Families at the Intersection of Racial Injustice, COVID-19, and Child Welfare

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Introduction

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The arrival of COVID-19 in the United States changed the nation. On March 19, 2020, California was the first state to issue a stay-at-home order due to the pandemic (Exec. Order No. N-33-20, 2020). Six days prior, on March 13, 2020, Breonna Taylor was fatally shot by police in her apartment. By May 31, 2020, 42 states and territories enacted mandatory stay-at-home orders (Moreland et al., 2020). Six days prior, on May 25, 2020, George Floyd was killed during an arrest by Minneapolis Police Officer, Derek Chauvin, who knelt on Mr. Floyd's neck for approximately 9 minutes. Earlier during the same month, video surfaced of Ahmaud Arbery being fatally shot after he was confronted while out on a jog.

While COVID-19 brought so much to a standstill, racial injustice appeared to proceed undeterred, which catalyzed national and international demonstrations against racism and police brutality. Businesses, media companies, professional associations, and other groups published statements about their plans to tackle systemic racism in their respective industries. Child welfare agencies and professional societies followed suit and likely encountered, or re-encountered, our profession's longstanding tension between strengthening families and protecting children, which cannot be treated as mutually exclusive (Sugrue, 2019).

The following provides faith-based, medical, psychological, and legal perspectives regarding the families at the intersection of child welfare involvement, racial injustice, and COVID-19. After reviewing a variety of concerns regarding the experiences of these families, we conclude with final thoughts for faith-based leaders, medical practitioners, mental health specialists, and lawyers/advocates involved in Child Protective Services (CPS) cases.

A Faith-Based Perspective on CPS, COVID-19, and Race

Charles F. Boyer, DMin

The pandemic has caused more children to be at home. This reality is extremely challenging for all families, but far more so for Black families. They face additional stress, childcare issues, cramped living conditions, and financial strains. Black children are already overrepresented in the child welfare system. When environmental stressors are exacerbated, increased disparity will inevitably occur (Brown et al., 2020). The prophetic role of Black faith leaders ("prophetic" meaning here to see the inevitable, challenge

oppressive systems, and imagine new realities) is sorely needed at the intersection of suspected child maltreatment, racial injustice, COVID-19, and CPS involvement.

Black children are 23% of those represented in the child welfare system (KIDS COUNT Data Center, 2020). Research shows race plays a role in the disproportionality (Rivaux et al., 2008). The insidious cyclical nature of systemic racism breeds poverty, implicit bias, unjust criminal and youth legal systems, the school-to-prison pipeline, limited quality healthcare, and apartheid-like housing and educational segregation. The dual pandemics of systemic racism and COVID-19 leave the most vulnerable in our society, Black children, at major risk.

We cannot understand the struggle of many Black parents to adequately care for children without understanding poverty. Economic strains lead to poor housing, nutrition, and health. Single mothers and poor families are often faced with impossible choices due to a lack of resources. Wealthier parents have access to childcare, while poor parents have to choose between work or childcare, often necessitating older siblings caring for their younger brothers or sisters. Also, poor Black parents struggling with substance use have less options than wealthier White parents.

Poverty is also the major factor in the way COVID-19 has disproportionately hit Black communities (Henry, 2020). Many people of color are service and labor workers, doing everything from food service delivery to home health aide jobs. Many do not have the privilege of working remotely. These essential workers encounter obstacles to social distancing and sheltering in place, and they have more human contact. It is the risk taken by service workers that allows the wealthy to stay safe. Also, many economically disadvantaged people live in multigenerational living spaces (Pew Research Center, 2011). These factors ensure increased community spread.

Ever since the inception of the United States, generationally persistent racial injustice has been inextricably linked to public policy and government institutions. Implicit bias is also present and operative in the child welfare system. Even when factors such as poverty are controlled for, research shows implicit bias plays a major role (Dettlaff, 2011). Starting from the very beginning of the spectrum, Black mothers are under an unwarranted level of scrutiny (Ellsworth et al., 2010; Kunins et al., 2007). Black children are more likely to be removed from the home than White children, and race has been identified as a significant factor in these decisions (Rivaux et al., 2008; Pryce et al., 2019). The very growth of the child welfare system tracks the growth of one of the nation's most racialized institutions: the criminal justice system.

