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Impact of COVID-19 on Latinx and Black Communities

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CERTIFICATE OF APPROVAL

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This is to certify that the Clinical Research Project of

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Abstract

This critical literature review project explored the impact of COVID-19 on Latinx and Black communities. According to the Centers for Disease Control and Prevention, as of September 28, 2022, around 16% of COVID-19 cases in the United States were among Latinx people, and 14% of cases were among Black people (Centers for Disease Control and Prevention, 2022). Since COVID-19 began, clinicians have become more conscious of the effects of health disparities within racial and ethnic minorities, which has warranted increased advocacy by educating health and mental health providers and creating and providing resources to these communities and clinicians. The review focused on the health disparities and outcomes of the COVID-19 pandemic, the impact of the pandemic on mental health, and how the COVID-19 pandemic discouraged the help-seeking behaviors of the Latinx and Black communities. Results from the review indicate that the COVID-19 pandemic significantly exacerbated the present health and mental health disparities, in addition to deterring help-seeking behaviors in these communities. Findings are presented in terms of theoretical and practical implications and directions for future investigations. Recommendations for clinicians are also included based on the review of the literature.

DEDICATION

I dedicate my clinical research project work to my family. A special feeling of gratitude goes to my parents, Edwin and Consuelo Zuluaga, for their devoted love, prayers, and encouragement throughout this journey. My parents have been my biggest inspiration to pursue my dreams and be the best version of myself. I will forever be grateful for all of my parents' sacrifices for our family. To my sister, Paola, and brother, Edwin Jr., who have been the most loving and reassuring siblings, I am beyond thankful for the times when they have lifted my spirits in my lowest moments and reminded me of my full potential. I want also to acknowledge my partner, James Hamilton, who has stayed by my side through the trials and tribulations. You have taught me the true definitions of patience and optimism. I will be eternally appreciative to my family because this would not have been possible without their endless support.

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CHAPTER I: INTRODUCTION AND HISTORY

The coronavirus disease 2019 (COVID-19) pandemic has impacted worldwide, leading to over 621 million cases, including 6.5 million deaths, reported to the World Health Organization (WHO) as of October 2022 (WHO, 2022). According to the Centers for Disease Control and Prevention (CDC), as of this writing, the United States had 96,209,313 confirmed cases, including 1,054,196 deaths (CDC, 2022). While the COVID-19 pandemic has had a broad effect on the lives of many, Latinx and Black communities have had to bear the brunt of it. As of September 28, 2022, around 16% of COVID-19 cases in the United States were among Latinx people, and 14% of cases were among Black people (CDC 2021b). It is notable to consider that Latinx people account for around 18% of the U.S. population, while Black people make up 13.6% (U.S. Census Bureau, 2021). Based on these numbers, there are significant racial gaps in COVID-19 cases to consider.

According to the CDC (2021a), COVID-19 is caused by a virus called SARS-CoV-2. It is part of the coronavirus family, which includes common viruses that cause a variety of diseases from head or chest colds to more severe (but rarer) diseases like severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) (CDC, 2021a, para. 4). It is known to spread through droplets projected from the mouth and nose when breathing, coughing, sneezing, or speaking (CDC, 2021a). The virus was reported to have originated in bats and was transmitted to humans through yet unknown intermediary animals in Wuhan, Hubei province, China, in December 2019 (Singhal, 2020). Scientists have also discovered various COVID-19 variants and subvariants in the last few years.

Per Lin et al. (2022, as cited in Davies et al., 2021), the United States went through various waves of COVID-19:

> The initial stage was caused by the rapid spread of the wild strain, followed by the co-circulation of the wild strain and the Epsilon variant. The Epsilon variant was detected for the first time in California, U.S., in July 2020. (p. 1)

The Alpha variant, also known as B1.1.7, underwent 23 mutations (Rashedi et al., 2022), which was estimated to be 40-80% more transmissible than the wild strain (Volz et. al., 2021, as cited in Davies et al., 2021), replaced both the wild strain and the Epsilon variant and was finally replaced by the Delta variant. The Delta variant was first identified in India in December 2020 (McCrone et al., 2021). According to the CDC tracking, "the proportion of Delta variant infections among all samples sequenced in the United States rose from nearly zero to nearly 100% during May 2020 and August 2021 due to the high infectivity of the variant" (Lin et al., 2022, p. 1). Delta ultimately led to a devastating rise in hospitalizations in some states.

In November 2021, the WHO identified the new SARS-COV-2 mutant variant of concern named Omicron (B.1.1.529) (WHO, 2022). It was first identified in South Africa and Botswana and was said to have altered the course of the pandemic. Data have suggested that it is more transmissible than the Delta variant and "capable of significant immune evasion (i.e., evades the immune protection provided by antibodies from vaccines or prior SARS-CoV-2 infection)" (Del Rio et al., 2021, p. 319). Bhagavathula et al. (2022) reported that in the first week of 2022, a record number of over one million new COVID-19 cases in a single day were reported in the United States, and the Omicron variant accounted for the substantial majority of new cases (as cited in Hong, 2022). As the Omicron cases heightened, many government representatives who disagreed with the data and recommendations provided by health officials spread misleading information. For instance, the Florida surgeon general called for the "unwinding of the testing

psychology" and that people should stop planning and living lives around COVID-19 testing (as cited in Beals, 2022).

Further, political leaders stated that testing and COVID-19 prevention-related hysteria were driving people and their lives. Bhagavathula et al. (2022) reported that some medical commentators also asked people to stop wasting COVID-19 tests and that asymptomatic people were consuming too many tests. As of January 2022, during the Omicron surge, Black, American Indian/Alaskan Native, and Latinx people experienced the highest rates of death (36.5, 33.1, and 29.4 per 100,000 population, respectively) (Ndugga & Artiga, 2021). These numbers reflect the significant impact of the surge and the information inconsistences provided by the powers in charge on those in communities who already distrust the healthcare system.

The COVID-19 pandemic's severe impact on several ethnic groups in the United States has further exposed health disparities within the country's society. The literature has defined health disparities as a particular type of health difference related to economic, social, or environmental disadvantage (Healthy People 2020, 2008). It is detrimental to those groups who have been systematically disadvantaged in their healthcare because of racial or ethnicity, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or physical disabilities; sexual orientation, gender identity; geographical location; or other characteristics historically associated with discrimination or exclusion (Healthy People 2020, 2008). Health disparities in the United States were already pervasive before the pandemic. Nearly two decades ago, two surgeon general's reports, published in the early 2000s, brought recognition to health disparities (Institute of Medicine, 2012) and documented disparities in access to mental health care by ethnicity and race. Despite the documentation and recognition of disparities for years and general advancements in people's health over time, many differences have continued and,

unfortunately, broadened. For example, as of 2018, life expectancy among Black individuals was four years lower than their White counterparts, with the lowest expectancy among Black men (Institute of Medicine, 2012). Before COVID-19, recent data suggested that people of color fared worse compared to White people throughout various health measures, including pregnancy-related deaths, infant mortality, the prevalence of chronic conditions, and general physical and mental health status (Ndugga & Artiga, 2021).

According to the CDC (2021c), it was reported in late July 2021, the 7-day ongoing average of COVID-19 cases reached over 60,000. This case rate is believed to reflect the case rates before the COVID-19 vaccine was available to all individuals (CDC, 2021c). Artiga et al. (2021) reported that as of September 20, 2021, across 43 states, the rate of 53% of White people, who have received at least one COVID-19 vaccine dose, was 1.1 times higher than the rate for Latinx people and 1.2 times higher than the rate for Black people. Unfortunately, Black, Latinx, and low-income individuals reported less likelihood of trusting COVID-19 public health officials than White individuals (Jimenez et al., 2021). Also, Black and Latinx adults are more prone to "wait and see" before obtaining the COVID-19 vaccination (Jimenez et al., 2021). COVID-19 does not impact all individuals equally as the research had supposed. Notably, the COVID-19 virus disproportionally affects more individuals with health comorbidities such as heart disease, asthma, and diabetes, thus significantly affecting minorities who have higher likelihood of these diseases (Kim et al., 2020a). Many individuals with low-wage jobs are considered essential workers or live with essential workers and have a higher chance of exposure to the virus (Kim et al., 2020a).

To understand the impact of COVID-19 on communities of color, it is vital to understand its relation to existing health disparities in U.S. society and other underlying problems of racial

inequalities that contribute to these. Racial inequalities are embedded in beliefs, practices, and policies that deny resources and goods to people of color (Shapiro, 2004), which makes it more challenging. Minorities may require more support from their White counterparts to be successful. According to Pew Research Center (2020), most Americans believe the country has not yet achieved racial equality. About 61% of Americans say that the country needs to continue making changes for the equality of Black Americans, while 30% say America has made the changes to encourage equality (Pew Research Center, 2020). From 400 years of slavery to modern discriminatory laws and regulations against immigrants, the country's history has been embedded with ethnic and racial inequalities, which have paved the way to the issues that racial and ethnic communities continue to face, specifically the Latinx and Black populations.

The COVID-19 pandemic has had direct health effects and other impacts on these communities at various levels. The pandemic has impacted people of color and other underserved groups' financial security, mental health, and overall well-being (Ndugga & Artiga, 2021). As reported by Ndugga and Artiga (2021), Kaiser Family Foundation (KFF) survey data from February 2021 revealed that about 6 in 10 Latinx adults (59%) and about half of the Black adults (51%) said their household lost a job or income due to the pandemic, compared to about 4 in 10 White adults (39%) who said the same. Furthermore, adults with a household income under $40,000 were three times as likely, compared to those with a household income of $90,000 or more, to say they have had trouble paying for basic living expenses in the last three months (55% versus 19%). As of late March 2021, Black and Latinx adults were more likely than White adults to report a lack of confidence in their ability to make their next housing payment and to report food insufficiency (Ndugga & Artiga, 2021, as cited in KFF, 2021). The CDC (2020b) also reported that communities with higher numbers of racial and ethnic minorities have higher levels

of exposure to pollution and other environmental hazards; therefore, this is linked to several health conditions (e.g., asthma, other underlying health conditions) that increase the risk of becoming ill or dying from COVID-19.

Not only has COVID-19 had a financial impact but also an academic impact. During March 1 and September 19, 2020, in the United States, 93,605 students tested positive for COVID-19, and it was reported that 42% were Latinx and 17% were Black, emphasizing a disproportionate effect of the pandemic on children of color (Leeb et al., 2020). Unfortunately, the pandemic led to many children shifting to remote learning, causing school-based health care and school-based meals to be eliminated during this time, and children of lower socioeconomic status were mainly affected by these losses. Despite the districts around the country attempting to continue providing these resources, many students were still unable to continue to benefit from these resources. The lack of access to these resources contributed to adverse health outcomes for these children and their families (Hoofman & Secord, 2021).

Ultimately, it can be concluded that although health disparities have slightly improved over time, the COVID-19 pandemic exacerbated and brought to light the health disparities that were already present. The COVID-19 pandemic has not only impacted the Latinx and Black communities at a health level but impacted all aspects of life. It is important to understand how these disparities impacted areas of mental health and help-seeking behaviors of these populations during the pandemic to address these impacts effectively.

Definition of Terms

The following terms are defined to assist the reader in understanding the concepts included in this literature review.

- *Alpha (B.1.1.7)*—The literature defines *Alpha* as a variant of SARS-CoV-2, first identified in Great Britain in November 2020, and cases rose in December of that year. It then became the dominant variant in the United States. Consequently, the CDC classified it as a variant of concern (Katella, 2023).
- *Black*—The literature defines the term *Black* as "generally refers to a person with African ancestral origins. In some circumstances, usually in politics or power struggles, the term Black signifies all non-White minority populations" (Agyemang et al., 2005, p. 1017). Individuals may prefer to identify as Black because they do not identify as African and/or American (Anderson et al., 2004). Alternatively, the term *African American* describes "a person of African ancestral origins who self-identifies or is identified by others as African American" (Agyemang et al., 2005, p. 1016). This literature review utilizes the term *Black* to identify and describe this specific minority group as it seems to be more inclusive term of various subgroups within the community.
- *Delta (B.1.617.2)*—The literature defines *Delta* as a variant of SARS-CoV-2, first identified in India in December 2020, that spread quickly and affected countries, even when vaccination coverage was high. Del Rio et al. (2021) stated that this Delta variant became most prevalent in the United States in March 2021, leading to a surge of new infections, particularly in the Southeast United States. With low vaccination rates and limited public health mitigation measures, Delta spread largely because of uneven vaccination coverage in the United States. The Delta variant is highly transmissible, estimated to be about 60% more transmissible than the Alpha variant.
- *Epsilon*—The literature defines *Epsilon* as a variant of SARS-CoV-2, first identified in May 2020 in California. It then split into subvariants B.1.427/B.1.429. The COVID cases

from the Epsilon variant quickly increased and became widespread in the United States. It has been reported in at least 34 other countries (Thakur et al., 2022).

- *Latinx*—The literature defines the term *Latinx* as "inclusive of identities that go beyond the everyday gender and racial norms that are rapidly shifting and being redefined in today's culture" (Ramirez & Blay, 2017, p. 8). Torres (2018) suggested that the term *Latinx* "represents the variety of possible genders as well as those who may identify as non-gender binary or transgender" (p. 284). This term is viewed as gender neutral. Alternatively, the term *Hispanic* is defined as "someone who is a native of or descends from, a Spanish-speaking country" (Exploratorium, 2017, p. 1) This literature review utilizes the term *Latinx* to identity and describe this specific minority group because it is a more inclusive term of various subgroups within the community.
- *Omicron (B.1.1.529)*—The literature defines *Omicron* as a variant of SARS-CoV-2 first identified in South Africa and Botswana. Omicron is more infectious than its antecedents; thus, it has spread rapidly globally (WHO, 2022). Given the subsequent ample opportunities to reproduce, Omicron has had the opportunity to develop specific mutations of its own. It led to the subvariant BA.2 arising, which was slightly more infectious than the original Omicron, BA.1 (WHO, 2022).
- *Subvariant*—The literature has defined *subvariant* as a mutation that belongs to a currently circulating variant of concern and is composed of some marginally unique properties such as "additional amino acid changes that are known or suspected to confer the observed change in epidemiology and fitness advantage as compared to other circulating variants" (Cocherie et al., 2022, p. 4).
- *Variant*—The literature defines *variant* as:

> a viral genome (genetic code) that may contain one or more mutations. In some cases, a group of variants with similar genetic changes, such as a lineage or group of lineages, may be designated by public health organizations as a variant being monitored (VBM), a variant of concern, or a variant of interest due to shared attributes and characteristics that may require public health action. (CDC, 2022, p.1)

Statement of Problem

The research has shown the continuous impact of health disparities on people of color, specifically the Latinx and Black communities. According to Carratala and Maxwell (2020), 13.8% of Black individuals reported having fair or poor health compared with 8.3% of White counterparts, and 10% of Latinx individuals reported having fair or poor health compared with 8.3% of White counterparts (CDC, 2021b). Per the American Psychiatric Association (2017d), 48% of White Americans received mental health services among adults with mental health illnesses, compared to 31% of Black Americans and Latinx Americans. The COVID-19 pandemic has exacerbated these disparities significantly, suggesting how rooted these disparities are within our system. The CDC (2022) reported 133,408 Latinx and 103.229 Black lives have been lost due to COVID-19. These numbers indicated the disproportionate impact of COVID-19 on minorities. Concern continues to grow over the unequal healthcare treatment of minorities. Unfortunately, the lack of education, awareness, and advocacy on the impact of health disparities on minority communities has contributed to the absence of strategies, resources, and recommendations during global emergencies, such as the COVID-19 pandemic. Therefore, it is essential to understand that because the COVID-19 pandemic is ongoing and studies are beginning to be generated, there is a demand to document the impact it is having on these

communities and an urgent need to raise awareness about the effects of the pandemic to better support and provide for the communities' and healthcare providers.

Purpose of the Literature Review

The purpose of this critical literature review project (CRP) was to evaluate the current literature focusing on COVID-19's impact on the present health disparities in the Latinx and Black communities, the impact of COVID-19 on the disparities of mental health of the Latinx and Black communities, and how COVID-19 may have discouraged the help-seeking behaviors of these communities. Since COVID-19 began, clinicians have become more conscious of the effects of health disparities within racial and ethnic minorities, which has warranted increased advocacy by educating health and mental health providers and creating and providing resources to these communities and clinicians. Therefore, increased awareness of the impact of global pandemics and other catastrophes, specifically on racial and ethnic minorities, is essential for clinicians to address when providing services to these communities.

Research Questions

The following questions guided this critical literature review:

I. How did the COVID-19 pandemic exacerbate the present health disparities in the Latinx and Black communities?
II. What is the impact of the COVID-19 pandemic on mental health disparities of Latinx and Black communities?
III. How did the COVID-19 pandemic discourage help-seeking behaviors of Latinx and Black communities?

Search Procedure

To complete this literature review, databases such as American Psychological Association PsycARTICLES, APA PsycINFO, and EBSCO Information Services were used to examine professional, peer-reviewed journals, dissertations, and books related to health disparities and outcomes of the COVID-19 pandemic on Latinx and Black communities and the impact of the disparities on the mental health and help-seeking behaviors of these communities. The literature reviewed focused on Latinx and Black minorities of all ages and genders. It included how various social factors, such are discrimination, culture, socioeconomic status, housing, transportation, education, and health care system related to health disparities, affect these communities. The research questions were evaluated through the support of the current literature. Search terms included *Latinx, Black, variant, subvariant, Epsilon* (*CAL.20C), Alpha (B.1.1.7), Delta (B.1.617.2), Omicron (B.1.1.529), COVID-19 pandemic, mental health disparities, health disparities, stigma, racism, discrimination, structural racism, help-seeking,* and *treatment seeking.* Additionally, references within original sources were searched.

Limitations/Delimitations

While this literature review attempted to be comprehensive regarding the health disparities within Latinx and Black communities and the outcomes and impact of the COVID-19 pandemic on the mental health and help-seeking behaviors of these communities, in addition to attempting to comprise a multitude of considerations, databases, and literature, this is not an extensive review. Access and availability to nationwide research may have been restricted conceivably due to data on the COVID-19 pandemic being relatively new-found and continuing to change rapidly. This author acknowledges the limitations of this literature review.

CHAPTER 2: HOW DID COVID-19 EXACERBATE THE PRESENT HEALTH DISPARITIES IN THE LATINX AND BLACK COMMUNITIES?

The health disparities within the Latinx and Black communities were already present before the COVID-19 pandemic. The virus exacerbated the already present disparities but also created other outcomes. This is the primary reason these minority communities have been profoundly stricken during the pandemic. Therefore, this chapter not only focuses on the impact of the pandemic on the present health disparities, but it also provides an understanding of how disparities developed within the Latinx and Black communities.

To better understand the idea of health and mental health disparities, it is important to differentiate between race and ethnicity. The concepts of race and ethnicity are often used interchangeably (Markus & Kitayama, 2010). However, subtle differences between them clarify the extent of the continued impact of health disparities in the Latinx and Black communities. *Race* is defined as a "social construct primarily based on phenotype, ethnicity, and other indicators of social differentiation that results in varying access to power and social and economic resources" (Fiske, 2010, p. e456; Williams, 1997). It is essential to note that race is a social construct and can be viewed as imaginary because groups are not necessarily divided by genetic differences (Fiske, 2010; Williams, 1997). Alternatively, Bradby (2012) defined *ethnicity* as an individual's identification with a group culture, categorized in terms of religion, language, traditions, and celebrations. Because socially, there are disparities in race and ethnicity, it creates the idea of racial superiority, which continues to persist and contributes to structural racism.

According to Krieger (2014), structural racism refers to:

> the totality of ways in which societies foster discrimination, via mutually reinforcing systems of bigotry (e.g., in housing, education, employment, earnings, benefits, credit,

> media, health care, criminal justice) that in turn reinforced biased beliefs, values, and distribution of resources. (p. 1455)

This suggests that ethnic and racial minorities experience significant disadvantages over their White counterparts. Gee and Ford (2011) provided an example of structural racism: social segregation, which separates social groups. For instance, Angelon-Gaetz et al. (2010) discovered that a nuclear weapons site was segregating their Black workers from their White counterparts while exposing Black workers to a greater level of radiation. Structural racism promotes discrepancies in access to society's goods, services, and opportunities by race, which determines power hierarchies and societal values (Jones, 2000). It triggers unrelenting health disparities in the United States (Jones, 2000). This is an example of how systems encourage the success of White individuals and denounce the attainments of minorities, which leads to racial and ethnic discrimination. The National Association of School Psychologists (2019) defined *discrimination* as the improper treatment of individuals based on their actual or perceived affiliation to a group. It may comprise overt and covert behaviors (National Association of School Psychologists, 2019). These behaviors include microaggressions or indirect or subtle behaviors that involve negative beliefs or attitudes toward the minority group (National Association of School Psychologists, 2019). For instance, immigrants are often exposed to discriminatory behaviors. Immigrants frequently must work in hazardous and demanding environments (De Castro et al., 2006). In addition to the dangerous working conditions, the workers are significantly underpaid for their challenging work. Hence, they are subjected to a significant number of health threats.

COVID-19 has exposed acts of discrimination in various contexts (e.g., social, political, historical). Discriminatory behavior at the structural level helps support values and beliefs that inappropriately shape the distribution of resources within minority communities. This is known

as *inequity*, which "has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust" (Whitehead & Drever, 1999, p. 5). Often, inequity is viewed as the cause of disparities. *Disparity* "is the quantity that separates a group from a reference point on a particular measure of health expressed in terms of rate, proportion, mean, or some other quantitative measure" (Keppel et al., 2005, p. 3). The main difference between inequity and disparity is that inequity implies unfairness, whereas disparity means differences (Meghani & Gallagher, 2008, p. 614). Disparities can be avoidable when there are policies and regulations in place that fight against the perpetuation of inequity. Because inequities contribute to disparities, addressing the societal and underlying conditions is essential (Satcher, 2010). Ultimately, these factors contribute to placing minorities at risk of unfavorable health and mental health outcomes.

As Woolf and Braveman (2011) reported, to understand health disparities, there needs to be an understanding of the determinants of health. Not only are there biological aspects, such as sex, age, and genes, but also "downstream" and "upstream" determinants (Woolf & Braveman, 2011). Downstream determinants include medical care; environmental issues, such as air pollution; and health behaviors, such as smoking, pursuing or declining medical services, and not adhering to treatment recommendations (Woolf & Braveman, 2011). Upstream social determinants include personal resources and social environments, such as income, education, housing, employment, and engagement in recreational interests (Woolf & Braveman, 2011). The upstream determinants frequently influence the downstream ones (Woolf & Braveman, 2011).

Consequently, social factors are leading contributors to health disparities. For instance, if socioeconomic factors were reduced or eliminated, it would also reduce or eliminate these disparities in the racial and ethnic communities (Institute of Medicine, 2003). A study by LaVeist

et al. (2011) estimated that the economic costs of health disparities due to race for Black, Asian Americans, and Latinos from 2003 through 2006 were slightly more than $229 billion. A report issued by the Urban Institute in September 2009 estimated that the Medicare program would save $15.6 billion per year if health disparities were eliminated (LaVeist et al., 2011). A research study that considered preventable diseases in Black and Latinx communities, including hypertension, stroke, and diabetes, determined that if the prevalence of the selected conditions in the Black and Latinx communities was minimized to the exact prevalence as those diseases that occur in the non-Latino, White population, about $23.9 billion in health care costs would be prevented exclusively in 2009 (Waidmann, 2009). The costs of health disparities are massive, and it can be assumed that it takes a significant toll on the economy; yet, these disparities persist.

Health and Healthcare

Disparities in health and access to healthcare significantly contribute to the well-being of Latinx and Black communities. Arias et al. (2021) indicated that between 2019 and 2020, the Latinx life expectancy was reduced by 3.0 years and 2.9 years for the non-Latinx Black population compared to 1.2 years for the non-Latinx White population. In 2020, the Latinx population had a life expectancy advantage of 1.2 years over the non-Latinx White population, declining from an advantage of 3.0 years in 2019 (Arias et al., 2021). According Grief and Miller (2019) minorities are disproportionately more often stricken by infectious diseases than the rest of the population**.** Critical factors, such as limited healthcare access, medical mistrust, and others, have contributed to late diagnosis and negligible care of infectious diseases among susceptible minority communities (Lopez et al., 2021). Historically, the Latinx population has had limited healthcare access (Pedraza et al., 2022). According to Pedraza et al. (2022), in 2019, 18% of the Latinx population and 6.3% of White individuals did not have healthcare access per the U.S.

Census Bureau. Notably, 21% of Latinx individuals did not visit a medical physician because of high costs, in contrast with 13% of White people (Pedraza et al., 2022).

As for the Black population, Vasquez Reyes (2020) reported that in 2018, approximately 11.7% of Black individuals in the United States had no health insurance compared to White people. Per the U.S. Department of Health and Human Services (2022), Black individuals were more prone to report the absence of a form of care in 2011, 2012, and 2018 than their White counterparts. Black individuals were more likely to report worries related to medical costs and difficulties paying medical bills (Mead, 2021). The Affordable Care Act, enacted into law in 2010, has provided healthcare insurance to these communities (Vazquez et al., 2020). For example, between 2013 and 2016, the act assisted in lowering the uninsured rate among nonelderly Black Americans by more than one-third, from 18.9% to 11.7%. Despite the passing of this law, Black individuals are still highly uninsured compared to Whites (7.5%) and Asian Americans (6.3%) (Sohn, 2017). Hence, due to excessive costs, uninsured individuals tend to avoid medical checkups, exams, treatments, and medications (Vazquez et al., 2020). According to Maroko et al. (2020), in a study from New Jersey, Latinx individuals reported primarily getting tested for COVID-19 at public test centers because they were unable to afford the private testing cost.

