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Spring 2016

 Center on Society and Health

Health Equity in Richmond, Virginia

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Introduction

The health of Virginia and Richmond area residents is related to many factors.¹ Across the country, disease rates vary dramatically by age, gender, race, and ethnicity as well as with the prevalence of risky health-related behaviors.²⁻⁶ Place matters in healthⁱ because characteristics of the areas in which people live affect health choices, behaviors, environmental risks, and access to medical care.⁷⁻¹² Local conditions that may affect health outcomes include levels of stress and environmental toxins, the social and economic characteristics of individuals and families (such as education and income), and the characteristics of the communities in which people live. Public health has become increasingly concerned about the many social and environmental characteristics that may impact health directly or indirectly. This report will focus on population, community characteristics, and health trends in the Richmond metropolitan area that may affect health outcomes for residents. A health equity report like this allows the data to show us the location and magnitude of health disparities in the context of the local social and environmental factors that shape health and well-being.

ⁱ Health, as defined by the World Health Organization, is “a state of complete physical, mental and social well-being.”

This health equity report is meant to provide insight into the community and population characteristics that may impact the health of residents in the Richmond metropolitan area.

- Part I of this report provides information about the Richmond metropolitan area with a focus on Richmond City, including population data, socioeconomic conditions, community characteristics, and health indicators and outcomes.
- Part II of this report focuses on challenges and opportunities in Richmond City, particularly workforce development, mental health, and children's services. The topics in this section reflect the findings of a year-long community-university engagement project to gather data on community perceptions of important social determinants of health in disadvantaged neighborhoods.

This report was developed by Virginia Commonwealth University's Center on Society and Health (CSH), an academic research center that studies the health implications of social factors—such as education, income, neighborhood and community environmental conditions, and public policy. Its mission is to answer relevant questions that can “move the needle” to improve the health of Americans and present our work in formats and venues that are useful to decision-makers and change agents.

Funding for this report comes from an NIH Clinical and Translational Science Award (CTSA) to the VCU Center for Clinical and Translational Research,ⁱⁱ as well as a CTSA supplement awardⁱⁱⁱ to conduct a one-year community-engaged research study. This report examines social determinants of health in metropolitan Richmond utilizing data from

a variety of sources, including the U.S. Census Bureau, the Virginia Department of Education, U.S. Department of Justice, Centers for Disease Control and Prevention, Virginia Atlas of Community Health, and the U.S. Department of Labor. We also present findings from research conducted by a community-university partnership (*Engaging Richmond*), composed of residents of Richmond's East End and university faculty/staff. Community-based, participatory research (CBPR) was employed as a framework to work with and listen to community residents about the strengths, needs, and challenges they perceived in the community.

Engaging Richmond collected data from diverse community members about their priorities around social determinants of health through a series of 17 focus groups in Richmond's East End,^{iv} 10 focus groups in other Richmond neighborhoods, and individual interviews. Data from these sources were analyzed using a grounded approach. Our team collaboratively coded and analyzed data from the focus groups, identifying a wide range of themes of importance to the community. The findings were interpreted by the full team to set priorities for community action. Mental health was the foremost concern identified by this year-long community dialogue. We then collaboratively engaged in priority setting exercises (asking questions regarding the themes residents identified in regard to frequency, importance, vulnerable populations, and ability to take action) and identified three top priorities: mental health, parental participation and workforce development.

ⁱⁱ This publication was supported by CTSA award No. UL1TR000058 from the National Center for Advancing Translational Sciences. Its contents are solely the responsibility of the authors and do not necessarily represent official views of the National Center for Advancing Translational Sciences or the National Institutes of Health.

ⁱⁱⁱ NIH-UL1R031990.

^{iv} The *Engaging Richmond* team conducted 13 focus groups with community residents (men, women, parents, seniors, homeless, employed and unemployed, and residents from different areas of the community) and 4 focus groups with service providers (approximately 170 participants total). They also conducted individual interviews with staff from local service provider agencies.

Population, Community Characteristics, and Health in Virginia, Metropolitan Richmond, and Richmond City

POPULATION

Historically, both urbanicity and population density have held an association with public health—and they also determine the type, quantity, and quality of resources available to a population. Urbanization has been linked with growing health disparities among urban residents, especially those in low income and minority communities.¹³

Urban areas tend to face distinctive challenges in the social environment (e.g., crime) and the built environment (e.g., environmental hazards), while also conferring some specific advantages (e.g., enhanced social networks and a wider range of social and health services).¹⁴ The risks associated with the social and built environments in which people live are not restricted to urban environments; nevertheless, the maps and data presented throughout this report highlight the interconnectedness of health and place and its primary relation to the concentration of poverty and segregation.

With more than 8 million residents in 2013, Virginia’s population is predominantly urban (75%) with a median age of 37.5 years.

The profile of the 1.27 million residents of the Richmond metropolitan area resembles that of the state population, with 77 percent of the population in urban areas and a median age of 38.1 years (see Table 1).

| Table 1. Population of Richmond City, Metropolitan Richmond, and Commonwealth of Virginia (2012) | | | |
|--|---------------|-----------------------|-----------|
| | Richmond City | Metropolitan Richmond | Virginia |
| Population | 206,936 | 1,270,735 | 8,105,120 |
| Population density* | 3,459.9 | 222.5 | 205.2 |
| Median age in years | 32.3 | 38.1 | 37.5 |
| Under 18 | 19.0% | 22.9% | 22.9% |
| 65 and over | 11.2% | 12.6% | 12.6% |

Source: U.S. Census Bureau 2010 – 2012 American Community Survey 3-year estimates
*Population density in persons per square mile

The Richmond metropolitan area^v encompasses 20 counties and cities (see Box 1).

The largest population centers are Chesterfield County, Henrico County, and Richmond City. The highest population density is found in the cities of Richmond, Colonial Heights, Hopewell, and Petersburg (see Map 1). Richmond City, located in central Virginia, had an estimated population of 214,114 in 2013, an increase of 8.3% from 2000.^{vi}

Richmond City’s population had a lower median age (32 years) and the population had fewer children and fewer seniors compared to the metropolitan area and the state. As an urban area, Richmond City was denser than the metropolitan area and the state (3,459.9 persons per square mile, compared to 222.5 and 205.2, respectively) (see Table 1).

THE SOCIAL ENVIRONMENT

Across the U.S. there are significant health disparities by race and ethnicity, education, and income.¹⁵ The health of a population is strongly linked to demographic factors such as racial and ethnic composition and the socio-economic conditions in which people live. Poverty is associated with many of the factors that increase health risks: material hardship; acute and chronic stress; overburdened or disrupted social supports; toxic environmental exposures; unhealthy behaviors; and reduced access to information, services, and technology.¹⁶

Race/Ethnicity

The racial and ethnic distribution of the population is strongly linked to both historical and contemporary conditions. These patterns are often shaped by a history of segregation and restrictions in the housing market.^{17–19} In