Fifty years ago, President Richard Nixon declared a drug war that targeted Black people in response to accomplishments of the civil rights movement (LoBianco, 2016). As a result, Black people are more than three times more likely to be arrested, convicted, and incarcerated for substance use, possession, and distribution despite the fact that rates of drug usage among Black people are similar and, in many cases, less than those of Whites (Carson & Sabol, 2012). The prison population drastically increased from 1970 to present day, making the United States the world's greatest incarcerator (Lee, 2015). As incarceration rates rose, the number of children in foster care rose dramatically (O'Neill Murray & Gesiriech, 2004). Women have been incarcerated at increasingly higher rates and their children removed as a result (Rippey, 2020).

The stressors of poverty and structural racism under normal conditions are enough to be deemed a socio-spiritual crisis. Now with the pandemic, the crushing weight of this crucible is exacerbated, and the factors cited for intervention have been magnified. Substance use and overdose, food insecurity, and domestic violence have dramatically increased (Welch & Haskins, 2020). On top of all of this, these same factors have led to higher COVID-19 death rates of Black people (Centers for Disease Control and Prevention [CDC], 2021c).

Child Maltreatment and Heath Disparities During COVID-19

Paulett Diah, MD, FAAP

Racism, a system of advantage and disadvantage based upon race and not purely on prejudicial

beliefs (Heard-Garris et al., 2018), which structures opportunity and assigns value based on how one looks (Jones et al., 2008), is a core social determinant of health (Trent et al., 2019). Defined by the World Health Organization (WHO) as, "The conditions in which people are born, grow, live, work, and age," social determinants of health are influenced by economic, political, and social factors, which are heavily linked to health inequities, independent of genetics or behavioral choices (Trent et al., 2019). Healthcare access and quality, education access and quality, economic stability, social environment and community, and neighborhood environment affect a wide range of health risks and outcomes (CDC, 2021a). According to Sondik et al. (2010), health inequities among racial minorities are pronounced, persistent, and pervasive.

Further, racism is a driver of, and may be a cause of, health inequities. It is associated with low birthweight, mental health issues, and increased poor health outcomes (Trent et al., 2019). Paradies et al. (2015) conducted a meta-analysis that corroborated prior studies showing the magnitude of associations between racism and mental health. Gee and Ford (2011) revealed that individuals who reported experiencing racism had greater rates of illnesses than those who did not. Chronic stress results in prolonged exposure to stress hormones, such as cortisol, leading to chronic inflammatory reactions, which predispose individuals to chronic disease (e.g., heart disease and diabetes mellitus). Also, racism, as a stressor, can be experienced vicariously by children (Heard-Garris et al., 2018). While this body of research has been invaluable in advancing knowledge on health inequities, it still locates the experiences of racism at the individual level. Yet the health of social groups is likely most strongly affected by structural, rather than individual, phenomena (Gee & Ford, 2011).

In addition to the above, in 2020, we witnessed the development of the healthcare emergency, the COVID-19 pandemic. Kyerematen et al. (2021) stated that the COVID-19 pandemic was a children's rights crisis, and Bryant et al. (2020) stated that adverse childhood experiences (ACEs) had potential to worsen during the COVID-19 pandemic. Pre-existing difficulties with access to healthcare and health equality were challenges system wide.

The CDC reported 30.1% of pediatric COVID-19 cases between ages 0 and 4 were Hispanic/Latino, and 27.1% between ages 5 and 17 were Hispanic/Latino (CDC, 2021b). In a sample of 576 children under age 18 from 14 states that were hospitalized with COVID-19 between March 1, 2020 and July 25, 2020, Black non-Hispanic children and Hispanic/Latino children had hospitalization rates of 10.5 and 16.4 per 100,000, respectively; the hospitalization rate for White children was 2.1 per 100,000 (Kim et al., 2020). Data concerning underlying medical conditions was available for 222 of these 576 children, and researchers found 37.8% of the children had obesity, 18.0% had chronic lung disease, and 15.4% had prematurity. Notably, a higher prevalence of chronic disease was seen in the Hispanic and Black children (45.7% and 29.8%, respectively) compared with White children (14.9%). The presence of underlying medical conditions, which predispose children to COVID-19 associated hospitalizations, appear to have a racially disparate impact.