Uninsured Black and Latinx individuals face detrimental health outcomes. For instance, Black individuals have been disproportionately diagnosed with chronic diseases such as hypertension, asthma, and diabetes (Vasquez Reyes, 2020). Diabetes treatment rates are lower for Black and Latinx people, and research has demonstrated that even with insurance, these individuals have a lower chance of obtaining newer medications (Willi et al., 2015). This is perhaps because insurance does not always cover the entire cost of these medications, making it

difficult to obtain good-quality treatment. Another health issue within these communities is obesity. Mainly, the rates among Black and Latinx are much higher than their White counterparts and much higher in southern U.S. states (Baumgartner, 2021). According to Vasquez Reyes (2020), Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases and chief medical advisor to President Joe Biden, has stated:

> It is not that [Black Americans] are getting more infected more often. It is that when they do get infected, their underlying medical conditions . . . wind them up in the ICU and ultimately give them a higher death rate. (p. 303)

This is true as well for the Latinx community. Unfortunately, individuals with any of these underlying issues are more susceptible to experiencing high-risk symptoms of COVID-19 (Kompaniyets et al., 2021).

Bailey et al. (2021) suggested that more than 100 studies established that bias, prejudice, and stereotyping contributed to pervasive disparities in health care by race and ethnicity. Several studies have determined the disparities in treatment and severity of various illnesses such as coronary disease, HIV, and cancer in minorities (Institute of Medicine, 2003). Disparities in receipt of coronary revascularization procedures have been associated with more significant mortality among Black individuals (Peterson et al., 1997). Khansa Ahmad et al. (2019, as cited in Vasquez Reyes, 2020) explored the relationship between cardiovascular diseases and poverty, which cardiovascular disease has shown to be a contributor to the considerable number of Black deaths during the pandemic. The study concluded that the American healthcare system has not been able to address the elevated disparity of individuals who live in poverty and suffer from cardiovascular disease (Ahmad et al., 2019). Also, studies of cardiovascular disease data suggest that disparities in cancer care are linked with higher death rates among minorities (Bach et al.,

1999). These findings have also implied substantial disparities in the administration of suitable cancer diagnostic tests (McMahon et al., 1999), treatments (Imperato et al., 1996), and analgesics (Bernabei et al., 1998).

Per Lopez et al. (2021), morbidity and mortality rates from HIV/AIDS in the United States are greater among Black and Latinx people. Per Evans (2020), in 2018, Black people contributed to 13% of the U.S. population but 42% of new HIV/AIDS diagnoses. Likewise, Black individuals with HIV are unlikely to obtain antiretroviral therapy (Moore et al., 1994), prophylaxis for pneumocystis pneumonia, and protease inhibitors (Shapiro et al., 1999) compared to non-minorities (Institute of Medicine, 2003). Kompaniyets et al. (2021) suggested that the lack of access to high-quality care to treat life-threatening illnesses puts these groups at higher risk of contracting COVID-19.

The impact of health disparities also has greatly affected maternal and child health. Over the years, research has indicated that there has been an overall decrease in infant mortality. According to data, infant mortality declined 50% more between 2010 and 2016 in states that expanded Medicaid than in states that did not, and Black infants experienced the greatest reduction (Bhatt & Beck-Sagué, 2018). Although there has been a reduction in mortality rates due to the expansion of Medicaid, there continue to be disparities in rates. Between 2011 and 2016, there were 11.3 deaths per 100,000 live births among Latinx women, White women died at a rate of 13 deaths per 100,000 live births, whereas Black women died at a rate of 42.4 deaths per 100,000 live births (Burns, 2020, as cited in Oribhabor et al., 2020). Recent studies have suggested that variation in hospital quality may be responsible for a significant portion of racial and ethnic disparities in severe maternal morbidity and mortality. Recent research results have demonstrated that women from racial and ethnic minorities deliver in hospitals that are different

and of lower quality than those frequented by Whites (Howell, 2018). It has been estimated that if Black women gave birth in the same hospitals as White women, approximately 1000 Black women would be able to avoid severe and detrimental incidents during labor hospitalizations, which, in turn, would decrease Black maternal mortality rates from 4.2% to 2.9% (Creanga et al., 2014, as cited in Oribhabor et al., 2020).

Health disparities exist for children with chronic illnesses (Berry et al., 2010). White et al. (2021) reported numerous chronic disease conditions might increase the risk of severe COVID-19 illness in some children and teens, according to estimates. For instance, in the United States, almost 1 in 5 children aged 2-19 years are obese (White et al., 2021). From 2017 to 2018, Mexican American (26.9%), Latinx (25.6%), and non-Latinx Black (24.2%) children were more likely to be overweight or obese than non-Latinx White (16.1%) and non-Latino Asian (8.7%) children (White et al., 2021). Like Latinx and Black adults, the health disparities are found more in children with asthma, diabetes, and cardiovascular illnesses (White et al., 2021). It has been shown that children who struggle with obesity are more likely to suffer from cardiovascular diseases in adulthood, suffering from high cholesterol, high blood pressure, impaired glucose tolerance, insulin resistance, type two diabetes, asthma, and sleep apnea conditions (Mohanan et al., 2014; Narang & Mathew, 2012; Umer et al., 2017). Based on the study by White et al. (2021), it can be suggested that health disparities can impact anyone within these communities, no matter the age.

COVID-19 pandemic impacts on Latinx and Black communities were likely aggravated by the health disparities discussed above. According to current COVID-19 death data, of the 1,125,000 official COVID-19 deaths in the United States, 155,136 Black individuals and 170,422 Latinx individuals have died (CDC, 2023). Notably, official numbers are believed to be

underestimated as many of the deaths of individuals who had COVID-19 may have been attributed to their underlying medical conditions. COVID-19 cases are twice as prevalent in Latinx and Black individuals as in White individuals (CDC, 2023). According to Kompaniyets et al. (2021), Black and Latinx adults are more likely to have underlying health conditions that increase their risk of severe COVID-19 illnesses, such as diabetes, obesity, and heart disease. Furthermore, these communities had a greater probability of being uninsured and lacking a usual source of care, which made accessing COVID-19 testing and treatment difficult (Substance Abuse and Mental Health Administration (SAMHSA), 2020a). In addition to these factors, essential working jobs have played a significant role in increasing the exposure of the COVID-19 virus for the Black and Latinx individuals who has contributed to the higher infection and death rates seen in these communities (SAMHSA, 2020a).

Employment and Essential Workers

Employment serves for many as an opportunity to obtain various social determinants of health, such as health insurance, income, housing, and many others (Forchuk et al., 2016). However, for Black and Latinx people, it is not always feasible to obtain these benefits via employment or become employed themselves. This is because, historically, the Latinx and Black communities have faced endless employment discrimination. According to the CDC (2020b):

> nearly a quarter of employed [Latinx] and Black American workers are employed in service industry jobs, compared to 16% of non-[Latinx] Whites. Black [people] make up 12% of all employed workers but account for 30% of licensed practical and licensed vocational nurses, who face significant exposure to the coronavirus. (p. 2)

Better physical and mental health is linked with employment, leading to health insurance access (Kurtzleben, 2020). Hence, access to employment benefits and safer job environments would improve the overall quality of life for people of color.

During the pandemic, about 40 million individuals in the United States filed for unemployment benefits; yet, Black and Latinx people have suffered disproportionate work loss (Kurtzleben, 2020, as cited in Lopez et al., 2021). According to the U.S. Bureau of Labor Statistics (2020), in April 2020, at the height of the first wave of the pandemic, national unemployment rates were 16.7% for Black people and 18.9% for Latinx people and 33.1% higher in comparison to 14.2% of White people (as cited in Lopez et al., 2021). Per González et al. (2020, as cited in Lopez et al., 2021), "as of April 10, 2020, an estimated 6 in 10 working-aged [Latinx] adults lived with someone who either lost employment, work hours on the job, or income" (p. 719). As for those who lost their employer health insurance coverage, 13% of Black and Latinx individuals lost their coverage versus 6% of White individuals (Sloan et al., 2020). Adversely, it has been documented that those who are unemployed are more susceptible to stress-related illnesses, such as cardiovascular disease, hypertension, and diabetes, which are all risk factors for negative COVID-19 outcomes (U.S. Department of Health and Human Services). Notably, gender and education also contributed to this community's unemployment increase during the pandemic. For instance, Black and Latinx women experienced the greatest decline in employment during the COVID-19 pandemic and, despite economic recovery, continue to experience the lowest labor force participation, lower than pre-pandemic levels (Claxton, 2019). This is possible because gender roles play a significant role within these communities because Latinx and Black women tend to have more responsibilities in the care of the children and families than men (Claxton, 2019). Also, women were likely working jobs requiring face-to-face

services that were eliminated due to the lockdowns. Likewise, individuals without a college degree tend to have less access to remote jobs and earn less than higher-income earners (U.S. Census Bureau, 2019). Many low-income earners are unable to pay their bills, let alone medical expenses, and in these cases, they are forced to exhaust financial savings (U.S. Census Bureau, 2019). Reports in March 2021 exposed the financial burden that the pandemic had on these communities. Lower-income adults continued to face significant financial challenges and strive to rebuild finances during the pandemic worsening their already present financial stressors (Horowitz et al., 2021).

Vasquez Reyes (2020) reported that in 2018, 45% of low-income employees depended on an employer for health insurance. These workers are forced to continue attending work despite their health conditions to keep their benefits (Vasquez Reyes, 2020). These situations are worsened when employees are only allowed to be absent from work if they test positive for COVID-19 (Vasquez Reyes, 2020). However, the way the virus spreads is complicated; consequently, the worker may have already infected those they came in close contact with (Artega et al., 2020, as cited in Vasquez Reyes, 2020). For instance, Black people often work with the public because they have low-wage jobs, usually in the food service industry, public transportation, and health care. This elevates their exposure to COVID-19 and puts them at considerable risk of spreading the virus within their communities (Vasquez Reyes, 2020).

Not only are Latinx and Black workers deterred from absences, but they are less likely, compared to any other racial or ethnic group, to have access to paid family leave through their employer (UnidosUS, 2020). Approximately 40% of Black workers earn low wages and have no paid sick days. Workers without paid sick leave may be likelier to continue working when ill (UnidosUS, 2019b). Only 25% of Latinx employees have access to paid parental leave compared

to 49.7% of their White counterparts (UnidosUS, 2019b). Per the National Low Income Housing Coalition (2020), it was estimated that 57% of Latinx workers had lost their jobs, hours at work, and work-related income during March and April 2020. This makes it challenging for Latinx and Black workers to care for their physical health and for family members that may be ill. Inadvertently, Latinx and Black workers have become even more essential to the workforce in the last few years (Schnake-Mahl et al., 2021).

The concept of essential workers during the pandemic expanded to become more than just "healthcare workers" but also those who were putting their lives at risk to meet the needs of their communities. A Lancet editorial ("Plight of Essential Workers," 2020) stated:

> although some people have been able to shift their jobs to their homes, millions of workers have jobs that cannot be done at home—not only custodial staff and orderlies in hospitals, but also teachers and childcare workers, grocery clerks and supermarket workers, delivery people, factory and farm workers, and restaurant staff, often without adequate [personal protective equipment]. (p. 1587)

According to the U.S. Department of Housing and Urban Development (2022, as cited in Poteat et al., 2020), there is a significant overrepresentation of Black Americans in essential service industries, including sub-standard healthcare sectors, such as home health aides, nursing home staff, and hospital janitorial, food service, laundry, and other sectors. A Lancet editorial ("Plight of Essential Workers," 2020) mentioned, "these people leave their homes to help maintain a semblance of normality for others, at elevated risk to themselves and their families" (p. 1587). Despite essential workers risking their lives to provide for themselves and their families, they earned less than the minimum wage or lost their jobs because of lockdowns. Their services have always been valuable, but during the COVID-19 quarantine, it became evident how much these

communities contribute to producing vital goods and services while underlining the value of the essential workers and their families.

Education

Cohen and Syme (2013) reported that education is a major social determinant of health and is essential to achieving health equity. Educational attainment and disparities in health are closely linked (Hahn & Truman, 2015). Moreover, education is highly correlated with income and occupation, and "less education predicts earlier death" (Freudenberg & Ruglis, 2007, p. 1). Furthermore, education most often determines access to health care and health-related benefits through occupational attainment, including paid time off and paid sick leave (Robert Wood Johnson Foundation, 2009). Adults with less education report worse general health, more chronic conditions, and more functional limitations than those with higher levels of education (Lucas & Benson, 2019; Villarroel et al., 2019). According to the National Center for Education Statistics (2019), about 45% of Black individuals and 43% of Latinx individuals attended high-poverty schools compared to 14% of Asian Americans and 8% of White people. There has been a significant reduction in the dropout rate between racial groups between 2000 and 2013. While this is true, Latinx individuals remain the majority of students who drop out of high school, followed by Black and White individuals (National Center for Education Statistics, 2019). The statistics imply that Black and Latinx communities have more challenges than their White counterparts and other minority groups to achieve academically, impacting employment opportunities and limiting their chances to obtain healthcare.

Regarding the impact of COVID-19 on schools, during the pandemic, schools were required to close and eventually transition to virtual education to maintain the public health safety of educators and students. Fay et al. (2020) described schools as the "third pillar of a

pandemic-resilient society" (p. 4). Schools have the ability to provide many resources to students and families, "including academic intervention supports, food and nutrition programs, childcare, after-school support, and social, physical, and mental health services" (White et al., 2021, p. 2). These resources can contribute to health outcomes for many children, especially those experiencing poverty and systemic disadvantage (Robert Wood Johnson Foundation, 2009).

Children of color, particularly Black and Latinx children, are at a higher risk of infections, severe illnesses, and death from COVID-19 due to poverty (Kim et al., 2020b). During the school closures, these children did not have access to support (e.g., in-person tutoring, after-school programs, study groups), making it challenging to succeed academically. Even before the pandemic, these communities had to face these challenges. Feinberg et al. (2011) found that before the pandemic, Black and Latinx children with developmental delays were 78% less likely to be identified for early intervention services and 78% less likely to receive early intervention services after they had been identified. In areas with a disproportionate number of people experiencing poverty, schools were often under-resourced, overcrowded, and understaffed, contributing to increased risk for the transmission of COVID-19 and adding to the challenges associated with reopening safely (Levinson et al., 2020). The overcrowding and intergenerational housing of remote school students also impacted the parent or guardian's decision to have them attend school in person (White et al., 2021). Consequently, these communities had limited options for their families' well-being (White et al., 2021).

Educators in under-resourced schools may also be unable to provide high-quality virtual learning or support to all students, especially those with disabilities (White et al., 2021). A Kraft and Simon (2020) survey reported that in the summer of 2020, nearly one-third of teachers in majority Black schools reported that their students did not possess the necessary technology to

participate in virtual instruction. In schools with fewer than 10% Black students, one in five teachers said the same. There have been similar reports regarding Latinx students. In a YouthTruth survey (2020) of more than 60,000 secondary students and 22,000 upper elementary students, 30% of Latinx respondents indicated that reliable Internet access was an obstacle to distance learning.

Friedman et al. (2021) found that Black children lacked adequate access to technology for online learning, with accessibility issues particularly challenging across socioeconomic lines. In the fall of 2020, 6% of Black children whose parents had a graduate degree lacked adequate access to technology (Friedman et al., 2021). While almost 36% of Black children with parents with no higher education had insufficient technology access, and 20% of all children with the same level of parental education did. In addition, 25% of Black youth spoke with teachers less than once per week. Unfortunately, parents who were essential workers were less available to support online instructions (Dorn et al., 2020).

Soltero-González and Gillanders (2021) found that Latinx parents from low-income backgrounds experienced stress when supporting their children during remote learning during the COVID-19 crisis. Approximately 75% of parents reported that their children became bored with the repeated practice of literacy and mathematics skills and online lessons (Soltero-González & Gillanders, 2021). As a result, parents described having to “batallar” or “battle” with their children to complete assignments (Soltero-González & Gillanders, 2021). In the parents’ opinion, the change to remote learning away from peers and classroom routines caused their child’s apathy toward learning (Soltero-González & Gillanders, 2021). Also, parents felt overburdened by the expectations of keeping their young children interested in learning on top of their existing tasks (Soltero-González & Gillanders, 2021).

Dorn and colleagues (2020) reported an analysis in the fall of 2020 based on Curriculum Associates' i-Ready Diagnostic assessment, indicating starker disparities between groups. The analysis reported that students in the fall 2020 sample learned only 67% of mathematics and 87% of reading compared to their grade-level peers who would typically have learned by the fall (Dorn et al., 2020). This resulted in a three-month drop in mathematics and one-and-a-half months in reading (Dorn et al., 2020). However, students of color suffered the greatest losses. For instance, Black students lost up to five months of mathematics learning by the fall, while White students lost up to three months (Dorn et al., 2020). The less access to learning prerequisites such as devices, Internet access, and live contact with teachers created gaps of opportunity that translated into wider achievement gaps for Latinx and Black students during the COVID-19 pandemic (Dorn et al., 2020).

Environmental, Housing, and Transportation Issues

There is a greater prevalence of environmental issues in poor and minority communities, contributing to many COVID-19 risk factors (Moore et al., 2020). Notably, compared to White children, Black and Latinx children are more likely to grow up in communities near toxic waste sites (Landrigan et al., 2010). Latinx individuals account for 90% of all seasonal agricultural and migrant farm workers (Mehta et al., 2000). McCauley et al. (2001) indicated that due to close proximity to spraying fields, the presence of multiple family members working in the fields, the poor quality of housing in which migrant farm families frequently live, and the lack of adequate facilities to clean pesticide-contaminated work clothes, migrant farm families are likely to be exposed to high levels of pesticides.

Unfortunately, children in the Latinx and Black communities are experiencing environmental issues that are far out of their control, placing them at a health disadvantage

compared to their White counterparts. Being exposed to environmental toxins in childhood can be harmful to health outcomes, eventually having long-term consequences in adulthood. Specifically, as discussed previously, underlying health illnesses affect these communities the most and can worsen when exposed to toxins, which increases susceptibility to serious COVID-19 because exposure to toxins weakens the respiratory and immune systems of these individuals (Wong et al., 2022). For instance, Braveman et al. (2022) stated:

> Flint, Michigan, in 2014, officials changed the city's water source to cut costs, inducing the erosion of old lead pipes—with resulting widespread lead poisoning among children. City officials then repeatedly ignored residents' concerns. The Flint water crisis reflects a long history of segregation, disinvestment in infrastructure, and officials' ignoring Black residents' concerns, with devastating long-term health impacts. (p. 174)

Similarly, in mid-February 2021, a snowstorm caused a water crisis in Jackson, Mississippi, that exposed defects in infrastructure and lack of government investment, and racial inequalities, all of which hinder the ability to resolve the longstanding water issues in urban communities (Meng, 2022). This crisis left about 40,000 Black residents without water (Jones & Gardner, 2022). Meng (2022) noted that problems related to drinking water contamination can lead to public health illnesses and deaths, making these communities even more vulnerable to health disparities.

COVID-19 also affected individuals living in densely populated metropolitan areas who do not have health insurance and limited access to health care (Shadmi et al., 2020). These factors contributed to an increased risk of infection and adverse outcomes (Moore et al., 2020). A study of 131 predominantly Black counties in the United States found an infection rate of 138/100,000. The death rate was 6/100,000, more than three times higher than the infection rate

in predominantly White areas (Thebault et al., 2020, as cited in Moore et al., 2020). Furthermore, the death rate in predominantly Black counties was six times higher than in predominantly White counties (Yancy, 2020, as cited in Moore et al., 2020). According to a 2020 map of COVID-19 cases in New York City, minority neighborhoods were the most affected (Moore et al., 2020).

Per UnidosUS (2019a), while the Trump administration was in place, several rules were proposed that affected housing eligibility, including the "public charge" and "mixed status" rules that prevented low-income immigrant communities from accessing public assistance. For example, Arriaga (2022) reported that the Department of Housing and Urban Development proposed a rule on May 10, 2019, preventing mixed-status families from living in subsidized housing under Section 214. Arriaga (2022) also reported that the Trump-era rules created a persistent "chilling effect," with immigrants and their families disenrolling from, or not enrolling in, critical health, nutrition, housing, and economic services as a result.

Fortunately, since the Biden administration took office, there have been strives to reverse many of the detrimental policies to minorities. According to Arriaga (2022), as part of the immigration reform initiative signed by President Joe Biden on February 2, 2021, three executive orders were issued, including one regarding "Inadmissibility on Public Charge Grounds," which enacted changes to the harmful Public Charge Rule of the previous administration. By signing the executive order "Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans," agencies are instructed to develop strategies to promote integration, inclusion, and citizenship. President Biden's American Rescue Plan also has helped over 8 million households through Emergency Rental Assistance. Over 41% of aid recipients were Black Americans at the end of June 2022 (White House, 2023). In addition to the foreclosure moratorium, the Biden administration enhanced mortgage payment

forbearance options and enhanced loan modifications to resolve delinquency issues (White House, 2023). ARP's homeowner assistance fund is also helping struggling homeowners pay utilities and mortgage payments (White House, 2023). Although the new government administration has implemented these new policies, there continue to be gaps in the system that hinder these communities.

A further area of concern is the impact of overcrowded housing on the spread of COVID-19 in the Black and Latinx community. Per the WHO's guidelines on housing and health, crowded housing increases the risk of infection (World Health Organization, 2018). Airgood-Obrycki (2020) analyzed data from the U.S. Labor Department's physical proximity index to identify jobs performed at arm's length by consumers that are often impossible to perform remotely. Data from the American Community Survey were then cross-referenced to these jobs. The analysis found that one-third of American households have at least one member working in a high-proximity job. Black households have 40% high-proximity workers and 45% Latinx households, which is 11% more than White households (Airgood-Obrycki, 2020).

Additionally, these households are likely to be multigenerational, making them more vulnerable to living in overcrowded conditions due to the presence of a higher-contact worker, an older adult who may need care, and a lack of space for self-isolation (Airgood-Obrycki, 2020). According to a report from the nonprofit Boston Foundation, overcrowded housing directly correlates to COVID-19 outbreaks (Logan, 2020). According to the University of Massachusetts Donahue Institute, cities with the highest density of crowded housing also experienced COVID-19 outbreaks (Logan, 2020) in addition to having a large population of frontline workers who continued to work during the peak of the pandemic in the Spring of 2020 (Logan, 2020). Notably, all these cities have large Black or Latinx populations (Logan, 2020).

Another issue that the Black and Latinx community faced during the COVID-19 pandemic due to their environment was access to testing sites. Latinx people were more likely to reach testing sites by walking or using public transportation. However, they felt unsafe traveling to testing centers due to crowding and waiting times, ultimately increasing their risk of getting infected (Galletly et al., 2021). This is also true for the Black community. The latest data indicate that insufficient testing options are available in low-income neighborhoods, and "drive-by" sites are mostly accessible to people with private vehicles (Poteat et al., 2020). Without the accessibility of testing sites, these communities were unable to know if they were transmitting the virus. Even further, these communities have limited access to at-home tests, which would have helped limit the need to find transportation to these sites.

Immigration Status

Immigration status significantly impacts the Latinx and Black communities. Initially, the Trump administration hoped to seal the nation's borders against the pandemic by excluding noncitizens and visitors (Triandafyllidou, 2022). The Trump administration ended temporary protected status for Haitian, El Salvadoran, and other migrants who fled their countries decades ago during civil unrest while also halting asylum applications (Triandafyllidou, 2022). Additionally, due to the Tariff Act of 1930, U.S. Customs and Border Protection closed the border with Canada and Mexico, particularly impacting Central Americans remaining in Mexico (Triandafyllidou, 2022). COVID-19 has disproportionately affected refugees and asylum seekers (Mattar & Piwowarczyk, 2020). Strategies to reduce virus transmission, such as social distancing, hand hygiene, and mask-wearing, were challenging in refugee camps due to overcrowded living and diminished sanitation (CDC, 2020a; Reynolds et al., 2021). Furthermore, the COVID-19 pandemic shut down asylum court proceedings, causing more uncertainty for

asylum seekers (Reynolds et al., 2021). These conditions raise new concerns about new challenges brought on by the outbreak of COVID-19.

According to Reynolds and colleagues (2021), in many refugee camps, there is a lack of information, inconsistent compliance with public health measures, and insufficient testing, which leads to unreliable information and underreporting of cases. Schwenk (2020) reported that the Farmville, Virginia Detention Center, run by Immigration Centers of America, had a 90% infection rate in August 2020. Similarly, the Eloy Detention Center in Arizona saw a 10-fold increase in cases in just 3 weeks in June 2020. Sanitizer and soap were scarce, and shower facilities were limited (Triandafyllidou, 2022). As well as the increase in infections at detention centers, Gottesdiener (2020) pointed out that immigration and customs enforcement's (ICE) ongoing deportation flights to Latin America and the Caribbean were raising alarms (Gottesdiener, 2020). ICE deported detainees who had tested positive for COVID-19 on more than 450 flights since the start of 2020 (Gottesdiener, 2020). Eleven countries have confirmed COVID-19 testing of returned deportees (Gottesdiener, 2020). The U.S. Border Patrol has also made over 30,000 arrests of Haitians between October 2020 and August 2021 (Yates, 2021). The number of Haitians detained at the U.S. land border is the second highest since 1992 when authorities intercepted 38,000 Haitians at sea (Yates, 2021). The continued deportations of immigrants to Latin America and the Caribbean have become a significant source of the virus in countries with already fragile healthcare systems (Gottesdiener, 2020).