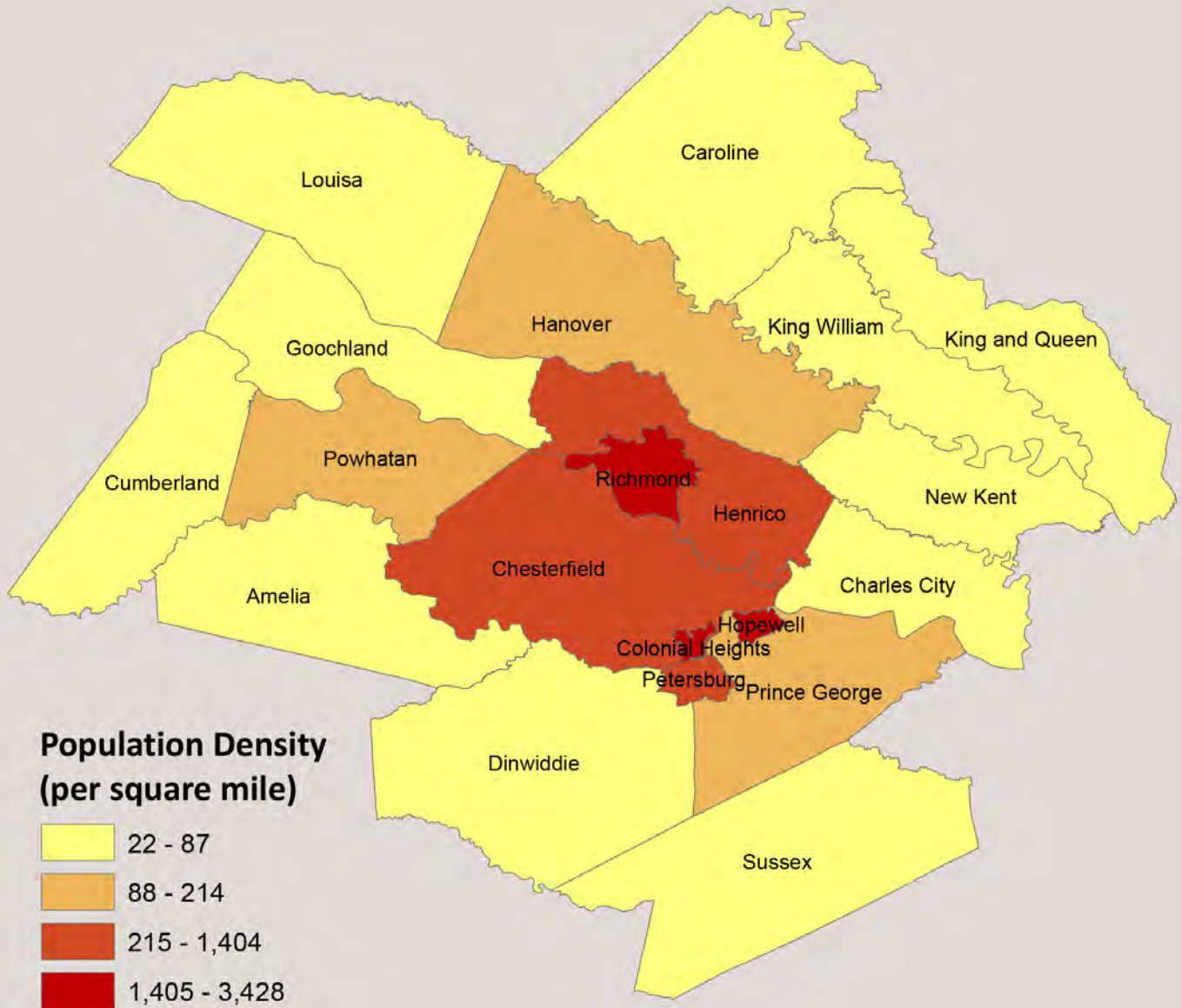
Box 1. Metropolitan Richmond Area Counties and Cities (2013 Estimated Population)

| |
|--------------------------------|
| Amelia (12,745) |
| Caroline (29,298) |
| Charles City (7,130) |
| Chesterfield (327,745) |
| Colonial Heights City (17,634) |
| Cumberland (9,841) |
| Dinwiddie (27,904) |
| Goochland (21,626) |
| Hanover (101,330) |
| Henrico (318,611) |
| Hopewell City (22,163) |
| King and Queen (7,130) |
| King William (16,097) |
| Louisa (33,945) |
| New Kent (19,507) |
| Petersburg City (32,538) |
| Powhatan (28,259) |
| Prince George (37,253) |
| Richmond City (214,114) |
| Sussex (11,810) |

^v As defined by the metropolitan statistical area (MSA).
^{vi} The 2000 population was 197,790 (Profile of General Demographic Characteristics: 2000, Census 2000 Summary File 1 (SF 1) 100-Percent Data).

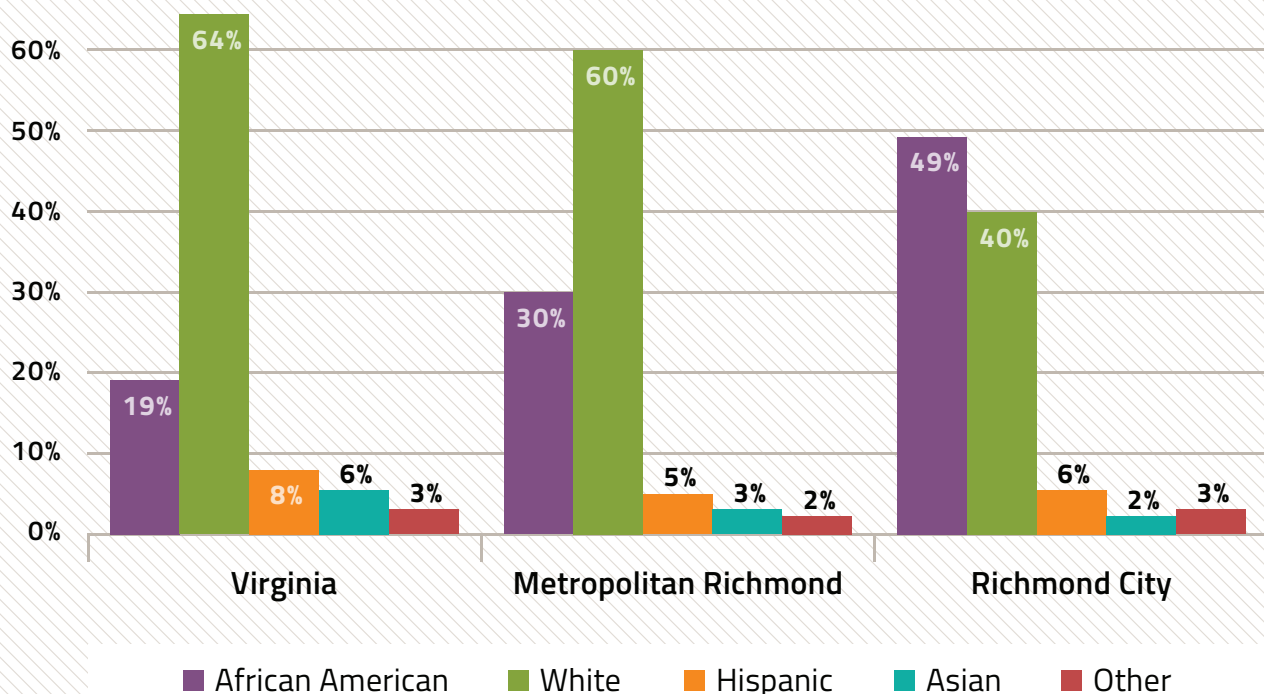
Source: U.S. Census Bureau, Population Division.
Annual Estimates of the Resident Population:
April 1, 2010 to July 1, 2013.

Map 1. Population Density, Richmond Metropolitan Area, 2010



Source: 2013 Estimated population: U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013; Area (square miles): US Census Bureau, Population, Housing Units, Area, and Density: 2010 - County - County Subdivision and Place more information, 2010 Census Summary File 1

Figure 1. Racial/Ethnic Composition of Richmond City, Metropolitan Richmond, and Commonwealth of Virginia, 2012



Source: U.S. Census Bureau 2010 – 2012 American Community Survey 3-year estimates