Since the health crisis, general pediatric and pediatric subspecialties witnessed a sharp decline in healthcare services. Statewide lockdowns dramatically limited foot traffic to pediatric services, and reports to various State CPS agencies rapidly fell. In March 2019, the New Jersey child abuse hotline received 7,501 reports. In March 2021, after Governor Murphy issued a stay-at-home order, the SCR received 5,117, a reduction of 32% (Napoliello, 2020). Kaiser et al. (2021) conducted a retrospective study of data from 52 children's hospitals regarding emergency department and inpatient encounters in children ages 5 and under from January 1 to August 31, 2020. When compared to prior years, they found a sharp decline in pediatric volume and a significant decline in child physical abuse volume for a particular week. Voddi et al. (2021) also reported a decline in physical abuse and sexual abuse examinations by 72% and 63%, respectively, during COVID-19. Similarly, Cho et al. (2021) reported a reduction in incoming consultation to a child abuse program during March 2020. Notably, these findings point to a decrease in child maltreatment reports, but they do not establish an actual decline in child maltreatment during the pandemic.

Psychological Perspectives (COVID-19, Maltreatment, Injustice)

Tyshawn Thompson, MA

Black, Indigenous, and people of color (BIPOC) communities in particular have been disproportionately impacted by the COVID-19 pandemic. This is concerning given the many pre-pandemic issues marginalized communities faced, such as the healthcare disparities previously discussed. According to Fors (2018), BIPOC children are disadvantaged in terms of healthcare discrimination. She reported that modern healthcare is blemished by racial inequity and that quality healthcare is contingent upon social status, which systemically puts BIPOC communities at a disadvantage. These realities further decrease social status and healthcare opportunities for already disadvantaged groups. This vicious cycle can be incredibly distressing, especially to families requiring assistance to meet their children's needs during a pandemic.

As mental health providers working with children in a child maltreatment context, it is important to understand the child's family system to treat them—that is why we consider the effects of COVID-19 on caregivers and parenting stress. Brown et al. (2020) found that during COVID-19, caregivers have experienced mood changes, increased stress, and increased depression and anxiety symptoms. In Brown et al.'s study, Latinx parents reported the highest levels of COVID-19 associated stress among the ethnic groups studied. Decreased family support, social distancing, stay-at-home orders, financial strain, and the inability to adequately socially distance due to living in public housing were among the most notable stressors identified by these caregivers. Brown et al. (2020) also found that caregivers who experienced greater stress in the form of financial decline, as well as those who endorsed higher symptoms of depression and anxiety, had a higher potential for child abuse. Conversely, parents who felt supported—that is, they received financial support and social support and felt somewhat in control during the pandemic—were noted to have a lower potential for child abuse (Brown et al., 2020). This finding elucidates that a potential protective factor against child maltreatment is parental support and strengthening families.

Research suggests that individuals from various marginalized or non-privileged groups are at higher risk for ACEs (Mersky et al., 2013; Merrick et al., 2018). ACEs include child maltreatment, separation from a parent, having household members with mental illness, and other potentially traumatic events, which may result in subsequent health issues and functional impairment. Making things worse, upon seeking healthcare services for these issues, non-privileged groups are likely to face additional inequities (Fors, 2018).

While individuals from marginalized groups are at higher risk for ACEs (Mersky et al., 2013; Merrick et al., 2018), it is worth reiterating that reports of child maltreatment have not increased since the beginning of the pandemic. Baron et al. (2020) explored this finding by reviewing the effects of COVID-19 stay-at-home orders on students. They indicated the shift to online instruction put children at an increased risk for undetected abuse because school personnel are key reporters of child maltreatment. If undetected maltreatment has indeed increased due to remote learning and the strain of the pandemic on families, then it is reasonable to be concerned about the safety and welfare of children in families with pre-pandemic poverty, inequities, and systemic disadvantage working against them (Brown et al., 2020). As a solution, the impulse to reopen schools is understandable. However, it is important to underscore that strengthening these at-risk families, and striving to remedy the injustices against them, does not have to wait for schools to reopen and would surpass what increased surveillance could accomplish by itself.

The Courts During COVID-19 and Structural Racism

Pantea Yazdian Maddux, JD

The courts play an integral role in child maltreatment cases. They act as the fact finders responsible for determining whether a child has been abused or neglected, and they determine the child's need for protection by the state. Through hearings, conferences,

and trials, the courts must also ensure that parents are receiving the services they need to improve their ability to care for their children. Child maltreatment cases are handled in various courts; juvenile, family, and some trial courts have jurisdiction over these cases. In addition, local courts are bound by their states' civil laws and procedures, which differ by jurisdiction across the nation. However, they share in the essential role of ensuring the safety, permanency, and well-being of children.