Several barriers prevent immigrants from obtaining health care in the United States, including fear of legal consequences, including deportation, as well as not having insurance (Pedraza et al., 2022). Because many undocumented individuals cannot receive government benefits, they are often forced to work in high-risk environments (Pedraza et al., 2022). During

the pandemic, this increased their exposure to the virus and prevented the ability to quarantine or protect themselves or others due to being employed in essential work services (Andrasfay & Goldman, 2021). There were states in the United States where immigrants were impacted more than others during the pandemic. For instance, Latinx individuals in New York City and Chicago reported that immigration status contributed to disparities during the pandemic; only 23% had insurance, while 64% were undocumented, affecting their access to healthcare (Maroko et al., 2020).

At the time, the Trump administration attributed the increase in cases and spread of the virus to immigrants from Latin America, specifically from Mexico (Boyce & Nevins, 2022). The Florida governor, Ron DeSantis, claimed during the surges of COVID-19 cases in June 2020 were mainly within the agricultural community, describing it as an "overwhelmingly Hispanic" community even though the outbreak did not coincide with Florida's peak agricultural season, and that most cases came from non-agricultural areas (Chang et al., 2020). The impact of statements by government and political figures attributing outbreaks of the virus to immigrants influenced the Latinx immigrants and the community's views on the virus and the level of trust in the government. Galletly et al. (2021) reported that in a recent study, 35% of Latinx participants believed that they would not be entitled to healthcare because of their migratory status; they feared that their need for medical attention or a COVID-19 test would result in negative attention.

Another challenge to care and access for many in the immigrant community is limited English proficiency, which limits health literacy. For instance, the Joint Commission (2015) reported that patients with limited English proficiency have decreased access to care, increased emergency room visits, longer inpatient hospitalizations, and worse clinical outcomes due to

language barriers. COVID-19 care can be negatively impacted by language barriers, from inadequate prevention messages to less accessible language-sensitive inpatient care, potentially made worse by physical distance and greater patient isolation (Macias Gil et al., 2020), specifically related to the Latinx and Black communities who are incredibly vulnerable.

Lang and Schwartz (2021) reported a phone survey conducted by community organizers for Espacio Migrante and the Haitian Bridge Alliance between April 2020 and June 2021 assessed the needs of 335 Central American, Haitian, and African migrants and asylum seekers to determine whether the two organizations were able to provide them with cash assistance. Espacio Migrante and the Haitian Bridge Alliance provided prepaid cards to qualified applicants that they could use to buy food, medicine, and other necessities (Lang & Schwartz, 2021). This study's quantitative data come from a survey of 335 people receiving cash assistance. The survey included 92 Spanish-speaking respondents from Latin America and the Caribbean; 100 respondents from 13 African countries; 141 respondents from Haiti; and 2 English-speaking respondents from Jamaica (Lang & Schwartz, 2021). Inquiries about language, family composition, immigration status, housing, employment, and health care were included (Lang & Schwartz, 2021). Open-ended questions related to migration plans and community needs were also included (Lang & Schwartz, 2021).

The survey found that migrants and asylum seekers in Tijuana, particularly Black individuals and those who did not speak Spanish, did not have access to health care. Pregnant women were outright ignored. Although migrants tended to be young, the survey also found that many suffered from health problems, including hypertension, asthma, and gastrointestinal problems. Due to a lack of information regarding where to access care and information that suggests disparate treatment on the part of providers, some were treated while others were unable

to receive care. According to the survey, Central Americans were twice as likely to be treated for illness than Africans or Haitians in Tijuana. However, Central Americans and Black individuals reported similar challenges at the border. Black individuals faced a greater challenge with language, which hindered their ability to access healthcare. As Ortega et al. (2020) indicated, people with language barriers are typically also unable to access public health information from the Internet, newspapers, magazines, or community organizations, so cultural and linguistically appropriate public health messaging is critical. As Mitchell et al. (2019) observed, older Latinx adults, who have limited language proficiency and are at greater risk of poor outcomes from COVID-19, are also less inclined and less willing to use technology (e.g., phone calls, texts, social media, patient portals) for health information. Kluge et al. (2020) indicated that language barriers and inadequate translations restricted access to information during the pandemic. As a result, undocumented migrants could remain unaware of basic information and eligibility for COVID-19 testing and treatment despite their lack of status (Lang & Schwartz, 2021).

According to Sentell and Braun (2012), individuals with restricted English proficiency and reduced health literacy are more susceptible to worse health outcomes. Pedraza et al. 2022) indicated that in the United States, about 41% of Latinx adults are deficient in health literary skills, and only 4% are competent in health literacy to the extent of making conscious health choices. Low health literacy increases the chance of having poor health, increased rates of chronic illnesses, and two times higher mortality risk compared to those with higher health literacy (Pedraza et al., 2022). Andrasfay and Goldman (2021) reported that it had been found that Spanish-speaking immigrants with low health literacy are particularly likely to suffer adverse health outcomes. Moreover, the incidence rate of COVID-19 increased by 21.7%, and the mortality rate increased by 17% for individuals with racial minority status and limited

English proficiency because of comorbidities, crowded housing, and public transportation use (Andrasfay & Goldman, 2021). This highlights the importance for government officials to implement laws and policies that can provide health coverage to immigrants, as well as increase bilingual health providers to help instill trust in the community to seek health services when needed and provide resources and information that will help educate Latinx individuals on the importance of seeking health services.

Accessibility to Vaccines and Treatment

The accessibility to vaccines and treatment was exceedingly limited for the Latinx and Black communities. In early pandemic reports, Latinx and immigrant essential workers did not receive personal protective equipment and sick time with pay to allow them to be quarantined without losing their jobs or income (Gabatt, 2020). According to Lusk and Chandra (2021), numerous reports of outbreaks and deaths among agricultural workers in fruit and vegetable farms and meat and poultry processing plants have been reported. Many undocumented immigrants are working in these industries, and their conditions often lack social distancing and adequate personal protective equipment (Armus, 2021; Telford & Kindy, 2020). It has been documented by government inspectors, union representatives, and worker complaints that such conditions continued in poultry processing plants despite federal OSHA guidelines on protective equipment and social distancing (Olayo-Méndez et al., 2021).

The Biden administration intended that everyone in the United States and its territories receive COVID-19 vaccinations regardless of their immigration status by February 2021 and that vaccination sites ensure that undocumented immigrants have access (McLaughlin & Spiegel, 2021). Unfortunately, the state determines who can be vaccinated, who are priority groups, and what identification is required to receive a vaccine. Thirty-one U.S. states require individuals

who receive the COVID-19 vaccination to show they are either residents or workers (McLaughlin & Spiegel, 2021). A lack of communication regarding the documents undocumented immigrants are required to have for vaccinations, residency requirements, fear of legal repercussions, and a lack of prioritizing workers in some essential industries that undocumented laborers dominate have contributed to systematic inattention to vaccinations and lower immunization rates within this community (McLaughlin & Spiegel, 2021). Even with the federal mandate to make vaccinations available to all, there have been instances in Florida, for example, where undocumented immigrants have been denied vaccine access (McLaughlin & Spiegel, 2021).

Based on a 2022 study by Wiltz et al., minority patients are more likely to receive outpatient therapy with monoclonal antibodies and inpatient therapy with remdesivir and dexamethasone. Although Wiltz et al. (2022) did not account for differences in patient demographics, underlying health conditions, and clustering within hospitals, differences were observed. As part of a study conducted by the National Center for Immunization and Respiratory Diseases (NCIRD) Division of Viral Diseases (2022), electronic health records from 30 healthcare facilities participating in the National Patient-Centered Clinical Research Network (PCORnet) were analyzed. Between January and July 2022, nearly 700,000 COVID-19 patients aged 20 and over received specific treatments, including Paxlovid, Lagevrio, Veklury, and mAbs. There were also significant racial differences in the treatment received based on the study results (NCIRD, 2022). Compared to White patients, Black patients received approximately 36% fewer Paxlovid prescriptions, and Latinx patients received 30% fewer prescriptions (NCIRD, 2022).

Further, treatment differences were also evident when groups more susceptible to severe COVID-19 infection were examined. Among Black patients ages 65 to 79, the Paxlovid medication access was 44% lower than among White patients of the same age (NCIRD, 2022). Even though older adults are more likely to suffer from COVID-19 complications, racial health disparities also emerged among immunocompromised people, who are also more likely to suffer from COVID-19 complications (NCIRD, 2022). There was a lower rate of Paxlovid and mAb treatment in immunocompromised Black patients, multiple races, and Latinx patients than in immunocompromised White and non-Latinx patients (NCIRD, 2022). Historically institutional racism within these communities could explain the racial disparities in getting treatment in these communities (NCIRD, 2022), as discussed earlier in the chapter. In addition to limited knowledge of treatment options, lack of Internet access for telemedicine services, limited transportation, and linguistic barriers, there was also a lack of knowledge of treatment options (NCIRD, 2022). Furthermore, it was noted that medical providers could have explicit and implicit biases that affect their prescribing practices, instilling distrust in these communities and deterring them from accepting or seeking treatment (NCIRD, 2022).

CHAPTER 3: WHAT IS THE IMPACT OF COVID-19 ON MENTAL HEALTH DISPARITIES OF LATINX AND BLACK COMMUNITIES?

Discussing mental health disparities in Latinx and Black communities is just as important as medical health disparities. The COVID-19 pandemic has exacerbated disparities in mental health within each respective community. While the pandemic made it more difficult for certain communities to access mental health care, it is not arguable that this pandemic increased the importance of mental health wellness. The literature has defined *mental health disparities* as "unfair differences in access to or quality of care according to race and ethnicity, which are quite common in mental health" (Smedley et al., 2002, p. 69).

Another definition of mental health disparities, considered more unified, is from the Centers for Disease Control and Prevention (CDC). The CDC's definition of mental health disparities falls within one of three categories:

> (1) disparities between the attention given mental health and that given other public health issues of comparable magnitude, (2) disparities between the health of persons with mental illness as compared with that of those without, or (3) disparities between populations concerning mental health and the quality, accessibility, and outcomes of mental health care. (Safran et al., 2009, p. 2)

All these distinct definitions suggest that disparities in access to services impact the well-being of Latinx and Black communities.

Likewise, social determinants also influence mental health disparities. The CDC (2019) reports that some of the determinants of mental health disparities are food insecurity, housing instability, socioeconomic status, income, geographic location, race, ethnicity, disabilities, age, gender, gender identity, sexual orientation, education, language proficiency, health insurance

status, and health literacy. The American Psychiatric Association (2017d) reported that most racial and ethnic minority groups have comparable or fewer mental disorders than White individuals. Nevertheless, the outcomes of mental illness in minorities may be enduring. To maintain an individual's mental health, it is essential that they receive mental health care (Centers for Disease Control and Prevention, 2022). According to Maura and Weisman de Mamani (2007), studies analyzing disparities between health and mental health indicate that racial and ethnic communities have less access to mental health services. They are also less likely to utilize and receive essential mental healthcare. They receive poorer quality of care; are less content with expert mental health services; and have higher rates of withdrawal from these services when compared to Whites (Maura & Weisman de Mamani, 2007).

Kormendi and Brown (2021) added that some barriers to mental health care for racial/ethnic minorities include economic, environmental, cultural, and linguistic challenges. Minority group members with mental illnesses also undergo racist and discriminatory practices from various power entities, including clinicians, politicians, and researchers (Gary, 2009). Audit studies have shown that Black and Latinx adults have significant difficulty securing mental health appointments due to discrimination by mental health care professionals (Conner et al, 2010; Kugelmass, 2016). This can be problematic for minorities because it leads to a further lack of resources and failure to provide adequate culturally evident-based treatments to these communities.

Unfortunately, the pandemic intensified the struggle to access mental health care. Thomeer et al. (2022, as cited in Centers for Disease Control and Prevention, 2022) stated, "the COVID-19 pandemic has been a challenge for everyone, and racial and ethnic minority groups have been placed at higher risk for COVID-19 infection, COVID-19 severe illness or death, and

pandemic-related stressors" (np). Stressors such as unemployment, the loss of a loved one, and the stigma associated with COVID-19 can be emotionally distressing and may contribute to mental health problems or exacerbate existing mental health problems. Individuals may experience mental health issues if they are exposed to additional stressors on top of those concerning COVID-19 and lack access to the resources and support required to cope with these challenges (Centers for Disease Control and Prevention, 2022). Considering the extensive impact of the COVID-19 pandemic, this chapter further highlights the determinants of mental health disparities and the impact of the pandemic on the mental health of the Latinx and Black communities to serve as guidance to achieve culturally mindful mental health treatment for people of color.

Racism/Discrimination

As previously discussed, racism and discrimination are ideologies embedded in health and mental health disparities. A 2015 meta-analysis revealed that racism is twice as strongly associated with mental health than physical health (Paradies et al., 2015). A 2015 review found that self-reported discrimination correlates with indicators of mental health symptoms and distress and diagnostic psychiatric disorders (Lewis et al., 2015). According to Paradies (2006), an analysis of studies on racism and health found that mental health outcomes were negatively related to racism. Another meta-analysis was based on 134 studies on discrimination and health. It provided an in-depth understanding of the relationship between perceptions of discrimination and mental and physical health outcomes (Pascoe & Smart Richman, 2009). According to the meta-analysis, perceived discrimination negatively impacts mental and physical health (Pascoe & Smart Richman, 2009). In addition to causing significant stress responses and negative psychological stress responses, perceived discrimination is associated with unhealthy and non-

healthy behavior participation (Pascoe & Smart Richman, 2009). Considering these findings, perceived discrimination may contribute to negative health outcomes (Pascoe & Smart Richman, 2009).

Several recent studies provided additional evidence that discrimination has widespread adverse health effects (Williams et al., 2019). Racist and discriminatory behavior can create significant stress for these communities leading to racial trauma, which is used to denote "severe cases of racism-related stress" (Truong & Museus, 2012, p. 228) "and may include symptoms such as anger, shock, self-doubt, depression, dissociation, physical pain, and spiritual pain" (Hernández & Harris, 2022, p. 97).

Racial trauma can create substantial psychological distress. As a result of perceived discrimination, heightened stress responses develop, as well as participation in unhealthy behaviors and nonparticipation in healthy behaviors (Pascoe & Smart Richman, 2009). Sibrava et al. (2019) conducted one of the first studies to explore the link between discrimination experiences and PTSD among Black and Latinx individuals. Researchers examined the experiences of Black and Latinx individuals who had been diagnosed with PTSD who faced racial discrimination over the course of a longitudinal clinical sample (Sibrava et al., 2019). Researchers found that the frequency of discrimination experiences correlated significantly with social adjustment, quality of life, overall functioning, and comorbidity rates, demonstrating how discrimination can have a substantial, cumulative impact on one's wellbeing (Sibrava et al., 2019).

Furthermore, perceived discrimination uniquely predicted the diagnosis of PTSD and no other anxiety or mood disorder (Sibrava et al., 2019). According to the findings, for some Black and Latinx individuals, discrimination might be traumatic in and of itself but may not meet all

criteria for being diagnosed with PTSD (Sibrava et al., 2019). However, the experiences result in stress-related symptoms, which is why these experiences must be taken into account when considering a PTSD diagnosis to explain stress-related symptoms related to discrimination suffered by these communities (Sibrava et al., 2019). Therefore, it can be concluded that discrimination based on race and ethnicity plays a significant role in developing PTSD (Sibrava et al., 2019).

There is also evidence that discrimination predicts increased depression symptoms, after one year, among Black individuals (Conner et al., 2010), and these increased symptoms of depression were found to be associated with an increased risk of mood and anxiety disorders among Latinx individuals (Leong et al., 2013). Pieterse et al. (2012) focused on Black American adults across gender, explored the relationship between racial discrimination and numerous mental health concepts, such as anxiety, depression, and overall distress. Results indicated a correlation between racial discrimination and mental distress (Pieterse et al., 2012). A meta-analysis by Lee and Ahn (2012) synthesized the findings of 60 independent samples from 51 studies examining racial/ethnic discrimination against Latinx individuals and the outcomes in the United States. The study found that anxiety strongly correlates with discrimination, followed by depression and academic and job performance/dissatisfaction. Another mental health outcome found was unhealthy behaviors (Lee & Ahn, 2012). As a result of discrimination, Latinx individuals can experience nervousness, sadness, hypervigilance, suicidal ideation, and a general feeling of low quality of life (Torres et al., 2011). When working with Latinx individuals who have experienced discrimination in the past, Lee and Ahn (2012) recommended that they assess how they perceive themselves and the world as a whole. As a result, it may be more important to

help Latinx individuals cultivate positive views about themselves and others to reduce negative outcomes than to cultivate cultural identity or social support (Lee & Ahn, 2012).

Another area of concern that is affecting the mental health of Latinx and Black communities is racialized incarceration. The United States is estimated to have the largest number of incarcerated persons worldwide, with a disproportionate number of Black and Latinx individuals (Medlock et al., 2018). Nowotny et al. (2021) reported that one in three Black men and one in six Latinx men born in 2001 would face incarceration or prison within their lifetimes. According to Carson (2020), there were 1,096 Black prisoners per 100,000 Black residents, 525 Latinx prisoners per 100,000 Latinx residents, and 214 White prisoners per 100,000 White residents in the United States at the end of 2019.

According to Minton and Zeng (2021), 62% of White inmates, compared to 55% of Black inmates and 46% of Latinx inmates, had a mental health problem in state prison. However, there seems to be some ambiguity in these data. Prins (2014) indicated that the methodology used to assess mental illness prevalence among Black and Latinx inmates might underrepresent mental illness prevalence within these communities. For example, mental health screening tools used by jails reproduce racial disparities, meaning fewer Black and Latinx people are screened positive and remain unreferred and unidentified (Prins et al., 2012). Black individuals with mental health conditions, especially schizophrenia, bipolar disorder, and other psychoses, are more likely to be incarcerated, misdiagnosed, and overmedicated than other ethnic groups (Grayson, 2020). Specifically, in a study of formerly incarcerated Latinx men, depression, loneliness, and alcohol use were found to be common mental health problems (Muñoz-Laboy et al., 2014).

There has been a dramatic shift from treating mental illness in hospitals to treating it in carceral facilities, resulting in U.S. jails and prisons becoming the largest providers of mental health services (Williams & Etkins, 2021). According to a study by Kaba et al. (2015), non-White mental health patients in the city jail system are more likely to delay receiving their diagnosis at least seven days after admission. According to Anthony-North et al. (2017), individuals with serious mental illnesses who are non-Latinx Black and Latinx are 2.5 and 1.7 times more likely to be placed in solitary confinement than White individuals. It can be presumed that if many of the incarcerated individuals suffering from mental illnesses could receive early mental health treatment, there would be a possibility of a decrease in incarceration rates within these communities. However, this is the reality that many Latinx and Black individuals have to face when exposed to racist/discriminatory behavior, which negatively impacts their overall mental health.

Stigma

When the topic of mental health arises, continued negative beliefs and perceptions are associated with the subject, better known as *stigma.* The literature defines stigma as "stereotypes or negative views attributed to a person or groups of people when their characteristics or behaviors are viewed as different from or inferior to societal norms" (Dudley, 2000, p. 450). This becomes a more substantial issue when experienced by minorities who struggle with mental health problems because it can feel like they are experiencing a "double" stigma. Gary (2009) explained double stigma as the shame communities face due to being affiliated with their own racial/ethnic group and the feeling of shame for seeking mental health services.

According to Schouler-Ocak et al. (2021), mental health stigmas and discrimination against migrants, refugees, asylum seekers, ethnic minorities, and people of color profoundly

impact mental health outcomes. DeFreitas et al. (2018) suggested that there is a gap in the literature examining the correlation between mental health stigma and Latinx individuals. This is possible because there is a level of shame that many Latinx individuals experience when discussing the topic of mental health.

Mendoza et al. (2015) conducted a study with Latinx college students focusing on the mental health stigma and self-concealment related to the attitudes toward pursuing professional mental health services. The study indicated a decrease in mental health treatment seeking among those who experienced higher levels of stigma (Mendoza et al., 2015). This was also seen among Latinx caregivers providing care for a mentally ill family member. Among those who cared for a relative with schizophrenia, mental health stigma was associated with more depressive symptoms, suggesting that stigma prevented them from discussing their relative with others and obtaining the required social support (Magaña et al., 2007). Jimenez et al. (2013) also discovered that older Latinx individuals reported more embarrassment concerning mental illness than Black or White individuals, and this shame may be associated with beliefs concerning disappointing family members.

Conner et al. (2010) found that older Black individuals were also more likely to experience mental illness stigma than their White counterparts. Also, the results revealed that most participants who had never sought mental health treatment were Black, which was related to a negative attitude toward mental health treatment versus White participants who previously sought mental health treatment. Considering these differences, some may be attributed to actual treatment experiences. In particular, Black participants exhibited mistrust of mental health services and believed that mental health treatment was not the most effective strategy for reducing mental health symptoms compared to White older adults, who were more likely than

their Black counterparts to feel comfortable consulting with mental health professionals with different racial backgrounds as well as seeing therapists younger than themselves. The results of this study suggest that Black older adults prefer a therapist who is similar to them in terms of race and age if they choose to seek treatment. In 2007, Mental Health America reported that 63% of Black individuals believed depression was a "personal weakness," and only 31% of Black individuals thought depression was a health issue. "Five reasons a majority of the population withheld information on their illness included: concern of hurting the family, it would ruin their career, people might think they are crazy, they cannot afford to appear weak, and shame" (Neely-Fairbanks et al., 2018, n.p.).

Stigma Within the Latinx Community

Within the Latinx and Black communities, mental illness is viewed similarly. Guarnaccia and Martinez (2003) noted that mental illness is often associated with being "loco" or insane in Latinx communities. As Grayson (2020) mentioned, mental health within the Black community is also considered a "taboo." This is due to the belief that "what goes on in this house stays in this house!" and "we don't need White folks thinking we're all crazy" (Grayson, 2020, n.p.). Barrera and Longoria (2018) indicated that within the Latinx community, those who experience mental health challenges are viewed as dangerous and that the "disease" is untreatable, leading to helplessness and an inability to seek support. Per Barrera and Longoria (2018):

> mental or emotional problems can be attributed to experiences out of their control, such as *fatalismo* (supernatural phenomena). Such phenomena are *susto* (shock/fright), *mal de ojo* (evil eye), *nervios* (nerves/anxiety), *espanto* (spooked), and *miedo* (fear), which have very similar symptoms of diagnosable mental disorders. (p. 3)

For instance, Latinx individuals often associated mental health symptoms with experiencing *nervios* or *susto* and reported somatic complaints (Barrera & Longoria, 2018). The American Psychiatric Association (2017b) stated that "*nervios* is a common symptom of distress among Latinx people, whereas *susto* refers to a culture-bound syndrome that includes psychological and physical symptoms" (p. 7).

Latinx individuals tend to have a strong sense of cultural/spiritual identity; however, this can contribute to stigma regarding seeking mental health treatment. This community has cultivated a strong sense of resiliency by implementing coping skills to face adversity grounded in spiritual/religious belief systems. For instance, among Latinxs, building strong family connections and robust social support networks have been identified as valuable strategies for coping with distress (Garcini et al., 2022; Yakushko, 2010). Likewise, engagement in religious or spiritual practices and building trusting networks in the community have been shown to increase perceptions of hope and trust among Latinx people (Garcini et al., 2022). A study among 20 leaders working with Latinx immigrants and refugees highlighted that cognitive reframing focusing on individual values, such as hopefulness, not giving up, having a focus, accepting suffering as part of life, and having a vision of the future, are constructive strategies used by Latinx immigrants to cope with adversity (Yakushko, 2010).

Likewise, attributes such as giving to others have been found to be helpful strategies for managing distress among Latinx individuals (Yakushko, 2010). Due to individuals within the Latinx community having strong spiritual/religious connectedness, it is common that help-seeking behaviors are decreased. It is not uncommon for these individuals to look to God or their social and community support systems as a form of coping. Religious and/or spiritual

communities tend to trust their beliefs to cope with distress rather than seeking help from mental health professionals.

Stigma Within the Black Community

Even when the symptoms of mental illness are severe, Black individuals are discouraged from seeking treatment due to stigma and judgment (Grayson, 2020). In a qualitative study by Alvidrez et al. (2008), more than one-third of Black participants who were already mental health participants believed that mild depression or anxiety would be regarded as "crazy" by their peers. In addition, over one-quarter of the participants surveyed believed that discussing mental illness would not be appropriate among family members, even when discussing problems with an outsider, such as a therapist (Alvidrez et al., 2008). Black individuals commonly use other means of coping with mental health concerns (Fripp & Carlson, 2017). Black individuals tend to reach out to a collection of informal support resources (e.g., family, friends, spiritual leaders) and prefer to receive services from physical health care providers rather than professional mental health clinicians (Avent et al., 2015; Avent Harris & Wong, 2018; Hays & Lincoln, 2017).