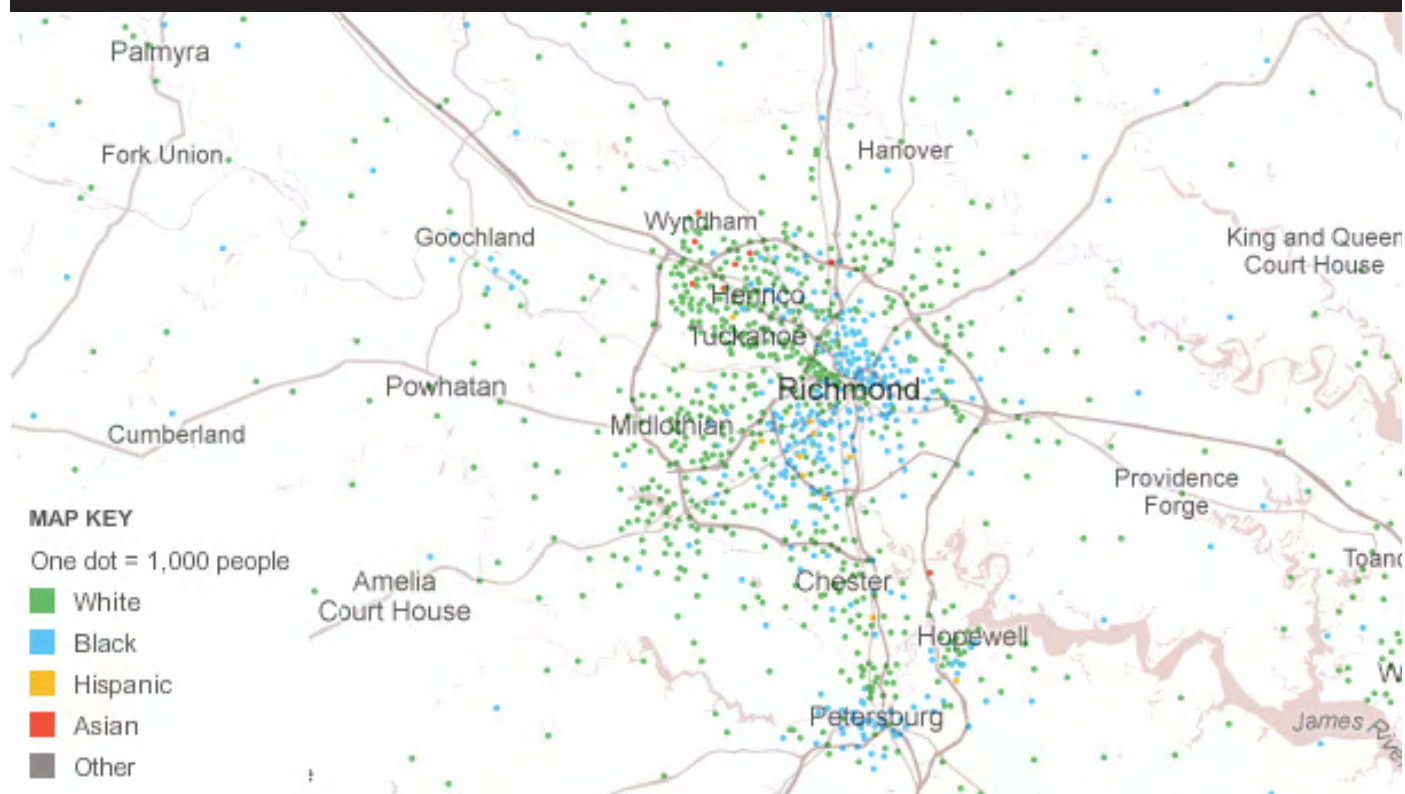
Richmond, as elsewhere, highway construction and public housing projects isolated African American neighborhoods, while socioeconomic conditions often stemming from discriminatory policies prevented African Americans from moving to suburban areas.²⁰ Consequently, there are notable differences in the ethnic and racial composition of neighborhoods across Richmond City and the metropolitan area. The Richmond metropolitan area is about 29.7% African American and 5.1% Hispanic, whereas the African American population in Richmond City is the majority at 49.2% (see Figure 1).¹⁵ Maps 2 and 3 show the racial and ethnic distribution in metropolitan Richmond and Richmond City. These maps clearly indicate the extent to

which racial and ethnic groups are segregated at the local level.

Education

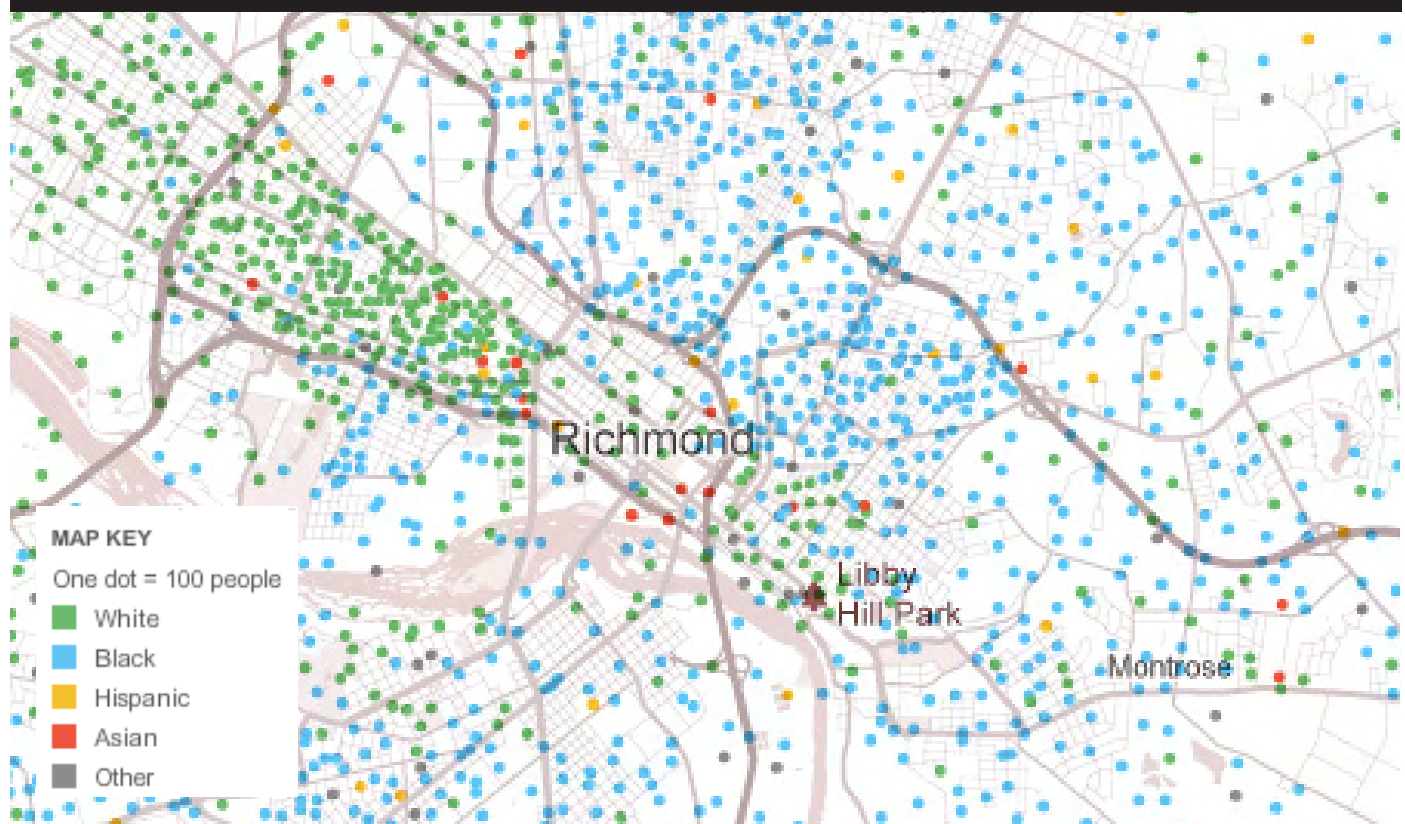
As is true in other communities, socioeconomic conditions in Richmond City exert an important, and often unrecognized, influence on health status. Education, for example, is a pathway to higher income and net worth, which also has strong influences on health status and access to health care. National statistics indicate that adults (age 25 and older) who lack a high school education or equivalent are three times more likely to die before age 65 as are those with a college education.²¹ They are also more likely to engage in unhealthy behaviors, such as cigarette smoking.²²

Map 2. Population Distribution of the Richmond Metro Area by Race and Ethnicity (2005 – 2009)



Source: New York Times, Mapping America: Every City Every Block (<http://projects.nytimes.com/census/2010/explorer>) 2005 – 2009 American Community Survey data

Map 3. Population Distribution of Richmond City by Race and Ethnicity (2005 – 2009)



Source: New York Times, Mapping America: Every City Every Block (<http://projects.nytimes.com/census/2010/explorer>) 2005 – 2009 American Community Survey data

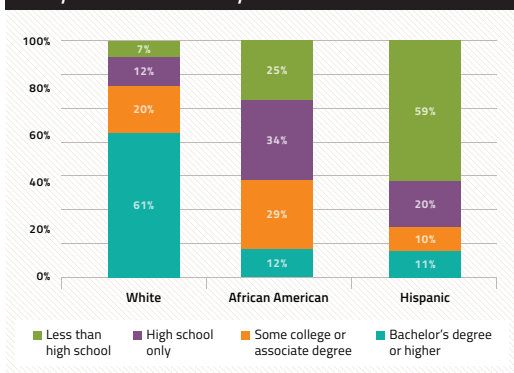
Educational attainment varies greatly by race and ethnicity (see Figure 2). According to data from the American Community Survey for 2012, more than a third of the city's African American adults have not completed high school, and 58.7% have no education beyond high school. Of the Hispanic residents, 59.2% do not have a high school diploma, and 79.2% lack an education beyond high school. In contrast, only 7.0% of the city's White adults have not completed high school, and only 19.0% lack an education beyond high school.

