Employment					.73
Unemployed	165 (56.70)	54 (54.55)	78 (56.52)	33 (61.11)	
Employed	126 (43.30)	45 (45.45)	60 (43.48)	21 (38.89)	
Currently married	54 (18.56)	18 (18.00)	24 (17.52)	12 (22.22)	.74
Frequency of use of contraception other than condoms					.27
Always	81 (28.72)	25 (26.88)	42 (30.66)	14 (26.92)	
> half of the time	15 (5.32)	7 (7.53)	3 (2.19)	5 (9.62)	
About half the time	13 (4.61)	7 (7.53)	4 (2.92)	2 (3.85)	
< half of the time	17 (6.03)	4 (4.30)	11 (8.03)	2 (3.85)	
Never	156 (55.32)	50 (53.76)	77 (56.20)	29 (55.77)	
Outcomes					
Percentage of condom use in past 30 days	0.23 ±0.41	0.2 ±0.39	0.23 ±0.41	0.25 ±0.41	.001
STI and HIV knowledge	6.88 ±1.94	7.18 ±2.00	6.64 ±1.87	6.93 ±1.90	.11
Heard of PrEP	113 (39.37)	36 (37.11)	52 (37.96)	25 (47.17)	.43
Would consider taking PrEP	127 (45.20)	38 (40.43)	58 (42.96)	31 (59.62)	.06
Contraception (IUD/diaphragm)	18 (6.16)	6 (6.00)	8 (5.80)	4 (7.41)	.91

Note. IUD = intrauterine device; PrEP = preexposure prophylaxis; STI = sexually transmitted infection.

^aIncome was calculated on the basis of US Census poverty thresholds by size of family and number of children.

one-month follow-up ($P = .029$) had significantly less education relative to the baseline sample.

The mean percentage of condom use was 23%; nearly 30% of women reported always using contraceptives other than condoms, either ongoing methods (e.g., the pill, IUD [intrauterine device], diaphragm) or one-time methods (sterilization). The mean STI and HIV knowledge score was 6.88 (of a possible 10). Almost 40% of women had heard

of PrEP, and 45.2% reported that they would consider taking PrEP (Table 1).

Changes Over Time

There were significant increases from baseline to posttest with respect to HIV knowledge score ($P < .001$), awareness of PrEP ($P < .001$), and consideration of taking PrEP ($P = .001$). The changes from posttest to the one-month follow-up for these three outcomes trended

in the right direction but did not reach statistical significance. Condom use increased from baseline to the one-month follow-up but was not statistically significant. Knowledge about STIs and HIV ($P < .001$), awareness of PrEP ($P < .001$), and consideration of taking PrEP ($P = .003$) increased significantly over time (Table 2). Despite the intervention, participants expressed a reluctance to take medication owing to concerns about effects on future children.

TABLE 2— Changes Over Time in Outcome Variables: Women-Centered Program for Women of Color, Los Angeles, CA, 2018–2021

	Pretest, Mean \pm SD or No. (%)	Posttest, Mean \pm SD or No. (%)	One-Month Follow-Up, Mean \pm SD or No. (%)	P
STI and HIV knowledge	6.88 \pm 1.93	8.46 \pm 1.72	8.48 \pm 1.59	<.001
Percentage of condom use in past 30 days	0.23 \pm 0.41	0.31 \pm 0.44	0.25 \pm 0.42	.1
Heard of PrEP	113 (39.37)	150 (81.08)	118 (88.72)	<.001
Would take PrEP	127 (45.2)	110 (59.46)	72 (54.55)	.003
Contraception (IUD/diaphragm)	18 (6.16)	13 (6.77)	10 (7.41)	.6

Note. IUD = intrauterine device; PrEP = preexposure prophylaxis; STI = sexually transmitted infection.

Apprehension about medication toxicity may reflect uncertainty surrounding long-term HIV prevention safety.¹² However, participants were more likely to consider using PrEP or PEP as the program progressed.

SUSTAINABILITY

SPA-6 community, local, and statewide health providers attended a town hall to discuss the WC4WC results. The collaboration broadened staff networks and increased referrals; sites integrated the curriculum into ongoing women's programs, although ongoing funding was challenging. Federal, state, and private foundations are potential funding sources for sexual health intervention sustainability (e.g., hiring of permanent intervention staff).

PUBLIC HEALTH SIGNIFICANCE

Given the overrepresentation of women of color living in poverty, recent US Supreme Court rulings (e.g., *Dobbs v Jackson Women's Health*) significantly restrict reproductive choices and sexual health, exacerbating a public health crisis.¹³ Increased information and skills that prevent unintended pregnancies and STI and HIV transmission and

increase condom use need to be more easily accessible in communities of color where disease transmission is high. It is important to acknowledge women's reluctance to engage in prevention regimens that may protect their sexual health but undermine their reproductive health. Future public health campaigns focusing on the safety and efficacy of new prevention medications should increase trust, compliance, and health care uptake among women of color.¹⁴ *AJPH*

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PUBLICATION INFORMATION

Full Citation: Wyatt GE, Chin D, Loeb TB, et al. Women-Centered Program for Women of Color (WC4WC): a community-based participatory, culturally congruent sexual health intervention in

Los Angeles County, California. *Am J Public Health*. 2023;113(S2):S110–S114.

Acceptance Date: March 19, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307296>

CONTRIBUTORS

G. E. Wyatt conceptualized the intervention, wrote sections focused on community-based participatory research, and participated in all aspects of data collection and article preparation. D. Chin and T. B. Loeb reviewed the literature and participated in the data analysis and the writing and editing of the article. E. Norwood-Scott and J. A. McEwan participated in data collection and modifying the curriculum content for the intervention and contributed to the literature review and drafting and revising the article. M. Zhang was responsible for data coding, data entry, conducting analyses, and write-up of findings and tables. A. M. Smith-Clapham assisted with modifying the curriculum during the study, contributed to the literature review and writing, and provided oversight of article preparation and editing. M. Cooley-Strickland contributed to the literature review and the writing and editing of the article. C. Trinidad, J. R. Flynt, Y. Wells, and R. Divinity helped to conceptualize the study, monitored the well-being of women enrolled and staff, and made referrals when needed. H. Liu contributed to conceptualization, analysis, and write-up and editing of the article.

ACKNOWLEDGMENTS

This study was funded by the Cal Wellness Foundation (grant CA-2017-257).

We express appreciation to the Cal Wellness Foundation, including president and CEO Judi Belk and program officers Crystal Crawford and Connie Robinson; Alexandria Yip and Citalin Lopez-Torres at To Help Everyone; Jennifer Wooten at Watts Healthcare Corporation; and Stephanie Haynes at Black Women for Wellness for recruiting, facilitating, and following participants. Also, we thank Alex Kim and Graciela Albarran for their assistance with the formatting of the article and the literature search.

Note. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Cal Wellness Foundation.

CONFLICTS OF INTEREST

The authors have no competing interests to declare that are relevant to the content of this article.

HUMAN PARTICIPANT PROTECTION

The study was approved by the institutional review board of the University of California, Los Angeles.

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Gun Violence Prevention: A Public Health Approach

Edited By: Linda C. Degutis, DrPH, MSN, and Howard R. Spivak, MD

Gun Violence Prevention: A Public Health Approach acknowledges that guns are a part of the environment and culture. This book focuses on how to make society safer, not how to eliminate guns. Using the conceptual model for injury prevention, the book explores the factors contributing to gun violence and considers risk and protective factors in developing strategies to prevent gun violence and decrease its toll. It guides you with science and policy that make communities safer.



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Toward a Community-Led, Public Health Approach to Multilevel Violence Prevention for Black and Brown Transgender and Gender-Diverse Communities

Danielle S. Berke, PhD, and Mother LaTravious Collins, ABA

ABOUT THE AUTHORS

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There is currently a war on Black and Brown transgender and nonbinary (TNB) people in America. TNB people include those whose gender differs from the sex assigned to them at birth, those who do not identify with gender binary constructs of “man” or “woman,” and those who are expansive or fluid in their gender. The year 2021 was the deadliest on record for TNB communities, with at least 57 documented murders of TNB individuals; 66% of the victims were Black women, 86% were people of color, and 69% were killed with a gun.¹ These numbers are likely an underestimate, as TNB victims are often misgendered in official reports¹ and most murders of TNB people remain unsolved. Beyond lethal violence, data indicate that nearly one in 10 TNB individuals have been physically assaulted in the past year and 47% experience sexual violence in their lifetimes.²

Victimization of TNB people must be understood within the larger context of discrimination at the intersection of interlocking systems of oppression (e.g., racism, sexism, heterosexism, and cisgenderism). Discrimination against individuals and structural sources of oppression are mutually reinforcing or co-constitutive and jointly contribute to interpersonal violence against TNB people. For Black and Brown TNB people, community violence linked to cisgenderism and gender oppression is intertwined with White supremacy.² TNB people of color are uniquely targeted and criminalized by police, government, and media, as evident by widespread dissemination of misinformation in news, political scapegoating, biased law enforcement, and legislation designed to exclude Black and Brown TNB people from public life (e.g., “walking while trans” bills).³

Because of discrimination, TNB people of color experience disproportionately higher rates of unemployment, housing insecurity, and incarceration compared with White TNB people. In the National Transgender Discrimination Survey (NTDS),² Black TNB people had nearly twice the unemployment rate of all TNB respondents (26% vs 14%) and over three times the unemployment rate of the broader US population (7%). Black transgender respondents also reported a much lower rate of homeownership (14%) compared with transgender respondents of all races (32%) and the general US population (67%). An alarming 41% of Black respondents reported experiencing homelessness compared with 19% of all transgender respondents. Thirty-five percent of Black respondents had been arrested or held in a cell because of bias compared with 7% of all transgender respondents. These disparities are directly linked to the pervasive violence to which Black and Brown TNB people are exposed in the public sector (e.g., employment, housing, health care, prisons).²

In addition to its direct influence on morbidity and mortality, community violence and discrimination have significant health impacts, elevating risk for depression, anxiety, suicidality, substance use disorder, and HIV.^{4,5} Further, community violence perpetrated in the public sector disproportionately erodes trust in the very organizations upon which TNB communities of color depend to access life-saving and quality of life-supporting services. For example, 34% of Black NTDS respondents, compared with 23% of respondents of all races, reported delaying necessary health care because of anticipated violence or mistreatment by providers.²

These impacts further reinforce health inequities and cycles of poverty.²

PRIORITIES FOR MULTILEVEL INTERVENTION

Given the mutually reinforcing contributions of individual and structural discrimination to violence-linked health inequities for Black and Brown TNB people, a multilevel approach to violence prevention for these communities is essential. Here, we outline a set of strategic priority areas for interrupting this epidemic of violence, its intersecting drivers, and its downstream consequences.

Empowerment Self-Defense

Black and Brown TNB individuals deserve tools and strategies for resisting the onslaught of victimization that pervades daily life. Empowerment self-defense (ESD) approaches are group-based interventions that empower participants with physical, verbal, and psychological tools to understand their bodies as sources of strength while explicitly holding perpetrators responsible for violence.⁶ Despite the demonstrated efficacy of ESD programs to prevent violence in presumably cisgender samples,⁶ research and the dissemination of ESD for TNB populations are scarce.

Trans women and transfeminine people of color face specific experiences of oppression at the intersections of racism, cisgenderism, and sexism (termed “transmisogynoir”)⁷ associated with a constellation of victimization types (e.g., hate crimes, police violence, workplace violence, violence in sex work, community gun violence) distinct from that predominately examined in ESD research (i.e., cisgender women’s risk of campus

sexual assault). Although emerging evidence suggests that community-based support in the development of self-defense strategies is protective for Black trans women survivors of violence,⁸ public health initiatives promoting cultural attunement and effectiveness of ESD for structurally vulnerable Black and Brown TNB women are needed.

In a series of pilot studies, our team has documented high perceived credibility of and demand for ESD programming among Black and Brown trans women. In a pilot trial in which the majority of participants were Black and Brown trans women, we found high rates of acceptability, feasibility, and preliminary efficacy⁹ of an ESD violence prevention approach tailored for and embedded in the Brooklyn Ghost Project,¹⁰ a Black and Brown TNB-led grassroots community-based organization (CBO) in New York City founded by the second author. In the program implementation process, we created formal peer-support employment opportunities in ESD training for TNB people.^{9,11} This aspect of implementation provided an opportunity to disrupt cycles of poverty comprising the socio-ecological context of interpersonal victimization.

Further, numerous community-led (rather than research-driven) self-defense initiatives currently exist in CBOs that serve TNB people of color, including THORN,¹¹ a Chicago-based project arming Black and Brown TNB people with self-defense tools (e.g., stun guns, pepper spray), and Trans Wellness Center,¹² a Los Angeles, California-based coalition of CBOs providing comprehensive services for TNB individuals, including a free self-defense class led by a trans woman of color who is a former national judo champion. Public health efforts to support and strengthen self-defense

initiatives must amplify and credit the work of community leaders and commit to avoid co-opting, exploiting, or threatening TNB community control. THORN distributes self-defense resources only in situations in which recipients are not asked to do anything in return (e.g., issue payment, participate in research or health programming) for accessing these resources.¹² This policy of non-extractive investment in the safety of Black and Brown TNB people is a sound model for the field. Additionally, we refer readers to several excellent self-auditing guidelines^{13,14} for critically evaluating community partner engagement to promote nonexploitative dynamics (i.e., relationships that ensure lasting benefits to community members).

Equitable Community-Government Partnerships

Public service organizations mandated with enforcement of antidiscrimination policy often fail to recognize or utilize the much-needed expertise of TNB-led organizations. Not only is this exclusion a missed opportunity for enhancing civil rights, it also perpetuates alienation of TNB individuals from the public sector and further desensitizes broader society to the community’s suffering. Community-government partnerships that equitably invest in TNB community expertise to support the implementation and enforcement of policy-level violence prevention efforts are a promising intervention avenue.

In 2019, New York State passed the Gender Expression Nondiscrimination Act, prohibiting discrimination against TNB persons in public accommodations. Despite the promise of this policy, Black and Brown TNB New Yorkers have been largely excluded from its

implementation and enforcement. Leveraging constituent expertise of TNB-led CBOs in New York City to evaluate the impact of this legislation and to deliver trainings to fill implementation and enforcement gaps presents a clear opportunity for change. Compensating and empowering structurally vulnerable community members to enforce antidiscrimination policies is one way to counter the dehumanization experienced by TNB individuals in institutional settings and increase the community's visibility as experts, rather than victims.

Funding Grassroots Community-Based Organizations

The continued survival and thriving of Black and Brown TNB communities in the face of ongoing violent oppression reflects community resilience and leadership. Black and Brown trans-led grassroots CBOs have always been and continue to be the primary line of defense against the harms of community violence.⁸ Unfortunately, these organizations are grossly underfunded. The inadequate funding of Black and Brown trans-led organizations and operations ensures that services and programs delivered for the community are designed, created, facilitated, and organized with minimal community input.

In the last decade, federal and foundation funding for TNB issues has increased tremendously. However, TNB communities are rarely the primary recipients of these funds, which instead accrue to White cisgender-led organizations that become gatekeepers of these funds to funnel down to Black and Brown trans-led grassroots CBOs forming what they call "partnerships." However, all too often these "partnerships"

are strategically designed and implemented to proclaim ownership and extract the expertise and labor of Black and Brown TNB communities. Reorganization of funding priorities and policies to incentivize the funding of Black and Brown TNB-led CBOs is urgently needed. We urge public health professionals and funding agencies to trust the expertise and vision of Black and Brown TNB leaders, who embody transformation and survival, by investing in bold violence-prevention solutions that resist and reimagine the structural conditions of violence that prevent Black TNBs from thriving.¹⁵ This includes, but is not limited to, strategies targeting economic empowerment, housing justice, and decriminalization and decarceration.¹⁵

CONCLUSION

Community violence against TNB people is a public health crisis in the United States warranting a multilevel public health intervention approach. We amplify the work of Black TNB community leaders to highlight high-priority components of a multilevel public health approach to violence prevention for these communities that emphasizes empowering TNB community and interrupting structural contributions to victimization. *AJPH*

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PUBLICATION INFORMATION

Full Citation: Berke DS, Collins ML. Toward a community-led, public health approach to multilevel violence prevention for Black and Brown transgender and gender-diverse communities. *Am J Public Health*. 2023;113(S2):S115–S118.