However, when they decide to seek treatment, they often face numerous barriers (Ward et al., 2009). For instance, the concept of family is a significant value within the Black community; hence, Black individuals may not seek treatment because they believe that doing so may negatively reflect on their family, a tacit admission that the family has failed to solve the problem on its own (Williams, 2011).

Mental health stigma has also been documented within the Black immigrant community (e.g., African and Caribbean Black individuals). Nadeem et al. (2007) indicated that Black immigrant women expressed more concern about mental illness stigma than U.S.-born Black and White women. However, the study failed to specify relationships between variables based on

country of origin. It is evident that Latino, African, or Caribbean cultures are not the same (Nadeem et al., 2007). Nonetheless, research conducted with Latinx cultural groups reveals similar values within the Latinx and Black communities, such as reliance on family, that influence their help-seeking processes (Nadeem et al., 2007). They were also asked whether any barriers or concerns would prevent them from seeking mental health care, so they may not have been exposed to all the subtleties of treatment-seeking (Nadeem et al., 2007). The literature does not often highlight the Black immigrant woman's perspective on the role of stigma related to mental health.

When examining how Black immigrants seek mental health services, it is through traditional healers rather than health professionals that help is sought due to stigmatizing beliefs (Fenta et al., 2007). Studies have shown that Black immigrants share negative attitudes toward mental illness and include beliefs that people with mental illness are incompetent, weak, or morally defective (Pederson et al., 2021). Another common belief within the community is that God has punished the individual or triggered them by the possession of evil spirits (Hope et al., 2020). Religion and religious beliefs can be a protective factor for Black and Latinx individuals. However, Caplan (2019) reported that religious beliefs may contribute to the stigma associated with mental illness and treatment. This is because religious beliefs may associate the causes of mental health problems with beliefs in demons, lack of faith, or sinful behavior (Caplan, 2019). Negative religious coping has been associated with depression and increased psychological distress in individuals and aggravating the positive association between acculturative stress and psychological distress (Da Silva et al., 2017). These findings suggest that counselors should be able to assess for potential negative religious coping in the lives of recent Latinx young adult immigrants during the intake assessment process (Da Silva et al., 2017). Counselors should

consider negative religious coping when conceptualizing Latinx young adult immigrants' cases (Da Silva et al., 2017). As part of the treatment planning and intervention selection process, counselors should consider negative religious coping strategies and clients' well-being (Da Silva et al., 2017). Individuals who engage in more negative religious coping may experience increased stress and depression compared to positive religious coping (Pargament et al., 1998). This reliance on negative religious coping may lead to individuals experiencing spiritual bypass, a state wherein they suppress emotional and psychological reactions and overcompensate with spirituality and religion (Cashwell et al., 2004; Welwood, 2000). Spiritual bypass, like negative religious coping, can be harmful to one's emotional and mental wellness. This underscores the role that religion may play in Black individuals' decisions to seek help and should encourage clinicians and researchers to look more closely at individuals who engage in negative religious coping behaviors because they may be among the most hesitant to seek treatment. Although religion and faith practices can serve as a positive form of coping with mental health distress, it is also important to understand the role of the religious entities and beliefs that encourage the stigmatization of mental health.

Overall, the stigma of mental health embedded within the Latinx and Black communities makes it exceptionally challenging to obtain the services to achieve healthy emotional well-being. Many within these communities may feel a sense of burden to be both a person of color and live with a mental disorder because society and their own groups place barriers to make it even more difficult to receive the necessary resources to care for their mental health.

Mental Health of Latinx Community

Perveance of Mental Health. It was reported that the Latinx community is more susceptible to social and economic obstacles because they:

> come from a lower-income group, be uninsured, be multiracial, be younger, have had an unplanned pregnancy, have completed less formal education, express stronger emotions in their native language, have undocumented legal status, come from single-parent households, and may experience discrimination for being lesbian, gay, or transgender. (U.S. Census Bureau, 2019)

These challenges put them at a higher risk of developing mental health disorders. According to the National Hispanic and Latino Mental Health Technology Transfer Center Network (MHTTC; 2020), three types of mental health disparities impact the Latinx community: disparities in rates of psychiatric disorders, lack of access to high-quality, evidence-based, culturally grounded treatment options, and treatment outcomes. It is important to explore the data reported for each of the disparities to understand the extent of the mental health impact on the members of this community.

A National Survey on Drug Use and Health (NSDUH) conducted in 2020 demonstrated that nearly eight million adults (18.4%) of Latinx descent suffered from a mental illness. A total of 1.9 million (24.4%) of those with mental illnesses had a serious illness or one that affected how they functioned (SAMHSA, 2020b). Atdjian and Vega (2005) reported an overdiagnosis of depression among Latinx individuals. Mental Health America (2022) reported that during the period between 2015 and 2018, there was an increase in the rate of major depressive episodes among Latinx youth from 12.6% to 15.1% for ages 12-17, from 8% to 12% among young adults ages 18 to 25, and from 4.5% to 6% among those ages 26 to 49. This is also true for Black Latinx individuals, who have reported higher levels of depressive symptoms than their White Latinx counterparts (Ramos et al., 2003).

Latinx young adults are also experiencing increased suicidal thoughts, plans, and attempts (Mental Health America, 2022). While not as high as the overall U.S. population, 8.6% (650,000) of Latinx 18-to-25-year-olds had serious thoughts of suicide in 2018, compared with 7% (402,000) in 2008 (Mental Health America, 2022). A total of 3% (224,000) made a plan in 2018, compared to 2% (116,000) in 2008, and 2% (151,000) attempted to commit suicide in 2018 (Mental Health America, 2022). Additionally, there is a higher prevalence of binge drinking, smoking (cigarettes and marijuana), illicit drug use, and misuse of prescription pain relievers among Latinx adults with mental illnesses (Mental Health America, 2022).

The American Psychiatric Association (2017b) reported that although Latinx Americans are less likely to suffer from mental health disorders than non-Latinx White individuals, unfortunately, U.S.-born Latinx individuals suffer from mental health disorders at higher rates than foreign-born Latinx individuals. This has been attributed to the "immigrant paradox," which suggests that even though most immigrants leave behind turmoil when leaving their countries and endure challenging experiences, they are in better health than their U.S.-born counterparts when they arrive (MHTTC, 2020). Even with the protective factors that some of the members in the community may have, mental health issues for the Latinx community are suggested to be increasing for individuals between the ages of 12 to 49. Latinx older adults are more likely to be depressed than other groups. Studies report rates of depression reaching 32% for Latinx individuals, 26% among Black individuals, and 15% among non-Latinx White individuals. These rates vary according to depression definitions, measures used, validity, reliability, and language, but they also vary depending on the country of origin and level of acculturation (Aranda, 2013).

When examining the Latinx subgroups, there are differences in the rates of mental health disorders as well. The prevalence of mental health disorders varies by heritage: Puerto Rican

individuals were more likely to meet the criteria for a mental health disorder (49%) than individuals with Mexican (35%), Salvadoran (30%), or other Central American (33%) ancestry (Ramos-Olazagasti & Conway, 2022). Alegría et al. (2007) discovered that the prevalence of disorders among Puerto Rican subjects was higher than that of Mexican Americans. As Vega et al. (1998) reported, the prevalence of mental disorders among Mexican Americans born in Mexico was remarkably lower than that among Mexican Americans born in the United States. Approximately 25% of Mexican immigrants generally had some form of the disorder (both mental disorders and substance abuse), compared with 48% of U.S.-born Mexican Americans (Vega et al., 1998). Another recent study by González et al. (2010) examined Latino subgroups across adulthood on the incidence of major depression through collaborative psychiatric epidemiology surveys. According to the study, Puerto Ricans had the highest prevalence of major depression (12.2%), Mexican Americans the lowest (4.4%), and Cuban Americans the middle (5.5%) (González et al., 2010). These findings suggest that the Latino population is not homogeneous and that different Latino subgroups express and experience depression differently (González et al., 2010).

The time these Latinx immigrants spent in the United States may have contributed to the development of mental disorders and the utilization of mental health services. This is possibly contributed to the challenges immigrants experience while in the US, such as cultural differences in diagnosis, coping and treatment of symptoms and illness behavior, changes in family structures and processes in adaptation, acculturation, and intergenerational conflict, and the impact of acceptance by the receiving society on employment, social status, and integration (Kirmayer et al. (2011).

Utilization of Services. The rise in mental health problems in the Latinx community appears to be aggravated by the lower utilization of mental health care. Based on the results of seven epidemiological studies, Cabassa et al. (2006) determined that Latinx adults were less likely to seek formal mental health care than White adults. The Latinx population is twice as likely to seek treatment for mental health problems in non-mental health care settings, such as within religious organizations (National Alliance on Mental Illness California, 2020). Studies indicate that Latinx Americans received treatment at approximately one-half the rate of non-Latinx Whites in the past year and that these disparities have not improved over time (Cook et al., 2013). Lower mental health services utilization rates among the Latinx youth population may be attributed to language barriers within the health care system (Rios-Ellis, 2005; Rubens et al., 2013). Latinx youth's cultural beliefs or stigma about mental health problems than non-Latinx youth, which may also contribute to the underutilization of mental health services.

Generally, studies have shown that Latinx older adults and youth are more vulnerable to mental distress resulting from immigration and acculturation (American Psychiatric Association, 2017b). Hence, Latinx adolescents are also experiencing significant emotional distress. Approximately 18.9% of Latinx students in grades 9 to 12 in 2015 had seriously considered attempting suicide (Kann et al., 2013). About 15.7% had planned to attempt suicide, 11.3% had attempted suicide, and 4.1% had made a suicide attempt that resulted in an injury, intoxication, or overdose that required medical care (Kann et al., 2013). Recent data indicated that Latinx child suicide rates increased by 92.3% from 2010 to 2019 (Price & Khubchandani, 2022). Suicide deaths primarily occurred among boys (59.6%) and those between the ages of 10 and 12 (99.9%) (Price & Khubchandani, 2022). Price and Khubchandani (2022) also reported that suicide was most commonly committed by hanging, strangulation, and/or suffocation (76-85%).

The American Psychiatric Association (2017b) reported that approximately 1 in 10 Latinx individuals with a mental disorder utilize mental health services through a primary care provider. Only 1 in 20 obtain such services from a mental health specialist (American Psychiatric Association, 2017a). Based on seven epidemiological studies, Cabassa et al. (2006) determined that Latinx adults were less likely to seek formal mental health care than White adults.

To explain why Latinx people tend to underutilize mental health services, Keyes et al. (2011) conducted a survey examining the degree to which markers of immigrant adaptation, such as only speaking Spanish and strong ethnic identifications, affected mental health services. The researchers interviewed 6,359 Latinx participants using the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a national survey of Latinx residents of the United States. According to Keyes et al. (2011), Latinx individuals have a greater sense of ethnic identity, speak Spanish, and spend less time in the United States, which has been associated with lower use of mental health services for some mood disorders, regardless of whether they have medical insurance, some income, or have greater severity of symptoms. Additionally, they noted that Latinx individuals are more likely to distrust the medical community due to past experiences of discrimination or ineffective care, as well as cultural stigmas and attitudes related to psychiatric conditions (Barrera & Longoria, 2018).

Systematically, Vega and Alegría (2001) reported that the mental health research on the Latinx population had not shifted in the past 25 years. Despite improvements in mental health services, the prevalence of mental illness has remained relatively constant among Latinx individuals (Vega & Alegría, 2001). This is alarming because it is a reminder of the stigma, barriers, policies, and unqualified treatment that continues to impact the progression of the mental health state of the Latinx community.

Mental Health of Black Community

Prevalence. The 2020 National Survey on Drug Use and Health found that more than five million Black adults (17.3%) reported having a mental illness. In the case of those who suffer from mental illness, 1.4 million (27%) suffer from a serious mental illness (SAMHSA, 2020a). Nearly five million (15.4%) Black adults are estimated to suffer from a substance use disorder (SAMHSA, 2020a). Among these individuals, 2.1 million (44.7%) used illicit drugs, and 3.3 million (70.1%) drank alcohol (SAMHSA, 2020a). According to Berkeley (2021), in 2018, 11.4 per 100,000 Black American men and 2.8 per 100,000 Black American women died by suicide. Researchers at the National Institutes of Health (NIH), a leading federal agency for healthcare research, observed a median rate of 10% Black participants in their mental health studies (Murray, 2022). Among Black Americans, participation in studies focused on substance abuse prevention declined to 7% (Murray, 2022). Even though Black people account for 13.4% of the American population (Murray, 2022), there is a considerable absence of Black individuals represented within the literature on mental health disparities making it challenging to ascertain the actual statistics of those affected by mental health illness and who are without treatment in this community.

When providing mental health diagnoses to Black individuals, standardized tests and manuals are often culturally biased toward White individuals' norms and language values (Berkeley, 2021). This leads to the misdiagnosis of Black individuals and provides an erroneous label that can hinder the ability to obtain proper treatment. For instance, Olbert et al. (2018) found that Black Americans are 2.4 times more likely to be diagnosed with schizophrenia. Black individuals treated in state psychiatric hospitals were also more likely to be diagnosed with schizophrenia than their White counterparts, and race was the strongest predictor of

schizophrenia admissions (Barnes, 2008). Although McGuire and Miranda (2008) found that the rate of lifetime major depression among Black Americans is lower than among White Americans living in similar areas, Black individuals are likely to rate the severity of their depression as severe and incapacitating (Williams et al., 2007). Experiencing acute mental health symptoms can create a barrier of its own for Black individuals to keep up with daily responsibilities.

Compared with 15.3% of White adults, 6.2% of Black adults received prescription medication for mental health services (Berkeley, 2021). There is also an inappropriate use of antipsychotic medication among Black individuals and higher dosages of these medications being used by Black individuals (Atdjian & Vega, 2005). This is because Black individuals are less likely to receive antidepressants when first diagnosed with anxiety or depression. According to Strakowski et al. (2003), clinicians tend to overemphasize psychotic symptoms and underemphasize mood-related symptoms in diagnosing schizophrenia spectrum disorders in Black individuals. In a more recent study, Gara et al. (2019) found that Black individuals with moderately severe to severe depression were significantly more likely to be misdiagnosed with schizophrenia. Hence, Black individuals are more likely to receive antipsychotic medications (Berkeley, 2021). This over exposure to antipsychotic medications can lead to greater risk side effects (Berkeley, 2021) and increasing feelings of apprehension in Black individuals to seek mental health treatment.

Studies have shown that mental health disparities within the Black community tend to be overlooked due to social barriers. Specifically, addressing the impact of barriers to mental health for Black women, Cristancho et al. (2008), Miranda et al. (2003), and Tidwell (2004) suggested that system-level barriers to mental health for Black women could include access to services (e.g., inaccessible location, transportation issues, a lack of health insurance), availability to

services (e.g., limited access to group counseling, in-home services), social issues (e.g., lack of child care), poor care quality (e.g., limited access to culturally competent clinicians and case management), and cultural mismatch (e.g., limited opportunities to work with clinicians of ethnic and racial minorities) (Cristancho et al., 2008; Miranda et al., 2003; Tidwell, 2004). An increasing body of literature on systemic barriers offers valuable insights. However, it does not provide any insight into whether other beliefs, at the individual level, might serve as barriers for Black women, such as internalized stigmas associated with mental illness, shame and embarrassment associated with mental illness, lack of knowledge about mental illness, and cultural norms (Ward et al., 2009). The internalized stigma can create fear of seeking treatment. For instance, Sussman et al. (1987, as cited in Satcher, 2001) found that Black individuals were 2.5 times more likely to fear mental health treatment than their White counterparts.

Utilization of Services. The deterrence of seeking treatment for Black individuals transcends generations. A study by Bussing et al. (1998) focused on differences in ADHD knowledge and information-based culture and ethnicity, specifically for Black and White parents. Results indicated that among parents of children with ADHD, Black parents were less likely than White parents to use specific medical labels to describe how their child was struggling and expected a shorter course of treatment (Bussing et al., 1998).

Pertaining to Black older adults' knowledge of depression, Zylstra and Steitz (1999) suggested that the knowledge of depression among older Black adults was less than that of elderly White adults. This results from minimal education on the topic of mental health as well as the stigma associated with mental health (Zylstra & Steitz, 1999). Jorm (2011) explained that public knowledge about mental disorders had received significantly less attention than physical diseases. Historically, the Black community has been reluctant to discuss mental health

conditions. Many times, the lack of knowledge leads this population to believe it is a sign of personal weakness (Henderson et al., 2013). Henderson et al. (2013) noted that distrust of health care providers and a lack of access to resources could contribute to low levels of knowledge in understanding the etiology of mental illness. The lack of understanding of the importance of mental health makes it problematic for Black individuals to obtain adequate resources to care for their mental health. The idea of minimizing the significance of mental health within the Black community becomes a vicious cycle that ultimately hinders the potential to live a healthy life.

It is notable to emphasize the impact of mental disparities within the Black immigrant community. A recent Pew Research Center Report estimated that 1 in 10 Black Americans is an immigrant (Tamir, 2022). Approximately 4.6 million Black immigrants lived in the United States in 2019, an increase from about 800,000 in 1980 (Tamir, 2022). However, the Caribbean remains the most common region of origin for U.S. Black immigrants (Tamir, 2022). It is also half of the foreign-born Black population who were born in this region (46%) (Tamir, 2022). In a study by Cohen and colleagues (1997) of outpatient psychiatric patients in New York City, Black Americans were significantly more likely to report a history of alcohol abuse and delusions, and Caribbean-born patients were significantly more likely to report depression and aggression. It has been reported by Anglin et al. (2014) that a national study in the United States found that prior arrest history is related to the prevalence of major depression among Caribbean Black and Black individuals.

Miranda et al. (2005) indicated a lower risk of probable depression among Caribbean-born women with low socioeconomic status than among U.S. Black individuals with access to health care. As discussed in the Latinx Mental Health section, this may be related to the "immigrant paradox." To minimize mental health risks, immigrants are believed to possess

protective factors such as strong family ties and social support (Ornelas & Perreira, 2011; Potochnick & Perreira, 2010), as well as religion and the ability to send remittances to family members in their country of origin, all of which have been shown to relieve some of the hardships encountered while living abroad (Negi, 2013).

COVID-19 Impact on Mental Health for Latinx & Black Communities

Prevalence and Utilization. As stated earlier, the COVID-19 pandemic exacerbated already present health disparities in the Latinx and Black communities. Unfortunately, there is limited research on the impact of the COVID-19 pandemic on the mental health of these minority communities. Due to the pandemic being a fairly recent event, research on the topic and how it has impacted minority communities is still developing.

During the pandemic, Latinx adults in the United States reported considerably more anxiety and depressive symptoms than non-Latinx White individuals (Czeisler et al., 2020; Ettman et al., 2020; McKnight-Eily et al., 2021). In addition, McKnight-Eily et al. (2021) reported that during the pandemic, Latinx individuals were four times more likely to have suicidal thoughts than non-Latinx Black individuals or non-Latinx White individuals and twice as likely as other racial and ethnic groups to have suicidal thoughts. McKnight-Eily and colleagues (2021) also reported that during the pandemic, the rates of substance use increased in the Latinx community; approximately 37% of Latinx individuals reported recent or deteriorating substance use. The Latinx youth also saw an increase in mental health issues during the pandemic, such as elevated rates of anxiety, depression, suicidal ideation, and substance use (Czeisler et al., 2020). The significant stress in obtaining adequate resources during the pandemic, such as access to COVID-19 testing and mental and primary health care, exacerbated the already present mental health disparities (Ruprecht et al., 2021; Vega et al., 2009). By

creating already present barriers to healthcare and mental health access, COVID-19 heightened stress and depression levels due to isolation, job loss, and increased workload for essential workers.

This was also the case for the Black community, which was experiencing mental health challenges and vicarious trauma due to acts of racist and discriminatory violence toward community members during the pandemic. According to the American Psychiatric Association (2017c), Black individuals were experiencing significant stressors during the pandemic related to:

> anxiety from not being able to follow stay-at-home recommendations to protect themselves from COVID-19 due to their job situation; separation from friends and family, especially those who are sick or in the hospital; grief over the loss of friends and family members; emotional stress of close living situations and finding care for children out of school; financial stress of health care costs, job loss, and more; and ongoing difficulties accessing health care services. (p. 2)

Sneed et al. (2020) discovered that Black individuals in Michigan were disproportionately impacted by COVID-19 mortality. Sneed et al. (2020) suggested that Black individuals experienced more fears about contracting the virus and being hospitalized but still faced a reduction in mental health treatment despite these fears. For example, Millett and colleagues (2020) reported that the percentage of Black individuals with a mental health diagnosis who received mental health treatment was only 31%, as opposed to 48% of their White counterparts.

Further, it appears that significant COVID-19 infection can result in specific mental health consequences, such as higher rates of posttraumatic stress disorder, anxiety, and depression, as well as specific neuropsychiatric symptoms (Smith et al., 2020). Because ethnic

minorities and inner-city residents are more likely to suffer mental illnesses and require complex health care, COVID-19's impact has been felt in all aspects of life (Smith et al., 2020). A needs assessment using a mixed-methods approach conducted by Okoro et al. (2022) utilized a survey questionnaire to ask 183 respondents from the Black community about their greatest worry related to COVID-19. Interviews and focus group discussions were also conducted to explore the individual and community perspectives further. Results indicated that the major areas of concern were health (41.0%), family (25.1%), finances (8.2%), and education (4.9%) (Okoro et al., 2022). The researchers concluded that the COVID-19 pandemic had an overwhelming effect on mental health and wellness, healthcare access and utilization, and social aspects of Black life. As developing themes surfaced, there was a seriously deteriorating mental health situation for many, limited access to healthcare and underutilization, and profound disruption of the Black community's societal cohesive identity (Okoro et al., 2022).

In another study by Saltzman et al. (2021), 341 adults across the United States completed a survey about questions related to demographics, depression, social isolation, work environment, and preexisting mental health conditions. Results revealed that those who identified as Latinx individuals were more likely to experience depression symptoms and live in communities with higher rates of COVID-19. The results also suggested that the percentage of respondents who identified as Black who met the threshold score for depression was lower than that of Latinx respondents, but they lived in communities with a higher percentage of those with poor or fair health, demonstrating that underlying comorbidities play a significant role in the disparities in COVID-19's effects (Saltzman et al., 2021). According to McGuire and Miranda (2008), over half of Latinx individuals with depressive disorders did not receive treatment.

Evidence shows that almost 60% of Black Americans who require mental health care do not receive it (McGuire & Miranda, 2008).

Per reports from the Substance Abuse and Mental Health Services Administration (SAMHSA) (2020a), amid the COVID-19 pandemic, Black and Latinx communities also had to deal with the opioid epidemic. Compared to previous years, Friedman et al. (2021) found that Latinx and Black individuals suffered the highest number of overdose-associated cardiac arrests in 2020. Research indicates that the onset of the pandemic led to a rise in overdose death rates nationally (Faust et al., 2021), regionally (Currie et al., 2021), and locally (Glober et al., 2020). Overdose deaths attributed to the pandemic have been linked to various factors, such as reduced access to interventions, increased stress because of isolation and lack of mental health support, and changes in drug types, combinations, and purity (Ghose et al., 2022). It has severely impacted racial/ethnic minority communities by lowering life expectancies for Black and Latinx individuals (Ghose et al., 2022). Life expectancy has dropped by three years among Latinx individuals, 2.9 years among Black individuals, and 1.2 years among White individuals (Ghose et al., 2022). Black and Latinx communities are most affected, as they have been shaped by decades of racial and economic segregation, resulting in concentrated poverty and health inequalities (Ghose et al., 2022). With limited health and mental health care resources, these vulnerable neighborhoods have limited resources to address opioid abuse, increasing overdose deaths.

There is limited availability of prevention, treatment, and recovery services for Black or Latinx individuals. Unfortunately, Black and Latinx individuals suffering from mental illness and substance use disorders are more likely to be incarcerated and homeless, which puts them at a greater risk of contracting COVID-19 (SAMHSA, 2020a). It is extremely difficult for homeless

and incarcerated individuals to follow the CDC's recommendations regarding social distancing, hand washing, and self-quarantining. Ultimately, COVID-19 may be more likely contracted by individuals reentering the community after incarceration without treatment, services, and supports (SAMHSA, 2020a).

Essential Workers. Black and Latinx individuals, immigrants, and non-immigrants also comprise a significant part of essential workers. Grooms et al. (2022) reported evidence that Black essential workers had demonstrated worse mental health than their White counterparts. Grooms et al. (2022) also found that Black and Latinx essential workers reported higher levels of depression and anxiety, highlighting how the pandemic disproportionately affected these communities. While many were quarantining during the pandemic, essential workers were providing goods and services that society needed. A study by Pineros-Leano et al. (2022) described the effect of the COVID-19 pandemic on the mental health needs of Latinx families from the viewpoints of direct service providers working with Latinx communities, which found that providers reported that most Latinx individuals experienced loss of employment, cut hours at work, became essential workers, but obtained no extra pay to work in dangerous and often unhealthy conditions.