Fully 89% of the 2013 graduating class in Virginia graduated on time, but the percentage in the Richmond metropolitan area ranged from a low of 76.0% in Richmond City to 95.5% in Hanover County (see Table 2 and Map 5). Statewide, graduation rates were higher among females than males and higher among White students than Hispanic and African American students.²⁴ In Richmond City, which had the lowest on-time graduation rate, the rates were 80.1% for females, 71.9% for males, 84.8% for Whites, 76.7% for African Americans, and 49.2% for Hispanics.²⁵

Educational attainment in Richmond City, where 81.2% of adults age 25 and over have completed high school, was lower than in metropolitan Richmond (86.6%) and Virginia (87.4%) in 2012.²³ Map 4 shows educational attainment by census tract in Richmond City. The percent of adults without a high school diploma is highest in the East End (Brauers, Fairmount, Mosby-Upper Shockoe, Whitcomb) (48.8%), Northside (Gilpin Court, Barton Heights, Highland Park, Bellevue) (46.3%), and Broad Rock Industrial Park (42.9%).

Virginia school divisions with higher on-time graduation rates also tended to have more students enrolling in higher education.

Figure 2. Educational Attainment in Richmond City, VA by Race and Ethnicity



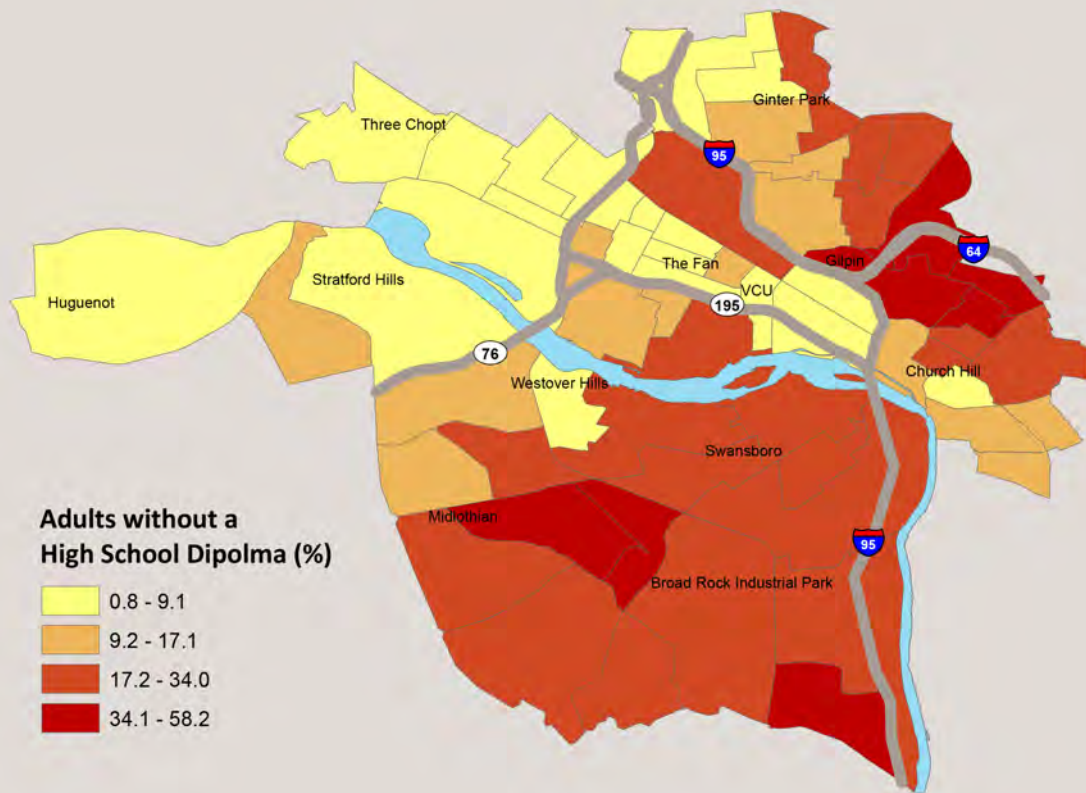
Source: U.S. Census Bureau 2010–2012 American Community Survey
Note: Racial groups include Non-Hispanic population only. Hispanic can include any racial group.

Table 2. Richmond Metropolitan Area School Data, by Division

| County | On-Time Graduation ¹ | Reading Proficiency ² | Math Proficiency ³ | College Enrollment ⁴ |
|------------------|---------------------------------|----------------------------------|-------------------------------|---------------------------------|
| Amelia | 92% | 69% | 66% | 40% |
| Caroline | 85% | 75% | 74% | 39% |
| Charles City | 94% | 63% | 55% | 38% |
| Chesterfield | 90% | 75% | 80% | 55% |
| Colonial Heights | 91% | 73% | 76% | 60% |
| Cumberland | 82% | 61% | 59% | 37% |
| Dinwiddie | 82% | 64% | 75% | 42% |
| Goochland | 91% | 78% | 79% | 52% |
| Hanover | 96% | 82% | 88% | 62% |
| Henrico | 90% | 67% | 76% | 56% |
| Hopewell City | 79% | 58% | 65% | 37% |
| King and Queen | 83% | 72% | 44% | 34% |
| King William | 93% | 64% | 66% | 46% |
| Louisa | 90% | 62% | 54% | 34% |
| New Kent | 90% | 84% | 84% | 44% |
| Petersburg City | 78% | 37% | 47% | 35% |
| Powhatan | 88% | 76% | 70% | 47% |
| Prince George | 83% | 82% | 89% | 51% |
| Richmond City | 76% | 49% | 60% | 41% |
| Sussex | 78% | 52% | 49% | 45% |

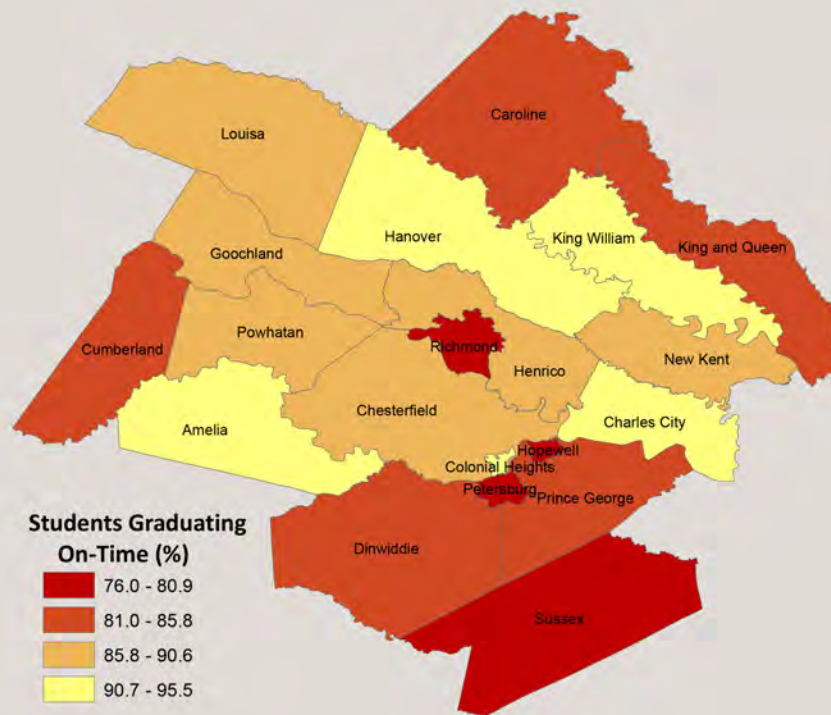
Source: (1) Four-year graduation rate, class of 2013, (2) Percent passed reading SOL, grade 4, 2012–2013, (3) Percent passed math SOL, grade 4, 2012–2013, (4) Students enrolled in higher education within 16 months of earning a high school diploma, 2013 cohort

Map 4. Adults without a High School Diploma, Richmond City, 2008 – 2012



Source: 2008 – 2012 American Community Survey

Map 5. Students Graduating On-Time*, Richmond Metropolitan Area, 2013



Source: VA Dept. of Education, Division-Level Cohort Report, Four-Year Class of 2013 (First-time 9th Grade Cohort in 2009 – 2010).