Acceptance Date: January 2, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307221>

CONTRIBUTORS

Both authors collaborated equally in the conceptualization and writing of the original draft. D. S. Berke played a lead role in reviewing and editing the original draft.

ACKNOWLEDGMENTS

This editorial was supported by a grant awarded to D. S. Berke from the National Institute on Minority Health and Health Disparities (R21MD014807). At the time of the study, D. S. Berke was a scholar/affiliate scholar with the HIV/AIDS, Substance Abuse, and Trauma Training Program, at the University of California, Los Angeles, and supported through an award from the National Institute on Drug Abuse (R25DA035692).

This editorial is dedicated to the life and legacy of Mother LaTravious Collins (February 8, 1983–October 12, 2022).

The authors thank the members of the Gender-Based Violence Laboratory, Maiya Hotchkiss, Craig Gilbert, and Ash Smith for their contributions to the Empowerment Self-Defense pilot research described in this editorial. We are grateful to Sarit Golub and the reviewers of earlier versions of this manuscript, whose editorial comments and feedback have greatly improved this work. Most importantly, we thank the constituents of the Brooklyn Ghost Project (brooklynghostproject.org) and the Black trans women leaders whose vision makes possible a more equitable and violence-free future for all people.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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The Promise of Racial Healing to Achieve Health Equity Through School-Based Prevention

Kevin Tan, PhD, MSW, Jenna Mahoney, MSW, LCSW, Jeanna Campbell, MSW, Tiffany Laursen, ALM, Durriyyah Kemp, EdD, and Bo-Kyung Elizabeth Kim, PhD, MSW

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In the wake of the American Public Health Association's formal declaration of racism as a public health crisis, there is an urgent need for more approaches to promoting the socio-emotional well-being of K–12 Black, Indigenous, people of color (BIPOC) students, educators, and families.¹ Cumulative exposures and reexposures to direct and indirect acts of racism can adversely affect emotion regulation and the ability to sustain meaningful relationships, disrupting socioemotional health and well-being.² Race-based stress can lead to racial trauma, and merely perceived experiences of racial discrimination can produce such stress.²

Household and community-level experiences of racial trauma have effects similar to those of other adverse childhood experiences,^{3,4} and calls to address racism within K–12 schools by interrupting and preventing the transmission of intergenerational cycles of trauma at the systemic, institutional, and individual levels are well placed.^{5,6} Such action will need to counteract the whitewashing of the public K–12 curriculum, evident

through the censoring of antiracist books and the movement to ban the teaching of accurate US history about race, exacerbating generations of systemic disadvantage in BIPOC communities.⁷

ANTIRACISM AND SCHOOL-BASED APPROACHES

Theory and research highlight the critical role of schools in promoting socioemotional wellness through culturally responsive programs and practices⁸; efforts to eradicate racism in our schools must be a priority. Interracial dialogue and programs aimed at fostering perspective taking can catalyze anti-racism action and promote overall school socioemotional well-being.⁹ Broadly, best practices in addressing racial trauma and stress emphasize the role of radical healing, transformation, liberation, and empowerment as conduits for remedial action from the racialized cycles of stress and trauma.^{10,11}

Social-emotional learning programs are a vital response, and they have

been widely implemented across K–12 schools to address individual well-being.⁸ Yet, many existing programs fail to explicitly address interpersonal, institutional, and structural racism—manifested in a spectrum of racist acts and policies—and their harm to social-emotional well-being.¹² Critics have described social-emotional learning programs that focus on interpersonal skills at the individual level without countering the ills of institutional and structural racism as promoting “White supremacy with a hug.”¹³ Evaluations of school-based prejudice reduction programs demonstrate that simply reducing prejudice among ethnoracial majority students does not change social behaviors.¹⁴ More attention is therefore needed on strategies that challenge the system of racism. The need for more work that promotes antiracism and socioemotional wellness among K–12 populations is urgent.

THE PROMISE OF RACIAL HEALING AS PREVENTION

We believe that racial healing can offer promise as a prevention tool by directly addressing the ills of racism at both the interpersonal and broader institutional and structural levels. Racial healing is recognizing and unlearning to overcome one's internalized messages about one's own ethnoracial identity and those of others. It can promote student, educator, and parent socioemotional well-being and foster individual and collective agentic action toward dismantling White supremacy.¹⁵

Racial healing is a process that is both introspective and interpersonal. It begins with exploring our internalized racism and cycles of racial socialization in ways that bring about an integrated awareness of our own ethnoracial

identities as a means of challenging privilege and fostering collective healing and systemic reforms.¹⁵ For BIPOC individuals, this may involve rejecting norms around White superiority; celebrating cultural heritage, traditions, and identities; and fostering hope and strength through solidarity with other BIPOC individuals. Among White individuals, this process could mean unlearning and challenging their own privilege that stems from White supremacy toward interrupting and disrupting cycles of interpersonal and institutional racism.^{15,16}

Given the insidious nature of racism, schools should no longer be neutral toward racism. Instead, schools should directly address the racial healing of students, educators, and parents to positively impact individuals and communities. Much like the restorative justice work that engages all parties involved to heal and restore what is broken,¹⁷ racial healing should engage both BIPOC and White individuals in healing from historical trauma we have incurred collectively through racism. Restorative justice brings together those who have created harm with those who have been harmed in efforts to promote sustainable growth toward collective healing for the betterment of society.¹⁷

Relatedly, racial healing seeks to foster “emergence and integrative awareness”^{15(p20)} among White individuals to deal with how they benefit both historically and contemporaneously from structural racism, but also how much they lose as a result of racism. A true recognition is necessary that undoing racism and letting go of the privilege gained at the expense of BIPOC suffering does not create new racial hierarchy with White individuals at the bottom. In fact, this recognition will liberate them from racial resentment

stemming from guilt and shame.¹⁸ Racial healing, thus, can address the harms of racism collectively while seeking to repair and restore relationships in working toward a vision of a racially diverse, just, equitable, and harmonious country.

To clarify, racial healing work is not to create space for BIPOC individuals to educate and empathize with White individuals. To emphasize, this work cannot and should never be used as another mundane “diversity training” that focuses on White individuals’ learning while silencing BIPOC voices. Instead, racial healing is about bringing diverse individuals together to explore their lived experiences while developing restorative actions within individuals and society.

Our research team from the School of Social Work and Cooperative Extension at the University of Illinois, Urbana-Champaign received funding from the state’s Healing Illinois⁹ initiative to explore the promise of racial healing as an essential strategy to promote socio-emotional wellness (details on Healing Illinois are provided in the Appendix, available as a supplement to the online version of this article at <http://www.ajph.org>). Between December 2020 and March 2021, we hosted 17 focus groups centered around racial healing involving 88 Illinois students (aged 12–18 years), parents, and educators. The project aimed to understand the need, desire, and capacity for racial healing of the students, parents, and educators.

Groups were organized based on status (students, parents, and educators) and separated by their ethnoracial identity: White only, BIPOC, and mixed (both White and BIPOC individuals). The purpose of organizing groups based on status and ethnoracial identities was to explore whether themes associated

with racial healing and student socio-emotional needs would differ.

Overall, our study revealed the need to center students’ voices in furthering this work around racial healing. Participants generally recognized the socio-emotional impact of the dual stresses of the pandemic and racial reckoning on young people. However, students, parents, and educators alike were unprepared to talk about their fear, vulnerability, and suffering induced by racism and the political divide. Repeated calls were also made across all our groups for parents and educators to be accepting of, comfortable with, and trained in racial healing. Nonetheless, despite the hesitation to engage in racial healing and to engage in the difficult conversation on racism, we found hope in the promise of racial healing.

Students were notably far more optimistic than parents and teachers that the ills of racism can be overcome, and this optimism was particularly strong in the group of mixed White and BIPOC students. A student in this group noted that “I think [to make positive change] we need to be more self-aware with each other and be more open.” One student in the BIPOC group noted that “There’s been, like, a huge spark in everyone just trying to educate themselves and, like, bring awareness to everything, and it’s just really good to see how many people are just willing to hop on that.” Another BIPOC student emphasized that “If we are not better ourselves right now, we are bettering for our future generation.” Still another student in the mixed-race group noted that addressing the harms of racism was significant not only for young people but also for parents and educators: “I think they [adults] just need to do better.”

Our experience highlights the incredible resilience of students in the face of

racial stress and trauma. Despite their fear, vulnerability, and suffering, they displayed a restless desire to bring about change, illustrating the importance of focusing on student voices in furthering racial healing work. Students demanded more of both themselves and adults to do something about racism, for now and for the future. The expectation is that engaging students in racial healing dialogues will cultivate a sense of optimism for the future, as indicated by our participants, consistent with preexisting approaches to addressing racial stress and trauma such as radical healing, transformation, and liberation.^{10,11}

HOW TO PROMOTE RACIAL HEALING

Given our work in school settings, we fully recognize that multiple challenges exist in implementing the process described here in schools. For example, individuals generally rarely engage in conversations around interpersonal racism and its harms,¹⁵ teachers commonly struggle with high workloads and burnout,¹⁹ and significant institutional and structural barriers exist with respect to discussing the impact of racism with students in K–12 schools specifically.²⁰ If racial healing is to occur, it must move beyond the traditional delivery of school programming efforts and be interwoven into day-to-day conversations with our young people. We provide four strategies to promote racial healing in schools based on our study findings.

Develop Diversity-Oriented Competencies

Many participants highlighted the need for educators to develop cultural competencies. One White student called for

greater inclusion and infusion in teaching curricula concerning race, religion, and “everything.” White students suggested that social media etiquette be taught, and all students stated that it is important to include young people in conversations. White parents and one BIPOC parent suggested that educators teach positive race relations through cultural competency and cultural humility. According to one White parent, students could learn that “there is diversity” that goes beyond appearance and relates to “identities, customs, and traditions.” White and BIPOC parents further suggested teaching students coping skills, emotional intelligence, and conflict resolution strategies while promoting racial healing.

Coordinate Open Community Dialogues

BIPOC educators, and sometimes White educators, suggested that schools host community dialogues focusing on diverse race relations and socioemotional wellness. As part of their outreach in bridging the home–school interlinkage, schools can consider hosting racial healing workshops to provide parents with the necessary skills and support to mitigate the adverse impacts of racialized trauma and stress within their households. Attention to the composition of a school’s student body and teaching and administrative force and to the quality of the school climate is critical in promoting racial healing and open conversations about race.⁷

BIPOC educators cautioned that BIPOC students appeared “a little bit more hesitant” when discussing “extremely touchy and sensitive topics” with White teachers. Echoing this, a BIPOC parent described conversations as necessary but “uncomfortable” and,

in advocating for community dialogues, highlighted the need to acknowledge “our own humanity.” Creating a safe space for BIPOC students is needed, and this means that societal and mainstream racism within non-BIPOC communities must be addressed.

Improve Schools’ Socioemotional Climate

Although all groups highlighted the need to improve schools’ socioemotional climate, BIPOC and White educators were more inclined to suggest it. One White educator lamented, calling out insufficiency and requesting more flexible and culturally responsive curricula, “I don’t have a lot of time to diverge from [standard] content. But I also don’t want to completely ignore current events.” White parents wanted more communication from educators and school administrators (e.g., resources such as electronic newsletters and emails that would help parents navigate sociopolitical issues with their children). BIPOC students suggested promoting conversations about politics, assemblies to enhance awareness of diversity and civil rights, and structured time for diverse classmates to come together.

In this push to improve the school socioemotional climate, it is also essential to protect BIPOC students, educators, and families to ensure that such initiatives do not impose a “minority tax.”²¹ In our focus groups, we observed a sense of weariness among BIPOC individuals, an example of what is known as “Black fatigue”: physical and mental strain faced by BIPOC individuals as a result of the persistent and intergenerational impact of racism.²² As mentioned, racial healing cannot levy the added burden on BIPOC individuals. If true liberation and empowerment are

to occur through racial healing, White individuals should proactively engage and stand up as allies with intentional learning and unlearning. Racism cannot be undone without White individuals so far as we live in a White supremacist world.

Develop Macro-Level Systems of Support

All the groups suggested macro-level systems of support in advancing the need for racial healing. Participants highlighted the importance of increasing the number of mental health and counseling professionals in schools who can support the process of racial healing. Suggestions included creating parent-teacher apps to improve communication, increasing support, including funding and resources to allow difficult classroom discussions and conversations about race, and adding trained professionals to help in implement these suggestions. A BIPOC educator aptly summarized: "Looking ahead, there's just so much unknown. We don't know how [current events are] going to impact these kids. . . I think just really having those resources ready, the professionals out there that can help us navigate some of these difficult situations." Another BIPOC educator addressed why we need preventive strategies intersecting race relations and socioemotional well-being in schools: "The suicide rate is up, drug use is up, alcohol use is up; we have got big issues coming."

The benefits of developing systems of support for BIPOC individuals were evident in our study. At the end of our focus groups, our BIPOC participants, despite sharing that they felt overwhelmed, often expressed appreciation

for the conversation and relief that it had occurred.

RACIAL HEALING AND BEYOND

We believe that schools should play an essential role in addressing the impact of racial trauma and stress and engaging in antiracism efforts across the spectrum of interpersonal, institutional, and structural barriers,²⁰ and participants in the dialogues seemed to agree. Although there are significant challenges in K-12 schools in addressing the impacts of racism,²⁰ we need to redouble efforts to prevent poor socioemotional outcomes caused by racial stress and trauma. Given Florida governor Ron DeSantis's recent decision to prevent the teaching of Black history in schools, urgent attention is needed to curb the impact of such structural assaults on teaching about racism; there is a strong likelihood that other states will follow suit with similar policies.²³

These types of backlash further demonstrate the need for collective racial healing. We, as a country, are suffering from divisive thinking that in countering racist history, we somehow diminish the accomplishments of this country. Learning from history and standing against racism will be an enormous feat as a society. Legislative action at the federal level is necessary to elicit support and protection for racial healing work. Lobbying legislators to take a stand on racism and support racial healing is necessary. Most important, White and BIPOC individuals must work together toward racial healing. We all need to heal.

Racial healing must come first to achieve socioemotional well-being among all students. This truly is the

first step toward achieving health equity among school-aged children, and this healing must occur across ethnoracial groups, students, and adults. As the students held firm to their hope in our focus groups, we must be as hopeful as they are that schools can be sites of healing and liberation and catalysts for societal changes. Our young people deserve nothing less. **AJPH**

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PUBLICATION INFORMATION

Full Citation: Tan K, Mahoney J, Campbell J, Laursen T, Kemp D, Kim B-KE. The promise of racial healing to achieve health equity through school-based prevention. *Am J Public Health*. 2023;113(S2):S119-S123.

Acceptance Date: March 13, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307288>

CONTRIBUTORS

K. Tan, J. Mahoney, and B.-K. E. Kim originated and discussed the original conceptual ideas. J. Mahoney, J. Campbell, and T. Laursen conducted the literature review. J. Campbell and T. Laursen performed the analysis. D. Kemp and B.-K. E. Kim provided critical feedback. K. Tan took the lead in writing the article, but all authors contributed to and helped shape the article.

ACKNOWLEDGMENTS

This project was supported by a Healing Illinois grant awarded to K. Tan and D. Kemp by the Illinois Department of Human Services in partnership with the Chicago Community Trust (grant C202126218).

We acknowledge the following research assistants who supported the Healing Illinois project: Leyda Garcia-Greenawalt, Grace McClowry, Yolanda O'Connor, Katelynn Moser, Scarlett Davalos, Thomas Bates, Sabrina O'Connor, Terence Alexander, Stefanie Kim, Argentina Coy, and Paul Saban. We thank restorative justice facilitators Jorge Elvir and Donald Owen for their work with the team. Also, we thank all the young people, parents, and educators who participated in the study. Finally, we acknowledge Paul Saban for his contributions to an earlier version of this article.

Note. The contents are solely the responsibility of the authors and do not necessarily represent the views of the funder.