These essential workers were also not likely to be able to work from home to minimize virus exposure. Ray and Ong (2020) reported that teleworking is lower among Black and Latinx workers in the United States than among White and Asian workers. For example, Latinx and Black workers were 50% less likely than White workers to telework regularly (Ray & Ong, 2020). Based on a study by Gaffney et al. (2021), in May 2020, 24% of Latinx workers and 30% of Black workers teleworked, while 41% of White workers and 51% of other/multiple race workers teleworked. Despite this, these statistics have increased since the outbreak of the

pandemic. Burrows (2023) reported that White home-based workers increased from 7.2 million to 18.4 million from 2019 to 2021, while Black home-based workers increased from 0.7 million to 2.6 million, and Latinx home-based workers roughly tripled from 1.1 million to 3.2 million in the same period. Even though telework jobs have increased for these communities, disparities still exist, and factors such as education levels, income levels, and types of employment determine the likelihood of having a telework job (Burrows, 2023). Because essential workers were unable to prevent exposure to the virus in the workplace, they experienced significant mental distress.

Grooms et al. (2022) examined mental health distress among essential workers during the COVID-19 pandemic across racial and ethnic groups. An individual health questionnaire and a general anxiety disorder questionnaire were assessed using a nationally representative data set. According to their findings, essential healthcare workers reported the highest rates of mental health distress during the COVID-19 pandemic. When analyzed by race and ethnicity, they found that Black essential healthcare workers reported excessive anxiety levels; in contrast, Latinx essential healthcare workers reported excessive levels of depression. Additionally, Black and Latinx essential non-healthcare workers were at greater risk of experiencing anxiety and depression. Moreover, the financial insecurity caused by the pandemic also added to the psychological distress of essential workers and these communities in general. The financial decline caused job losses, reduced wages, increased financial instability, and the enactment of disadvantageous government policies, all of which contributed to higher levels of mental health distress in the Latinx and Black communities.

Financial Stress and Government Pandemic Measures. A series of Commonwealth Fund investigations into the disparate impacts of COVID-19 have been conducted in the United

States and nine other countries between March 30, 2020, and May 25, 2020 (Getachew et al., 2020). In the United States, the survey analyzed adult Americans ages 18 and older, including a sample of Black and Latinx adults. Analysis revealed that the impact of the pandemic on Americans' mental health, economic hardships, and opinions of government leaders varied with race, gender, and income (Getachew et al., 2020). The survey's results concluded that as a result of COVID-19, Black and Latinx adults have experienced economic hardship at rates that are two to three times higher than White adults (Getachew et al., 2020).

In particular, more than half of Latinx and nearly half of Black individuals who responded to the survey said they had financial difficulties or had exhausted their savings or borrowed money, considerably higher percentages than the 21% of White individuals who reported the same concerns (Getachew et al., 2020). The pandemic poses a particular risk to Latinx and Black people with respect to mental health concerns as well. In response to the pandemic, it was reported that nearly 40% of Latinx and 39% of Black individuals had stress, anxiety, or great sadness, compared to 29% of White individuals (Getachew et al., 2020). These financial strains Latinx and Black individuals experienced during the pandemic led to less access to resources, which negatively impacted mental health, and this was further complicated by the fact that these communities were also more likely to be impacted by government constraints (Getachew et al., 2020).

The COVID-19 pandemic also prevented immigrants and U.S. citizens living in mixed-status families from accessing a variety of government and state-sponsored pandemic relief measures due to legal status restrictions (Broder & Blazer., 2011). As reported by Grooms et al. (2022), providers also stated that undocumented immigrants were especially vulnerable to the effects of the pandemic since they could not access government support, including stimulus checks and unemployment benefits. Even though private donors provided assistance, most funds

were exhausted in the first hour, leaving many undocumented immigrants without relief (Grooms et al., 2022). Some providers reported that some of their undocumented clients were not eligible for rent relief or emergency financial assistance due to not having proof of income (Grooms et al., 2022).

Immigrants who had immigrated to the United States seeking better opportunities found themselves in situations they might have encountered prior to migration due to this lack of ability to provide for themselves and their families (Grooms et al., 2022). These communities often felt a fear of receiving economic help or services they qualified for because of the possibility of being deported (Grooms et al., 2022). Undocumented Latinx providers said they felt excluded, forgotten, and queried their belonging in the country during this time when they had no safety net (Grooms et al., 2022). Also, the hostile rhetoric used by the Trump administration during the pandemic exacerbated feelings of stress and hopelessness (Grooms et al., 2022).

Social Distancing and Overcrowded Environments. Latinx and Black communities have found it challenging to maintain social distance and minimize exposure to overcrowded environments. As Blow (2020) explained, social distancing is not a privilege afforded to those who share living spaces, rely on mass transportation, or have "essential" jobs that do not pay them unless they risk their health to work. A study by the Healthy Foundation (2023) found that overcrowding can result in psychological distress and worse mental health due to less privacy and increased conflict within a household. Overcrowding can be caused by a number of factors, such as the availability and affordability of housing, as well as demographics (Healthy Foundation, 2023). Almagro and colleagues (2021) examined the determinants of exposure to COVID-19 during the initial wave in New York City. The study found a correlation between overcrowded housing complexes and a higher COVID-19 caseload, as well as more Black,

Latinx, and low-income families living in overcrowded buildings (Almagro et al., 2021). These populations also experience disproportionate burdens of disease exposure through overcrowded housing (Almagro et al., 2021). For example, it has been estimated that Latinx individuals live in multigenerational households more than twice as often as Whites (Cohen & Passel, 2016; Johnson & Appold, 2017) and live with their grandchildren more than four times as often as their non-Latino counterparts (Chen et al., 2015). Due to the large number of people living in these homes, privacy can be difficult, so when mental health services transitioned to telehealth, these individuals were unable to have their therapy sessions in privacy. As a result, many minority people avoided mental health services during this time to avoid private information disclosure.

Within the Latinx and Black communities, family and social support are part of the culture and can also serve as protective barriers for these communities. However, the most important interventions in pandemics disrupt very social processes that promote mental health, such as support resources, daily interactions, and social influences on coping (Marroquín et al., 2020). Several effects of true quarantine on mental health and emotional distress have been documented, including depression, generalized anxiety, insomnia, and posttraumatic stress (Brooks et al., 2020). As a result of social isolation, Latinx individuals are experiencing an increase in mental health distress (MHTTC, 2020). Closures and overcrowding make the availability of community services to this population less likely (MHTTC, 2020). In the Black community there were similar struggles due to social distancing. Family provides support to Haitians in many ways, including financial, childcare, immigration, housing, emotional, and psychological. The importance of being physically present and surrounded by family is key to Haitian culture. The lack of support during the pandemic negatively affected this community's mental health. For example, church and spiritual leaders have always been a source of support

and assistance to the Haitian community. Unfortunately, during the COVID-19 closure many of these social supports were closed down, thus, leaving these communities isolated from their support system.

English Proficiency and Health Literacy. People of color, including undocumented immigrants, who do not have access to primary care, are more likely to use emergency rooms. As a consequence of fears of contracting COVID-19, many of them went without medical care, while others were exposed without need having sought medical treatment (Rothman et al., 2020). There is no doubt that people who are not fluent in an official language have difficulty gaining access to mental health services. Among these barriers are obtaining mental health care information when there is a language deficit are finding mental health clinics or hospitals, scheduling an appointment timely, and determining the affordability of treatment (Ohtani et al., 2015). Due to the language barrier, health information may not always be presented in a culturally appropriate manner. It can lead to misunderstandings and make it difficult to follow guidelines or understand the importance of social distancing and other preventive measures.

Primm et al. (2010) reported that limited English proficiency and health literacy pose barriers for these communities, especially for immigrant populations. For instance, a 2007 study revealed that only 8% of non-English-speaking Latinx individuals, who reported a demand for mental health services, obtained services (Primm et al., 2010). Rozenfeld et al. (2020) created clinical and social risk models for COVID-19 infection and found that non-English-speaking patients were 2.09 times more likely than English-speaking patients to contract COVID-19. In April 2020, the Chief Equity and Inclusion Officer at Massachusetts General Hospital assembled a team of native Spanish-speaking physicians to assist the limited English-proficient Spanish-speaking patients admitted to the hospital with COVID-19 by providing them with clinical care

(Knuesel et al., 2021). The doctors found that they admitted nearly 20 times the number of Spanish-speaking patients with limited English proficiency during the pandemic (Knuesel et al., 2021). Also, over 40% of the patients were infected with COVID-19 (Knuesel et al., 2021). These findings are most likely related to the lack of understanding of the COVID-19 protocols and preventive measures put in place to diminish the virus spread; however, due to the language barrier, it was difficult to understand these protocols.

Among Latinx and Black communities, a language barrier is interconnected with health literacy. Health literacy contributes to a number of problems, including inappropriate or no use of healthcare services; improper use of medications; financial drain on individuals and society; and social inequity (Nielsen-Bohlman et al., 2004). Members of racial and ethnic minorities are more likely to have lower literacy levels, as are the elderly and those with lower educational levels, groups for whom clinical trials are very few (Nielsen-Bohlman et al., 2004). Santos-Lozada and Martinez (2018) conducted research to examine the health status of Latinx adults in the United States. A survey of Mexicans, Puerto Ricans, Cubans, Dominicans, and other Latinx individuals in Spanish revealed that respondents reported poor/fair health conditions more often than their counterparts who answered the survey in English.

Those with limited English proficiency may receive inferior mental health care due to ineffective interpretation services, as interpreters may “normalize” or obscure pathological symptoms (Flores, 2005). For individuals with limited English proficiency, trained interpreters and bilingual health care providers enhance patient satisfaction, quality of care, and health results (Flores, 2005). During the COVID-19 pandemic, interpreters were limited because of the high demand. This made obtaining these services difficult, particularly when telehealth services were utilized.

Access to Telehealth Services. This limited Black and Latinx individual' access to mental health services. For example, a growing body of evidence indicates that minorities faced significant barriers to telehealth, including a lack of familiarity with technology, a low level of health and digital literacy, sensory impairments, a lack of broadband access, and a lack of assistance during the pandemic (Hirko et al., 2020). A cross-sectional analysis by Pierce and Stevermer (2023) of 7742 family medicine encounters at a single U.S. institution in the initial month of the COVID-19 pandemic concluded that Latinx and Black people were less likely than White people to use telehealth services during the first few months of COVID-19. There was also an interesting finding during COVID-19: almost 40% of Latinx members received a telehealth visit compared to 34% for White members, 33% for Asian members, and 28% for Black members (Business Wire, 2021). These data show that Latinx members were much more likely to use telehealth services. However, it was also noted that before the pandemic, the Latinx community used telehealth services (Business Wire, 2021). This may be related to the high amount of stress during the pandemic, which may have led the Latinx community to seek out services or have a greater trust in services than the Black community.

Business Wire (2021) also reported that despite that telehealth increased visits during COVID-19, it was not sufficient to compensate for the drastic reduction in in-person visits in all racial and ethnic groups. Before COVID-19, Black people had the lowest percentage of combined telehealth and in-person visits with 56% and continued to have the lowest percentage with 49% following COVID-19 (Business Wire, 2021). It is estimated that Black people with similar demographic, clinical, and socioeconomic characteristics have 7% fewer mental health visits than White people (Business Wire, 2021). In particular, the rates are striking because

surveys suggest that people of color are more likely to suffer from mental health issues and stress than other populations (Business Wire, 2021).

Based on the literature on health disparities, disasters, and pandemics, Saltzman et al. (2021) concluded that the overlapping of stressors during the COVID-19 pandemic, including physical health issues, work-related issues, and difficulty accessing health care, creates a worrisome outlook for mental health. It can be concluded that the pandemic exacerbated the rooted mental health disparities as well as discouraged members of the Latinx and Black communities from seeking the necessary help to improve their mental health.

CHAPTER 4: HOW DID COVID-19 DISCOURAGE HELP-SEEKING BEHAVIORS OF LATINX AND BLACK COMMUNITIES?

The health and mental disparities discussed in previous chapters have negatively impacted help-seeking behaviors for the Latinx and Black communities. This is because disparities have created barriers to access health care for these individuals. Unfortunately, the COVID-19 pandemic has exacerbated these disparities, causing challenges for these communities to engage in help-seeking behaviors and consequently deterring Latinos and Black individuals from obtaining the services needed to care for their physical and mental well-being. This chapter reviews help-seeking behaviors and the impact of the COVID-19 pandemic on the help-seeking behaviors of the Latinx and Black communities.

Help-Seeking Behaviors

Literature generally defines help-seeking behavior as actively seeking assistance from others (Rickwood et al., 2005). Essentially, it refers to communication with others to obtain help in the form of understanding, advice, information, treatment, and general support in response to a specific issue or distressing experience (Rickwood et al., 2005). According to Rickwood and Thomas (2012), help-seeking behavior for mental health is an adaptive coping process to obtain external assistance to resolve mental health problems. There are two types of approaches to seeking help: formal and informal. Formal help-seeking involves seeking advice, support, or treatment from a professional who has a legitimate and recognized professional role (Rickwood & Thomas, 2012). Various professionals are available to assist individuals, including specialists, generalists, primary healthcare providers, and non-health professionals, such as teachers, clergy, and community and youth workers (Rickwood & Thomas, 2012).

The term “treatment-seeking” has been used to distinguish between seeking help from specific healthcare providers and seeking community support and services (Rickwood & Thomas, 2012). Therefore, an informal help-seeking network can include friends and family members (Rickwood & Thomas, 2012). Some sources of help have a personal relationship with the help-seeker rather than a professional relationship (Rickwood & Thomas, 2012). Another form of help-seeking approach that has recently surfaced is “self-help” (Rickwood, 2010). The rapid advancement of computer-mediated communication technologies has provided opportunities for mental health support. This facilitates the help-seeking process for individuals who may struggle to connect interpersonally (Rickwood, 2010).

Rickwood et al. (2005) also highlighted a help-seeking process that defines help-seeking in four stages. The first stage stated is the *awareness and appraisal of problems*, which is the capacity to identify symptoms, and knowing that you have a problem that requires professional help (Rickwood et al., 2005). Cheng et al. (2018) suggested recognizing mental health disorders is linked to a positive attitude toward seeking help. A study by Pederson and colleagues (2023) found that Black individuals with higher specific knowledge about mental health were 26% more likely to report willingness to seek mental health assistance. Therefore, when individuals recognize mental illness, they are more likely to use mental health services than those with general knowledge about mental illness (Pederson et al., 2023). Notably, the percentage of those individuals who were likely to report willingness to seek treatment was still significantly low, suggesting treatment seeking within this community continues to be a challenge. Similar findings were obtained within the Latinx community regarding health literacy and the recognition of symptoms. For instance, a study of Latinx individuals by Coffman and Norton (2010) showed

that low health literacy correlates to difficulties identifying symptoms, learning about treatment options, and navigating the healthcare system but also hesitation to seek help.

The second stage is the *expression of symptoms and need for support*, and this suggests that as part of this awareness, the help-seeker should be able to articulate it and express it in a manner that others can understand (Rickwood et al., 2005). The third stage is *availability of sources of help;* this stage is the ready accessibility to help and support to cope with the problem, as well as the individual seeking assistance being able to understand where and how to obtain those resources (Rickwood et al., 2005). However, this stage can be challenging for Latinx and Black individuals who, based on the literature previously discussed, may not have the ease of access to these resources to solve their problems. Last, stage four is the *willingness to seek out and disclose to sources,* which implies that there must be a willingness and capability on the part of the help-seeker to share their inner state with the source of help (Rickwood et al., 2005). It is important to note that various factors can impact the help-seeking process, and in the case of many Latinos and Black individuals, it is not always a straightforward process.

Barriers to Help-Seeking Behaviors for Latinx and Black Communities

Structural Barriers

Racism and Discrimination. The Latinx and Black communities have experienced historical racism and discrimination that have impacted their views of seeking help from health and mental health professionals. Perception of racial discrimination can also influence patterns of health care utilization, including selecting a health provider who shares the same ethnic and racial background as the individual, a reduction in perceived quality and satisfaction with health care, and a delay in seeking medical and mental health care (Burgess et al., 2008). Lee et al. (2009) assessed the extent to which perceived provider discrimination explained racial/ethnic

differences in healthcare utilization and, consequently, health outcomes. A sample of 5,642 adults in the United States was used to evaluate the relationships among perceived provider discrimination, healthcare utilization, and health status (Lee et al., 2009). According to the results, Black, Latinx, and Asian patients reported significantly more discrimination from providers and poorer health than non-Latinx White patients (Lee et al., 2009). Based on the findings of this study, it can be concluded that the perception of racial discrimination can negatively impact the utilization of healthcare services and health outcomes for racial and ethnic minorities (Lee et al., 2009). For this reason, it is essential to promote equity in health care and improve health outcomes for all individuals, regardless of race or ethnicity, to address and reduce perceived provider discrimination.

Regarding the Latinx community, a 2017 poll developed by the Harvard T. H. Chan School of Public Health and colleagues reported that nearly 1 in 5 Latinx adults avoid medical care due to a fear of discrimination or poor treatment. Smyser and Ciske's (2001) cross-sectional survey indicated that 21% of Latinx individuals in Southeast Seattle experienced discrimination in a healthcare setting, as a result of which they did not seek healthcare when necessary. The investigators found that 70% of Latinx individuals who had experienced prior discrimination in a healthcare setting subsequently delayed seeking needed healthcare, compared with 48% of Latinx individuals without prior reported discrimination (Smyser & Ciske, 2001). In another study, López-Cevallos and Harvey (2016) examined the association between immigration status and perceived healthcare discrimination among Latinx individuals living in rural areas; results reported that nearly 40% of Latinx individuals interviewed said they had experienced healthcare discrimination, such as being prevented from accessing services, being hassled, or being made to feel inferior in some way.

Grayson (2020) reported that Black individuals would look for subtle indications of whether a therapist holds racist attitudes due to the fear and concerns of being mistreated because of their race or ethnicity. An Artiga et al. (2020) survey focusing on race and health revealed that specifically Black women, particularly mothers, reported experiencing higher rates of discrimination in healthcare settings. Among Black women who had a child under the age of 18, 37% said that they had experienced unfair treatment based on their race while receiving health care for themselves or a family member in the past year, and 41% said a health care provider talked down to them or did not treat them with respect at some point in the past three years (Artiga et al., 2020). In the case of Black men, 15% have experienced unfair treatment based on their race while receiving health care for themselves or a family member in the past year, and 17% reported that a health care provider talked down to them or did not treat them with respect at some point in the past three years (Artiga et al., 2020). Furthermore, Black women were more likely than Black men to experience a lack of trust in their healthcare providers, to assume something without asking, or to be blamed for their health issues (Artiga et al., 2020).

The experiences of many Latinx and Black individuals in health care have been racially discriminatory and have significantly impacted their health and well-being. Studies indicate that a considerable proportion of members of these communities avoid seeking health care altogether due to past discrimination, and those who have experienced discrimination are more likely to delay seeking health care. As a result of this type of discrimination, individuals may feel inferior and less deserving of these healthcare services in addition to being unable to generally access the healthcare they need, ultimately exacerbating health disparities in this community. The importance of culturally sensitive care that is free from discrimination cannot be overstated in enhancing health outcomes for Latinx and Black individuals.

Affordability and Accessibility of Health Services. Buchmueller et al. (2016) documented the effect of the Affordable Care Act on health insurance coverage for Latinx, Black, and White individuals; among Latinx and Black individuals, 40.5% were uninsured in 2013, compared to 14.8% of White individuals. Private insurance coverage gaps were larger, but these gaps were partially offset by higher rates of public coverage among Black and Latinx individuals (Buchmueller et al., 2016). The main provisions of the Affordable Care Act went into effect in 2014, and the gap in coverage for Latinx and Black individuals has decreased specifically by 7.1% points for Latinx individuals and 5.1% points for Black individuals (Buchmueller et al., 2016). There was a more significant increase in coverage in states that expanded Medicaid (Buchmueller et al., 2016), which provided a comprehensive coverage option, at little or no cost, to eligible low-income people who are disproportionately Black and Latinx (Aboulafia et al., 2021). This expansion of healthcare access was life-changing for these communities because it provided those with the chance to care for their physical and mental health.

Although policies and government monies have been implemented to increase healthcare access for these communities, disparities in healthcare access continue to persist. For instance, according to Dieleman et al. (2016), the United States spent $2.4 trillion on psychological treatment in 2013, while $187.8 billion was spent on substance abuse treatment. However, these resources were not dispersed equally among Black and Latinx communities (Cook et al., 2013, 2017). The cost of treatment and the insurance coverage can substantially decrease access to psychological treatment and all healthcare (Rowan et al., 2013). Brown et al. (2016) revealed that fewer primary care/health care providers are available nearby in neighborhoods with a higher number of Black and Latinx adults. Other reports have suggested that racial inequalities

within facility admissions and insurance segregation can limit healthcare choices for these communities (Aboulafia et al., 2021).

Cabassa et al. (2006) compared Latinx individuals to their White counterparts and showed that Latinx individuals underutilize mental health services, report greater delays in receiving mental health care, are less likely to be satisfied with the mental health care they receive, and are less likely to use specialty mental health care services. Research through a 2012 national sample has also revealed that 3.3% of Latinx women seek mental health services from specialists, while 5.9% reported seeking services from a general practitioner (Ai et al., 2012). According to the National Comorbidity Survey and Epidemiology Catchment Areas Survey, Black Americans use mental health services half as frequently as White Americans (Barksdale & Molock, 2009). A study conducted by the National Survey on American Life demonstrates that only 32% of Black Americans receive mental health care, with the youngest and oldest participants being the least likely to do so (Neighbors et al., 2007). Despite this, research indicates that the use of mental health services by Black Americans is much lower than that of other ethnic groups, regardless of age or gender (Thompson et al., 2013).

It is essential to note that access to health insurance can vary depending on the Latinx and Black origin subgroups. It is noteworthy that Puerto Ricans born on the island are U.S. citizens by birth, facilitating circular migration and allowing them to qualify for federal and state health insurance programs (e.g., Medicare, Medicaid). The Cuban immigrant community benefits from having refugee status in the United States, which permits them to access Medicaid benefits (Vargas Bustamante et al., 2009). Latinx individuals of Mexican origin and non-Mexican origin have differences in healthcare access and utilization, insurance coverage, and care affordability (Vargas Bustamante & Chen., 2012). This is because, although the Affordable Care Act has

reduced disparities in healthcare for the Latinx community, there are continuing disparities in income, English proficiency, and documentation status that impact healthcare access outcomes between Mexicans and other Latinx groups (Vargas Bustamante & Chen., 2012).

A higher proportion of Black Caribbean immigrants are insured than the foreign-born population. For example, in 2019, Trinidad and Tobago's immigrant-origin population had the lowest rates of uninsured (17%) among the largest Caribbean groups, while individuals with immigrant origin from Haiti and Cuba had the highest rates of uninsured among Caribbean immigrants (18% and 17% respectively) (Batlova & Lorenzi, 2022). Access to health insurance can vary depending on the specific Latinx and Black origin subgroups. Factors such as citizenship status, refugee status, and country of origin can impact federal and state health insurance programs such as Medicare and Medicaid eligibility. Therefore, help-seeking behaviors can also vary depending on the level of healthcare access for the specific origin subgroups.

Accessibility to health insurance is not the only factor that impacts seeking behaviors for Latinx and Black communities but also the affordability of healthcare. Brodie et al. (2022) reported that at least 6 of 10 Black adults (60%) and Latinx adults (65%) are experiencing difficulty affording healthcare costs compared to roughly 4 of 10 White adults (39%). High healthcare costs can deter Latinx and Black individuals from seeking help. It may cause a conflict between seeking healthcare services or being able to afford other expenses, such as rent, bills, or even groceries. Therefore, it is typical for Latinx and Black individuals to receive health care in nonoptimal organizational settings (such as emergency rooms) and to lack continuity of care (Bulatao, 2004). As an example, Peters et al. (2023) found that between 2018 and 2020, non-Latinx Black adults were more likely to visit the emergency department for all types of

mental health disorders assessed, including substance abuse disorders, anxiety disorders, mood disorders, and schizophrenia, than non-Latinx White and Latinx adults. However, these options may not always provide the same level of care or access to specialists that insured individuals have, which can exacerbate challenges in engaging in help-seeking behaviors.

Immigration Status and Government Policies. Derr (2016) suggested that most studies demonstrated lower mental health services use rates among Latinx immigrants than U.S.-born Latinx individuals. Fortuna and Pérez (2005) compared the diagnoses and mental health care use of undocumented Latinx immigrants with those of legal immigrants and U.S.-born Latinx individuals. As a result, undocumented Latinx immigrants had lower rates of service use than anyone else; they had fewer mental health appointments and lower lifetime inpatient and outpatient service use rates than Latinx immigrants with legal documents and those who were U.S.-born (Fortuna & Pérez, 2005). There was also a study by Dettlaff and Cardoso (2010) that found that preschool Latinx immigrant children received more mental health services than U.S.-born Latinx children of the same age group, while adolescent Latinx undocumented children received significantly fewer mental health services. The difference may result from these adolescents being noncitizens themselves, which creates a barrier to accessing services (Dettlaff & Cardoso, 2010). Even youth who are citizens may encounter barriers to accessing services due to their parents' immigration status, as they fear being deported or prevented from becoming naturalized if they try to obtain services for their children (Dettlaff & Cardoso, 2010). There are significant differences in mental health care use among Latinx immigrants and U.S.-born Latinx people, and these differences are affected by their legal status, irrespective of their age.