*Students graduating on-time were part of the first-time 9th grade cohort in 2009 – 2010 and completed high school in four years

Hanover, which had the highest on-time graduation rate, also had the highest percentage of students enrolled in higher education within 16 months of earning a high school diploma (62%) (see Table 2).

Reading and mathematics achievement also varies across the Richmond metropolitan area. Table 2 shows the percentage of 4th grade students who passed the reading and math Standards of Learning (SOL) tests in metropolitan Richmond. During 2012–2013, more than 40 percentage points separated the highest and lowest achieving districts in reading and math.

“I wouldn’t have no problem going to school if going to school wasn’t just like going to the projects. Whole bunch of fighting, same ‘ole thing every day.”

—Richmond high school student

Residents of Richmond City neighborhoods who participated in focus groups endorsed the importance of education, such as learning to read, to help ensure employability as well as for personal success and to help children succeed. Many were frustrated with the learning environment in local schools, citing problems with fighting, in particular, that impedes students’ success. In addition to the need for formal education, Richmond residents spoke often about the importance of other types of educational opportunities, such as health and nutrition education.

Income and Poverty

Like education, income has a strong influence on health. Nationally, families living below the federal poverty level are 3.6 times more likely to report fair or poor health than are those with incomes at least twice the poverty level.²⁶ Experiencing poverty during childhood influences a child’s cognitive, emotional, behavioral, and physical development. Childhood poverty also decreases a child’s likelihood of high school graduation.^{27, 28}

Poverty rates are highest in Richmond City, where one in five families had incomes below the poverty threshold in 2007–2011 (see Map 6). In five census tracts in Richmond City, the majority of family households had incomes below the poverty threshold. In 20 census tracts at least 25% of families had incomes below poverty, representing 30% of all Richmond City census tracts.²⁹ In the East End, more than half of families live in poverty (see Map 7).

Poverty rates in Richmond City are significantly higher than those of either the metropolitan area or the Commonwealth (see Table 3). The rate of extreme poverty (incomes below 50% of the poverty level) is two to three times higher in Richmond City (14.1%) compared to the metropolitan area and the state (5.7% and 5.2%, respectively). More than one in four (26.3%) Richmond City residents live in poverty (\$22,050 or less for a family of 4 in 2010), compared to more than 1 in 10 residents of the metropolitan area and the state (11.8% and 11.5% respectively).

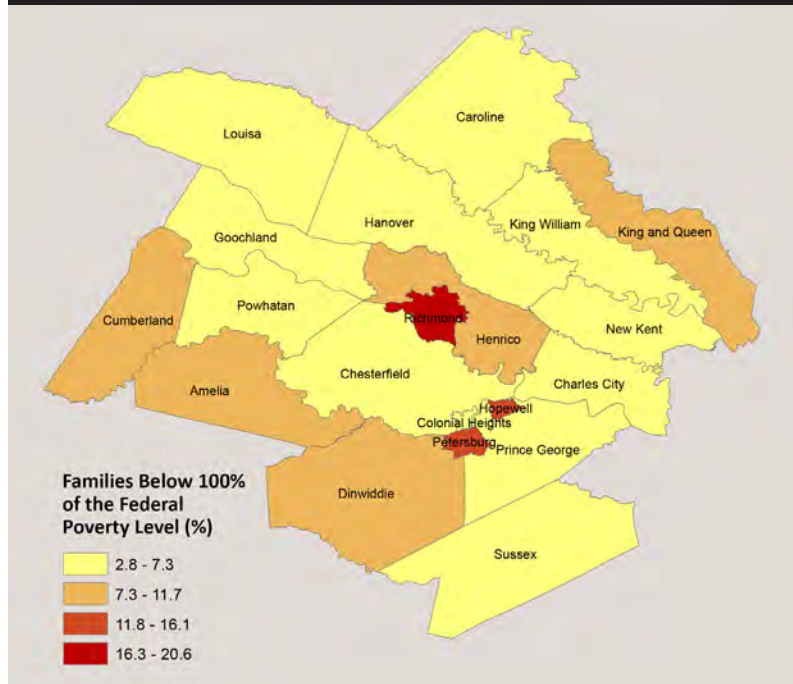
Like educational attainment, poverty rates vary by race and ethnicity. According to

Table 3. Socioeconomic Characteristics of Richmond City, Metropolitan Richmond, and Virginia

| | Richmond City | Metropolitan Richmond | Virginia |
|--------------------------------------|---------------|-----------------------|----------|
| Educational Attainment | | | |
| Less than High School (K – 12) | 18.8% | 13.4% | 12.6% |
| High School Only | 22.8% | 27.1% | 25.4% |
| Some College | 24.1% | 27.5% | 27.0% |
| Bachelor's Degree or Higher | 34.3% | 32.1% | 35.0% |
| Poverty Rate | | | |
| Below 50% of the Poverty Threshold | 14.1% | 5.7% | 5.2% |
| 50 – 99% of the Poverty Threshold | 12.2% | 6.1% | 6.3% |
| 100 – 199% of the Poverty Threshold | 20.6% | 16.1% | 15.6% |
| 200% and above the Poverty Threshold | 53.1% | 72.1% | 72.9% |

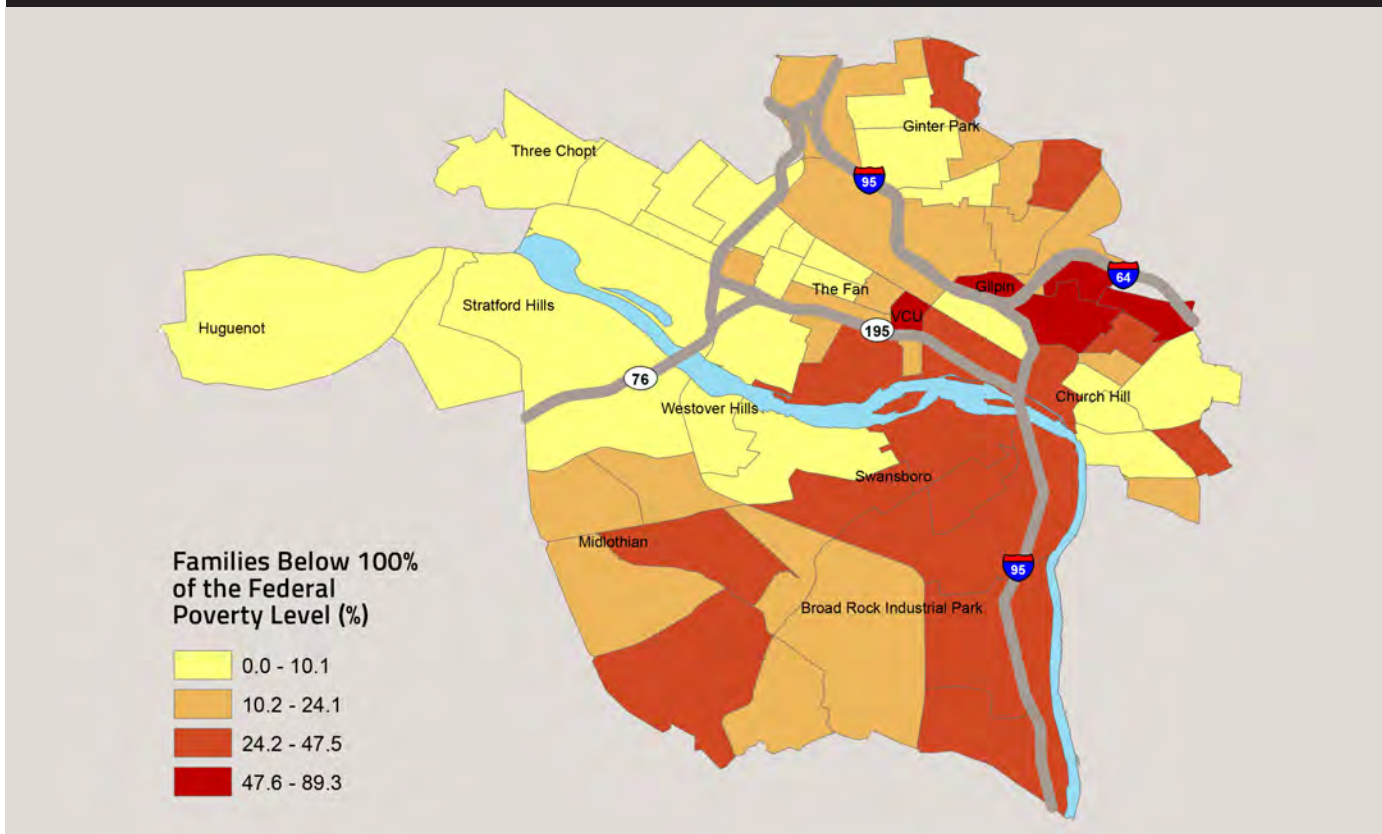
Source: U.S. Census Bureau 2010 – 2012 American Community Survey 3-year estimates