CONFLICTS OF INTEREST

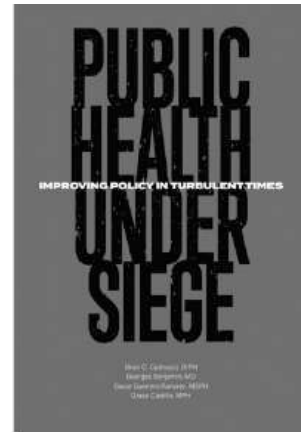
The authors have no conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

The institutional review board of the University of Illinois, Urbana-Champaign, approved the study procedures.

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2021, SOFTCOVER, 250 PP.
ISBN: 978-0-87553-319-3

Public Health Under Siege: Improving Policy in Turbulent Times

Edited by: Brian C. Castrucci, DrPH, Georges C. Benjamin, MD, Grace Guerrero Ramirez, MSPH, Grace Castillo, MPH

This new book focuses on the importance of health policy through a variety of perspectives, and addresses how policy benefits society, evidently through increased life expectancy and improved health. The book describes how detrimental social determinants can be to the overall population health and emphasizes how the nation is centered on policy change to create equal health care opportunities for all sectors of health.

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Strengthening Families to Disrupt Intergenerational Health Inequities With Adolescents at Risk for Commercial Sexual Exploitation, Substance Use, and HIV

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Individuals aged 13 to 24 years account for one out of every five new HIV diagnoses in the United States.¹ The commercial sexual exploitation (CSE) of children is a major risk factor for transmission of HIV and other sexually transmitted infections.² CSE is a complex crime encompassing recruitment of minors for the performance of commercial sex acts, buying sexual services, and “survival sex” or the exchange of any sexual activity for basic needs regardless of the monetary value.² While children from every demographic in the United States have experienced CSE, minoritized adolescents—particularly those identifying as racially/ethnically minoritized or minoritized because of sexual

preference or gender identity (lesbian, gay, bisexual, transgender, queer or questioning, or other [LGBTQ+]) are disproportionately vulnerable.²

The substance abuse, violence, and HIV/AIDS syndemic refers to the documented clustering of substance abuse, violence (including CSE), and HIV among marginalized groups.³ A syndemic lens views these phenomena as interrelated health disparities occurring within a broader milieu of power relations, trauma, and structural inequities.³ A syndemic approach to CSE prevention recognizes the contribution of social environments to vulnerability and centers families and communities as key protective resources.⁴

Family-based public health interventions must shift away from the historical focus on individual risk factors (e.g., gender, race, sexual orientation) to adequately consider how identity, historical trauma, and systemic and internalized oppression (sexism, racism, homophobia, and transphobia) affect minoritized individuals' vulnerabilities and disproportionate exposure to adversity.² Key to preventive public health approaches is recognizing that adversity-impacted adolescents who simultaneously experience adverse childhood experiences, financial strain, and housing instability are most vulnerable to CSE, substance use, and HIV infection. While racially/ethnically minoritized adolescents navigate added burdens of racial stress, trauma, and discrimination, their parents are shouldering the added responsibility (and stress) of enabling their children to cope with racism and discrimination.⁵ Public health practitioners working with high-risk populations must therefore be careful not to perpetuate narratives about minoritized families that fail to examine how oppressive power structures impede healthy family functioning.⁶

Positive parenting is associated with adolescent resilience and favorable health and developmental outcomes.⁷ Viewed from a syndemic framework, resilience becomes an ecological construct because it takes more than individual capacity to adapt positively under conditions of adversity and traumatic stress.⁶ Our work uses strengths-based approaches to disrupt interconnected risk factors through the implementation of family-based preventive interventions that promote positive parenting and family resilience through targeting family functioning, communication, and cohesion. In addition, families must find cultural meaning in the services and resources made available to them.⁶ The cultural tailoring of preventive family

interventions with demonstrated efficacy among at-risk adolescents, therefore, offers a pragmatic pathway to successful integration of evidence-based interventions to benefit populations at highest risk for CSE, substance use, and HIV.

Our adaptation of “Support To Reunite, Involve, and Value Each other” (STRIVE),⁸ offers one such example. STRIVE, a five-session manualized psychoeducational family intervention that incorporates cognitive behavioral therapy strategies to facilitate development of communication skills, problem solving, and creating a positive family atmosphere has demonstrated efficacy in reducing substance use, risky sexual behavior, and delinquent behaviors among racially/ethnically minoritized adolescents aged 12 to 17 years with lived experience of homelessness. We adapted STRIVE for implementation among racially/ethnically minoritized adolescents with lived experience of homelessness at risk for CSE in Chicago, Illinois.⁹ Educational content for adolescents and parents or caregivers on healthy relationships and CSE was added to original STRIVE content. The adapted (STRIVE+) intervention aimed to reduce risk for CSE through education and promoting a positive family atmosphere by targeting improved communication and problem-solving to disrupt negative trajectories leading to the adolescent running away or being kicked out of the home.

We piloted STRIVE+ using a longitudinal mixed-methods design with seven racially/ethnically minoritized adolescents (aged 12–17 years) with recent lived experience of homelessness and their parents or caregivers (six parents and one grandparent). We defined lived experience of homelessness broadly to include being without a safe and stable home, living in a shelter, having contact with the child welfare or juvenile justice

system, running away from home, or being asked to leave the family home at least once overnight in the past six months. Results are reported elsewhere.¹⁰ The purpose of the current editorial is to share lessons learned from implementing the adapted STRIVE+ intervention to aid public health practitioners working with high-risk minoritized adolescents and their families. These lessons derive from qualitative findings from semistructured interviews with participants and our experiences piloting the adapted intervention.

WHOLE HOUSEHOLD STRENGTHS-BASED FAMILY INTERVENTIONS

From the start, STRIVE+ worked to build upon existing strengths by creating a positive atmosphere between the adolescent and parent. Participants immediately recognized the value of focusing on positive aspects of the family and emphasized the value of offering STRIVE+ to additional household members beyond the enrolled dyad, ideally extending the intervention to the entire household when feasible. We enrolled only one adolescent at a time, even in cases where multiple adolescents in the same family were eligible. However, participant feedback highlighted how family dynamics are created and influenced by more than just the enrolled dyad and suggested extending the intervention to all interested members of the household. As one adolescent explained, “It should be all about involving the entire household, ‘cause most siblings and most adults kind of really need just to sit down and understand one another.”

Participants shared how STRIVE+ facilitated communication among household members and emphasized that

extending the intervention to the entire household may further improve household communication. Parents additionally identified their need for support in improving relationships, particularly with adolescents they regarded as defiant or with whom the relationship was already strained. Participants suggested that STRIVE+’s promotion of constructive dialogue and positive family atmosphere may work preventively to preempt behaviors such as kicking defiant adolescents out of the home or adolescents leaving home without permission. As one mother shared, “It wouldn’t necessarily be [for just kids] experiencing homelessness or kids that’s a runaway. I would say kids that [are] on the verge of running away or parents that don’t quite know how to talk to their children.”

Recruitment challenges are a common barrier to effective implementation of family-based interventions, and attempting to enroll entire households may further challenge recruitment efforts. Therefore, when implementing family-based interventions with enrolled participants, we suggest offering the intervention to additional interested household members as feasible to amplify potential benefits.

PRIORITIZING CULTURAL RELEVANCE

Limited resources can create competing priorities when piloting new or adapted interventions in the community. However, prioritizing cultural relevance is crucial for advancing our understanding of implementing impactful interventions in communities who need them most. We intentionally adapted STRIVE+ with cultural and contextual relevance in mind.⁹ To be inclusive of multiple, intersecting identities among adolescents targeted for recruitment (e.g., Black and LGBTQ+),

we included both adolescents and community stakeholders with expertise working with each of these identities in the adaptation process. We also prioritized cultural relevance by employing a diverse study team representative of those we were trying to recruit.¹¹ Even when teams are not diverse, ensuring cultural humility should be an intentional effort.¹¹

Central to prioritizing cultural relevance is embracing a paradigm shift away from cultural competence frameworks that have further contributed to discrimination and marginalization of certain populations and toward a cultural humility approach.¹² Cultural humility includes positioning oneself as a lifelong learner who continually engages in self-reflection and critique while seeking to build foundational relationships through respectful communication, feedback, and mutual learning.¹³⁻¹⁵ Through acknowledging power imbalances and implicit biases, respectful partnerships facilitate institutional accountability and truly center trauma-informed care.¹⁵ We centered a cultural humility approach in the training of team members facilitating STRIVE+ as well as through weekly working alliance measures and check-ins conducted to ensure participant satisfaction and acceptability.

In addition to cultural humility, eliminating language barriers is an important component of cultural relevance. Participants suggested STRIVE+ be made available in languages besides English to enable participation of non-English-speaking family members and families who would otherwise not be able to participate. One adolescent shared, "If STRIVE+ had Spanish . . . I think my mom and my grandma could have a benefit. They're both adults now, but there are certain things that they could benefit from. . . . They don't communicate enough when it comes to

serious topics emotionally." Restricting small pilots to English speakers has been justified on the basis of inadequate resources as it can be expensive and time-consuming to translate materials and support additional staff needed to implement the intervention. However, funders may also be more supportive of implementing adapted interventions with demonstrated efficacy rather than interventions with unknown benefit. Regardless, cultural relevance should be prioritized in pilot budgets to ensure adapted interventions can be adequately piloted within the targeted population.

MAXIMIZING FLEXIBILITY FOR PARTICIPANT NEEDS

STRIVE+ was delivered through in-person sessions at community locations convenient to participants, including school-based health centers and homeless shelters. Designing the adapted intervention to be mobile proved critically important for participant recruitment and retention. When the COVID-19 pandemic impacted everyone's mobility, we subsequently shifted to virtual STRIVE+ sessions. While virtual recruitment proved less than ideal, engaging with those already enrolled via phone or video was found to facilitate continued engagement even one year after the intervention.

For in-person STRIVE+ sessions, we provided participants with bus passes to offset transportation costs, and feedback indicated that this was an important factor for participant engagement. As one parent explained, "I'm unemployed, so I have no income. The transportation on my end, it was really hard, but then they started providin' the bus card, so that helps a lot." We initially distributed bus cards during sessions so they could be used for the ride home and to the next session, but soon

realized that some families needed the bus pass to get to the session that day. We subsequently ensured participants received bus passes before each session. Assessing attendance challenges may illuminate unique needs and subsequently adjusting available resources may result in improved intervention retention.

In addition, we learned that offering family-based interventions in a hybrid manner offers the most flexibility and potential for maximizing participant engagement and retention. For example, some participants reported a preference for the STRIVE+ in-person sessions. As one adolescent remarked, "I actually prefer in person to be honest because it's different. Everyone's in the same space." A caregiver similarly explained, "I definitely would prefer it in person . . . 'cause talkin' over the phone, or on video, is just not the same as actually talkin' to someone in person. I was more comfortable actually sittin' in the room, seein' someone look me in my eyes and literally payin' attention . . . was more comfortable for me."

However, other participants described wanting greater flexibility, expressing their preference for the virtual sessions and wishing the virtual format had been offered before the pandemic as well. As one adolescent explained, "I like them being held on video 'cause sometimes it be hard tryin' to get over there." Another adolescent shared, ". . . at the time I was very busy, and I had a lot on my plate, and, if they woulda had these video calls then, it woulda been way easier on me 'cause then I wouldn'ta had to worry about being in two different places at the same time."

Some participants suggested offering maximal flexibility by offering a "hybrid" video option during in-person STRIVE+ sessions so that even if unforeseen barriers arose, they would still be able

to attend sessions. We suggest hybrid options offer maximal flexibility at minimal impact to study budgets. It may be difficult to predict individual barriers among intervention participants (e.g., some may not have access to stable Internet connection to access virtual meetings, whereas others may still be unable to travel to and from in-person sessions regardless of bus passes being provided), and offering the most flexibility offers maximal accessibility and participant retention.

INSIGHTS FOR PUBLIC HEALTH PRACTITIONERS

While the intergenerational transmission of trauma has garnered a lot of attention lately,¹⁶ less attention has been given to intergenerational transmission of resilience in response to trauma. Our work with young people with lived experience of homelessness focuses on teaching adolescents and the positive, supportive adults in their lives how to build on family strengths to develop the necessary skills to thrive despite adversity.^{11,17–19} Positive family connections are important for healthy development, yet families of racially/ethnically minoritized adolescents are often overlooked in interventions or viewed as problematic rather than a potential resource for improving adolescent health.⁵ Engaging families as a protective factor serves as a key disruptor to syndemic risk factors.²⁰ We share lessons learned from our pilot work with one family intervention for adolescents at risk for CSE, HIV, and substance use to aid public health practitioners working with vulnerable adolescents and their families. These lessons include welcoming entire households, incorporating cultural tailoring, and offering maximum flexibility while assessing and responding to participant needs.

We understand the challenges inherent in integrating family interventions into public health practice to benefit adolescents and their families at highest vulnerability.^{21,22} Just as substance use, violence, and AIDS/HIV are intertwined, so are adolescents, parents, families, and communities. Focusing on the social environments of adolescents at risk for CSE, substance use, and HIV is critical to our prevention efforts.²³ As adolescents' resilience depends on family and community systems being able to provide adequate resources,²³ effective prevention efforts hinge on our ability to strengthen those systems through well-planned community-based engagement and family-based interventions.

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PUBLICATION INFORMATION

Full Citation: Bounds DT, Rodrigues SM, Milburn NG. Strengthening families to disrupt intergenerational health inequities with adolescents at risk for commercial sexual exploitation, substance use, and HIV. *Am J Public Health*. 2023;113(S2):S124–S128. Acceptance Date: March 13, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307284>

CONTRIBUTORS

D. T. Bounds conceptualized the study, acquired study funding, and oversaw collection of the data and writing of the article. S. M. Rodrigues analyzed qualitative data and wrote the article. N. G. Milburn critically reviewed and revised the article.

ACKNOWLEDGMENTS

This study was supported through an award from the National Institute on Drug Abuse (R25DA035692) and by the Cohn Family Foundation and National Center for Advancing Translational Sciences of the National Institutes of Health (NIH) through grant 5KL2TR002387-02, which funds the Institute for Translational Medicine.

At the time of the study, D. T. Bounds was a scholar with the HIV/AIDS, Substance Abuse, and Trauma Training Program (HA-STTP), under the

mentorship of Norweeta Milburn (co-PI of HA-STTP), at the University of California, Los Angeles. We are tremendously grateful to our STRIVE+ participants for their valuable contributions of time and for sharing their experiences with us.

Note. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

CONFLICTS OF INTEREST

The authors report no potential or actual conflicts of interest.

HUMAN PARTICIPANT PROTECTION


The study received institutional review board approval (18021703) from the Rush University Medical Center. All participants provided written informed consent before participating in the study.

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Oral Health in America: Removing the Stain of Disparity

*Edited by: Henrie M. Treadwell, PhD
and Caswell A. Evans, DDS, MPH*

Oral Health in America details inequities to an oral health care system that disproportionately affects the poor, those without insurance, underrepresented and underserved communities, the disabled, and senior citizens. This book addresses issues in workforce development including the use of dental therapists, the rationale for the development of racially/ethnically diverse providers, and the lack of public support through Medicaid, which would guarantee access and also provide a rationale for building a system, one that takes into account the impact of a lack of visionary and inclusive leadership on the nation's ability to insure health justice for all.

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Inclusion of Expanded Adverse Childhood Experiences in Research About Racial/Ethnic Substance Use Disparities

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Investigations of the impact of adverse childhood experiences (ACEs) on health outcomes have been of major public health importance in the past several decades. The original studies of ACEs were monumental because they unveiled that seemingly common family-level childhood stressors (e.g., maltreatment, family dysfunction) affected individuals' health throughout their lifetime.¹ Individuals who experience ACEs, which are stressful and potentially traumatic experiences during childhood, are more likely to engage in substance use^{2,3} and suffer from the main leading causes of death (e.g., cardiovascular and respiratory diseases, cancer).⁴ However, a major limitation of the original ACE studies was that participants were mostly White, middle-income, highly educated adults.⁵ Thus, although public health interventions have been developed to target ACE prevention and detection, these were developed while the experiences of a substantial portion of the population were neglected. In addition, assessments of community-level stressors

that particularly affect racially/ethnically minoritized and economically diverse populations, many of which are rooted in structural racism and discrimination,⁶ remain excluded from this work.