Starting in March 2020, COVID-19 resulted in prolonged shutdowns of non-essential businesses. Although courthouses were among the buildings to shut their doors, the judiciary was still under pressure to provide essential child welfare operations. However, during an unprecedented shutdown, courts began to roll out remote technology-based access to judicial proceedings. However, this sudden and significant change in judicial procedure caused delays, adjournments for non-urgent matters, and difficulty accessing the courts. Given that African Americans and families of Indigenous ancestry are disproportionately represented in the child welfare system (Berget & Slack, 2021), it stands to reason that these judicial closures and delays will have a racially disproportionate impact.

During the pandemic, some courts developed their own approaches to move the judicial process forward. For example, a Los Angeles juvenile court suspended all court-ordered family visitation, while other localities encouraged in-person family visits (Kelly et al., 2020). Courts implemented virtual conferences, hearings, and trials (American Bar Association, n.d.). Non-urgent cases would have to be adjourned to accommodate for urgent virtual hearings (Judicial Council of California, 2020). Surely, some families lacked the electronic capabilities to access the virtual judiciary. In addition, previously ordered in-person services, such as psychological evaluations and psychotherapy, were suspended, delayed, or became inaccessible as providers went fully remote.

In response to these concerns, the federal government provided guidance through the Children's Bureau (CB), a federal agency organized under the United States Department of Health and Human Services' Administration of Children and Families. In a March 27, 2020 letter to legal and judicial leaders across the nation, the CB made clear that despite the public health crisis, courts were expected to continue judicial proceedings, family visits where possible, and services and efforts towards reunification (Milner, 2020). The bureau emphasized that "prolonged or indefinite delays in delivering services and postponements of judicial oversight place children's safety and well-being in jeopardy…" (p. 2).

Further, the CB strongly discouraged the blanket orders limiting family visits, finding it "contrary to the well-being and best interest of children…" They also offered specific guidance for courts, lawyers, and agencies to continue serving the best interests of children. The fallout of what the CB endeavored to address is yet to be fully known. However, given the disproportionate representation of African Americans and families of Indigenous ancestry in the child welfare system, it is reasonable to conclude that these concerns have had a racially disproportionate impact.

From a legal perspective, the effects of COVID-19 on parents involved in the child welfare system is not limited to judicial process. Previous writers have discussed in detail the increased risk of illness from COVID-19 for African Americans, those of Indigenous ancestry, and low-income families (Raifman & Raifman, 2020). It appears that this increased risk exists largely due to structural racism in employment, housing, and healthcare laws (Yearby & Mohapatra, 2020).

Structural Racism in Employment Laws

Racial and ethnic minorities are disproportionately exposed to COVID-19 because of their employment in "essential" jobs that cannot be performed remotely from home. Communities of color make up a disproportionate number of frontline workers (Hawkins, 2020). In addition, the majority of agricultural workers and home healthcare workers are made up of ethnic minorities and women of color, respectively. However, we lack employment laws to ensure that "essential workers" are protected while at work and that access to equal pay, paid sick leave, and unemployment insurance benefits are made available

to them. One writer suggests that Jim Crow-era employment laws continue to create disparities today (Yearby & Mohapatra, 2020). Without remedying these concerns, families are left vulnerable to stress, job loss, and financial decline, which can increase child maltreatment risk.

Structural Racism in Housing Laws

We lack federal housing laws to address health-related housing hazards that leave low-income racial minorities more susceptible to COVID-19 infections. As Yearby and Mohapatra write, "African American and Latinx households are almost twice as likely to lack complete plumbing than White households, and Native American households are 19 times more likely to lack complete plumbing" (2020, p. 8). These authors also stated that living in housing with health violations, such as challenges in accessing clean and safe water, increases the susceptibility of these families to COVID-19 and presumably to investigation by CPS for environmental neglect. However, they explain, the only federal housing law addressing a health hazard pertains to lead paint, even though research points to other health hazards plaguing racial minorities and low-income families living in hazardous conditions.

Structural Racism in Healthcare Laws

The rates of hospital closures in African American neighborhoods often leave racial minorities with limited access to local healthcare (Yearby & Mohapatra, 2020). Also, as previously indicated, research has also shown that African Americans receive poorer medical care than their White counterparts (Ayanian et al., 1999). In addition, those without health insurance often do not receive the healthcare they need for themselves and their children, which may increase the risk for medical neglect. While the Coronavirus Aid, Relief, and Economic Security (CARES) Act does provide Medicaid coverage for COVID-19 testing and treatment, the healthcare provisions of the act must be expanded to provide protection to all without healthcare benefits. The absence of certain laws perpetuates disparities that place families of color at greater risk of poverty, contracting COVID-19, and involvement in the child welfare system.