Map 6. Families Below 100% of the Federal Poverty Level, Richmond Metropolitan Area, 2008 – 2012



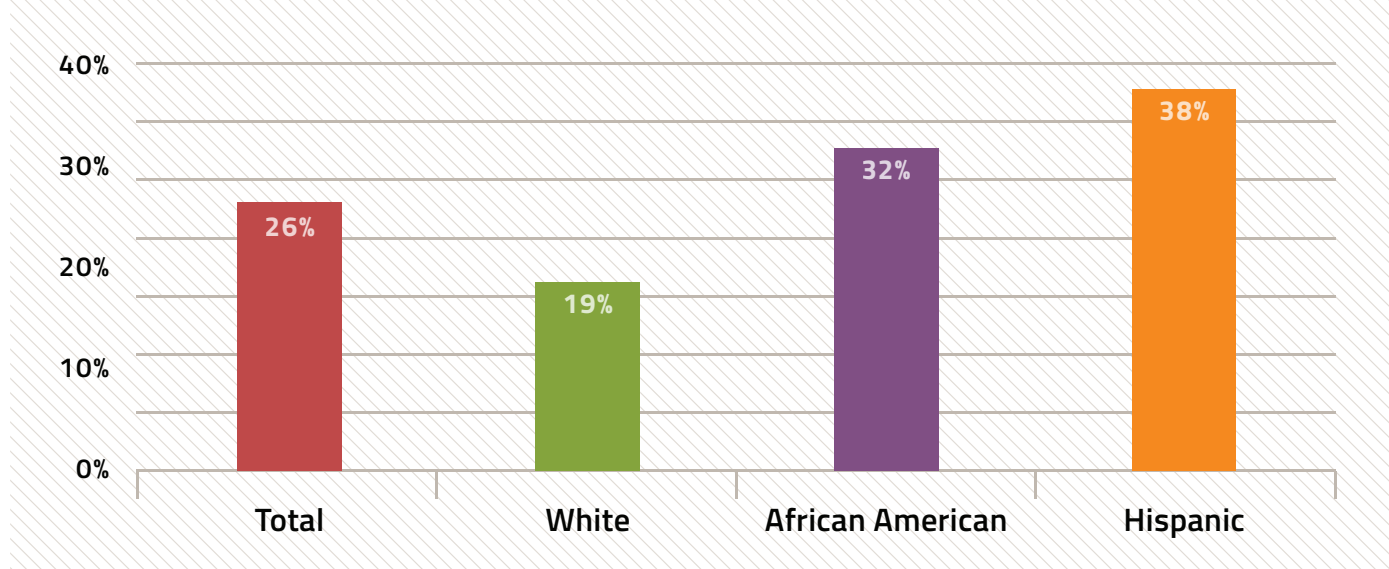
Source: 2008 – 2012 American Community Survey, 5-year Estimates

Map 7. Families Below 100% of the Federal Poverty Level, Richmond City, 2008 – 2012



Source: 2008 – 2012 American Community Survey

Figure 3. Individuals in Poverty in Richmond City by Race and Ethnicity



Source: U.S. Census Bureau 2010 – 2012 American Community Survey

Note: Racial groups include Non-Hispanic population only. Hispanic can include any racial group.

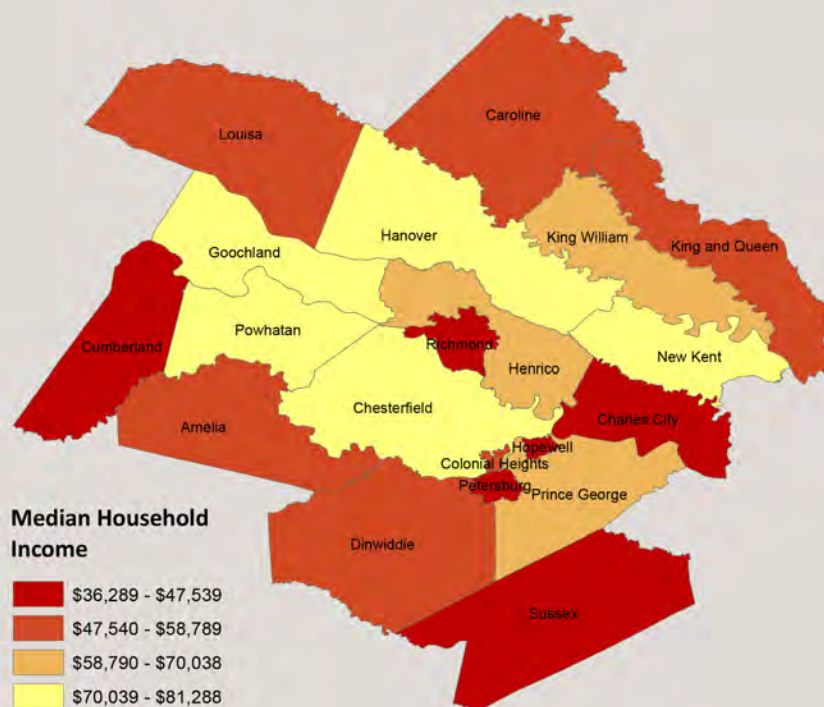
American Community Survey data for 2012, African Americans and Hispanics in Richmond City are far more likely to live in poverty (32% and 38% respectively) than Whites (19%) (see Figure 3).