We argue that it is imperative to expand the conceptualization and assessment of adversity in substance use research, as exposure to both family- and community-related ACEs (e.g., community violence, discrimination) increases the risk of alcohol and drug misuse, which is causally associated with disease, disability, and early death. We posit that increasing the number of studies focused on examining the ways community-level adversities affect substance use risk is crucial in health equity research, as community-level adversities disproportionately affect individuals of color and those of low-income backgrounds.

ADVERSITIES ROOTED IN STRUCTURAL RACISM AND DISCRIMINATION

To elucidate pathways affecting the health of minoritized communities, it is

necessary to expand our understanding of what constitutes adversities, and how we measure them. The Philadelphia ACEs Study was launched with the goal of identifying childhood adversities particularly salient to racially/ethnically and socioeconomically diverse participants residing in urban settings.⁵ Results from the study showed that, among this population, certain adversities were described as being more salient stressors than those traditionally captured in most ACE studies⁷ (herein referred to as "traditional ACEs"). For example, parental separation was deemed a less salient stressor during childhood than community violence and economic hardships.⁷ These "expanded ACEs" include experiencing poverty, discrimination, bullying, community violence, migration-related stressors, and foster care involvement.^{7,8} Expanded ACEs are mainly community-level stressors and differ from traditional ACEs, which focus on family-level adversities (e.g., abuse and neglect, household dysfunction).⁸ Subsequent studies on expanded ACEs have been conducted, including secondary data analysis of a prospective longitudinal study that followed a majority low-income Black cohort. Twenty percent of this cohort only endorsed expanded ACEs,⁹ meaning that had they been surveyed for traditional ACEs only, they would have been incorrectly assessed as not exposed to ACEs.

Expanded ACEs reflect stressors that are fundamentally caused by structural racism and structural violence and play out in policies and practices that perpetually marginalize communities of color.^{6,10} Many expanded ACEs, such as living in an unsafe neighborhood or experiencing poverty, represent experiences that are concentrated in particular geographic areas, whereas others, such as experiencing racism or the

deportation of a family member, are predominantly experienced by individuals from racially/ethnically minoritized groups. The conceptualization of these ACEs cannot be separated from the social environment or from the intergenerational impacts of segregation, historical trauma, and racial trauma.⁶ Fundamental cause theory demonstrates how socioeconomic status and racism are persistent and enduring causes of health inequities, even though the specific mechanisms linking these fundamental causes with health outcomes can change over time.^{11–13} These two fundamental causes can work in concert (e.g., structural racism causes socioeconomic inequality) but also separately (e.g., racial inequalities in health outcomes persist even when socioeconomic status is held equal between two groups). Williams et al.¹³ highlighted how racism operates to affect health via structural factors, including residential segregation, concentrated poverty, disproportionate incarceration, and anti-immigrant policies; these in turn result in the disproportionate impact of toxic stress on children of color over the lifespan.¹⁴ Studying how racism and inequality shape exposure to traditional and expanded ACEs, and how these in turn affect substance use outcomes, therefore requires conceptual and methodological attention to analytic approaches that model complexity, dynamic change over time, and interactions between individuals and their environment.

EXPANDED ADVERSITIES AND THEIR ROLE IN SUBSTANCE USE

Racial/ethnic disparities in substance use have been previously documented, but research on why and how these

disparities exist in the first place remains underdeveloped.¹⁵ The ACE literature has established that experiencing traditional ACEs increases the risk of developing substance use disorders in adulthood (for a review, see Leza et al.³). Theoretical frameworks linking ACEs and health outcomes throughout the lifetime posit that exposure to ACEs can lead to impairments in socioemotional, cognitive, and biological domains.¹⁶ Therefore, individuals with these disruptions in development can adopt health-risk behaviors, such as substance use, to cope with stress, which then places them at higher risk for disease, disability, and early death.¹⁷ Given that expanded ACEs are rooted in structural racism and discrimination, substance use may be a major mechanism linking ACEs and poor health in racially/ethnically minoritized individuals.

Research on traditional ACEs and substance use consistently finds that individuals exposed to traditional ACEs are more likely to engage in alcohol and drug misuse, and develop a substance use disorder.³ However, investigations into racial/ethnic differences in the association between traditional ACEs and substance use have yielded mixed findings. For instance, although the association between traditional ACEs and alcohol use was weakest for White respondents compared with racially/ethnically minoritized individuals, the relation between traditional ACEs and illicit drug use was significant only for White and Asian/Pacific Islander respondents.^{18,19} This type of nuanced finding points to the possibility that the behavioral risks associated with traditional ACEs vary among racially/ethnically diverse groups, and it merits additional attention.

It is plausible that other risk patterns specific to racial/ethnic subgroups will

emerge as studies examining expanded ACEs increase. For example, Latinx youths experiencing the expanded ACE of deportation–migration stressors had higher odds of alcohol use than those who did not experience them.²⁰ Research suggests that, in addition to being differentially affected by ACEs, certain groups are also disproportionately exposed to them. Black youths were more likely to experience expanded ACEs, whereas White youths were more likely to report traditional ACEs.²¹ Researchers have also found that males are more likely to experience expanded ACEs (e.g., community violence) and females are more likely to experience traditional ACEs, although these findings are not specific to race/ethnicity.^{5,9} Thus, an intersectional approach, such as one that examines ways in which individuals with multiple marginalized and minoritized identities experience ACEs, is needed but remains underdeveloped.

Most studies have not explicitly examined ways traditional ACEs differentially affect racially/ethnically minoritized groups. Further, no studies to our knowledge have studied racial/ethnic differences in studies focused on expanded ACEs and substance use, but expanded ACEs have been associated with health risks such as substance misuse and a history of sexually transmitted infections.⁷ Moving forward, we need to incorporate both traditional and expanded ACEs into studies that are adequately powered to assess differential levels of risk for population subgroups. By doing so, we will gain a deeper understanding of risk and resilience pathways for racially/ethnically minoritized groups that move beyond those narrowly defined by traditional ACEs models, which were derived from the experiences of White and middle-income

participant samples. If certain ACEs are related to substance use for some racial/ethnic groups and not others, it is imperative to identify which protective mechanisms are at play to harness those findings into prevention efforts.

TARGETING INTERVENTIONS TO REDUCE DISPARITIES

Although ACEs are assessed via a checklist and their cumulative scores are used to estimate health behaviors, all ACEs do not “weigh” equally. For instance, in traditional ACE studies, sexual abuse has a stronger weight than other ACEs in predicting health outcomes in the general population.²² Elucidating pathways of risk for traditional and expanded ACEs among racially/ethnically minoritized individuals will better allow us to target interventions aimed at eliminating racial/ethnic health disparities.

A multilevel conceptualization of ACEs, including expanded ACEs, emphasizes the structural and social determinants of ACEs exposure,²³ including income inequality and structural racism. Moreover, a multilevel conceptualization also illuminates how traditional ACEs are related to social conditions. For example, at the community level, financial stress and high rates of unemployment can increase the likelihood an individual is exposed to adversities within the home. At the national level, immigration policies and enforcement practices result in individual-level trauma that affects the health of children of immigrant-origin parents.¹⁰ Increased societal awareness of the impact of ACEs has led to a focus on identifying ACEs in childhood to provide appropriate interventions and mitigate the impacts of these

potentially traumatic events. However, if these efforts are focused only on individual-level interventions for coping with trauma, they risk pathologizing individuals and families without changing the underlying social conditions that cause trauma in the first place.

Efforts to address expanded ACEs should include upstream interventions at the community and structural levels—rather than focusing only on the individual level—to more effectively address racial/ethnic mental health disparities.²⁴ Disparities-reducing, evidence-based community interventions range from policies focused on increasing generational wealth¹¹ to place-based interventions that address social and environmental conditions by leveraging community expertise and cross-sector collaborations.¹⁴ Approaches such as these may be particularly powerful in decreasing exposure to expanded ACEs because they increase family economic stability and improve neighborhood conditions. For example, in a recent cluster randomized trial focused on predominantly Black neighborhoods with high percentages of low-income households, South et al.²⁵ demonstrated that remediation of abandoned houses was associated with reduced weapons violations and reduced gun assaults in those neighborhoods. For both traditional and expanded ACEs, an emphasis on addressing these structural and social conditions via policies and structural interventions will have a greater impact on disparities in ACE exposure than attempting to mitigate the impact of these adversities at the individual level. Given that socioeconomic status and racism are fundamental causes of health disparities,¹² including disproportionate exposure to expanded ACEs and their health effects, structural

interventions aimed at reducing socioeconomic inequalities and dismantling racist policies and practices are necessary to make long-term progress in improving health equity.

CONCLUSION

Investigations into the impact of ACEs and health outcomes in the past decades have focused on the causal impact of ACEs on disease and early death—the last two levels of the ACE conceptual model.¹⁷ The expansion of the ACE framework to include expanded ACEs is a way to address a critical gap in the original ACE study—namely, a focus on how social and structural inequalities further shape adversity. We urge the field to shift the focus to the first two levels of the ACE conceptual model—(1) generational embodiment and historical trauma and (2) social conditions and local context¹⁷—by expanding the conceptualization and assessment of adversities in future substance use studies. In turn, this knowledge can advance structural and community-level interventions to prevent ACEs and promote health equity.

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PUBLICATION INFORMATION

Full Citation: Zhen-Duan J, Colombo D, Alvarez K. Inclusion of expanded adverse childhood experiences in research about racial/ethnic substance use disparities. *Am J Public Health*. 2023;113(S2):S129–S132.

Acceptance Date: January 2, 2022.

DOI: <https://doi.org/10.2105/AJPH.2023.307220>

CONTRIBUTORS

J. Zhen-Duan and K. Alvarez led the study conceptualization and manuscript preparation.

D. Colombo contributed to the manuscript preparation.

ACKNOWLEDGMENTS

The research presented in the current study was supported by the National Institutes of Health (NIH; award no. R25DA035692 [Zhen-Duan], K08AA029150 [Zhen-Duan], K23MH112841 [Alvarez], and R25MH094612 [Colombo]). We thank Julia Rabin, MA, Miguel Pinedo, PhD, and Claudia Lugo-Candelas, PhD, for their feedback on earlier drafts of this editorial.

Note. Only the authors are responsible for the analysis and conclusions reached, and the content does not necessarily reflect the official views of the NIH. The NIH did not have a role in any aspect of the research conducted.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

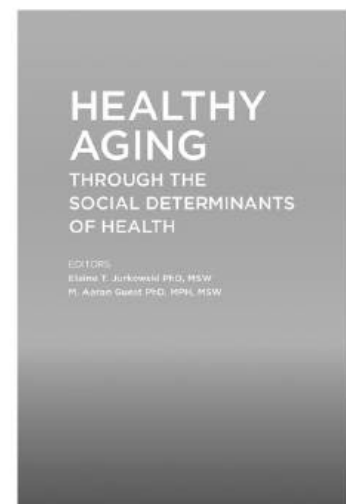
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Toward a Socioecological Model of Training and Mentoring to Reduce Disparities in Mental Health Service Use Among Black Youths

Donte L. Bernard, PhD

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 See also Hampton-Anderson et al., p. S140.

Across clinical settings, significant racial disparities exist in access to and the quality of mental health services. Relative to other racial/ethnic groups, Black youths are universally underserved in mental health care, despite the profoundly increasing rates of unmet psychological need within this population.¹ Although the reasons behind these disparities are multifaceted, attention is often placed on individual- or community-level characteristics (e.g., stigma, mistrust, socioeconomic factors) to explain why such disparities continue to persist. However, public health professionals (PHPs) may also contribute to and perpetuate these disparities, as their lack of culturally responsive training and mentorship leave them ill-equipped to appropriately respond to the unique challenges that Black youths encounter in our highly racialized society.²

The article by Hampton-Anderson et al. (p. S140) is an important contribution to the literature; it asserts that the

reduction of mental health care disparities is closely tied to the provision (or lack thereof) of culturally relevant trainings and mentorship to PHPs. Specifically, the authors ground their article within a socioecological framework and articulate the critical need for culturally responsive trainings and mentorship across three key areas. First, they contend that training and mentorship are needed to bolster the awareness and skills of PHPs to understand how risk and resilience among Black youths are shaped by social and cultural factors embedded across ecological systems (e.g., schools, neighborhoods). Second, Hampton-Anderson et al. assert that training and mentorship are also needed to assist PHPs in flexibly balancing treating and advocating for Black youths seeking mental health services who may also be navigating inequitable systems and policies that may further compound presenting problems (e.g., encounters with law enforcement). Third, they note that training and

mentorship are needed to enhance case conceptualization and approaches to treatment selection from a strengths-based perspective. They call upon such case conceptualizations to build upon cultural strengths, values, and practices (e.g., incorporation of the family) to address presenting concerns more effectively. Targeting training as an intervention point to reduce disparities has significant downstream effects that can fundamentally alter how future generations of PHPs are taught, how clinical interventions are approached, and how issues pertaining to race and culture are prioritized within clinical practice.

Collectively, the recommendations in the article underscore that systems-level changes are a necessary but not sufficient step to promote positive mental health outcomes among Black youths. In other words, increasing access to mental health care services has relatively little impact on reducing disparities if providers are not competently trained to address the needs of the populations requiring such services. Indeed, despite changes in policy (e.g., Children's Health Insurance Program) and clinical practice approaches (e.g., telehealth) that aim to reduce barriers to mental health care access and engagement, significant racial disparities remain.³ Further, scholars have found that PHPs may not possess a strong understanding of how health systems shape health disparities.⁴ Critically, even when current or emergent PHPs have an awareness of structural barriers that hinder mental health treatment access and engagement, PHPs still disproportionately focus on individualistic factors that unduly fault clients of color for not accessing or completing mental health services.⁵ Thus, systems-level change without foundational-level

training for PHPs that focuses on how or why such change can promote equitable service delivery may inadvertently create resistance from practitioners, agencies, and institutions. This resistance may reinforce racially biased beliefs and attributions as to why racial inequities persist that ultimately inform how Black youths are perceived and served in mental health care.

Importantly, although education and mentorship focusing on systems and structures of inequity are critical in the development of culturally competent PHPs, so too are opportunities to learn about and incorporate cultural strengths into mental health care practices. However, Hampton-Anderson et al. explain that conventional education and mentorship approaches often build from and reinforce deficit-based frameworks that unduly emphasize risk without highlighting cultural strengths that Black youths possess across ecological systems. This deficit-based approach is also embedded within standard evidence-based treatments, which seldom allow space for PHPs to integrate and target cultural strengths (e.g., racial identity, racial socialization) that may be useful in mitigating presenting problems. Concerningly, the exclusion of cultural strengths in clinical interventions has been highlighted as a primary contributing factor to poorer engagement and treatment completion rates among Black youths.⁶ As such, there is significant value in teaching PHPs strength-based paradigms and culturally relevant strength-based interventions, which have been associated with reductions in mental health concerns, including racism-related stress and trauma among Black youths.⁷ In addition, competency in strength-based case conceptualizations and treatment approaches would facilitate

important opportunities for advocacy across ecological settings,⁸ which is particularly important given recent pushes for interdisciplinary clinical health teams and community-based mental health approaches. As an example, engaging with stakeholders about Black youths from a culturally informed, strength-based framework holds promise to contextualize and normalize presenting problems, while reducing or challenging inequitable diagnostic patterns that disparately label Black youths with more severe behavioral problems.

As Hampton-Anderson et al. adeptly note, culturally responsive courses need to be embedded within curricula as opposed to being a supplement to PHP education. However, there are a myriad of structural barriers that prevent the widespread adoption of successful pedagogical approaches that broach topics of multiculturalism, race, and racism,⁹ and these barriers have significant downstream consequences that contribute to inequities in clinical practice. For example, despite the growing awareness of health disparities and systemic inequity across mental health professions, courses pertaining to diversity and multiculturalism seldom exist and, even when they do, are rarely required for students to earn their degree.¹⁰ The general lack of courses may be closely tied to the relative racial homogeneity of mental health care providers, who are overwhelmingly White. Indeed, White individuals often have difficulty with effectively teaching content or facilitating discussions relating to race and racism,¹¹ which may lead to such topics being taught superficially, in isolation from other coursework, or not at all. And yet, when clinical training integrates topics of race and culture, such issues are more likely to be explored in clinical practice, and can

considerably bolster rapport, engagement, and treatment outcomes.¹² Thus, there is a critical need to integrate and prioritize curricula that train current and future PHPs to be knowledgeable and conversant on topics pertaining to issues of race, racism, and structural inequity, so as to enhance the quality of teaching and care provided to clients of color. However, doing so necessitates systemic change across academic institutions and clinical settings that prioritize (1) the diversification of the PHP workforce, (2) an emphasis on required courses pertaining to diversity science, and (3) ongoing multiculturalism trainings for PHPs in teaching and mentorship roles.