Final Thoughts

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Faith leaders have a moral imperative to address these inequities. Prophetic and priestly voices must be heard calling for cultural, theological, and political reimagining. We must change the rhetorical framing of these issues from bad parents to racially traumatized caregivers who need resources that prioritize their children *and* the family. We must have community-led and informed solutions that are funded by reallocating resources from a system that is racially flawed to one that affirms humanity and intervenes prior to desperation (Samuels, 2020). This kind of advocacy from faith leaders can help build strong and safe families and fairer systems. Additionally, houses of worship can work collaboratively for block vaccinations and equity focused policies that provide quality low- and no-cost healthcare. Finally, the prophetic voice needs to be heard to abolish the drug war and any predatory aspects of the child welfare system. As a community, we need to demand policies and programs that mitigate poverty and trauma rather than exacerbate it.

Pediatric medical providers have an opportunity to address the conditions that lead to the poor outcomes illuminated by COVID-19 on BIPOC communities due to preexisting healthcare disparities. In 2016, the American Academy of Pediatrics (AAP) developed strategies to address health disparities in pediatrics (Trent et al., 2019). The AAP wrote its equity agenda through the development of a Task Force on Diversity and Inclusion and the release of Policy Statements, including *The Impact of Racism on Child and Adolescent Health* (Trent et al., 2019) and *Truth, Reconciliation, and Transformation: Continuing on the Path to Equity* (AAP Board of Directors, 2020).

The agenda aims to achieve health equity for BIPOC children by focusing on changes to the following five domains: 1) An internal processes through fostering an organizational culture aimed to eliminate racism

and promotes equity, diversity, and inclusion; 2) Education to equip AAP members with knowledge and skills to address equity, diversity, and inclusion; 3) Workforce and leadership to strengthen and diversify the pipeline to pediatrics and AAP leadership; 4) Clinical Practice to equip members with the knowledge, skills, and capacity to advance health equity and combat racism through clinical practice -- To provide linguistically and culturally effective care, specifically addressing bias and discrimination; and 5) Policy and advocacy to advance the AAP Equity Agenda through advocacy and policy development (AAP, 2021). Through adoption of the agenda at the community level, pediatricians will be better equipped to address healthcare disparities with many BIPOC communities.

Given the above, the role of mental health providers is challenging yet crucial. It is incumbent upon mental health providers to be aware of implicit biases and psychology's history in institutional oppression (Loeb et al., 2020), and to acknowledge race and ethnicity as salient variables in treatment that come with unique disadvantages. People from BIPOC communities experience inequality exacerbated by mental health stigma, limited access to treatment and insurance, as well as culturally insensitive providers and practices (Loeb et al., 2020). With greater awareness and responsibility, mental health providers can practice fairly and promote racial justice in their work, especially during this COVID-19 era where injustice is so apparent. The APA's *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (2017) is suggested reading as a starting point in the journey to provide culturally sensitive care and to combat injustice in communities with an extensive history of oppression.

Also, legal professionals have a responsibility to assess the needs of the children and families they come across and to advocate for the safeguarding of their rights. They must identify novel issues as they arise and pursue improvements. Also, attorneys for CPS-involved clients during this public health crisis have a unique duty to make sure the judicial process moves forward despite the impact of the pandemic on the courts.

Call to Action

Most lawyers, healthcare specialists, social workers, and other practitioners will not have the opportunity to lead in developing child maltreatment policies, guidelines, and initiatives for their workplace or profession. However, as frontline professionals and the end users of these products, we all can stand in the gap between BIPOC communities and policies that inadvertently risk contributing to systemic racism.

Therefore, in conclusion, we offer a call to action for self-policing within our disciplines by challenging workplace and national policies, guidelines, and initiatives that may promote inequity or worsen existing disparities (APA, 2019). These unintended outcomes may result when those in positions of authority multiply and hoard power and force conformity on less powerful communities who are not meaningfully heard or permitted to persuade during the deliberation of system changes that will affect them. These problems are particularly ripe to occur when professionals in power operate from either of these flawed perspectives: 1. That all races will be equally impacted by systemic change; 2. That families from certain racial groups require saving or developing, regardless of the collateral damage to their families and communities (Blum, 2015); and 3. That these families have no wisdom to contribute for meaningfully addressing the issues at hand (Kendi, 2019). Therefore, practitioners are encouraged to give voice to BIPOC communities based on how these communities perceive or may experience certain policies (Annie E. Casey Foundation, 2006). By calling for the retraction or revision to policies, practice decisions, and other initiatives when appropriate, we can collectively bend the arc towards racial justice in child welfare practices.

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