Maps 8 and 9 show large income disparities between counties within the Richmond metropolitan area as well as between census tracts in Richmond City. Goochland County had the highest median household income (more than \$80,000 per year), while Richmond City had the lowest (less than \$40,000 per year).³⁰ Within Richmond City there are also large income gaps: median household income was just over \$10,000 per year in the poorest census tract and more than \$175,000 per year in the wealthiest.³¹

COMMUNITY CONDITIONS

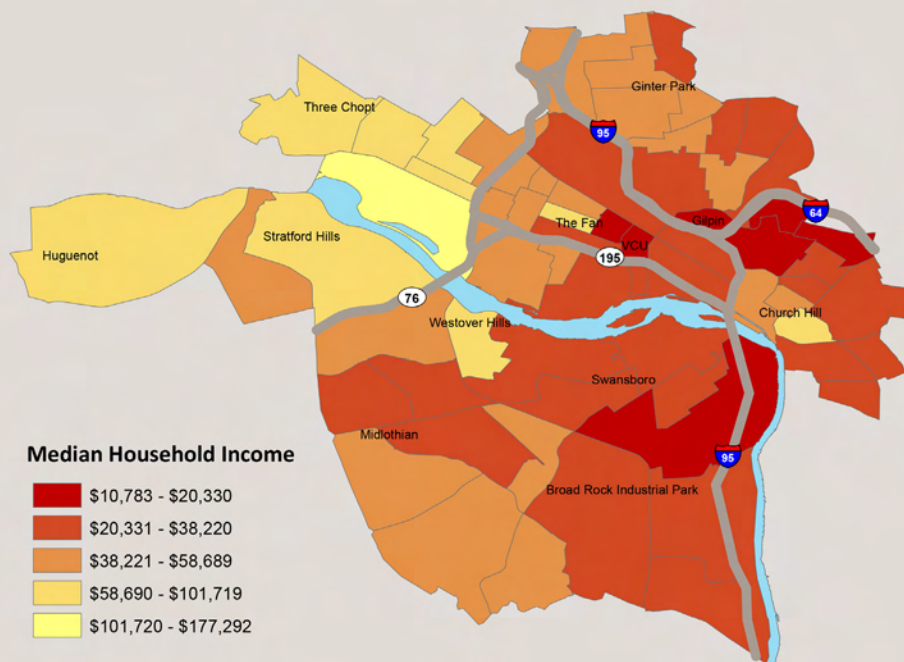
Health is affected not only by the education and income of individuals and their families but also by the neighborhoods and environment in which they live. For example, crime, the built environment, and neighborhood housing conditions can affect health regardless of one's income or education. Neighborhood conditions shape health in numerous ways. Insufficient institutional resources and built environments can make it difficult to see a health provider or find a place to exercise. Environmental toxins and unhealthy housing conditions can increase the risk of illness. Fear of crime and exposure to violence can create unhealthy levels of chronic stress.³²

Map 8. Median Household Income, Richmond Metropolitan Area, 2008 – 2012



Source: 2008 – 2012 American Community Survey, 5-year Estimates

Map 9. Median Household Income, Richmond City, 2008 – 2012



Source: 2008 – 2012 American Community Survey



Above Left: Warning 24 Hour Monitored Camera. Photo by Art180. **Above Right:** Photo by Art180.

Crime

Violent crime includes homicide, rape, robbery, and aggravated assault. According to the U.S. Department of Justice, the violent crime rate in Richmond City was 648.7 crimes per 100,000 persons in 2012 — the highest reported rate among large Virginia cities. This rate is higher than among U.S. cities of comparable size (100,000 to 249,999 inhabitants), which have an average crime rate of 494.1 per 100,000.³³ The violent crime rate in metropolitan Richmond and Virginia was considerably lower, at 243.4 and 190.1 crimes per 100,000 persons, respectively (see Table 4).

“I feel safe in the house. I feel like anything could happen while I’m outside. You never know what might happen when you step outside. Anything could happen.” —East End Resident

Nonviolent crime includes burglary, larceny-theft, and motor vehicle theft. According to the U.S. Department of Justice, the nonviolent crime rate in Richmond City was 43.81 crimes per 1,000 persons in 2012. This is higher than the rate of metropolitan Richmond and twice the Commonwealth rate (25.63 and 21.62 per 1,000, respectively) and higher than other U.S. cities with 100,000 to 249,999 inhabitants (36.81 crimes per 100,000 persons).³⁴ Map 10 shows the 2012 crime rate for Group A^{vii} arrests.³⁵

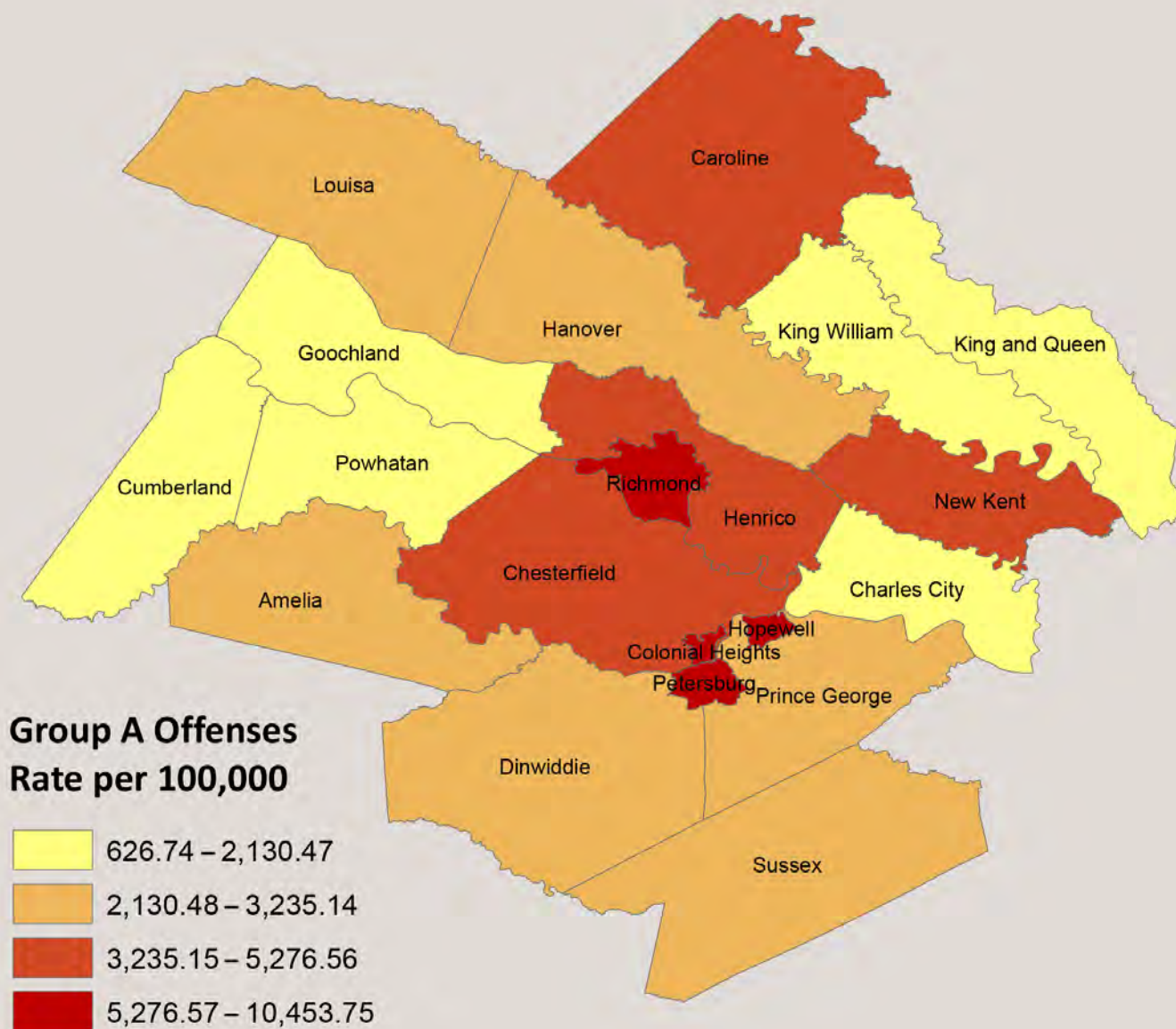
Table 4. Community Characteristics of Richmond City, Metropolitan Richmond and Virginia

| | Richmond City | Metropolitan Richmond | Virginia |
|--|---------------|-----------------------|----------|
| Violent Crime Rate ^a | 648.7 | 243.4 | 190.1 |
| Non-Violent Crime Rate ^a | 43.81 | 25.63 | 21.62 |
| Owner Occupied Housing 2010 ^b | 43.1% | 67.6% | 67.2% |
| Vacant Housing ^b | 11.4% | 8.1% | 9.2% |
| Overcrowding ^c | 2.7% | 1.6% | 2.0% |

Source: (a) Per 100,000 and 1,000. US Department of Justice—Federal Bureau of Investigation, 2012 Crime in the United States. (b) U.S. Census Bureau 2010 Census, Table DP-1. (c) Less than one person per room. U.S. Census Bureau, 2010–2012 American Community Survey 3-Year Estimates, Table B25014