Cardemil et al. (2007) found that there are differences in treatment-seeking from various ethnic groups. Results showed that about 66% respondents from Puerto Rico and Latinx

individuals who were born in the mainland U.S. reported seeking mental health services (Cardemil et al., 2007). In comparison, only 20% of respondents from Central and South American countries report treatment-seeking behaviors (Cardemil et al., 2007). This is a significant difference between the two groups. The proposed explanations for these results included a possible higher concern regarding immigration status, which would not be relevant for Puerto Ricans because they are U.S. citizens (Cardemil et al., 2007). Also, Puerto Ricans may be more familiar with navigating the U.S. healthcare system and mental health services than Central and South Americans (Cardemil et al., 2007).

In contrast to variations in Latinx Caribbean and Central and South American Latinx immigrants in treatment-seeking, Jackson et al. (2007) found no ethnic variation among Black Americans and Caribbean Black individuals in the frequency of seeking mental health assistance. While Caribbean Black individuals from Spanish-speaking countries reported more service use than Caribbean Black individuals from other countries, those who immigrated to the United States at an earlier age did not (Jackson et al., 2007). Similarly, Woodward et al. (2008) found no relationship between ethnicity and the need for assistance. The study examined only a small sample of Caribbean Black individuals (Woodward et al., 2008), which could explain the lack of correlation between ethnicity and assistance needs. A significant association was found between gender and informal support for Black individuals but not for Caribbean Black individuals, suggesting ethnic differences in gender and help-seeking that need further investigation (Woodward et al., 2008). Woodward et al.'s (2008) findings regarding substance use help-seeking are similar to those of other racial/ethnic groups. Black Americans who meet the criteria for substance abuse disorders seek help less frequently than those with mental health disorders. Another study conducted by Woodward and colleagues (2011) found that Black American men

had a greater reliance on informal support alone when it came to seeking treatment for mental disorders than Black Caribbean men. Based on these studies, it seems like there is a need for more research to continue to understand the variations in help-seeking behaviors for different ethnic groups as it relates to immigration-origin groups and documented status to help meet the treatment needs of Latinx and Black individuals regardless of their origin. Government policies also have a significant impact on the ability of immigrants to seek medical treatment. Raymond-Flesch and others (2014) completed a study examining the Deferred Action for Childhood Arrivals (DACA) population's health and access to care. The DACA program was established by the federal government in 2012 under the administration of Barack Obama (Waters, 2017). The program allows people who came to the United States illegally as children, also called "dreamers," to work, study, and live in the country for a limited period (Waters, 2017). To qualify for this right, these dreamers must apply, and they must be in school or have completed school or military service (Waters, 2017). Those who pass this checkup will not be deported or sent home for two years and can reapply. The applicant may apply for a work permit, a driving license, or college enrollment (Waters, 2017).

The study included 9 focus groups in California of 61 DACA-eligible Latinx individuals aged 18 to 31. Results demonstrated that most participants avoided the health care system whenever possible, first relying on their families and unlicensed healers and then seeking safety net providers if necessary. It is important to note that several barriers to care were identified, including the cost of care, a lack of intergenerational knowledge of the healthcare system, a lack of a driver's license, and mistrust of providers due to fear of discrimination and deportation. The greatest unmet health need was mental health care. It was important for the participants to know their health insurance options and access to primary care, dental coverage, and vision coverage.

Several participants reported refraining from high-risk behaviors to prevent financial and legal burdens that might imperil their immigration status.

A survey study by Galletly et al. (2021) of 336 adult Latinx immigrants in the United States found that 89 (27%) participants thought hospital emergency departments were the only places where uninsured immigrants could receive COVID-19-related testing or treatment. There were 106 participants (32%) who agreed that testing and treatment related to COVID-19 might adversely affect an individual's immigration prospects; 210 participants (62.5%) would not identify an undocumented household members or co-workers during contact tracing (Galletly et al., 2021). Noteworthy, the number of participants who reported being unwilling to identify an undocumented contact was higher among participants with deportation experiences than among those without (Galletly et al., 2021). Data collected by KFF (2023) on health coverage and care of immigrants indicated that although the federal and state level of legislation has proposed expanding health coverage for immigrants, such as Medicaid and the Children's Health Insurance Program, many immigrants, particularly those who are undocumented, remain ineligible for coverage options. As discussed in previous chapters, KFF (2023), the Biden administration has reversed prior Trump administration changes to public charge rules, and now allows immigrants to seek supplemental government services such as health insurance, food stamps, and other benefits without being punished. This new change in the rule has reduced fears among immigrant families participating in these services; however, there continues to be a lack of trust in the government, therefore, diminishing the motivation to engage in help-seeking behaviors for these communities (KFF, 2023).

Cultural Barriers

Stigma. Despite recognizing health and mental health disparities within the Latinx and Black communities, many continue to hesitate to seek professionals due to the structural barriers discussed above and the cultural barriers to seeking treatment. Stigma is a cultural barrier that has impacted the views and beliefs of these communities to obtain specific mental health treatment. For instance, Latina, Black, and immigrant women are likelier to endorse stigma concerns about depression treatment (Cooper et al., 2003; Nadeem et al., 2007). Among Latinx individuals, depression can be interpreted as being "crazy," weak, or drug use (Interian et al., 2007). Thus, stigma is a prominent concern for racial and ethnic minority groups and is responsible for a significant decline in treatment participation and adherence (Alegría et al., 2008).

Jimenez et al. (2013) indicated that one of the most well-documented barriers to depression treatment among Latinx individuals is stigma toward mental illness. Latinx individuals can hold various identities (e.g., being Latinx, immigration status, and experiencing a mental illness) that may intertwine and worsen the impact of mental-health-related stigma (Farooqi et al., 2019). According to Turan et al. (2019) and Mascayano et al. (2016):

> gender-based differences in expectations related to help-seeking rooted in cultural values such as *machismo* (men being able to handle their own problems without external help), *marianismo* (self-sacrifice for those one cares about, even to the detriment of oneself), as well as *familismo* (successfully fulfilling family obligations before all else) and *fatalismo* (accepting God's will or fate) may further impact Latinos' perceptions of people with depression. (p. 1913)

This also impacts their disposition to seek formal treatment. For example, *machismo* was associated with restrictive emotionality and depression in Latinx males (Fragoso & Kashubeck, 2000). The value of marianismo has been linked to higher anxiety and depression rates in women in self-silence, which restricts the expression of feelings or opinions to maintain a positive image of themselves (Kosmicki, 2017). Due to the preference of Latinx individuals to trust and confide in family and friends before considering a mental health professional with a stigma associated with mental disorders, the impact of *familismo* on Latinx help-seeking behaviors may be delayed (Cabassa et al., 2007). As for *familismo*, Paige (2022) argued that *fatalismo* negatively relates to self-efficacy in healthcare since it attributes health and mortality to outside forces. In a community sample of Latinx participants, the importance of *fatalismo* significantly predicted medical service usage but not mental health service utilization (Anastasia & Bridges, 2015). Interian et al. (2007) suggested that studies on Latinx cultural values and stigma have found that stigma, due to cultural expectations, discourages adults from seeking mental health care and adhering to treatment plans. Furthermore, Latinx individuals in the United States are reported to have poorer healthcare access and utilization patterns than other racial and ethnic groups (Ortega et al., 2015). Specifically, Mexican and Central American heritage Latinx individuals experience the greatest hardships (Alcalá et al., 2017; Vargas Bustamante et al., 2010) due to disparities in the source of care, lack of health insurance, and limited English proficiency (Chen et al., 2010).

An investigation conducted by Cheng et al. (2013) employed structural equation modeling to examine the effects of psychological distress and psycho-cultural variables (e.g., ethnic identity, other group orientation, perceived discrimination) on the perception of stigmatization by others and self-stigma regarding seeking psychological help, taking into account past counseling/psychotherapy experiences. A total of 260 Black American, 166 Asian

American, and 183 Latinx American students were included in the sample. All three groups demonstrated that higher levels of psychological distress and perceived racial/ethnic discrimination correlated with higher levels of perceived stigmatization by others when seeking psychological assistance, which, in turn, correlated with greater self-stigma. Interestingly, Black Americans with higher levels of ethnic identity were less likely to self-stigmatize seeking psychological assistance. According to the authors, Black American college students with higher ethnic identity have a more secure psychological foundation, so seeking psychological help is less stigmatized and less likely to result in negative self-evaluation (Cheng et al., 2013).

Awosan et al. (2011) indicated that one of the barriers to mental help-seeking behaviors is stigma. Ward et al. (2013) investigated Black men's and women's perceptions of stigma and preferred coping methods for mental illness. Study findings suggest that Black individuals have a negative attitude toward mental illness and perceive a high level of stigma associated with seeking mental health care. Nevertheless, the participants were slightly inclined to seek out some form of help. The study also discovered that Black individuals prefer to deal with mental health issues through religious and spiritual means rather than seeking professional assistance. A qualitative study of Black women's beliefs about depression by Waite and Killian (2008) found that women believed they were not susceptible to depression. They identified stigma as a significant barrier to seeking mental health services. In addition, the women believed that an individual develops depression due to having a "weak mind, poor health, a troubled spirit, and lack of self-love" (p. 189). Therefore, this stigmatized view of depression leads to avoiding seeking help because it reflects "weakness" (Waite & Killian, 2008) or just a personal flaw. Another qualitative study by Matthews et al. (2006) supported the negative views of seeking mental health. For instance, one of the participants in the study stated, "I made the mistake of

telling my best friend" He said, "You're crazy? Oh my God, I can't believe it. Get away from me. You're dangerous" (p. 261). As a result of these findings, exploring the relationships between beliefs in the Black community and coping is necessary to determine whether individuals seek treatment (Matthews et al., 2006). Furthermore, studies on gender differences within communities are warranted to investigate how gender and cultural representation impact preferred coping strategies (Matthews et al., 2006).

Ward et al. (2013) revealed that Black individuals also have positive beliefs and attitudes toward seeking mental health services; nonetheless, these beliefs are subject to the individual's experiences in seeking treatment. In one study of racial differences in beliefs about how mental illness's natural course relates to perceptions of treatment effectiveness, Black individuals were more likely to believe mental health professionals were able to assist mentally ill individuals than White individuals. Despite this, Black individuals were more likely to believe that mental health problems could be resolved on their own (Anglin et al., 2008). As a coping strategy, mental health services were avoided because of the belief that mental health problems can be resolved on their own (Ward et al., 2013). Therefore, positive views of help-seeking appear not to be associated with seeking treatment within the Latinx or Black community.

The research implicates the impact of stigma surrounding help-seeking behaviors for the Latinx and Black communities can create a barrier to obtaining treatment. While stigma can prevent seeking mental health services, language barriers can also limit access to quality healthcare services, preventing Latinx and Black individuals from seeking care when needed.

Language. Language is a significant factor in providing adequate mental health care. Latinx underutilization of mental health care is attributed to language barriers, as Vega and Alegría (2001) reported. Even though the number of Spanish-speaking individuals continues to

rise while the number of bilingual mental health professionals remains relatively small, this barrier appears to have no solution (Barrera & Longoria, 2018). Latinx individuals with limited English proficiency face challenges in seeking mental health treatment (Barrera & Longoria). As a result of being unable to communicate their service or treatment needs, individuals are more likely to drop out of treatment programs (Barrera & Longoria, 2018).

Jimenez et al. (2022) suggested completing comprehensive psychiatric evaluation centers on obtaining a clear and accurate explanation and description of symptoms. However, language barriers impact these individuals' ability to label their mental health problems and treatment needs (Jimenez et al., 2022).

Kim et al. (2011) indicated that individuals who experience a language barrier are less likely to receive effective or adequate mental health care or are more likely to leave treatment early. For example, Latinx adults with limited language proficiency are less likely to seek mental health services than their peers who are proficient or fluent in English (Kim et al., 2011). In a culturally appropriate approach to mental health for older Latinx individuals, it has been identified that idioms of distress are underrepresented (Nichter, 2010). According to a qualitative study that compared idioms of distress between older Latinx and older White individuals, Latinx individuals are more likely to refer to mental health distress using terms not included in traditional diagnostic tools, such as "general malaise" and "pain" (both physical and emotional) (Jimenez et al., 2022). The Black Caribbean community also faces language barriers that impact help-seeking behaviors (Batlova & Lorenzi, 2022). Specifically, the Haitian community is also impacted by the language barrier in seeking help (Batlova & Lorenzi, 2022). The shortage of translators and Haitian Creole-speaking providers makes it difficult for healthcare providers to communicate with patients (Batlova & Lorenzi, 2022). It is common for treatment errors to result

from miscommunication among Haitian immigrants (Batlova & Lorenzi, 2022). Haitians may fear receiving the wrong healthcare treatment because health providers cannot understand creole; this further influences the Haitian people to seek traditional medicine over Western healthcare practices (Batlova & Lorenzi, 2022).

Family and Community Pressure. Taylor and Kuo (2018) believed that Black and Latinx individuals may conform to normative pressures to "be strong" and persevere without assistance as a consequence of normative beliefs that mental illness is a "White man's issue." Additionally, Latinx youth may especially feel pressure to keep things within their families (Goldston et al., 2008). These family and community beliefs create a negative view of seeking help outside the community. Alternatively, evidence suggests that *familismo* is a protective factor for Latino families as this cultural value, for example, has been linked to positive health outcomes, including lower levels of substance and drug abuse (Unger et al., 2002). A study conducted by the Institute for Health Promotion and Disease Prevention examined the relationship between the cultural constructs cited above (i.e., *familism, respect, machismo*, and *fatalism*) and substance use (e.g., lifetime alcohol, cigarette, marijuana use) among 1,616 Latinx ninth graders attending seven high schools in Southern California (Soto et al., 2011). Researchers have found that Latinx individuals and lower levels of substance use may be related to *familismo*, which strengthens the responsibility of the individual to positively represent the family (Soto et al., 2011).

Awosan et al. (2011) focused on seeking the perspective of Black clients who did attend family therapy and the obstacles they faced in their effort to utilize therapy found that an obstacle was the reactions of friends and family. This is indicative of the persistent mental health stigma within the community. This may be why Black individuals are reluctant to seek mental health

services outside of family, friends, and spiritual/religious leaders (Awosan et al., 2011). Villatoro and Aneshensel (2014) reported that Black families with untreated mental illnesses serve as role models for not accessing formal services, which may communicate unfavorable social norms regarding treatment, even if that is not the intended message and lack experience accessing treatment. Family members with mental health problems may think professional intervention is inappropriate or ineffective (Villatoro & Aneshensel, 2014). An additional explanation for why concerns about family and cultural views of therapy are serious obstacles that may be related to specific negative experiences (misconstrued family values and cultural identity, misdiagnosed) of close family and friends in therapy (Awosan et al., 2011).

Albizu-Garcia et al. (2001) found that having a small social network of supportive individuals increased the likelihood of Puerto Ricans seeking mental health services. In other words, large supportive networks can act as a buffer when mental health needs arise, consequently delaying or replacing the need and urgency to access formal mental health services. In such cases, Latinx individuals may delay seeking assistance because they prefer to rely on family and friends who are trustworthy and supportive before considering mental health professionals and carry the stigma of mental illness (Cabassa et al., 2007; Cabassa & Zayas, 2007).

Religion and Traditional Healing Practices. The Black and Latinx communities utilize religion and traditional healing practices similarly. Pastoral care is often the first response for congregants who hesitate to seek formal treatment. According to recent research, Black church pastors feel obligated to address their members' mental health needs (Campbell & Littleton, 2018). Several studies have suggested that Latinx Christians also prefer to seek mental health assistance from religious leaders (Kane & Williams, 2000). According to Ward et al. (2009),

Black women are likely to employ religious coping methods to cope with mental health problems. However, they might also seek professional treatment for mental health issues because they utilize initial informal support, which can help gradually minimize mental health stigma and seek professional help (Ward et al., 2009). In a qualitative study, the use of religious coping, such as prayer and developing a relationship with God was found to be effective in coping with depression (Conner et al., 2010).

In addition, Latinx individuals seem to prefer mental health professionals with compatible values (Moreno & Cardemil, 2013). Evidence suggests that Latinx Christians tended to perceive mental health problems as the result of spiritual factors. For example, Caplan (2019) indicated that Latinos often attribute mental health issues to demonic forces, sinful behavior, or a lack of religious faith. To resolve physical or mental distress, Latinos may believe that prayers can cure a physical or mental condition and may seek guidance from priests, ministers, *espiritistas* (spiritual healers), *el curandero* (male folk healer), *la curandera* (female folk healer), or *el or la brujo/a* (witch doctors) (Bolger & Prickett, 2021). Generally, Latinx individuals are more comfortable returning to these practices since they have been used and passed down from generation to generation (Bolger & Prickett, 2021).

Likewise, in Black cultures, clerics or ministers are considered indigenous helpers, especially in relation to mental health (Harley, 2005). In indigenous healing for Black Americans, various techniques are used to achieve healing, including spiritual practices (e.g., prayer, hope, healing), folk magic (e.g., rituals, incantations, voodoo, hoodoo, use of roots, spells), counseling (e.g., advice, information), and medications (e.g., potions, herbs), and usually involves listening to the complaints of a "sufferer" so that therapeutic interventions can be developed (Harley, 2006).

Based on the information provided, it can be concluded that both the Black and Latinx communities utilize religion and traditional healing practices to cope with mental health issues. Religious leaders, such as pastors or priests, play a significant role in supporting and addressing their congregants' mental health needs.

Lack of Trust and Culturally Competent Provider. According to APA's Center for Workforce Studies data in 2019, 83% of the psychology workforce self-identified as 7% Latinx and 3% Black individuals (American Psychological Association, 2022). These numbers show a significant lack of diversity within the mental health field and few options for culturally competent providers for the Latinx and Black communities. A lack of cultural competence can create a barrier between the provider and client/patient, hindering treatment quality and, therefore, exacerbating the mistrust of the health care system. According to Smedley et al. (2003), Black individuals mistrust the U.S. healthcare system due to health disparities they experience throughout the system.

As Keith (2000) indicated, practitioners and administrators have sometimes failed to consider Black individuals' preferences when providing assistance. Among Black individuals, time spent with their providers, trust, and the provider's ethnicity have significant impacts on seeking and continuing treatment. Laszloffy and Hardy (2000) explained how cultural mistrust could prevent Black clients from revealing how racism affects their presenting problems. Most Black individuals express concern about how a White therapist, or a therapist of color whom they perceive to have similar characteristics to Whites, may react or respond to their problems in therapy (Laszloffy & Hardy, 2000). Both communities prefer mental health professionals who share similar values and beliefs. Unfortunately, there is an absence of Latinx and Black professionals.

Latinx individuals are likely to seek physical and mental health care services from clinics with ethnically and racially diverse staff members. According to patients, these clinics promote culturally competent services due to increased awareness of diversity and dialogue on it, as well as ongoing provider training and culturally relevant materials for patients (Paez et al., 2008). However, these community clinics can pose challenges to obtaining quality healthcare, such as the high workload of providers leading to poor quality of services (Li et al., 2022). Health providers reported several factors that influenced the care for this community and were viewed as stressors. Immigration and documentation status were identified as the major stress due to concerns of trust and fear of deportation (Valdez et al., 2011). Health providers throughout the years have demonstrated a bias toward patients, making it more challenging to gain the communities' trust.

Specifically, it has been reported that some White health care providers have problematic explicit views of their Black and Latinx patients, believing that these patients are less intelligent, less adept at adhering to treatment regimens, and more likely to engage in risky health behavior than their White colleagues (Van Ryn & Burke, 2000). In addition, Latinx patients were viewed as less likely to accept responsibility for their own care and more likely not to adhere to treatment recommendations (Mayo et al., 2007). These views perpetuate disparity and inequity, hindering effective and quality care for Latinx and Black individuals (Hall et al., 2015). Overall, Latinx and Black communities' barriers to help-seeking behaviors may not allow them to willingly see and disclose their health and mental health problems. During COVID-19, these barriers were exacerbated, making seeking help even more challenging for these communities.

How Did COVID-19 Discourage Help-Seeking Behaviors?

Globally, the COVID-19 pandemic has caused a public health crisis with significant impacts on health and mental well-being. One area of concern is the effect of the pandemic on help-seeking behaviors. As people navigated the challenges of social distancing, quarantines, and lockdowns, their willingness to seek medical or mental health assistance was hindered. Pre-pandemic, various barriers discussed above impacted the help-seeking behaviors within the Latinx and Black communities. Consequently, COVID-19 exacerbated the impact of these barriers within these communities and ultimately discouraged Latinx and Black individuals from engaging in help-seeking behaviors. The literature has further discussed how the COVID-19 pandemic discouraged these communities from seeking health-related help.

Fear of Stigma and Mistrust

Historically, the Black and Latinx communities have suffered numerous discriminatory experiences related to the healthcare system. Experimentation during slavery, the Tuskegee Syphilis Study, and the contraception trials in Puerto Rican women, among others, which predisposed Black and Latinx communities to skepticism about public health interventions (Gamble, 1997; Quintanilla, 2004). The COVID-19 pandemic has triggered reactions in these communities related to these past experiences, and the mistrust of the healthcare system has been exacerbated. The findings of a community-engaged qualitative study conducted by Jimenez et al. (2021) found that fear, illness, and loss experienced during the pandemic motivated individuals to seek more information on COVID-19 and mitigated the effects of the disease; vaccine skepticism was high, as was a desire for more transparent information about the future of the disease. It was found that distrust of health care during the pandemic was associated with racism and a previous history of medical experimentation, such as experiments carried out during

slavery, the Tuskegee Syphilis Study, and contraceptive trials conducted on Puerto Rican women among Black and Latinx participants (Jimenez et al., 2021). Based on these findings, it is evident that perspectives regarding mitigation behaviors, testing, and vaccines among Black and Latinx communities are influenced by these previous devastating experiences. Public officials are encouraged to provide transparent information to eliminate vaccine skepticism in these groups (Jimenez et al., 2021).

Oaten et al. (2011) found that stigmatization surrounding the fear of disease outbreaks at first may cause heightened hygiene levels and disease avoidance. However, generally, stigma can become a barrier to accessing health care. Earnshaw and Chaudoir (2009) found that stigmatized groups tend to have internalized feelings of inferiority compared to unstigmatized groups, which suggests that stigmatized groups are less likely to seek health treatment to avoid feeling inferior to their counterparts. According to Fischer et al. (2019), stigma may also inhibit outbreak control or reduce compliance with public health measures. As a result, the stigmatization in these communities may make members of these communities wary of seeking health care when experiencing symptoms of the disease for fear of being judged or discriminated against. In the case of COVID-19, the stigma related to the pandemic can be viewed as the social process that intends to exclude those perceived as a potential source of the disease and who may pose a threat to effective social life in a given society (Bhanot et al., 2021; Mikulincer et al., 2015). Because these communities are more vulnerable and more likely to be exposed to the virus, these communities can be viewed as a source of the virus by society.

Since the beginning of the COVID-19 pandemic, vaccine hesitancy has been a consistent issue within the Latinx and Black communities. According to Pedraza and colleagues (2022), in late December 2020, the Food and Drug Administration approved the first COVID-19 vaccine

for use in people over 16 years of age. Two additional vaccines were then approved for individuals over the age of 12 years (Pedraza et al., 2022). The majority of vaccines are currently available in the United States, but marginalized populations, such as Latinx and Black individuals, are skeptical about receiving vaccines (Pedraza et al., 2022). An analysis of pre-COVID-19 vaccine approval data conducted by Shekhar et al. (2021) indicated that Latinx healthcare workers have the second-lowest vaccine acceptance rates of any ethnic group. As a result of this study, 9.8% of Latinx respondents stated that they would not receive the vaccine, 60% would wait for a review, and only 30% would accept the vaccine immediately (Shekhar et al., 2021). Healthcare workers of Latinx descent showed a high level of vaccination hesitancy, which was concerning since they serve as examples to the communities in which they live regarding healthcare decisions (Pedraza et al., 2022). The hesitancy appeared to depend on political affiliation, medical history of chronic illness, views on the newness of the vaccine, and race/ethnicity (Shekhar et al., 2021).

This hesitancy influences the public, specifically in the Black and Latinx communities. Medical mistrust has been identified as a significant barrier to healthcare for communities of color by Morgan et al. (2022). It has been shown that medical mistrust impacts behavioral patterns and responses, resulting in lower satisfaction with care, less provider trust, and less treatment adherence (Benkert et al., 2019). Several studies have indicated that individuals of color are more likely than non-individuals to report experiencing discrimination in healthcare (Blanchard & Lurie, 2004). According to Blanchard and Lurie (2004), those who experienced racially discriminatory treatment in provider settings were likelier to delay medical treatment and not follow medical advice. For instance, Black individuals are also strongly motivated to protect themselves from health-related neglect and discrimination and to ensure they have access to the

information and health care necessary to avoid negative health outcomes and community-wide health disparities. Black individuals in the United States are determined to protect themselves, their families, and their communities, as they have been providing community-specific health education, identifying trustworthy health partners, and cultivating trust in their advice (Jaiswal & Halkitis, 2019). Black individuals may have initially associated the desire to protect themselves and their communities from poor health outcomes with suspicion of new or experimental vaccines (Fisher et al., 2020). Nevertheless, once vaccines are considered safe, effective, and necessary (National Foundation for Infectious Diseases, 2021), the same desire can motivate Black community members to get vaccinated. This could be true for Latinx individuals as well.