In conclusion, the present article by Hampton-Anderson et al. highlights that racial disparities in mental health care among Black youths reflect a multidimensional issue that stems in part from the lack of culturally relevant teaching and mentorship provided to PHPs. It is clear that systems-level change targeting macro-level policies and practice is required to reduce mental health care disparities. However, systems-level change is also needed to augment training programs that bolster PHPs' multicultural awareness, knowledge, and skills to address important issues pertaining to race, culture, and inequity that are too often minimized in mental health care. **AJPH**

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PUBLICATION INFORMATION

Full Citation: Bernard DL. Toward a socioecological model of training and mentoring to reduce disparities in mental health service use among

Black youths. *Am J Public Health*. 2023;113(S2):S133–S135.

Acceptance Date: January 29, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307250>

ACKNOWLEDGMENTS

The preparation of this editorial was supported by the National Institute of Minority Health and Health Disparities (K23MD016168; D. L. Bernard).

I thank Enrique Neblett, PhD, and Tanya Saraiya, PhD, for their comments on an earlier version of this editorial.

Note. All views and opinions expressed herein are those of the author and do not necessarily reflect those of the funding agencies or respective institutions.

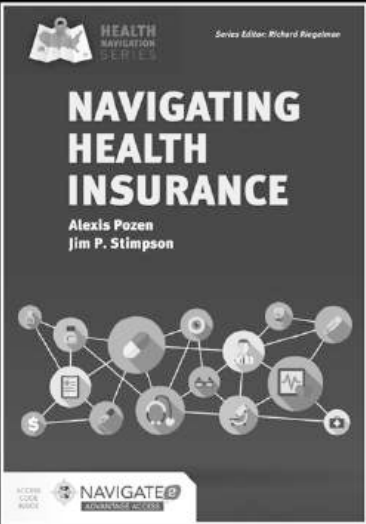
CONFLICTS OF INTEREST

The author has no conflicts of interest to disclose.

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Activity Space Assessments to Investigate Neighborhood Exposure to Racism-Related Stress and Related Substance Use Among Young Black Men: Connecticut, 2019

Tamara Taggart, PhD, MPH, Yusuf Ransome, DrPH, MPH, Ashley Andreou, MPH, Insang Song, MA, Trace Kershaw, PhD, and Norweeta Milburn, PhD

Objectives. To use activity space assessments to investigate neighborhood exposures that may heighten young Black men's vulnerability to substance use and misuse.

Methods. We surveyed young Black men in New Haven, Connecticut in 2019 on the locations (activity spaces) they traveled to in a typical week and their experiences of racism and any alcohol and cannabis use at each location.

Results. A total of 112 young Black men (mean age = 23.57 years; SD = 3.20) identified 583 activity spaces. There was significant overlap between racism-related events and substance use (alcohol and cannabis use) at specific locations. Areas with a higher prevalence of violent crime also had a greater frequency of racism-related events and substance use.

Conclusions. An activity space approach is a promising method for integrating objective and subjective experiences within neighborhood contexts to better understand the frequency and co-occurrence of racism-related stress and substance use among young Black men. (*Am J Public Health.* 2023;113(S2): S136–S139. <https://doi.org/10.2105/AJPH.2023.307254>)

Young Black men experience a disproportionate amount of racism-related stressors, including social disadvantage, violence, and aggressive and racialized policing.¹ Racism-related stress (the physical embodiment of these stressors) is a unique predictor of psychosocial distress and is associated with negative health outcomes, including alcohol and cannabis misuse among young Black men.^{2,3} Neighborhoods have historically been a consistent source of racism-related stressors, which manifest

through racialized risk environments. Racialized risk environment models conceptualize how physical, social, economic, and political components of a space can be racialized to perpetuate racial health inequities and maintain structural oppression.⁴ Current conceptualizations of neighborhoods often focus on racialized policing, which may be modified through legislative policy (e.g., reorganizing police funding).⁵ Missing, however, is the centering of young Black men's subjective experiences in these neighborhoods. We

discuss 1 method to investigate neighborhood contexts that may advance research and interventions to address young Black men's vulnerability to alcohol and cannabis use.

Despite recent advances, methodological weaknesses for assessing neighborhood effects on health remain.⁶ First, these methods do not adequately capture how neighborhood contexts are experienced differently by individuals during their routine activities. Second, reliance on residence alone to determine risk can lead to inaccuracies

and does not account for the extra-neighborhood settings young people experience during their routine activities. Third, current methods often focus on 1 risk factor at a time but rarely investigate the colocation and co-occurrence of risk.

An activity space approach has the potential to address these limitations by providing information on how individuals perceive and experience the varied social and physical spaces they inhabit during their daily activities.⁷ By gathering specific information about racism-related stressors, as well as substance use, within these spaces, we can more thoroughly investigate the specific social and physical characteristics of neighborhood structures that elevate the co-occurrence of these health risks.

One key finding from the application of racialized risk environment models is that the proliferation of violent crime within Black communities is a salient driver of health risks. In this study, we integrate components of activity space assessments, racialized risk environment models, and models of community violence to investigate the co-occurrence of racism-related stress and substance use among young Black men in New Haven, a small urban center in Connecticut.

METHODS

We conducted a cross-sectional activity space assessment of a community sample of Black men in 2019. Eligible participants were Black men aged 18 to 29 years who had resided in New Haven for at least 6 months, self-reported vaginal intercourse in the past 3 months, and were HIV negative. We recruited participants using social media, flyers in relevant venues, and community referrals. We captured activity spaces using an in-person ecological interview (i.e., activity space assessment) in which

participants listed and described all the locations (activity spaces) they traveled to in a typical week.⁷ For each location, participants reported whether they used any alcohol or cannabis at the location (substance use; yes = 1 and no = 0) and were unfairly treated, harassed, or ridiculed at the location (racism-related event; yes = 1 and no = 0). Participants who responded yes were provided a checklist to select the reasons why they thought they were unfairly treated (e.g., race, gender, physical appearance, and intoxication). We combined race and physical appearance and coded it “racism-related event” based on participants’ description of the event and previous work with this population.^{8,9} Participants received a \$25 gift card for completing an activity space assessment and a Qualtrics survey on demographics, psychosocial factors, substance use, and sexual behaviors. Detailed study methods are published elsewhere.⁹

We plotted the X–Y coordinates of racism-related and substance use events using ArcGIS (10.9; Redlands, CA). Using publicly available New Haven police data, we plotted the coordinates over violent crime (e.g., robbery, assault, and crimes involving firearms; Figure 1) to illustrate how these health risks varied across 1 indicator of racialized risk environments. We conducted a point pattern analysis using the nearest distance analysis and Ripley’s K-function to ensure that our statistics were unbiased.¹⁰ Nearest distance measures whether the different events co-occurred by calculating the summary of the nearest distance from 1 type of event to another. The Ripley’s K-function computes the number of events within the given distance from any event in the data set. Under the null hypothesis of complete spatial randomness, the expected value of $\hat{K}(r)$ given the distance r is the same as the area of a circle with radius r , πr^2 .¹¹

RESULTS

A total of 112 Black men (mean age = 23.57 years; SD = 3.20 years) identified 583 activity spaces. They reported 186 substance use and racism-related events; substance use events ($n = 156$) were reported about 2.5 times more frequently than racism-related events ($n = 65$) and 35 events co-occurred (Figure 1). The mean nearest distance between substance use and racism-related events was 151.60 meters (SD = 417.97 meters). All events were strongly clustered compared with the pattern from the complete spatial randomness hypothesis. We identified significant event co-occurrence by inspecting the observed data that were not inside the 95% confidence envelope from 999 Monte Carlo simulations. Areas with a higher prevalence of violent crime also had a greater frequency of substance use and racism-related events.

DISCUSSION

This study used activity space assessments along with concepts from models of racialized risk environments and community violence to identify racism-related stress and its co-occurrence with substance use. Our findings suggest that the frequency and co-clustering of these health risks vary by the distribution of violent crime within New Haven. Comprehensive approaches to addressing alcohol and cannabis misuse among young Black men should attend to the role of racism-related stress in substance use. Interventions that seek to increase health-promotive neighborhood contexts and reduce racism-related stressors through community capacity building and economic development could be coupled with individual-level capacitance and resiliency-building

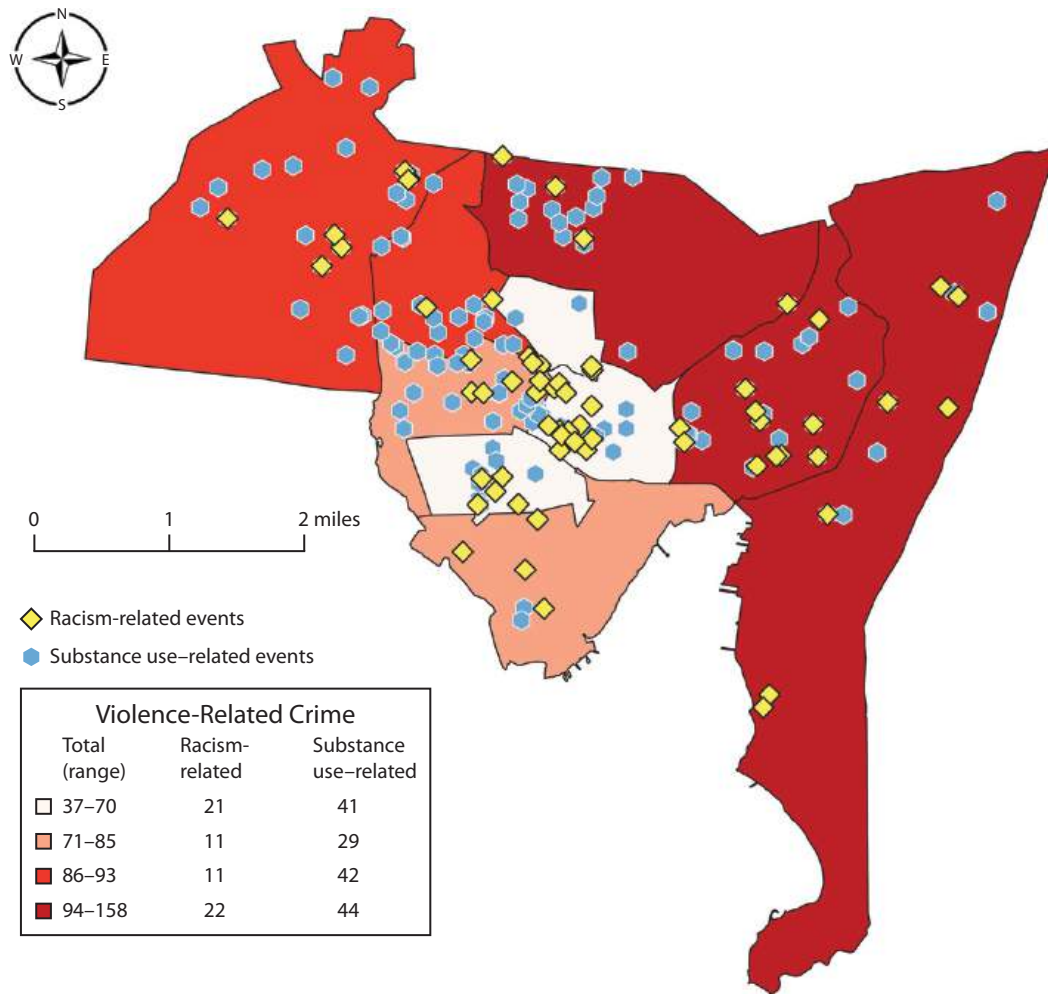


FIGURE 1— Prevalence of Racism-Related and Substance Use Events Relative to Prevalence of Violent Crime: New Haven, CT, 2019–2020

Note. Data on racism-related and substance use events were collected in 2019. We used 2020 police data for prevalence of violent crime.

programs to promote positive coping strategies that reduce substance use.^{1,12}

Study findings support the utility of activity space assessments as a method to capture both the subjective and objective experiences of young Black men in the neighborhoods they traverse.⁶ Conducting subjective and objective assessments of an activity space may provide a more nuanced understanding of how young Black men perceive risk, safety, and opportunity within the locations they frequent—residential and nonhome. This method also promotes the design of location- and

event-based substance use prevention interventions tailored to counter the spatial manifestations of racism-related stressors within neighborhood contexts. Moreover, activity space assessments may also facilitate the development of individual- and community-level metrics to assess subjective experiences, which may lead to creating and assessing identity-affirming spaces for young Black men and policies to combat the negative effects community violence has on health.

Although it is cross-sectional, to our knowledge, this is the first study to

examine the frequency and co-occurrence of racism-related stress and substance use employing an activity space approach. It focused on 1 small urban environment with high violent crime and may not be generalizable to other contexts. The methods used in this study did not allow us to determine whether 1 event preceded the other, which will be important for future investigations. Future research may also benefit from using activity space assessments to determine how overlapping marginalized social positions (e.g., socioeconomic status and sexual

identities) may differentially heighten health risks within neighborhoods.

PUBLIC HEALTH IMPLICATIONS

An activity space approach is a promising method for integrating objective and subjective experiences within neighborhood contexts to better understand racism-related stress and substance use among young Black men. *AJPH*

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PUBLICATION INFORMATION

Full Citation: Taggart T, Ransome Y, Andreou A, Song I, Kershaw T, and Milburn N. Activity space assessments to investigate neighborhood exposure to racism-related stress and related substance use among young Black men: Connecticut, 2019. *Am J Public Health*. 2023; 113(5):S136–S139.

Acceptance Date: February 4, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307254>

CONTRIBUTORS

T. Taggart, T. Kershaw, and N. Milburn contributed to the conceptualization, funding acquisition, and design of the study. All authors contributed to the acquisition, analysis, or interpretation of data. T. Taggart, Y. Ransome, and I. Song conducted the statistical analyses. Project administration, technical, and material support were provided by T. Taggart and A. Andreou. T. Taggart drafted the article. All authors contributed to the revisions of the article and reviewed and approved the final draft.

ACKNOWLEDGMENTS

This work was supported by the National Institutes of Health (NIH; awards R25DA035692, T32MH20031, P30MH062294, R01DA056264, and UG3AI169655).

We thank Miriam Olivares, GIS librarian at the Yale Center for Science and Social Science; community partners; and study participants.

Note. The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the NIH.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

This study was approved by the Yale University institutional review board.

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Cannabis: Moving Forward, Protecting Health

Edited by: David H. Jernigan, PhD, Rebecca L. Ramirez MPH, Brian C. Castrucci, DrPH, Catherine D. Patterson, MPH, Grace Castillo, MPH

This new book addresses the ongoing debate on cannabis policy and provides guidance on how to regulate its sale and distribution. Instead of taking a stance for or against cannabis use, the book:

- suggests we employ strategies similar to those used in alcohol control to create a solid foundation of policy and best practices;
- focuses on how we can best regulate a complex substance.

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Redefining the Role of Public Health Professionals Serving Black Youths Seeking Mental Health Care: Implications for Training and Mentoring

Joya N. Hampton-Anderson, PhD, Derek M. Novacek, PhD, Jenny Zhen-Duan, PhD, Saundra Latimer, MPH, Tyler Perry, BA, and Destini Renard, BA

 See also Bernard, p. S133.

Attrition rates for Black youths in mental health treatment settings are high, and the extant literature suggests this may be because treatment is not meeting their unique needs. Public health professionals, defined here as all individuals who work to increase the well-being of youths, can play a major role in changing these outcomes.

The purpose of this article is to suggest a broader scope of practice, or a redefined role, for public health professionals who work with Black youths seeking outpatient mental health care and to explicate ways in which training and mentoring can help accomplish this goal.

Bolstered by a socioecological conceptual model, we suggest 3 standards of practice that we believe must be satisfied to meet the requirement for this redefined public health professional role: using a sociocultural framework, exercising flexibility in one's assigned role, and understanding and incorporating culturally specific strengths and protective factors into care. (*Am J Public Health*. 2023;113(S2):S140–S148. <https://doi.org/10.2105/AJPH.2022.307194>)

Untreated mental health concerns among youths can negatively influence long-term emotional and physical health, making early intervention necessary to reduce public health impacts.¹ Black youths experience a number of unique, systemic stressors, such as racial discrimination, increased trauma exposure, and microaggressions, that can cause or exacerbate mental health distress.² Furthermore, as a result of stigma, healthy mistrust of the medical establishment, and experiences with clinicians providing an unequal standard of care, standard outpatient treatment models may not

meet the unique sociocultural needs of Black youths, who are then less likely to engage and remain in outpatient mental health services.^{3–8}

Minorities overall in the United States have less access to adequate facilities for mental health care than other groups. Kodjo and Auinger reported that 8% of distressed Black adolescents received counseling services, as compared to 19% of non-Hispanic Whites, even after control for income and parental education.⁹ According to another study, Black Americans used medical care such as pharmacotherapy and psychotherapy for major depressive disorder at a rate of 39.7%

(as compared with 54.1% among Whites).¹⁰

These disparities, which are consistent among Black Americans regardless of age and gender and have persisted for decades,¹¹ are notable because they mean that Black youths may not benefit from the unique aspects of outpatient care that may prove to be beneficial for symptom reduction. These potential benefits include a team-based approach to mental health care, sustained contact with a mental health care provider who may provide a point of contact outside of sessions, and support for chronic and sustained

mental health concerns that may vary in severity. A better understanding of how public health professionals can be trained and mentored to work in outpatient mental health centers to deliver comprehensive, culturally responsive interventions for Black youths is key in eliminating racial disparities in mental health treatment. Here, culturally responsive care means a collaborative approach to intervention that responds to the stated needs of the individual and takes into account systemic, contextual, and cultural influences that affect the individual and the resulting symptom presentation.

In 2020, Halkitis¹² proposed “a new public health psychology” to better join public health concerns with clinical care issues. He argued that neither arena fully incorporates critical sociocultural factors that affect health.¹² We agree that this disconnect is especially impactful for Black youths seeking mental health care. As such, here we expand the term “public health professional” to include mental health practitioners as well as anyone who interacts with youths in a preventive or clinical capacity (e.g., psychologists, psychiatrists, pediatricians, social workers, school psychologists, case managers).

In this article, we review disparities in mental health service use among Black youths and discuss common clinical presentations of youths seeking treatment in outpatient treatment settings. In addition, we outline 3 standards of practice that we believe must be satisfied to meet the requirement for a “redefined public health professional” role, a skill set we believe is necessary for working with all individuals but especially so if one seeks to provide comprehensive, culturally responsive care for Black youths. We conclude by discussing how public health professionals

can satisfy these standards of practice using a socioecological framework, which we define as considering societal, community, and individual-level factors. In using the term socioecological, we are calling for the systemic inclusion of cultural factors within this definition, which we define as influences outside of the individual that affect mental health and the potential for therapeutic engagement.^{13,14}

To support our assertions, we propose a conceptual model (Figure A, available as a supplement to the online version of this article at <http://www.ajph.org>) in which attention to these critical factors is presented as a potential way to reduce attrition of Black youths from outpatient care settings and support the training and mentoring of public health professionals working with this population. Using a critical conceptualization of ecological systems theory, we seek to interrogate existing care systems as they pertain to the mental health treatment of Black youths and families as a means of supporting changes in the fabric of how clinical care is provided. With an increased focus on systemic frameworks, flexibility, and strengths-based perspectives in our training programs for public health professionals in all disciplines, we can achieve a care environment that serves the needs of not only Black youths and families but all individuals.

DISPARITIES IN MENTAL HEALTH SERVICE USE AMONG BLACK YOUTHS

Black youths who need mental health care are less likely to receive it than their White counterparts.³ This is especially of concern now given recent statistics highlighting grave mental health service needs. For the first time since

1957, rates of anxiety disorders among Black Americans have exceeded those among White Americans,¹⁵ and from 2011 to 2015 there was more than a 50% increase in psychiatric emergency room visits among Black youths.¹⁶ Furthermore, suicide rates among Black youths 5 to 12 years old exceed those among White youths.¹⁷

These statistics can be coupled with data regarding critical mental health risk factors. For example, Black youths are disproportionately affected by traumatic stressors, with studies showing that they are at increased likelihood of experiencing adverse childhood experiences.¹⁸ Furthermore, Black youths are more likely to experience race-related adversity not accounted for in the original adverse childhood experience frameworks; such experiences are positively related to internalizing symptoms and increased risk for experiencing additional adverse childhood experiences.^{19,20} These findings are notable given that childhood adversity is associated with poorer mental health across the life span.² In the context of these disparities, Black youths have higher rates of attrition from mental health treatment, with estimates hovering around 61.5%.²¹

In efforts to reduce these mental health service disparities, significant health care and policy reforms have been established in the past decade with the aim of making mental health care more accessible.²² Researchers have found that despite these efforts, Black Americans, in particular, continue to lag in obtaining the mental health care they need relative to White and Latinx individuals.²³ Income-related barriers, lack of insurance, and underinsurance have been cited as the main barriers to obtaining mental health care.²⁴ However, socioeconomic factors

and logistical barriers (e.g., transportation issues) cannot fully explain racial/ethnic disparities in mental health care use.²⁵

Disparities in accessing mental health care among Black youths are also influenced by structural and cultural factors that are not accounted for in provision of services.²⁶ For example, negative experiences with the health care system affect mental health care service use by Black youths. This healthy mistrust of the medical system comes from a long-standing history of exploitation and discriminatory treatment by health care providers.⁵ Furthermore, widespread public and self-stigma relating to mental health problems pose significant barriers to engaging Black youths and their families in treatment.²⁷ Thus, public health professionals working in outpatient treatment settings must contend with myriad contributions to disparities. Understanding all of these contributors is necessary to establish a foundational therapeutic alliance with youths presenting to outpatient care with mental health symptoms.

YOUTHS SEEKING MENTAL HEALTH TREATMENT

Common clinical presentations for youths dealing with mental health symptoms fall into cognitive (e.g., trouble concentrating, thought distortions), behavioral (e.g., poor academic performance, sleep problems, social withdrawal), and emotional (e.g., irritability, anger, fear) domains.²⁸ It is critical to understand the socioecological factors that contribute to the onset and maintenance of such clinical symptomology and the interlocking set of stressors that may contribute to youths ultimately presenting for clinical care. This

understanding will ultimately promote more sustained improvement in clinical symptoms.

Black youths contend with many stressors that are developmentally expected¹⁴ as well as racialized.^{29,30} This group not only must manage common stressors, such as peer and family relationships and academic expectations, but also must navigate and cope with discriminatory experiences. Indeed, a recent study reported that Black youths reported an average of 5 discriminatory experiences each day.³¹ Furthermore, the COVID-19 pandemic, alongside a worldwide reckoning with racial injustice, has disrupted the lives of youths. The onset of virtual school, increased isolation, heightened exposure to racial trauma through widespread media exposure of police killings of unarmed Black people, the subsequent discourse regarding the sociopolitical precedent for these behaviors, and the expectations for the future all serve to increase youths' stress burden.³² Understanding the sociocultural nuance behind clinical symptom presentation leads to the need for a broader skill set than one that solely relies on symptom count and the administration of manualized treatments. In the next section, we outline 3 standards of practice that support this more responsive approach to practice.

THE REDEFINED PUBLIC HEALTH PROFESSIONAL: STANDARDS OF PRACTICE

Practitioners working in the preventive or clinical realm with individuals, and with Black youths in particular, must contextualize presenting symptoms and concerns in a broader socioecological framework and adjust how they work with clients accordingly. In this section,

we explicate this approach by highlighting 3 standards of practice that we believe would improve the standard of care for Black youths with mental health symptoms and constitute what we call a redefined public health professional role. We also address how public health professionals can be trained and mentored on incorporating these standards of practice.

Operate From a Sociocultural Framework

Stern et al.³³ highlight the necessity of a socioecological framework with particular attention to cultural factors for those concerned with the development of Black youths.³³ Social (e.g., peer and familial relationships) and cultural (e.g., racial identity and socialization, culturally specific strengths) factors are embedded within systems (e.g., mental health treatment settings, schools, neighborhoods) and constantly affect an individual's profile of risk and resilience over time. Therefore, to best serve Black youths as a public health professional, one must be willing to consider the effects of all of these simultaneous influences. Drawing from multicultural counseling theory, or a therapeutic process that draws on life experiences, cultural values, and intersecting identities of the client and focuses on culture-specific integration of intervention modalities,³⁴ this work must be embedded within case conceptualizations, treatment plans, and follow-ups.³⁵ Clarity around these influences may also highlight basic needs that must be met to achieve sustainable symptom reduction.^{35,36} Furthermore, attention to intersectionality theory, or the nexus between various forms of group membership and how that affects individual lived experiences, is necessary within

this framework.³⁷ This requires practitioners to examine structural inequalities and issues of social justice,³⁸ have comfort with naming and understanding identities they hold, and discuss the impact of intersecting identities with the patient as they become critical to the therapeutic process.³⁹

Be Flexible in One's Role

To incorporate a sociocultural framework into care delivery, one must be flexible in one's defined role. Public health professionals may be accustomed to working in silos, effectively delegating tasks that could be helpful to clients to other providers, and for practitioners, rigidly adhering to treatment manuals. Although at times this is the most appropriate choice if the task is outside of one's realm of expertise, or manualized approaches are best indicated, the difficulty with this approach is that it may undermine therapeutic rapport and discourage clients from returning to care if they feel that there was no immediate utility in the visit. The act of showing personalized care for another, on the other hand, is intricately linked to collectivism and the cultural value of interconnectedness, and it may best serve clients who hold those values. For example, for Black youths and families who may be disproportionately affected by systemic factors that compromise maintenance of basic needs, provision of resources (e.g., provision of food or snacks before therapy sessions, immediate connection to a social worker or case manager⁴⁰) may be considered a small representation of a collectivist cultural understanding and alignment and therefore is critical to keep in mind when considering service offerings and how one works with clients as a practitioner.⁴¹ Given the

systemic sociocultural factors that contribute to mental health symptoms, it is conceivable that this holistic assumption of responsibility for the clients with whom one works will ultimately help contribute to symptom reduction.

Understand Culturally Specific Strengths and Protective Factors

Given that much of the research literature regarding psychopathology is focused on risk factors and that much work involving underrepresented racial and ethnic minority groups involves comparative studies from a deficit model as opposed to within-group study designs, mental health practitioners may not always be aware of the abundance of cultural strengths that Black youths and communities hold when considering culturally responsive care models.⁴² This process represents a value incongruence between the assumptions traditional care settings were built upon and the values of Black youths and families. It is imperative that these cultural strengths are highlighted in work with clients as resources that can be leveraged in service of healing. Early work highlighted the central role of family, extensive kinship networks, the influence of religious and spiritual values, positive racial identity building, and race socialization as hallmarks of Black family strengths.⁴³ More recent work supports these factors as being protective in the face of stress. For example, the Engaging, Managing, and Bonding through Race (EMBRace) intervention has been shown to reduce experiences of racialized stress by helping parents and youths navigate the race socialization process.⁴⁴ Furthermore, the Celebrating the Strengths of Black Youth program, a preventive

intervention focused on building positive racial identity, has been shown to increase self-esteem among Black youths 7 to 11 years old.⁴⁵ This literature suggests that a rigid focus on treatments with minimal empirical support among Black youths can lead to the unintentional oversight of key cultural protective factors.⁴⁶ If outpatient clinics are not equipped to capitalize on existing strengths and meet clients' cultural needs and preferences, attrition may become a problem and lead to mental health care access barriers.⁴⁷

INFLUENCE OF SYSTEMS

Societal, community, and individual-level influences also affect how we are able to navigate as professionals within our respective fields. These systems have an impact on how we are trained to do our jobs as well as the research and clinical practices we employ. In this section, we discuss how redefined public health professionals can be trained and mentored to operate and advocate within these different ecological systems in ways that may have significant positive effects on mental health outcomes among Black youths.

Societal Level

At the societal level, to better serve Black youths in outpatient mental health care settings, the workforce needs to better reflect the population that it serves. For example, Black Americans are underrepresented in the professions of psychology⁴⁸ and psychiatry.⁴⁹ Black psychologists account for only 5% of the profession, as compared with 13% of the general population. By contrast, Black individuals are

well represented among social workers, accounting for 22% of new workers entering the profession.⁵⁰ Given the number of Black social workers, they may play an especially critical role in the outpatient treatment of Black youths. Public health professions must be prepared not only to recruit more providers of color but to also address the structural barriers (e.g., financial costs of education programs, student debt, low wages) that lead to burnout and early exit from the field among Black providers. Ensuring that these structural barriers are addressed with special attention to increasing the number of Black providers and reducing the burden on working individuals remains crucial to retention.

For example, retention efforts might include more comprehensive and accessible student loan repayment programs for providers. Public health professional training programs more broadly would also do well to further expand training and mentoring to include mental health topics such as diagnoses and familiarity with common treatments as well as guidance on consultation and interdisciplinary work with mental health professionals. This will allow for more seamless collaborations pertaining to public health outreach, clinical care, and mental health research.

In addition to increased representation, the training clinicians receive needs to be culturally responsive and aligned with the 3 standards of practice outlined here so that clinicians are prepared to address the needs of Black youths. Culturally responsive training needs to be provided throughout different career stages and levels. For instance, at the institutional level, infrastructure and appropriate time and compensation with respect to receiving early training and retraining and being

exposed to working with diverse families are vital. At the individual level, multicultural training needs to be embedded in course curricula and not provided in isolation. Furthermore, postgraduate training opportunities need to be prioritized by employers (e.g., bias reduction training to decrease cultural bias in health care settings⁵¹ or attention to broader themes in health equity work⁵²).

There are several recent calls to action to integrate social justice and anti-racism into the education and training of mental health providers.^{39,53} These calls emphasize providing training in multicultural therapy, cultural humility, and intersectionality. Moreover, providers need to be prepared to address the mental health consequences of racism and racial trauma and understand the racial/ethnic heterogeneity of Black youths.⁵⁴ Although many training programs provide opportunities to learn standard evidence-based treatments such as cognitive-behavioral therapy and dialectical behavior therapy, a growing number of culturally adapted interventions have been developed. For example, Metzger et al.⁵⁵ adapted trauma-focused cognitive-behavioral therapy to integrate racial socialization to address experiences of racial trauma.⁵⁵ To produce culturally responsive providers, it will be critical for training programs across mental health professions to provide clinical training in delivering these culturally responsive interventions with diverse client populations.

Finally, advocating for increased insurance reimbursement that supports the comprehensive care we propose in this article is critical to the sustainability of the multitiered work required to care for the entire individual.⁵⁶ The use of

technology has been presented as a way to improve coordination of care and thereby resolution of some of the time constraints that impede providers from optimizing care coordination, but more research is needed to delineate its use to facilitate more comprehensive services. Some studies have correlated the rise of telemedicine, touted as a significant mechanism to resolve health care inequality, during the coronavirus pandemic with resolving disparities in care through improved access.

The near ubiquity of smartphones has been posited as a tacit leveling of the playing field in health care access.⁵⁷ However, this technology can also serve to further exacerbate inequality, especially as it relates to artificial intelligence and algorithms that routinely draw on racial differences as a mechanism of determining care. This echoes a long-standing tradition of “race-based medicine” in which race essentialism has reared its head in perceived biological roots of difference (e.g., pain tolerance, risks related to body mass index among different races).