According to Lopes (2021), a survey conducted in 2021 indicated that 63% of Latinx people had received at least the first dose of the vaccine, 7% would obtain the vaccine immediately, 14% would consider it, 5% would receive it only if necessary, and 10% would not obtain it at all. Latinx community attitudes toward vaccination may have shifted significantly due to ongoing vaccination campaigns and vaccine availability (Pedraza et al., 2022). According to this survey, Latinx respondents who considered the vaccine expressed concerns about long-term effects, serious adverse reactions, safety, effectiveness, and the risk of contracting COVID-19 (Lopes, 2021). Guadalupe (2021) provided a quote by the former director of the National Institute of Allergy and Infectious Diseases, Dr. Anthony S. Fauci, in which he provides insight into the healthcare mistrust and hesitancy of ethnic minorities. He stated the following:

> They have understandable hesitancy because historically, minorities have not been treated well by the federal government in matters of research, so we must respect that hesitancy and explain to them that, in fact, ethical constraints have been put in place that would make those types of unethical behaviors impossible (para. 9).

Dr. Fauci said. “So right now, the vaccines are safe and effective, and we must get our communities of color to get vaccinated not only for their own good but for their families and their community” (para. 9).

Consequently, the fear and mistrust associated with COVID-19 impacted the mental health of Latinx and Black individuals. Lueck (2021) stated that COVID-19 might have amplified psychological barriers that can inhibit the willingness and ability of individuals to seek professional help, including debilitating feelings of shame and stigma. Latinx residents have also expressed emotional distress and generalized worry related to the pandemic’s substantial economic impact, which may be a detractor from prioritizing their vaccination given the community’s disproportionate representation in the labor markets that have been hardest hit by the pandemic’s business slowdowns and closures (i.e., restaurants, domestic work, and caregiving) (Moya et al., 2022; Moyce et al., 2021). Cobb et al. (2021) found that perceived COVID-19 health threats and the belief that Black Americans face racial discrimination in medical settings were both positively and significantly associated with higher levels of psychological distress for this group. This ultimately creates significant emotional distress for members of these communities and lessens the engagement of help-seeking behaviors for health and mental health services.

Inaccessibility to Care

During the pandemic, the lack of COVID-19 testing sites in Latinx and Black communities created a barrier to reaching or accessing the testing. People with symptoms and those who had traveled were the only people allowed to use these sites (Subbaraman, 2020). As a consequence of the lack of testing, minority populations suffered, many of whom were essential workers and could not be quarantined. As an example, testing accessibility in New York was not

proportional to need, while the amount of testing in White communities was more significant than in minority communities (Lieberman-Cribbin et al., 2020). As the pandemic began, many community clinics and federally qualified health centers, specifically those serving Latinx and Black individuals, closed, delaying testing and primary healthcare (Thankur et al., 2020). Vaccine locations for COVID-19 tended to be concentrated in more affluent zip codes with lower minority populations and farther from neighborhoods where Black and Latinx residents reside (Njoku et al., 2021). Without nearby clinics and healthcare facilities, transportation becomes an additional barrier for Latinx and Black individuals (Njoku et al., 2021). Regarding quality, residential segregation is responsible for the distribution of patients to overcrowded hospitals (Garcia et al., 2021). The same applies to mental health facilities during this period. The aftermath of the pandemic ultimately resulted in distress and a sense of helplessness concerning these communities' overall physical and mental health.

As reported by McKinsey & Company (2022), Black and Latinx Americans reported losing health insurance during the COVID-19 pandemic at a rate of three and two times greater, respectively, than White respondents, further limiting access to health care. This is possibly due to a difference in the use of routine care between different populations, which is also related to differences in the availability and coverage of networks and insurance (McKinsey & Company, 2022). These communities also suffered significant job losses as a result of the pandemic, further impacting access to insured care. The Pew Research Center (2020) reported in April 2020 that 61% of Latinx and 44% of Black Americans had lost their jobs or wages due to the COVID-19 outbreak, compared to 38% of White adults. The same April 2020 survey indicated that nearly three-quarters of Black individuals (73%) and Latinx (70%) individuals lacked emergency funds to cover three months' expenses; around half of their White counterparts (47%) answered

similarly. Almost all Black and Latinx adults, who do not have a financial reserve, say that they cannot cover their expenses for three months by borrowing money, using savings, or selling assets (Pew Research Center, 2020). Loss of employment and absence of funds makes it challenging for these communities to afford healthcare. For example, in 2020, it was estimated that 24% of Black adults and 25% of Latinx adults delayed care for reasons other than cost (KFF, 2021). In the survey, 52% of Black and 49% of Latinx individuals said they put off care because it would take too long to receive. Others reported a lack of transportation, an expectation that they would not be treated, and uncertainty about what to do when feeling unwell, all contributed to delaying care (KFF, 2021). In comparison, 19% of White adults delayed care (KFF, 2021). It is also important to point out that these barriers disproportionately impacted Black and Latinx individuals, as a large number of essential workers do not have the time or flexibility to travel to vaccination sites or take time off of work to receive vaccinations (Njoku et al., 2021).

Not only was it difficult to access COVID-19 treatment, but it also hindered people's ability to seek mental health services. According to Horesh and Brown (2020), COVID-19 disrupted people's familiar and otherwise easy access to their social support networks, such as behavioral health services, resulting in a decline in social support. For the first year of the COVID-19 pandemic, disorganized response policies led to uncertainty about whether and how long people had to stay physically separated from their support communities to stem the virus' spread (Horesh & Brown, 2020). Remarkably, as of September 2020, more Latinx adults (28%) and Black adults (19%) reported starting or increasing their alcohol or drug use compared to White adults (13%). Furthermore, fentanyl-related deaths, which have accounted for many overdose deaths during the drug epidemic, may also disproportionately affect Black communities (Cook-Cole, 2023).

A number of negative effects of the pandemic, including increased mental distress, job loss, infections, and deaths from COVID-19, have been experienced by people of color, including substance use problems. There were over 20 million people over the age of 12 who reported experiencing substance use disorders in 2019. However, only 10% of these individuals sought treatment in the past year. Among individuals with a past-year substance use disorder and unmet treatment needs, 24% did not know where to find services, and 21% did not have health insurance and were unable to afford services. There were fewer than half (42%) of people of color who completed substance use treatment, according to 2018 data. The issues of access to care and low utilization rates were more pronounced among people of color. People of color and Black individuals had less access to buprenorphine than White individuals and were less likely to receive special treatment and complete public-funded treatment (Artiga et al., 2021).

It is also important to note that individuals with mental health problems are known to have low levels of help-seeking. However, as discussed previously, these communities already have barriers that continue to fuel the avoidance of seeking help, exacerbating symptoms, especially during COVID-19. Lara-Cinisomo et al. (2023) found that the rate of depressive and anxiety symptoms was significantly higher in Latinas compared to Black women living in a Midwestern state during the pandemic. Symptoms of depression and anxiety were significantly higher for women anticipating a job loss or reduction of work hours. The reduction in work hours was also associated with higher depression and anxiety symptoms. General and specific concerns about COVID-19 had a positive association with depressive and anxiety symptoms. In Maryland, Bray et al. (2021) found a 94% increase in suicide among Black residents compared to a 45% decrease among White residents. Furthermore, the risk of domestic violence or intimate partner violence also increased during the pandemic.

Peitzmeier et al. (2022) indicated that the prevalence of intimate partner violence may have increased due to stay-at-home policies making it harder to escape abusive partners. Victims living with perpetrators who may monitor their activities may limit their chances of seeking assistance. Esperanza United (2021) indicated that the low reporting rates and self-help-seeking among Latinas experiencing domestic violence can create an impression that domestic violence services are unnecessary. According to Zarza and Adler (2008), in one study about half of Latina victims of abuse did not report abuse. Fear, low confidence in the police, shame, guilt, loyalty and/or fear of partners, fear of deportation, and previous victimization may contribute to underreporting (Zarza & Adler, 2008). The same contributors applied during COVID-19. In another study conducted from January through April 2021, Willie and colleagues (2023) interviewed 50 Black women who had experienced intimate partner violence. To identify sociostructural factors shaping housing insecurity, a hybrid thematic and interpretive phenomenological analytic approach was used guided by intersectionality. Results indicated that the COVID-19 pandemic affected Black women IPV survivors in various ways, according to their findings (Willie et al., 2023). Five themes were derived to capture factors contributing to housing experiences: challenges of separate and unequal neighborhoods, pandemic-related economic inequalities, economic abuse limitations, and the mental toll of evictions (Willie et al., 2023).

Once primary care and mental health services transitioned to telehealth or remote services, it increased services and access and added limitations to already present barriers for these communities. Njoku et al. (2021) indicated that access to traditional computers and home broadband could vary by race and ethnicity. Evidence suggests that Black and Latinx adults in the United States continue to be less likely, than non-Latinx Whites and Asians, to own

traditional computers or be connected to high-speed Internet at home (Atske & Perrin, 2021). Language also impacted the use of telehealth services and access to Internet-based resources. For Spanish-speaking Native Americans, inaccurate Spanish translations are a problem, causing confusion and wasting valuable time (Njoku et al., 2021). Additionally, websites fail to mention that vaccines are free, and vaccination clinics do not have translation help in specific languages. Many state and county health departments use translation software that is limited, and state vaccine-finder websites do not have translation help (Njoku et al., 2021). As a result of inadequate translation, non-English speakers may continue to experience fear, confusion, vulnerability, and skepticism about COVID-19. They may be unable to express their concerns or needs, avoiding seeking help when needed.

Misinformation and Governmental Policies

According to Pedraza et al. (2022), there are many theories about COVID-19 vaccines, creating widespread misinformation and distrust that affect the general population and increase vaccine hesitancy. Díaz and Celedón (2021) reported that Latinx communities had reported rumors that vaccines could cause DNA changes, tracking devices, infertility, cancer, and mutations. This hesitancy was also influenced by concerns about rapid vaccine development, concerns regarding rushed clinical trials, and a perceived lack of transparency regarding vaccine effectiveness (Jimenez et al., 2021). In the Black community, misinformation included denying COVID-19 case estimates and linking the disease to other infections, such as malaria and Ebola (Tibbels et al., 2021). There are those who believe COVID-19 does not exist in their country and is a government ploy to collect money from donors (Emojong, 2021; Igbinovia et al., 2021).

A study performed by Goon and Okafor (2020) in South Africa noted that there was an intentional misrepresentation of the facts regarding the immunity of certain races to COVID-19,

including Black individuals. Among the rumors with profound negative implications for people's perceptions of COVID-19 are that the vaccine will alter people's DNA, that it was developed in a hurry and is untrustworthy, that it contains a chip, that it is ineffective, that it is unsuitable for Black people, and that it has severe adverse side effects (Talabi et al., 2022). The deluge of misinformation overtook the efforts on the Internet to counter misinformation. During a March 2021 study, Herrera-Peco et al. (2021) reported that 49% of Latinx respondents considered COVID-19 misinformation to be a severe problem, and 20% of Latinx respondents claimed that misinformation about the COVID-19 vaccine had been shared directly with them, most commonly through Facebook (Latino Anti-Disinformation Lab, 2021). These studies emphasized how essential it is to address misinformation about the COVID-19 pandemic to establish trust within the healthcare system.

As for the impact of government policies on the help-seeking behaviors of the Latinx and Black communities, it is important to address the government administration during this critical time. During the COVID-19 pandemic, former U.S. president, Donald Trump, faced criticism for his views and statements regarding ethnic minorities. Trump's administration faced criticism for handling the pandemic's impact on ethnic minorities. COVID-19 disproportionately impacted Black and Latinx communities, with higher infection and mortality rates. Among other things, Trump's reluctance to impose a nationwide mask requirement and his refusal to wear a mask impacted the country's views on masks and created confusion over the importance of masks in preventing the spread of the virus (Kahane, 2021). Despite the governments' misperception of masks, data were obtained from the COVID-19 Impact Survey, a cross-sectional, nationally representative survey of adults living in the United States. This study examined 4688 non-institutionalized adults living in the United States from late April to early June 2020 (Hearne &

Niño, 2021). To estimate differences in mask-wearing patterns, logistic regression models with robust standard errors were used (Hearne & Niño, 2021). The results revealed that Black, Latinx, and Asian respondents were likelier than White respondents to wear masks (Hearne & Niño, 2021). This increase in prevention within the communities could be attributed to the high mortality rates from COVID-19 that may have instilled fear in these individuals.

According to Gonzales et al. (2020), President Trump specifically targeted Mexican and Central American communities through anti-immigrant rhetoric and implementation of policies hindering access to services, thereby exacerbating anxieties in these communities (Reilly, 2016; Verea, 2018). Díaz McConnell et al. (2023) examined how worries regarding deportation, respondents' citizenship and legal status, perceptions regarding the Trump administration, anti-Latinx discrimination, and pandemic-related concerns predicted variation in Latinx self-reported psychological distress. Results indicated that worrying about a family member or a friend being deported, perceiving higher anti-Latinx discrimination, and viewing COVID-19 as a threat to respondents' personal health and finances were significantly associated with higher psychological distress (Díaz McConnell et al., 2023).

As a result, ICE efforts and exclusionary policies were intensified during the height of the virus, creating a climate of fear and oppression (Cardoso et al., 2021). When President Trump suspended temporary protected status for some countries and ended DACA, immigrants with these protections became undocumented and at risk of deportation. Notably, with the support from President Biden's administration, the Department of Homeland Security continued to process DACA renewal requests and related employment authorization requests as of October 31, 2022 (Artiga & Pillai, 2023). However, it cannot process initial DACA and employment authorization requests under the current court order, so these requests remain on hold (Artiga &

Pillai, 2023). This continues to be an ongoing process through the courts (Artiga & Pillai, 2023). In addition to U.S. citizens, many Latinx families consist of under- or undocumented individuals. The mental and physical health of these "mixed-status" families may be adversely affected by the anti-immigrant policies implemented at the state and county levels. In 2017, Trump also denied federal aid to Puerto Rico following Hurricane Maria, despite giving copious aid to Texas and Florida after those states were struck by hurricanes, a decision that cost many lives (Woolhandler et al., 2021). These policies inflict daily stress that adversely impacts physical and mental health (Held et al., 2022).

For the Black community, Goodwin and Chemerinsky (2021) indicated that despite President Trump's bold and unsubstantiated claims that "nobody has done more for Black Americans than I have" (p. 322) and that his staff and senior officials are doing everything in their power to address the pandemic issues, the data do not support those claims. As a result, COVID-19 paints a different picture in terms of racial disparities on the impact of the pandemic on this community (Goodwin & Chemerinsky, 2021). During the Trump administration, policies were detrimental to various diverse groups, and ideas of incited racial, nativist, and religious hatred were spread by the president and fellow government entities, provoking vigilante and police violence (Woolhandler et al., 2021). According to Woolhandler et al. (2021), the administration also denied refuge to migrants fleeing violence and oppression and abused immigrant detainees; undermined health coverage for immigrants; weakened food assistance programs; curtailed reproductive rights; undermined global cooperation for health; triggered trade wars; shifted resources from social programs to military spending and tax windfalls for corporations and the wealthy; and subverted democracy both nationally and internationally. During his administration, President Trump followed the tradition of most previous U.S.

presidents by implementing policies and programs that continued to favor White counterparts at the expense of Black individuals and other minorities (Clayton et al., 2021).

In sum, the COVID-19 pandemic has profoundly affected help-seeking behavior, and several factors have contributed to this. Mistrust and stigmatization surrounding the virus, in combination with the politicization of the pandemic, have undermined public trust in government policies and public health authorities. In turn, this mistrust has led to a reluctance to seek health care and mental health treatment or to comply with recommended public health guidelines. To move forward, the underlying factors that have contributed to stigma, mistrust, and inequalities in healthcare access must be addressed. By increasing access to care for marginalized communities and implementing effective public health policies that address health and mental health disparities within the Latinx and Black communities, we can take preventable steps to assist ethnic minorities during future global epidemics and natural disasters.

CHAPTER V: DISCUSSION

Summary of Findings

This clinical research project critically reviewed the literature on the impact of the COVID-19 pandemic on the Latinx and Black communities. It specifically reviewed how existing disparities impacted the outcomes of the pandemic, the pandemic's impact on mental health disparities, and how the pandemic discouraged help-seeking behaviors among Latinx and Black individuals. The following chapter discusses the findings of the research questions, clinical implications, limitations, and recommendations based on this review. Three questions guided this review:

1. How did COVID-19 exacerbate the present health disparities in the Latinx and Black communities?
2. What is the impact of COVID-19 on mental health disparities of Latinx and Black communities?
3. How did COVID-19 discourage help-seeking behaviors of Latinx and Black communities?

Regarding question one, reviewing the disparities and outcomes of the COVID-19 pandemic on the Latinx and Black communities, the pandemic has highlighted and intensified existing inequalities for these groups in the United States. The lack of access to high-quality care to treat life-threatening illnesses has placed minorities at higher risk of contracting COVID-19. Hence, minorities are commonly stricken by infectious diseases at disproportionately greater levels than the rest of the population (Grief & Miller, 2019). This was the case for the Latinx and Black communities during the pandemic. Current CDC (2023) COVID-19 death data reported that 155,136 Black individuals and 170,422 Latinx individuals have died in the United States of

the 1,125,000 official COVID-19 deaths in the United States. COVID-19 cases are also twice as prevalent in Latinx and Black individuals as their White counterparts (CDC, 2023). Mainly, between 2019 and 2020, the Latinx life expectancy was reduced by 3.0 years and 2.9 years for the Black population compared to 1.2 years for the White population (Arias et al., 2021).

Unfortunately, Black and Latinx adults are more likely to have underlying health conditions that increased their risk of severe COVID-19 illnesses, such as asthma, diabetes, obesity, and heart disease (Kompaniyets et al., 2021). Individuals with any of these underlying issues are more susceptible to experiencing high-risk symptoms of COVID-19 (Kompaniyets et al., 2021). Critical factors, such as limited healthcare access, medical mistrust, and others, have contributed to late diagnosis and negligible care of infectious diseases among susceptible minority communities (Lopez et al., 2021). Mainly, these communities had a greater probability of being uninsured and lacking a usual source of care, which made accessing COVID-19 testing and treatment difficult (SAMHSA, 2020b).

During the pandemic, Black and Latinx children were at a higher risk of infections, severe illnesses, and death from COVID-19 due to poverty (Kim et al., 2020b). During the school closures, these children lacked access to support (e.g., in-person tutoring, after school programs, study groups), making it challenging to succeed academically. Alternatively, in areas with a disproportionate number of people experiencing poverty, schools were often under-resourced, overcrowded, and understaffed, contributing to increased risk for the transmission of COVID-19, and adding to the challenges associated with reopening in a safe manner (Levinson et al., 2020).

As the closure increase was occurring during the pandemic, so was unemployment. Black and Latinx people suffered disproportionate work loss (Kurtzleben, 2020). In April 2020, the

U.S. Bureau of Labor Statistics (2020) reported that at the height of the first wave of the pandemic, national unemployment rates were 16.7% for Black people, 18.9% for Latinx people, and 33.1% higher in comparison to 14.2% of White people. This meant that many lost their employer health insurance coverage. For instance, 13% of Black and Latinx individuals lost their coverage versus 6% of White individuals (Sloan et al., 2020). Adversely, the unemployed are more susceptible to stress-related illnesses, such as cardiovascular disease, hypertension, and diabetes, which are all risk factors for negative COVID-19 outcomes (U.S. Department of Health and Human Services, 2000, as cited in Singu, et al., 2020).

Education and gender also played roles in the increase in unemployment. During the pandemic, Black and Latinx women lost the most jobs, and even with economic recovery, they continue to have the lowest levels of employment (Baumgartner, 2021). Likewise, individuals without college degrees have less access to remote work and earn less than high-income earners (U.S. Census Bureau, 2019). There is a significant overrepresentation of Black and Latinx individuals in essential service industries, including sub-standard healthcare sectors, such as home health aides, nursing home staff, and hospital janitorial, food service, laundry, and other sectors (U.S. Department of Housing and Urban Development, 2022). Because of the large numbers of Black and Latinx essential workers who are not able to work from home, this creates an increase in exposure to the virus and unfortunately many of these workers are not provided with adequate protective equipment (“Plight of Essential Workers,” 2020).

To maintain public health safety, schools were required to close and eventually transition to virtual education. Schools have the ability to provide many resources to students and families. These are all resources that can contribute to health outcomes for many children, especially those experiencing poverty and systemic disadvantage (Robert Wood Johnson Foundation, 2009).

Black and Latinx children are at higher risk of infections, severe illnesses, and death from COVID-19 due to poverty (Kim et al., 2020b). School closures prevented these children from receiving academic support. For Black children, access to technology for online learning was particularly challenging across socioeconomic lines (Friedman et al., 2021). Low-income Latinx parents experienced stress when supporting their children during COVID-19 (Soltero-González & Gillanders, 2021). Due to the lack of devices, Internet access, and live teacher contact during the COVID-19 pandemic, Latinx and Black students had less opportunity to achieve (Dorn et al., 2020).

There is also a greater prevalence of environmental issues in poor and minority communities, contributing to many COVID-19 risk factors (Moore et al., 2020). Black and Latinx children are more likely to grow up in communities near toxic waste sites (United States. General Accounting Office, 1995, as cited in Satcher & Higginbotham, 2008). Exposure to environmental toxins in childhood can harm health outcomes, eventually having long-term consequences in adulthood. Specifically, as discussed previously, underlying health illnesses affect these communities the most and can worsen when exposed to toxins, which increases susceptibility to serious COVID-19 because exposure to toxins weakens the respiratory and immune systems of these individuals (Wong et al., 2022). COVID-19 has also affected individuals living in densely populated metropolitan areas who did not have health insurance and limited access to health care (Shadmi et al., 2020). For instance, a predominantly Black county's death rate was six times higher than a predominantly White county's (Moore et al., 2020). In communities where environmental issues are often associated with poverty (Moore et al., 2020), individuals are unable to afford treatment, especially during the pandemic when there was significant loss of employment and healthcare benefits.

Black and Latinx communities also had difficulty accessing testing sites during the COVID-19 pandemic. Latinx and Black people were likelier to walk or take public transportation to access testing sites (Pedraza et al., 2022). Due to crowding and long wait times, many felt unsafe traveling to testing centers, increasing their infection risk (Galletly et al., 2021). Low-income neighborhoods did not have enough testing options, and "drive-by" sites were primarily accessible by private vehicles (Poteat et al., 2020). These communities would not have known if they were transmitting the virus if testing sites were not accessible. These communities were also restricted from accessing at-home tests, which would have reduced transportation costs (Poteat et al., 2020). The closure of local clinics also impacted the ability to access COVID-19 tests making it more challenging to receive the care these individuals needed.

In these communities, immigration status also has played a critical role in health disparities, especially during the pandemic. Immigration status affected some states more than others during the pandemic. In some areas, such as New York and Chicago, Latinos' immigration status was reported to have contributed to disparities during the pandemic; only 23% had insurance, while 64% were undocumented, limiting their access to healthcare (Pedraza et al., 2022). Attributions of the virus to immigrants from Latin America, specifically Mexico, led to these individuals believing they would not be entitled to healthcare because of their migratory status; and fearing that their need for medical attention or a COVID-19 test would result in negative attention that would lead to deportation (Boyce & Nevins, 2022; Galletly et al., 2021). Spanish-speaking immigrants with low health literacy have been particularly likely to suffer adverse health outcomes because of a lack of understanding of preventative care, misinformation on accessing healthcare resources, and possible language barriers (Andrasfay & Goldman, 2021). In addition, as a result of comorbidities, crowded housing, and public

transportation use, the incidence rate of COVID-19 increased by 21% and the mortality rate by 17% for individuals with racial minority status and limited English proficiency (Andrasfay & Goldman, 2021).

Question two explored the impact of COVID-19 on mental health disparities of the Latinx and Black communities. The United States faced a longstanding mental health crisis before the COVID-19 pandemic. According to Bose et al. (2017), 19% of U.S. adults were living with a mental illness in 2017, and 4.5% were living with a severe mental illness. Unfortunately, the pandemic intensified the struggle to access mental health care. A 2022 CDC report stated that "the COVID-19 pandemic has been a challenge for everyone, and racial and ethnic minority groups have been placed at higher risk for COVID-19 infection, COVID-19 severe illness or death, and pandemic-related stressors" (Thomeer et al., 2022, n.p.).

During the pandemic, Latinx individuals were four times more likely to have suicidal thoughts than Black or White individuals and twice as likely as other racial and ethnic groups (McKnight-Eily et al., 2021). There is also evidence that Latinx individuals reported significantly more anxiety and depression symptoms than their White counterparts during the pandemic (Czeisler et al., 2020; Ettman et al., 2020; McKnight-Eily et al., 2021). Additionally, amid COVID-19, substance use increased among Latinx and Black with the highest number of overdose-associated cardiac arrests in 2020 (Friedman et al., 2021). Black individuals were not only impacted disproportionately by COVID-19 mortality but also faced reduced mental health treatment (Sneed et al., 2020). Only 31% of Black individuals receiving health treatment received mental health treatment, compared to 48% of White individuals, during the pandemic (Millett et al., 2020). Overdose deaths attributed to the pandemic have been linked to various

factors, such as reduced access to interventions, increased stress because of isolation and lack of mental health support, and changes in drug types, combinations, and purity (Ghose et al., 2022).

While many were quarantining during the pandemic, Latinx and Black essential workers were providing goods and services that society needed. During the pandemic, Black and Latinx essential workers reported higher levels of depression and anxiety (Grooms et al., 2022). These essential workers were also not likely to be able to work from home to minimize virus exposure. As discussed earlier, teleworking is lower among Black and Latinx workers in the United States than among White and Asian workers (Ray and Ong (2020). For example, Latinx and Black workers were 50% less likely than White workers to telework regularly (Ray & Ong, 2020).