Although these practices represent a historically racialized perspective on medical treatment, they have been mapped into modern technology implicitly (e.g., when health insurance companies use race in risk prediction scoring algorithms to determine coverage). Because seemingly equalized technologies are layered over a structurally unequal society, we have to be wary that technology does not serve as a flashy albeit superficial resolution to a more nuanced problem. Thus, addressing minority youth mental health concerns requires unique approaches that are dynamic and involve responsible use of technology.⁵⁸

Community Level

Outpatient treatment settings nestled in communities are critical to setting the foundation for culturally responsive care. The onus is on leaders in outpatient care settings (i.e., training directors and department heads) to support initiatives and clinic-wide expectations for culturally responsive research and client care. These structural changes have the potential to address the foundational concerns that promote health disparities and may positively affect clients in a sustainable way. Increasing cultural responsiveness in outpatient treatment settings requires resources to support changes in how interventions are typically developed, prioritized, and administered.³⁶

Another important consideration for working with Black youths in outpatient settings is training and advocacy around providing adequate, nonstigmatizing crisis response interventions. There are a number of clinical issues that may affect youths and their families and lead to mental health crises, including housing insecurity, financial difficulties, incarceration, and symptomology related to serious medical illness.

Advocating for the use of multitiered collaborations between law enforcement, mental health providers, and social service providers to support a collaborative approach to responding to mental health crises may help remove the added layer of criminalization that often comes along with sole law enforcement responses to mental health crises among youths.⁵⁹ With the increased prevalence of mental health issues affecting Black youths' physical and social health, advocating for the training of all relevant stakeholders to work together to better serve and help

this population when in crisis aligns directly with the aims of public health more broadly, as it supports the promotion of healthy lifestyles and the prevention of chronic impairment related to mental health problems.

Finally, public health interventions focused on providing psychoeducation through trusted organizations in the community (e.g., churches, grassroots organizations), peers, and social support networks have shown promise in reducing public and self-stigma in Black communities and should be continued. Knifton et al.⁶⁰ reported on community-based mental health conversations that significantly reduced reported mental health stigma.⁶⁰ In addition, Codjoe⁶¹ et al. identified key components of community-based approaches to reducing mental health stigma. They found that co-production and partnership with community members were essential in implementing interventions that were acceptable and accessible to individuals.⁶¹

Individual Level

In work with any client, culturally responsive care must be empirically informed, with flexibility, rapport building, and common factors at the forefront. In work with Black youths in particular, allowing space to discuss experiences with racism and race-based stress may be critical. Meyer and Zane⁶² conducted a study of individuals who had received treatment from outpatient mental health clinics. They found that issues related to race and ethnicity were more important to racial/ethnic minority clients than to White clients; clients who reported these issues as important were less likely to be satisfied with the services they received if these elements were not incorporated into their care.⁶²

Therefore, clinicians in outpatient care settings must be willing to broach conversations around racism and race-based stress as they become relevant in the therapeutic environment.⁶³

In addition, working from a strengths-based perspective requires incorporating the family within individual-based treatments, as family support is one of the most important sources of support for Black families. Black youths are more likely to turn to family members when experiencing mental health distress than other youths and more often want to include them in treatment.⁶⁴ Research has shown that family functioning both directly and indirectly relates to improved mental health among Black American clients; thus, it remains imperative to include families and, if clinically indicated, improve family functioning and communication in the treatment of Black American clients.

Provider stigma can also deter Black youths from mental health treatment through prejudicial beliefs and derogatory behaviors practiced in care settings.⁶⁵ Providers not trained to work with Black youths may overpathologize normative behaviors and fail to assess traumatic stressors such as racism in their mental health conceptualization.⁶⁶ Charles⁶⁷ conducted an ethnographic content analysis of clients' and family members' thoughts about provider stigma and found that clients experienced stigma from providers owing to factors such as blame and shame, disinterest, annoyance, degradation and dehumanization, coercion, and lack of "real" choice. The author noted that sensitizing providers to these perceptions might reduce the likelihood of the occurrence of such behaviors.⁶⁷

Furthermore, similar to our discussion regarding client stigma, public health interventions to reduce provider

stigma have emphasized the need to involve clients, in this case Black youths and families, in providing input on the development of treatment policies and procedures addressing provider and systemic stigma.⁶⁸ This emphasis needs to continue.

CONCLUSIONS

Taken together, the 3 standards of practice described here—using a socio-cultural framework, exercising flexibility in one's assigned role, and understanding and incorporating culturally specific strengths and protective factors into care—embedded within a critical conceptualization of ecological systems theory, highlight the ongoing need for systemic mental health treatment reform at all ecological levels and challenge epistemological assumptions that are central to treatment environments as they currently stand.

Black youths experience many barriers when seeking mental health services in a system not designed for them. To eliminate disparities in mental health treatment and meet the unique needs of Black youths, public health professionals must redefine their role. It is our hope that the approach described in this manuscript will build toward a new standard of care and become embedded in our public health professional training programs. We believe this will shift what is normative practice in our varied fields for the betterment of service to Black youths and families and, thereby, all. This will require rethinking public health professions at the societal, community, and individual levels. It is incumbent on all of us as clinicians, researchers, and service providers to rise to the challenge. It is our hope that this discussion ignites culturally responsive research and redefined care models to

equitably serve Black youths experiencing mental health concerns. *AJPH*

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PUBLICATION INFORMATION

Full Citation: Hampton-Anderson JN, Novacek DM, Zhen-Duan J, Latimer S, Perry T, Renard D. Redefining the role of public health professionals serving Black youths seeking mental health care: implications for training and mentoring. *Am J Public Health*. 2023;113(S2):S140–S148.

Acceptance Date: December 3, 2022.

DOI: <https://doi.org/10.2105/AJPH.2022.307194>

CONTRIBUTORS

J. N. Hampton-Anderson conceptualized and led the writing of the article. D. M. Novacek, J. Zhen-Duan, and T. Perry contributed to the conceptualization and writing of the article. S. Latimer and D. Renard supported the writing of the article.

ACKNOWLEDGMENTS

J. N. Hampton-Anderson, D. M. Novacek, and J. Zhen-Duan were supported through an award from the National Institute on Drug Abuse (R25DA035692). Additional support was provided by the Pitt Foundation (J. N. Hampton-Anderson), the Veterans Affairs Advanced Fellowship in Mental Illness Research and Treatment (D. M. Novacek), and the National Institute on Alcohol Abuse and Alcoholism (J. Zhen-Duan; K08AA029150).

Note. The views expressed in this article represent those of the authors and does not represent the funding agencies including the US Department of Veteran Affairs or the National Institutes of Health.

CONFLICTS OF INTEREST

There are no conflicts of interest to report.

HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this research because no human participants were involved.

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Our Communities Our Sexual Health

Awareness and Prevention for African Americans

Edited By: Madeline Sutton, MD, MPH;
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William C. Jenkins, PhD, MS, MPH

This groundbreaking book provides a comprehensive historical prospective of the disproportionate burden of HIV and other sexually transmitted infections (STIs) among African Americans. Chapters that follow explore the context of HIV and STIs in African American communities and include discussions of sexuality and the roles of faith and spirituality in HIV and STI prevention efforts. Additional chapters provide insight into strategies, e.g., HIV testing, condom distribution and marketing campaigns, parent-child communication, effective clinical care and support, and partnerships, for addressing HIV and other STI-related health disparities within these communities. The book is a valuable resource for practitioners, scholars, clinicians, educators, providers, policy makers and students.



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Implications of the COVID-19 Pandemic on Interpersonal Violence Within Marginalized Communities: Toward a New Prevention Paradigm

Amber M. Smith-Clapham, MA, Julia E. Childs, MSW, Michele Cooley-Strickland, PhD, Joya Hampton-Anderson, PhD, Derek M. Novacek, PhD, Jennifer V. Pemberton, PhD, and Gail E. Wyatt, PhD

During the COVID-19 pandemic, reports of domestic violence across the United States increased from 21% to 35%. Stay-at-home orders, designed to protect the public against the spread of COVID-19, along with heightened societal stressors as a result of the global pandemic, inadvertently increased rates of illicit drug and alcohol use, job loss, and isolation, resulting in increased stress and nonphysical (e.g., psychological, emotional, economic, technological) abuse that often escalated to physical violence.

These processes were exacerbated in marginalized communities. These risks were heightened among Black women and Latinas, who experience high rates of domestic violence, long-standing distrust in law enforcement, and compromised self-reporting or anonymous reporting of abuse.

We make recommendations for training key stakeholders (e.g., law enforcement, mental health clinicians, and public health care professionals) to facilitate the safety and well-being of domestic violence survivors and to better manage prevention or intervention efforts targeted at domestic violence. We make public health policy suggestions for individuals, communities, and governing structures. (*Am J Public Health*. 2023;113(S2):S149–S156. <https://doi.org/10.2105/AJPH.2023.307289>)

The COVID-19 pandemic stands as a catastrophic worldwide event that has included historically high unemployment rates, reduced social services, long quarantines, and severe social disconnection.^{1,2} Similar to what occurs during natural disasters such as earthquakes and catastrophic hurricanes, interpersonal violence (IPV) increased when stay-at-home mandates were implemented in spring 2020.^{1,3} For instance, during the period of 2019 to 2020, there was a 21% to 35% increase in reports of domestic violence across the United States.⁴ Of note, marginalized communities (e.g., underresourced,

socially isolated, discriminated against, underprivileged) experience the highest rates of domestic violence, with Black women and Latinas disproportionately affected.^{5–7} For example, in the latest published National Intimate Partner and Sexual Violence Survey from the Centers for Disease Control and Prevention (CDC), 12.3% of Black women and 12.1% of Black men reported experiencing IPV within the last year.⁸

We examine the prevalence of domestic violence overall, with careful consideration of its prevalence in marginalized communities. We outline non-physical abuse and how it contributed

to the increased rates of physical violence during the COVID-19 pandemic, in addition to the barriers to reporting abuse during this time. We make recommendations for training key stakeholders such as law enforcement, mental health clinicians, and public health care professionals to facilitate the safety and well-being of domestic violence survivors and to better manage prevention or intervention efforts targeted at domestic violence. We conclude with public health policy suggestions for individuals, perpetrators, communities, and governing structures to enhance advocacy for survivors of violence.

DOMESTIC VIOLENCE PREVALENCE

The total annual US medical costs associated with domestic violence exceeds \$5.8 billion, consequently increasing the health care costs for the entire population.⁹ Survivors of domestic violence are more vulnerable to chronic illnesses, including heart disease, diabetes, and traumatic disorders.^{9,10} These public health issues are of substantial financial and social significance to survivors, families, and society at large.¹¹ Domestic violence often occurs when there are power imbalances in relationships, whereby one partner seeks to control, manipulate, or overpower a member or members of the household.¹²

Although women may be perpetrators of IPV, domestic violence more often occurs when toxic masculinity or male privilege pervades the household, as perpetrators with this mindset believe that men control the decisions and that the survivor's purpose is to serve them.¹³ Failure to obey or comply is often met with some form of punishment, such as nonphysical abuse (e.g., psychological, verbal, economic, or technological abuse or threatening to report them to be deported) as a way to maintain control.¹²⁻¹⁴ Domestic violence increases when perpetrators suffer from substance or alcohol abuse, stress, or mental illness.^{3,15} Over time and without proper intervention, nonphysical violence can transition to physical violence; 25% of women in the United States have experienced physical violence.^{7,14,16}

Marginalized communities are disproportionately represented in lower socioeconomic areas⁷ and often consist of groups who are systematically

treated unfairly, discriminated against, or socially excluded.¹⁷ Domestic violence occurs in all communities regardless of race/ethnicity, education, socioeconomic or employment status, neighborhood, religious affiliation, or sexual orientation. However, underresourced communities have higher documented rates of domestic violence,⁴⁻⁷ perhaps because of the involvement of law enforcement, social service agencies, public schools, hospital emergency departments, and other public facilities with fewer economic resources and privacy protections compared with more affluent communities.¹⁴

Despite victims' rights, survivors of any socioeconomic stratum may deny incidents of abuse or refuse care out of fear that reporting their perpetrator to authorities may result in additional adverse consequences (e.g., stigma or shame from family, friends, or the larger community).¹⁸ Domestic violence affects Black women at disproportionately higher rates and often has lethal outcomes: they are killed in domestic violence incidents at more than double the rate of other racial/ethnic groups.⁵ In addition, 1 in 6 Latinas will experience domestic violence in their lifetime, representing another high-risk group.¹⁷ Women of color, those with low socioeconomic status, and dependent individuals are most affected by abuse^{14,18} and have been disproportionately affected by the adverse effects of the COVID-19 pandemic through job loss, increased family demands, and contracting COVID-19.¹⁵ Additional risks for violence victimization among marginalized groups may include the perceived inability to seek protection from social services or law enforcement because of historic mistrust of these systems.^{15,18}

NONPHYSICAL AND PHYSICAL ABUSE

It is critical to understand the precursors that lead to physical violence, as it often begins with nonphysical violence and escalates over time.^{16,18} When stress increases in a family because of lack or loss of resources, nonphysical violence such as emotional abuse, aggression, and neglect are more likely to occur, leading to an overall increase in both domestic violence and child abuse.^{1,7} The risk factors present in US society during the COVID-19 pandemic contributed to increased violence in the home possibly owing to systemic factors that led to the normalization of control and violence in relationships, even when restrictions eased and public access increased.^{13,19} For instance, if a perpetrator loses their job or experiences a reduction in family income and the survivor becomes the sole income provider, the perpetrator is more likely to abuse them in an effort to regain control and power.²⁰

Abuse in the COVID-19 Context

Homicides and physical violence have been key focuses for research, but other forms of abuse also require research and clinical attention, particularly those that increased during the COVID-19 pandemic. It is important to understand and recognize the signs of nonphysical abuse, as well as its escalation linked to poverty, isolation, and eventual physical violence,¹⁴ all of which were heightened during the COVID-19 pandemic.^{1,15} Most of the research on IPV during the COVID-19 pandemic focuses on the physical violence enacted on survivors (e.g., hitting, choking, pushing, biting, throwing items at).

The complexities of the abusive tactics leading to physical abuse are underresearched,^{16,18} such as psychological abuse (e.g., manipulation, gaslighting, control, shaming family and friends); verbal abuse (e.g., name calling, attacking personality traits or physical appearances); economic abuse (e.g., limiting spending, destroying credit score); technological abuse (e.g., GPS [Global Positioning System] tracking, ghostwriting, social media stalking); sexual abuse (e.g., forced penetration or pregnancies, coercion, harassment, revoked access to birth control); and abuse related to the survivor's immigration status (e.g., threatening to do something that leads to their deportation).^{10,12-14,16-18} Because of the unprecedented conditions created by

the COVID-19 pandemic, public health professionals, frontline clinicians, and abuse hotline workers may benefit from learning about understudied forms of physical and psychological abuse.

Box 1 identifies common types of IPV that may occur with explanations of how they may manifest during or after the COVID-19 pandemic. In accordance with the literature referenced in Box 1, 3 main themes emerged: (1) weaponizing COVID-19 using technological abuse; (2) using being sick with COVID-19 to cause isolation, psychological and emotional abuse, and coercion and threats; and (3) neglect or nonphysical sexual abuse from a lack of access to crucial medical care or medication. We explore these themes.

Weaponizing COVID-19 and Technological Abuse

Because COVID-19 is highly contagious, fear of contracting the disease has been used to manipulate and control family members: the lack of freedom owing to this fear can be weaponized.³ Many community mental health clinics and crisis centers transformed to a hybrid environment using Zoom or HIPAA (Health Insurance Portability and Accountability Act)-compliant video conference platforms.²⁴ This new reliance on technology will likely persist because use of telemedicine by social services, mental health, and medical practices has brought unprecedented convenience to the providers; however,

BOX 1— Common Types of Interpersonal Violence in the Context of the COVID-19 Pandemic

Types of Interpersonal Violence	How It Has Heightened During the COVID-19 Pandemic
Isolation	This form of psychological mistreatment involves minimizing or restricting access to other people ¹³ (e.g., prohibiting family and friend visits). The abusive person may control who may visit (or be socialized with) as a means of control and manipulation. They might not curtail their own social or employment activities and hold the rest of the household to a more stringent standard. ¹⁶
Psychological and emotional abuse	The perpetrator may fake being sick with COVID-19 and threaten to infect the survivor, leading to their extended isolation. Or the perpetrator could fake having contracted COVID-19 and pretend to spread it to the survivor. ¹³
Coercion, threats, and intimidation	The perpetrator can use COVID-19 mandates, news and media stories, and research to increase the survivor's fear of leaving the house and becoming sick or infecting others, thus keeping survivors isolated at home. ^{3,4} A perpetrator may prohibit family members' access to COVID-19 vaccines or boosters (by, e.g., citing false medical or religious justifications), thus potentially limiting independence, employment, education, travel, and entertainment access for survivors.
Economic abuse	Perpetrators may threaten to cut funding or medical support to survivors. Job losses could prevent survivors from amassing savings or resources to leave home, perpetrators could make survivors borrow money for them from family or friends or keep them from working by consistently exposing them to COVID-19. ¹² Women have been disproportionately affected by pandemic-related unemployment. ¹⁵
Child neglect and abuse	Children are at a higher risk for maltreatment, as families may not have the funds or resources to buy food or essential medications. ³ Adults may take out their frustration and anger on their children in violent ways. Children lack typical protective or escape outlets, such as attending in-person school or worship services. ^{1,15}
Immigration status-based abuse by coercion and threats	Partners may threaten survivors who are immigrants with being deported or destroy critical documents if they become sick, need medical care or hospitalization, ¹⁷ or seek public health resources.
Sexual abuse	Reduced or lack of access to contraceptives or birth control is a sexual violence-related risk factor that could result in forced unwanted pregnancies stemming from coercion or rape, ^{16,19} especially if the woman feared seeking medical help during the COVID-19 pandemic and governmental distribution of contraceptives has limited women's access. ^{21,22}
Technological abuse	Those who have traditionally accessed in-person services may not have had access to technological devices or may have lacked privacy in the home while online. ¹⁵ Abusive parties may have weaponized this lack of privacy with strategies such as surveillance and ghostwriting, thus resulting in technological abuse. ^{12,16,23}
Physical abuse	Physical abuse during the COVID-19 pandemic increased, as it normally does following natural disasters. ¹ The stay-at-home mandates and closed businesses correspond with an increase in substance use and untreated mental health symptoms, leading to more physical abuse. Pharmacies, marijuana dispensaries, illicit drug dealers, and liquor stores remained opened during the stay-at-home mandates. ¹⁵

telemedicine has also heightened concerns and risks for survivors of domestic violence.¹⁹ Health professionals need to be aware that clients who have traditionally accessed in-person services may not have confidential access to technological devices or they may lack privacy in the home to fully access services online.¹⁵

Health care trainees should be trained on how to provide telehealth to IPV survivors. This can be demonstrated through mock telehealth sessions in medical and psychology graduate courses supported by the American Medical Association and the American Psychological Association, in which the focus is on telepsychology-related knowledge, technical support, and safety plans for harm reduction.^{25,26}

Abuse Related to Contracting COVID-19

COVID-19–related manipulation may extend beyond threats and be compounded in restrictive living situations, at times increasing transmission of the virus. The perpetrator may use COVID-19 as an additional reason to keep survivors in isolation by instilling fear or threatening to leave them if they become ill.^{3,4}

The line between physical and non-physical violence may become blurred when the result is contracting or exacerbating a potentially deadly disease. There may be insufficient physical and emotional barriers when a cohabitant falls ill; this is particularly true in homes with a partner who is overly controlling and demanding. Ways that nonphysical violence can be perpetrated during a pandemic should be incorporated into trainings and definitions of abuse. This form of violence can be as simple as sneezing, touching, or refusing to isolate to a separate area of the home

when contagious.¹³ Conversely, the abused partner may be the one with COVID-19 but be expected to fulfill household duties despite being sick. This may prolong or intensify the severity of the illness.

Preventing Access to Crucial Medication

When individuals are placed under quarantine, access to essential needs may become problematic, particularly for individuals who identify as immunocompromised, disabled, or dependent (e.g., children, elders) or lack resources. Violence may result from new forms of neglect owing to contracting COVID-19. Even if the neglect is focused on an adult who is immunocompromised or disabled, there can still be traumatic, long-lasting effects for children who witness such abuse.¹⁰

Sexual Abuse

Restricting access to medications can be used as a form of violence, either through neglect of dependents or through direct intent to produce an unwanted pregnancy. Reduced or lack of access to contraceptives during a pandemic is a sexual violence–related risk factor that can result in forced, unwanted pregnancies, also referred to as “reproductive coercion.”^{12,16}

On June 24, 2022, the US Supreme Court repealed *Roe v. Wade*, reversing the nearly 50-year-old constitutional right to abortion access. In numerous states, the effect of *Dobbs v. Jackson Women's Health Organization* has restricted or eliminated access to abortions, contraceptives, birth control, and other forms of reproductive health services, which may further burden women in households with violent

partners,^{21,22} particularly those in which economic resources are limited (e.g., cannot travel to states without abortion bans, cannot stockpile abortion, or “morning after,” pills). Health care trainees, such as medical students, physicians, and nursing students, who work with female populations should be made aware of how to remain informed of local and state sexual and reproductive health regulations. For example, the *New York Times* tracks abortion laws in each state and provides online updates, including whether abortion is legal, banned partially or fully, or is permitted in some cases (e.g., rape, incest, gestational age).²⁷

BARRIERS TO REPORTING

Survivors of domestic violence often do not seek help from police for various reasons, including that the police have historically intervened in domestic disturbances with indifference, disrespect, and hostility.^{7,18,28} Survivors may fear that treatment by law enforcement will be disproportionately worse for their perpetrators than their abusive behavior merits²⁹ or that their children may be placed in their perpetrator's custody³⁰ or social services. Long-standing distrust of law enforcement serves to compromise self-reports and anonymous reports of abuse;¹⁸ distrust has been exacerbated by public sociopolitical unrest associated with police killings of unarmed Black men and women.

Some youths involved in incidents of abuse feel that they are unacknowledged and overlooked when law enforcement gathers information and conducts interviews for their reports.³¹ For women of color, distrust of law enforcement and language barriers founded on generations of discriminatory practices serves as a significant

barrier when seeking refuge from violence.^{14,15} Police violence has been disproportionately high in Black communities, and tensions elevate when law enforcement treats racial/ethnic minority citizens with increased surveillance and excessive or unwarranted violence.^{6,7}

ENVISIONING A SOLUTION AFTER THE PANDEMIC

Taken together, these processes support the need for systemic interventions to better support individuals experiencing, or at risk for, IPV. Perpetrators should be required to attend domestic violence courses, also referred to as “battered intervention programs,” and parenting classes (if a parent) whenever a police report is filed on domestic violence. One example of a successful intervention focused on perpetrators is called the Duluth model, which is designed to change behavior by teaching perpetrators to recognize past and present abuse patterns related to control and power as well as by having them claim responsibility for their actions.³²

The CDC discusses programmatic efforts that may change societal norms and thereby reduce violence, such as public education campaigns and bystander programs.^{33,34} The US Department of Justice’s Office of Community Oriented Policing Services is an example of a successful intervention that focuses on victims and perpetrators. The office promotes community policing development programs by providing federal grants to support training law enforcement in crisis intervention, de-escalation, tolerance, diversity, and antibias.³⁵

As US society collectively grapples with the “new normal” of a world of

uncertain future COVID-19 strains or alternate threats to global health,¹¹ it is essential for researchers and practitioners to consider how to best support those living with violence. In preparing future health care providers, training in best practices is essential. The following are recommendations for individual, community, and governmental policies and training.

Telehealth and Individualized Care

The increase in services provided via telehealth makes it especially important to assess whether the client is in a safe and private environment before initiating a therapeutic or medical session, including inquiring about any form of abuse. Questions regarding the extent of the client’s privacy should be incorporated into existing screening and intake assessments.¹⁹ If clients lack privacy, health care professionals should come up with potential solutions and advocate alternative arrangements that maximize safety during therapeutic encounters.

Nonphysical violence may also result in altered coping mechanisms, such as increased substance abuse, depression, anxiety, and loss of self-confidence.^{1,15} If a survivor indicates they are suffering from nonphysical abuse, mental health professionals can help to marshal a support network and generate ideas about how to safely receive support.²⁴ Traditional health service professional training programs must incorporate coursework and supervised clinical experience in the provision of resources and safety protocols as well as in their coverage of ethical, legal, and clinical issues of telehealth service provision.^{25,26}

Individualized care must be conceptualized broadly and flexibly, integrating

various levels of support. For example, survivors may liaison with crisis advocates (e.g., people trained in safety planning to support those fleeing and those who are unable to flee violent situations) and access crisis hotlines and text lines and virtual support groups.¹² Clinicians must be trained to offer support through safety planning, providing essential support, and advocating medical, educational, or social services. Through the Clinic to End Tech Abuse, funding is available to increase survivors’ access to private technological devices and help them regain or achieve technology freedom.³⁶

Even if domestic abuse survivors are able to leave their abusers, they may remain at heightened risk for violence. Most murders of IPV victims occur when the survivor makes the choice to leave or shortly after leaving their abusive home.^{28,30} During the stay-at-home period, the majority of states made provisions for firearms retailers to remain open in some capacity, contributing to an all-time national record in firearm background checks—an indicator that firearm sales substantially increased during the COVID-19 pandemic.^{3,20} Although stay-at-home mandates have come to an end, there will likely be future pandemics and disasters, and health care clinicians and trainees need to be prepared for when that time comes.¹¹

Acknowledging the reality that people experiencing abuse might not or cannot leave the abusive conditions, proactive strategies include intricate safety planning that accounts for real-time updates of shelter availability, court closures, police practices (e.g., nonbookings or no bail required for certain offenses), and travel restrictions related to future disasters and pandemics.³¹ Health care trainees should be knowledgeable about

these conditions or help their clients increase awareness of and access to these resources. Furthermore, care for those who are unable to flee abuse should be tailored to the individual's circumstances, for example, an appropriate crisis hotline, identifying trusted friends or family on whom they can rely during an emergency (accounting for COVID-19 mandates, children, and pets), and finding areas of the home that can be private and safe retreats. Oftentimes, COVID-19 policies caused many people to be at home simultaneously working or being in online school, so considerations for privacy during virtual sessions should be made for all who are at risk for exposure to violence.

Community Care

As communities reacclimate to how its citizens connect with one another because of COVID-19, teaching health care workers and the public how to identify abuse is essential. There is a need to be a good neighbor, one who can recognize when someone is in harm's way and take necessary action (e.g., reporting to authorities, passing along a phone number for crisis services, acting in an active bystander intervention).¹⁸ Bystander intervention is valuable, as neighbors have the opportunity to intervene.

Some communities have Neighborhood Watch, a program that enables neighbors to become trained and empowered to take action in their neighborhood. Although the program is not IPV specific, with appropriate training, neighbors can intervene and support each other's safety. However, such intervention needs to be culturally and contextually appropriate and take into consideration issues related to mistrust of law enforcement and social

services (as discussed earlier). In some communities, enlisting the support of relatives, friends, or clergy may be possible.

Training for active bystander intervention can be seamlessly embedded in community programming.³⁷ Increasing community awareness regarding IPV would remove the invisible nature of the abuse and prepare the community for how to help when future pandemics or disasters occur. Social service centers can provide free virtual training on bystander intervention, including de-escalation tactics, the process of reporting suspected abuse, hotlines for those who display signs of abuse, and available local supportive services for those experiencing abuse. These are all practical skills for health care clinicians.

Policy Recommendations

Communities need to assess how resources are distributed locally, statewide, and nationally to devote more services to domestic crises that occur with pandemics.

At the local level, there is a team of specially trained police officers and a survivor advocate called the Domestic Abuse Response Team in Los Angeles, California. They continued to respond to calls regarding domestic violence during the pandemic. The police assessed whether arrests were to be made, and the survivor advocate provided additional resources to the survivor, if needed.²³ However, police officers are not medically trained clinicians, and the survivor may not use the resources provided or consent to further services recommended by the survivor advocate. In response to this reality, it could prove useful to expand the Domestic Abuse Response Team model to be nationally adopted and to

include a team of trained professionals that accompany police when a domestic violence call comes in. This multidisciplinary team could include a conflict resolution specialist, crisis interventionist, survivor advocate, clinician, and medical doctor.

At the state level, a successful example is Right Care, a program developed in 2017 that connected police officers with trained social workers and paramedics to work together in responding to 911 calls. The program was created to combat overcrowding in jails in South Dallas, Texas; as a result, arrests in the city dropped.³⁸ Trained mental health clinicians and medical professionals must assess survivors and perpetrators properly to ensure their safety and recovery, especially when the perpetrators are not incarcerated for offenses or have not physically abused the survivor yet. Health care professionals who work with victims and perpetrators of domestic violence should be made aware of this collaborative model as a potential career option.

Mandatory training on survivor and perpetrator interventions and the indicators of IPV, including nonphysical violence, should be incorporated into curricula at medical schools for physicians, physician assistants, and nurse practitioners and at public health schools for emergency department professionals, social workers, and teachers. Such training offers the opportunity for mental health and medical providers to spot early abuse signs and to help survivors and perpetrators try to live safely together, as moving out of the home may not be a viable option. These interventions should be culturally congruent, incorporate the US history of structural racism, and include psychoeducation on the cycle of trauma and abuse.¹⁵

As mentioned previously, many types of nonphysical abuse increased because of COVID-19 (Box 1), and many new episodes appeared because of the hardships initiated or escalated as a result of the pandemic.

However, early interventions focused on behavioral change and psychoeducation could prevent abuse. For example, battered intervention programs are evidence-based interventions built on cognitive behavioral therapy, acceptance commitment therapy, and motivational interviewing and can be offered to perpetrators voluntarily or court ordered. Battered intervention programs differ across states, but all prioritize victim safety and are based on reversing male toxicity and control, psychoeducation, and behavioral modification. The program can be offered as individual, group, or marital therapy.³²

At the national level, the Coronavirus Aid, Relief, and Economic Security Act (2020) provided significant economic relief and sanctions for preserving housing access; it also made services available through the Family Violence Prevention and Services Act (1984). These funds provided a host of prevention and intervention resources related to domestic violence, including housing and emergency shelter, outreach, education, and case management. These services have been invaluable in providing much needed support and assistance for survivors.³⁹

The US Department of Health and Human Services reported that IPV occurs on college campuses and that about 20% of women experience some form of undesired sexual activity. Title IX of the Education Amendments of 1972 legislation enacted federal law that has been extended to prohibit sexual violence and harassment at federally funded colleges. Title IX offices provide

services to complainants and victims and respondents and perpetrators but also mandated education to help prevent sexual violence and harassment on college campuses.⁴⁰ Being trained in the prevention of sexual violence as young adults may carry forward throughout the lifetime.

CONCLUSIONS

The COVID-19 pandemic increased the likelihood that survivors of domestic violence remain in isolation with their perpetrators. The devastating impact was even greater for marginalized communities, especially for people of color. Clinicians and trainees must understand that violence in the home is a complex issue, one that may begin without physical abuse yet still qualifies as IPV. It may escalate to deadly proportions. Consequently, change must be enacted at individual, community, and national levels to accommodate the additional burden of the COVID-19 pandemic and to prepare for future disasters and pandemics. Furthermore, training in working with survivors of IPV must be prioritized for future and current public health professionals. *AJPH*

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PUBLICATION INFORMATION

Full Citation: Smith-Clapham AM, Childs JE, Cooley-Strickland M, et al. Implications of the COVID-19 pandemic on interpersonal violence within marginalized communities: toward a new prevention paradigm. *Am J Public Health*. 2023;113(S2):S149–S156.

Acceptance Date: March 13, 2023.

DOI: <https://doi.org/10.2105/AJPH.2023.307289>

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ACKNOWLEDGMENTS

This work was supported by the National Heart, Lung, and Blood Institute (grant U01HL142109), the University of California, Los Angeles, David Geffen School of Medicine COVID-19 Research Award Program (award HE-06), the Cal Wellness Foundation (grant 2017-257), and the National Institutes of Health (grant 5R25DA035692).

We thank Alex Kim, Graciela Albarraán, Noelani Rosario-Sabet, MA, and Tamra Loeb, PhD, for assistance in preparing this essay with literature searches and editing of initial drafts.

Note. The content of this manuscript is solely the responsibility of the authors and does not necessarily represent the official views of the funders.

CONFLICTS OF INTEREST

The authors have no competing interests to declare that are relevant to the content of this essay.

HUMAN PARTICIPANT PROTECTION

Institutional review board approval was not obtained as no human study participants were involved in writing this essay.

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