Because the COVID-19 pandemic also prevented immigrants and U.S. citizens living in mixed-status families from accessing a variety of government and state-sponsored pandemic relief measures due to legal status restrictions, this limited the access Black and Latinx individuals had to mental health services for these groups (Broder & Blazer, 2011). For example, a growing body of evidence indicates that minorities faced significant barriers to access telehealth during the pandemic, including a lack of familiarity with technology, a low level of health and digital literacy, sensory impairments, a lack of broadband access, and a lack of assistance during the pandemic (Hirko et al., 2020). Since in-person services transitioned to telehealth during the pandemic, the lack of Internet and deficits in digital literacy for these communities posed another barrier to obtaining adequate mental health services; therefore, experiencing significant mental health distress put them at risk of decompensating during this time.

Based on the literature on health disparities, disasters, and pandemics, Saltzman et al. (2021) concluded that the overlapping of stressors during the COVID-19 pandemic, including

physical health issues, work-related issues, and difficulty accessing health care, creates a worrisome outlook for mental health. For example, nearly 40% of Latinx and 39% of Black individuals had stress, anxiety, or great sadness, compared to 29% of White individuals (Getachew et al., 2020). It can be concluded that the pandemic exacerbated the rooted mental health disparities as well as discouraged members of the Latinx and Black communities from seeking the necessary help to improve their mental health.

Last, question three reviewed how COVID-19 discouraged the help-seeking behaviors of Latinx and Black communities. Lueck (2021) stated that COVID-19 might have amplified psychological barriers that can inhibit the willingness and ability of individuals to seek professional help, including debilitating feelings of shame and stigma. Perceived COVID-19 health threats and the belief that Black Americans face racial discrimination in medical settings were both positively and significantly associated with higher levels of psychological distress for this group (Cobb et al., 2021). Similarly, Latinx immigrants reported experiencing healthcare discrimination, such as being prevented from accessing services, being hassled, or being made to feel inferior in some way (López-Cevallos & Harvey, 2016). Ultimately, this created significant emotional distress for members of the Latinx and Black communities and lessened the engagement of help-seeking behaviors for health and mental health services.

Black and Latinx Americans reported lost health insurance during the COVID-19 pandemic at a rate of 3.0 and 2.0 times greater than White respondents respectively, further limiting access to health care (McKinsey & Company, 2022). Losing access to care can severely impact help-seeking behaviors. Latinx individuals also believed that they would not be entitled to healthcare because of their migratory status (Pedraza et al., 2022); they feared that their need for

medical attention or a COVID-19 test would result in negative attention that would expose their undocumented (Galletly et al., 2021).

It was difficult for Latinx and Black communities to access COVID-19 testing during the pandemic. Many minority populations suffered due to the lack of testing since they were essential workers. The need for testing did not correspond to the accessibility in these communities; testing occurred more in White communities than in minority communities (Lieberman-Cribbin et al., 2020). Delays in testing and primary healthcare occurred due to community clinics and federally qualified health centers closing as the pandemic began (Thankur et al., 2020). COVID-19 vaccine centers tend to be located in affluent zip codes with lower minority populations and further from neighborhoods populated by Black and Latinx individuals (Lieberman-Cribbin et al., 2020). The lack of nearby clinics and healthcare facilities created a transportation barrier for Latinx and Black individuals (Njoku et al., 2021). Moreover, residential segregation led to overcrowded hospitals as these groups had to seek services at hospitals (Garcia et al., 2021) rather than in clinics, which were shut down during the pandemic and limited access to telehealth.

The transition to telehealth or remote services during the pandemic increased primary care and mental health services but added more limitations to existing barriers. The access to traditional computers and home broadband varies according to race and ethnicity, according to Njoku et al. (2021). Access to Internet-based resources and telehealth services was affected during the pandemic, including being impacted by language. Inaccuracies in Spanish translations for Spanish-speaking Native Americans continued to be a problem during the pandemic (Njoku et al., 2021). Some websites also failed to mention that vaccines were free, vaccination clinics lacked translation assistance, state and county health departments used limited translation

software, and state vaccine-finder websites lacked translation assistance (Njoku et al., 2021). Within the communities, there is also concern about privacy and stigma associated with telehealth services among Black and Latinx individuals (Rajgopal et al., 2021; Silva et al., 2021). COVID-19 may have scared, threatened, or frightened non-English speakers because of inadequate translation leading to misinformation about COVID-19. When these individuals needed assistance, they may have been unable to express their concerns.

During the pandemic, the U.S. government implemented policies that were detrimental at the time, such as the public charge, focused on the Latinx community, specifically the immigrant community. The Trump administration has been criticized for handling ethnic minorities poorly during the pandemic. Gonzales et al. (2020) claimed that President Trump specifically targeted Latino and Central American communities, causing anxiety in these communities (Reilly, 2016; Verea, 2018). The Trump administration policies led to racial, nativist, and religious hate and violence during the pandemic (Woolhandler et al., 2021). The suspension of temporary protected status for some countries and ending of DACA caused immigrants with these protections to become undocumented and at risk of deportation at this time. The denial of federal aid to Puerto Rico in 2017 following Hurricane Maria, despite giving copious aid to Texas and Florida after those states were struck by hurricanes, was a decision that cost many lives (Woolhandler et al., 2021). As such, these policies inflict daily stress that adversely impacts physical and mental health (Held et al., 2022), but also it impacts the level of trust in the government and deters these communities from seeking help. Because of mistrust in government, these communities remain wary of seeking support due to apprehension of potential consequences, perceived inefficiency, or doubts about the legitimacy of support.

Misinformation about the COVID-19 virus also hindered help-seeking behaviors in Latinx and Black communities. In Latinx communities, reported rumors of vaccines causing DNA mutations, having tracking devices, causing infertility, cancer, and mutations, circulated and impacted seeking vaccination and other treatments (Díaz & Celedón, 2021). In addition, concerns regarding rapid vaccine development, rushed clinical trials, and a lack of transparency regarding vaccine effectiveness influenced this hesitancy (Jimenez et al., 2021). In the Black community, COVID-19 misinformation linked the virus to malaria and Ebola and the denial of the number of case infections in the community (Tibbels et al., 2021). Many Black and Latinx individuals believe COVID-19 does not exist in their country and that it is a government ploy to collect money (Emojong, 2021; Igbinovia et al., 2021). The amount of misinformation spread about COVID-19 created significant confusion and further impacted the level of distrust in the public health authorities that was already present due to historical experimentation on these communities without their consent; therefore, these communities relied on unproven treatment or unreliable sources instead of seeking professional help (Díaz & Celedón, 2021).

As a result of the COVID-19 pandemic, the behavior of people seeking help has been profoundly altered, and many factors have played a role in this. In conjunction with the politicization of the pandemic, mistrust and stigmatization surrounding the virus have undermined public trust in government policies. In turn, this mistrust has led to a reluctance to seek health care and mental health treatment or comply with recommended public health guidelines due to the substantial fear and worries these individuals feel regarding their future and their families. Additionally, there was a significant lack of culturally and linguistically competent clinicians that also created a barrier in obtaining culturally sensitive care. The underlying factors that have led to stigma, mistrust, and inequalities in healthcare access must be addressed. Taking

preventable steps to assist ethnic minorities during future global epidemics and natural disasters can be achieved by increasing access to care for marginalized communities and implementing effective public health policies that address health and mental health disparities within Latinx and Black communities.

Clinical Implications and Future Directions

The literature reviewed in this paper provides compelling evidence of the significant impact of COVID-19 on the Latinx and Black communities. The findings underscore the urgent need for health and mental health clinicians, policymakers, and advocates to take proactive steps to address these communities' complex and multifaceted challenges. Clinicians need to be proactive in discussing directly with Black and Latinx clients the impact of the pandemic on them and their families to better understand the pandemic sequelae for these individuals and families. Family is essential in these communities, and it is a contributing factor in the views on mental health and help-seeking behaviors; therefore, it may be possible to improve mental health outcomes for Latinx and Black communities experiencing mental health issues by implementing culturally relevant family interventions (Jimenez et al., 2022). Clinicians can provide psychoeducation to clients and dispel misinformation that has prevented many Black and Latinx individuals from seeking help.

Moreover, it is essential that clinicians also provide culturally responsive and trauma-informed care that takes into account the unique needs and experiences of the Latinx and Black communities. Clinicians should be sensitive to cultural differences and work to create a safe and supportive environment that fosters trust and respect. According to Paniagua (2005), some Latinx clients do not admit to their religious or folk beliefs in the first session, but the mental health practitioner needs to explore this subject to understand the client. These communities have

faced substantial historical trauma (e.g., racism, discrimination, stigma, anti-immigration policies, police brutality), and clinicians must consider how past traumas can continue to hinder these individuals.

To provide adequate care, it is critical that clinicians screen and assess for COVID-19-related mental health concerns, such as anxiety, depression, and trauma, among the Latinx and Black communities, as well as assess the impact of the virus on the communities. By developing and implementing COVID-19-specific screening instruments, we can detect COVID-19-related trauma symptoms earlier, preventing chronic trauma (Czeisler et al., 2020). To reduce the risks of increased substance abuse associated with COVID-19, resources such as social support, treatment options, and harm reduction services are essential (Czeisler et al., 2020). Mental health, substance abuse, and suicidal ideation should be periodically evaluated to determine if psychological distress has increased due to the pandemic (Czeisler et al., 2020). Mental health professionals should be cautious in identifying and addressing mental health concerns related to COVID-19, particularly in light of the disproportionate impact of the pandemic on these communities. Clinicians should also collaborate with community-based organizations and other healthcare providers to provide comprehensive and coordinated care to the Latinx and Black communities. Promoting health services and providing culturally and linguistically relevant prevention messaging concerning mental health practices should be the focus of communication strategies (Czeisler et al., 2020). Clinicians must strive to work as part of an interdisciplinary team to ensure that patients receive the full range of services they need, including medical care, social services, and mental health care.

Finally, clinicians should advocate for policies and programs that address the root causes of health disparities in the Latinx and Black communities. Clinicians should be vocal advocates

for policies and programs that promote health equity and social justice and work to dismantle systemic racism and other forms of oppression that contribute to health disparities.

Future research could continue to focus on understanding and addressing the social determinants that contribute to health and mental health disparities in the Latinx and Black communities. Most importantly, it is imperative to understand the specific impact of the recent pandemic on these communities' access to mental health care and help-seeking behaviors. According to Vasquez Reyes (2020), recognizing the social determinants of health and their role in shaping the impact of COVID-19 on the health of ethnic minority communities is crucial. By understanding the intersection of distinct structural barriers, mental health providers can better understand how COVID-19 and health disparities affect different groups. The goal is to promote health equity and social justice for all by recognizing the collective nature of the right to health (Vasquez Reyes, 2020). Therefore, clinicians can work to address these factors as part of their clinical practice.

Based on this review of the literature, a series of questions, both in English and Spanish, that can assist clinicians in evaluating the impact of the COVID-19 pandemic on the mental health of racial/ethnic minorities are suggested (see Appendix A and B). The questions can be used by clinicians during intake or initial assessments and can provide opportunities to discuss with Latinx and Black clients the barriers they face for continued help and support as well as for building trusting relationships.

Limitations

Because the COVID-19 pandemic is fairly recent, the literature is continuing to develop; therefore, there is limited literature on the topic. There have been disruptions in research and data collection, particularly for studies requiring in-person interactions or data collection.

Historically, research and healthcare have also excluded or underrepresented the Latinx and Black communities, leading to minimal research on these communities. These communities were underutilizing healthcare services during the pandemic. Therefore, it has been difficult to collect and analyze data on the impacts of COVID-19 on these communities.

A limitation associated with current studies regarding the impact of the COVID-19 pandemic on Latinx and Black communities is related to limited sample sizes, which restricts the literature discussing the differences in various subgroups within the Latinx and Black communities. According to a study by Pérez-Brescia (2022) examining the factors affecting the Latinx community's access to healthcare during COVID suggested that a small sample size could lead to biases, heterogeneity, and less robust results. Alegría et al. (2008) indicated that in their study, regarding the prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups, there was a lack of exploration of the differences in the mental health outcomes of the Latinx population and having a small number of participants does not allow for country of origin differences to be accounted for, which also impacts the understanding of the precursors for mental illness for these subgroups.. The importance of identifying how mental health disorders vary across Latino subgroups can allow researchers and mental health professionals to understand the needs of different subpopulations and target culturally responsive mental health services.

Another imitation was identified by Thomeer et al. (2022) regarding the ability of place of residence to explain differences in mental health outcomes during the pandemic. As a result, it seems plausible that contextual differences relating to the pandemic (e.g., rates and deaths from COVID-19, policies such as school closures) could explain disparities in anxiety and depression since White individuals are more concentrated in rural areas and Black, Asian, and Latinx

individuals are more concentrated in urban areas (Thomeer et al., 2022). As a result, research in the future could examine whether place of residence plays a role in mental health disparities (Thomeer et al., 2022). There is also a need for future research to continue to explore the extent of the factors contributing to adverse mental and behavioral health during the COVID-19 outbreak, including social isolation, a lack of school structures, unemployment, other financial worries, and other forms of violence (e.g., physical, emotional, mental, or sexual abuse) (Czeisler et al., 2020). There is also a gap in the literature exploring the mental health stigma in the Latinx and Black communities. DeFreitas et al. (2018) suggested a gap in the literature examining the correlation between mental health stigma and Latinos. This is possible because there is a level of shame that many Latinos experience when discussing the topic of mental health. Likewise, Taylor and Richards (2019) emphasized the gap in literature addressing Caribbean Black women's experience with mental health. The literature on interventions to address the stigma within ethnic minorities is also limited, which creates barriers for clinicians to develop adequate interventions to minimize mental health stigma (Taylor & Richards, 2019). The literature is significantly limited regarding these specific communities, which makes it challenging to ascertain the impact of health disparities as well the effects of the pandemic.

Recommendations

Health and mental health providers and other members of other public sectors must collaborate to address health disparities within the Latinx and Black communities. As Vasquez Reyes (2020) emphasized, since the COVID-19 pandemic goes beyond a health crisis and disrupts and affects every aspect of life, including family life, education, finances, and agricultural production, a multidisciplinary approach is required. The healthcare sector and other social and economic sectors need to form stronger partnerships. Collaboration is vital to

addressing the many connected issues that have emerged during this pandemic, particularly those that impact marginalized and vulnerable populations (Vasquez Reyes, 2020). Tai et al. (2022) indicated that to avoid unintended consequences, future pandemic mitigation policies should be analyzed early through an equity lens. During future pandemics, institutional investment in widely accessible, integrated healthcare delivery will be necessary as a foundation. Access to healthcare may be further bridged by medical homes providing transportation to and from medical appointments, language services, and outreach by community health workers (Tai et al., 2022).

It is essential to fund scholarships and provide financial assistance for higher education to address the lack of culturally competent clinicians and promote equitable access to healthcare. To cultivate a more diverse field, we need to invest in these underrepresented communities. Providing scholarships and financial aid to Latinx and Black students could remove some obstacles preventing them from pursuing higher education. It is our responsibility to support trainees' education so that they can develop cultural competence, understand their communities' needs, and provide culturally sensitive care. The increased representation of Latinx and Black healthcare professionals would ultimately improve marginalized populations' help-seeking behaviors, foster trust, and improve their health outcomes.

For Latinx and Black communities to be encouraged to seek help, mental health providers should address the stigma associated with mental health. To minimize the stigma of mental health, Harris et al. (2021) suggested that these communities would benefit from resources that combine traditional anti-stigma efforts with religious components. For example, mental health professionals and local pastors could collaborate to offer psychoeducational workshops and programs to educate the community about mental health. DeFreitas et al. (2018) recommended

that mental health practitioners develop programs specifically targeting ethnic minority groups to reduce the stigma associated with mental health services. People with mental health problems of the same ethnicity, individual interactions, and addressing specific stigma areas (e.g., interpersonal anxiety, severity, treatment ability of mental illness) can reduce stigma (DeFreitas et al., 2018), resulting in better mental health outcomes. Government officials must also implement policies and laws that provide health coverage to immigrants. Also, bilingual providers are essential for instilling trust in the community and minimizing the language barrier so they can seek health care when needed. They also provide resources and information to educate Latinx individuals on health care.

The expansion of telehealth services to Latinx and Black communities is a means of reducing COVID-19-related mental health consequences and the potential adverse mental health impacts of epidemics to provide treatment for mental health conditions such as depression, substance abuse and suicidal ideation among others (Czeisler et al., 2020). Expanding services requires addressing barriers in technology literacy, access to high-speed Internet, and access to smartphones and other devices (Czeisler et al., 2020).

As the Latinx and Black communities are encouraged to utilize technology, it is important to encourage them to seek valid mental health resources instead of relying only on social media platforms. Establishing collaborative partnerships and collaborating with community leaders are essential. Providers, organizations, and community members should collaborate to raise awareness about the importance of getting accurate and reliable information. Workshops, community forums, and culturally appropriate materials can be used to address mental health topics in a culturally relevant manner. Participating actively in the development and dissemination of the information would guarantee that it is culturally appropriate, accessible,

and trustworthy to these communities. By using validated sources such as healthcare institutions, government agencies, and mental health organizations, individuals can navigate the vast amount of information available. The goal is to empower the Latinx and Black communities to make better mental health decisions, improve help-seeking behaviors, and improve community wellbeing by emphasizing the importance of evidence-based resources.

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Appendix A

Impact of the COVID-19 Pandemic on the Mental Health of Racial/Ethnic Minorities

Questions

The following questions can assist clinicians in screening the impact of the COVID-19 pandemic on the mental health of racial/ethnic minorities. Clinicians can complete this screener with the client at the onset or at any stage of treatment. It is essential the clinician utilizes clinical skills, cross-cultural skills, and culturally adapted evidence-based approaches to further assess the severity of the pandemic on the patient's mental well-being.

Patient's Name: _____ Date: _____

Patient's DOB: _____ Age: _____

Gender: Male: _____ Female: _____ Other: _____

How do you define your marital status? *Please select one*.

☐Single

☐Married

☐Divorced

☐Widow/Widower

☐Other *(Please Specify)* _____

What is your race or ethnicity? *Select all that apply.*

☐White or Caucasian

☐ Hispanic or Latino/a

☐Black or African American

☐ American Indian or Alaska Native

☐ Asian or Pacific Islander

☐Multiracial or Biracial

☐Other *(Please Specify)* _____

What is your employment status?

☐Student

☐Employed

☐Unemployed

☐Retired

☐Other *(Please Specify)* _____

What is your occupation or job? _____

Instructions: Please answer the following questions based on your experiences during the COVID-19 pandemic and post-pandemic.

During the COVID-19 pandemic…

1. How has the COVID-19 pandemic affected you personally, and how has it impacted your mental health?
2. Can you tell me about any challenges you've faced related to the pandemic that have been particularly difficult for you? (e.g., loss of employment, death of family members or friends, exposure to the virus, etc.)
3. Can you talk about any specific ways that the pandemic has impacted your daily life and routine? (e.g., limited social interactions, virtual communication, remote work, etc.)

4. Have you or anyone you know been directly impacted by COVID-19? If so, how has that affected your mental health?
5. Have you noticed any differences in how the pandemic has affected your community compared to others?
6. Have you noticed any disparities or inequities in access to healthcare or other resources related to COVID-19 within your community?
7. Have you experienced any discrimination or marginalization related to the pandemic? If so, how has that affected your mental health?
8. Can you speak to any cultural or societal factors that may contribute to mental health stigma related to the pandemic in your community?
9. What resources have you found helpful in coping with the challenges posed by the pandemic, both in terms of your physical and mental health?
10. How do you think we can better support you and perhaps members of your community in addressing the mental health impacts of the pandemic?

Post-COVID-19 Pandemic…

1. Can you tell me about any challenges you've faced in the post-pandemic world that have been particularly difficult for you?
2. How has your daily routine or activities changed since the pandemic ended?
3. Have you noticed any differences in how the post-pandemic world has affected your community compared to others?
4. Have you experienced any lingering effects of the pandemic on your mental health?
5. Can you talk about any specific worries or concerns you have related to the post-pandemic world?

6. Have you noticed any differences in access to resources or opportunities in the post-pandemic world within your community?
7. Can you speak to any cultural or societal factors that may contribute to mental health stigma in the post-pandemic world for you and your community?
8. Can you speak to any changes you've noticed in how people in your community are responding to the post-pandemic world?
9. How have you been coping with the transition out of the pandemic and into the new normal?
10. What resources or support do you think would be helpful for you in adjusting to the post-pandemic world?

Additional Information:

_____

_____

_____

_____

_____

_____

_____

Appendix B

Preguntas Sobre El Impacto de La Pandemia de COVID-19 En La Salud Mental de Las Minorías Raciales/Étnicas

Versión en Español

Las preguntas siguientes pueden ayudar a los profesionales de la salud mental a evaluar el impacto de la pandemia de COVID-19 en la salud mental de las personas pertenecientes a minorías raciales/étnicas. Los profesionales pueden completar esta evaluación con el paciente al inicio o en cualquier etapa del tratamiento. Es esencial que el profesional utilice habilidades clínicas, interculturales y prácticas culturales basadas en evidencia para evaluar más a fondo la gravedad de la pandemia en el bienestar mental del paciente.

Nombre del Paciente: _____ Fecha: _____

Fecha de Nacimiento del Paciente: _____ Edad: _____

Sexo: Masculino: _____ Femenino: _____ Otro: _____

¿Cuál es tu estado civil? *Por favor, seleccione uno.*

☐Soltera(o)

☐Casada(o)

☐Divorciada(o)

☐Viuda(o)

☐Otro *(Por favor especifique)* _____

¿Cuál es su raza o cultura étnica? *Seleccione todas las que correspondan.*

☐Caucásico(a) o Blanco(a)

☐ Hispano(a) o Latino(a) o Afro-Latino(a)

☐Negro(a) o Afroamericano(a)

☐Indio(a) Americano(a) o Nativa(o) de Alaska

☐ Asiático(a) o Isleño(a) del Pacífico

☐Multiracial o Biracial

☐Otro *(Por favor especifique)* _____

¿Cuál es tu situación laboral o trabajo?

☐Estudiante

☐Empleado(a)

☐Desempleado(a)

☐Retirado(a)

☐Otro *(Por favor especifique)* _____

¿Cuál es tu ocupación o trabajo? _____

Instrucciones: responda las siguientes preguntas según sus experiencias durante la pandemia de COVID-19 y después de la pandemia.

Durante la pandemia de COVID-19…

1. ¿Cómo le ha afectado personalmente la pandemia de COVID-19 y cómo ha afectado su salud mental?
2. ¿Puede contarme sobre algún desafío que haya enfrentado relacionado con la pandemia que haya sido particularmente difícil para usted? (por ejemplo: pérdida de empleo, muerte de familiares o amigos, exposición al virus, etc.)

3. ¿Puede hablar sobre alguna forma específica en que la pandemia haya afectado su vida y rutina diaria? (Por ejemplo: interacciones sociales limitadas, comunicación virtual, trabajo remoto, etc.)
4. ¿Usted o alguien que conoce se ha visto afectado directamente por COVID-19? Si es así, ¿cómo ha afectado eso su salud mental?
5. ¿Ha notado alguna diferencia en cómo la pandemia ha afectado a su comunidad en comparación con otras?
6. ¿Ha notado disparidades o inequidades en el acceso a la atención médica u otros recursos relacionados con el COVID-19 dentro de su comunidad?
7. ¿Ha experimentado alguna discriminación o marginación relacionada con la pandemia? Si es así, ¿cómo ha afectado eso a su salud mental?
8. ¿Puede hablar sobre algún factor cultural o social que contribuye al estigma de la salud mental relacionado con la pandemia para usted o en su comunidad?
9. ¿Qué recursos ha encontrado útiles para hacer frente a los desafíos planteados por la pandemia, tanto en términos de su salud física cómo mental?
10. ¿Cómo cree que podemos apoyarle mejor a usted y a las comunidades minoritarias para abordar los impactos de la pandemia en la salud mental?

Despues de la pandemia de COVID-19 …

1. ¿Puede contarme sobre algún desafío que haya enfrentado en el mundo después de la pandemia que haya sido particularmente difícil para usted?
2. ¿Cómo ha cambiado su rutina o actividades diarias desde que terminó la pandemia?
3. ¿Ha notado alguna diferencia en cómo el mundo posterior a la pandemia ha afectado a su comunidad en comparación con otras?

4. ¿Ha tenido algún efecto persistente de la pandemia en su salud mental?
5. ¿Puede hablar sobre alguna inquietud o preocupación específica que tenga relacionada con el mundo después de la pandemia?
6. ¿Ha notado alguna disparidad en el acceso a recursos u oportunidades en el mundo posterior a la pandemia para usted o su comunidad?
7. ¿Puede hablar sobre algún factor cultural o social que pueda contribuir al estigma de la salud mental en el mundo después de la pandemia?
8. ¿Puede hablar sobre algún cambio que haya notado en la forma en que usted y las personas de su comunidad están respondiendo al mundo después de la pandemia?
9. ¿Cómo ha estado lidiando con la transición de la pandemia a la nueva normalidad?
10. ¿Qué recursos o apoyo cree que le serían útiles para adaptarse al mundo después de la pandemia?

Información Adicional:

_____

_____

_____

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_____

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_____