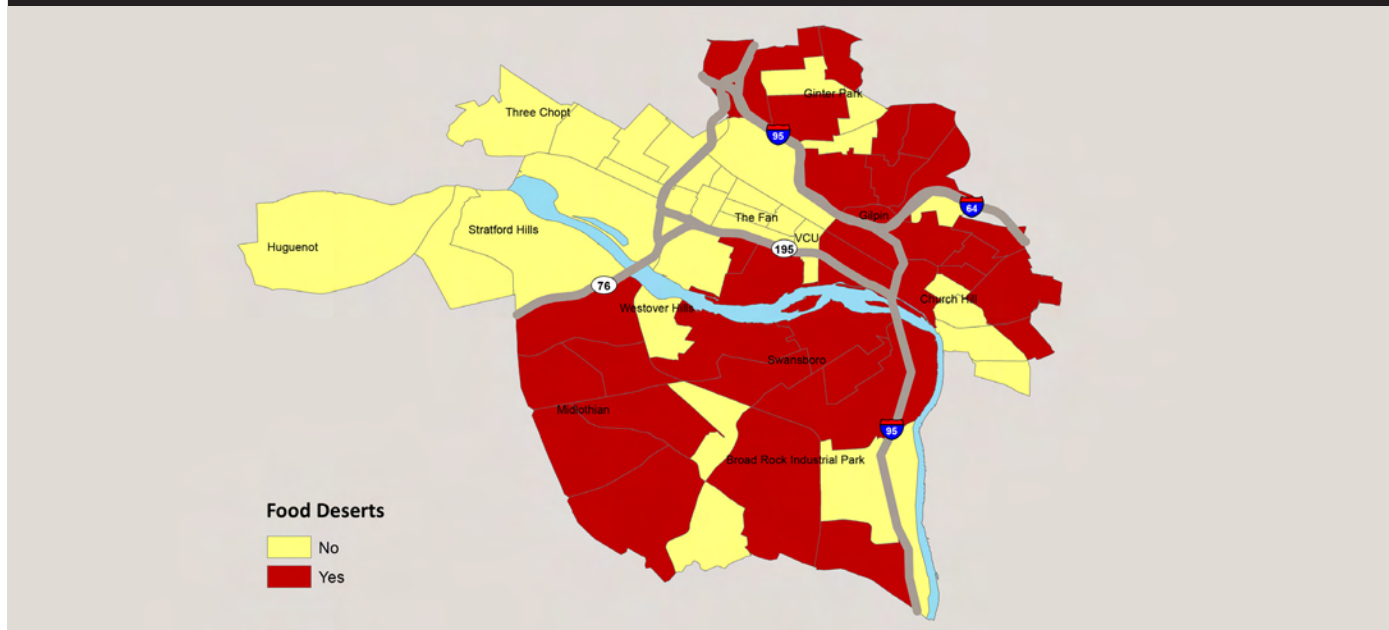
vii Group A arrests include arson, assault, bribery, burglary, counterfeiting/forgery, destruction/damage/vandalism of property, drug/narcotic offenses, embezzlement, extortion/blackmail, fraud offenses, gambling offenses, kidnapping/abduction, larceny/theft, motor vehicle theft, pornography/obscene material, prostitution offenses, robbery, sex offenses, stolen property offenses, and weapon law violations

Map 10. Group A Offenses, Richmond Metropolitan Area, 2012



Source: Crime in Virginia, 2012

Map 11. Census Tracts Qualifying as Food Deserts, Richmond City, 2010



Source: USDA Food Access Research Atlas, Low Income and Low Access Using Vehicle Access

Housing

There is growing recognition of the health effects of housing conditions, including the risks associated with substandard housing (e.g., unsafe drinking water, improper waste disposal, and disease vectors), crowding, mold and other allergens, inadequate heating, exposure to toxins, and safety hazards.³⁶

Data on housing quality are available on the completeness of facilities (kitchen and plumbing), overcrowding, and owner-occupancy. Throughout the Richmond metropolitan area, housing quality issues tend to be most severe in urban centers. Half or fewer housing units are owner occupied in Richmond City, Petersburg City, and Hopewell City. Overcrowding (defined as more than 1.0 occupant per room) predominantly affects city residents as well. Although most housing units have complete kitchen and plumbing facilities, they are more likely to be inadequate in city housing (see Table 5).

Food Access

The local food environment affects dietary patterns and health outcomes. Unhealthy eating habits, such as a diet deficient in fruits and vegetables, are linked to numerous acute and chronic health problems such as diabetes, hypertension, obesity, heart disease, and stroke.³⁷ Residents of areas with greater access to supermarkets appear to be less likely to be obese or overweight.^{38, 3} Neighborhoods differ in the availability of healthy foods and in food prices, distance to food providers, and the quality of foods available. These differences tend to be associated with residents' race and income.^{39, 40}

Food deserts are areas with especially poor food access. Defined as areas with low income and reduced access due to distance to the nearest supermarket and poor vehicle access,^{viii} 56 census tracts in metropolitan Richmond qualified as food deserts in 2010. Although most of these were in Richmond City (see Map 11), other food

viii This is just one of several possible criteria for identifying food desert census tracts.

Table 5. Richmond Metropolitan Area Housing Characteristics, by County

| Location | Ownership ^a | Overcrowding ^b | Inadequate Kitchen Facilities ^c | Inadequate Plumbing ^d |
|-----------------------|------------------------|---------------------------|--|----------------------------------|
| Amelia | 81.0% | 1.1% | 4.5% | 2.9% |
| Caroline | 82.9% | 1.6% | 2.4% | 1.2% |
| Charles City | 82.1% | 0.6% | 7.3% | 3.5% |
| Chesterfield | 77.8% | 1.0% | 1.7% | 0.6% |
| Colonial Heights City | 65.8% | 2.0% | 4.7% | 0.3% |
| Cumberland | 75.7% | 3.6% | 5.5% | 3.7% |
| Dinwiddie | 77.5% | 0.7% | 5.1% | 3.5% |
| Goochland | 91.6% | 0.5% | 2.7% | 1.7% |
| Hanover | 83.8% | 0.6% | 0.9% | 0.2% |
| Henrico | 65.8% | 1.7% | 1.4% | 0.4% |
| Hopewell City | 50.9% | 2.2% | 6.9% | 2.2% |
| King and Queen | 77.3% | 0.8% | 1.1% | 0.9% |
| King William | 83.2% | 0.8% | 2.2% | 1.7% |
| Louisa | 80.4% | 1.4% | 5.4% | 4.6% |
| New Kent | 89.6% | 0.9% | 1.5% | 1.7% |
| Petersburg City | 46.7% | 2.2% | 11.5% | 3.0% |
| Powhatan | 88.9% | 0.7% | 2.4% | 0.6% |
| Prince George | 74.5% | 0.9% | 4.8% | 0.7% |
| Richmond City | 44.1% | 2.4% | 4.1% | 3.7% |
| Sussex | 65.6% | 0.5% | 14.9% | 11.1% |

Source: (a) Percentage of owner occupied housing units: 2008 – 2012 American Community Survey Table B25003. (b) % overcrowded (more than 1.0 occupants per room): 2008 – 2012 American Community Survey Table B25014. (c) Percentage of housing units lacking complete kitchen facilities: 2008 – 2012 American Community Survey Table B25051. (d) Percentage of housing units lacking complete plumbing: 2008 – 2012 American Community Survey Table B25047.

desert census tracts were located in Henrico County, Petersburg City, Dinwiddie County, Cumberland County, Sussex County, Hopewell City, Chesterfield County, Colonial Heights City, and Louisa County. These areas of low food access have a strong impact on the shopping patterns of residents (see **Box 3**) and likely result in unhealthy diets and unfavorable health outcomes.

HEALTH DISPARITIES

Health disparities exist by sex and race/ethnicity, not just socio-economic status (see **Box 4**). Of course, these factors are deeply interconnected, making it difficult to identify any singular causes of disparities. Although many African Americans experience worse health than Whites because of a relative disadvantage in income and education, even African Americans within the same categories of income and education still experience poorer health outcomes than Whites, albeit less marked.

Minorities tend to have less health insurance coverage, higher cost barriers to access health care, and worse self-rated general health. Obesity, smoking, high blood pressure, cardiovascular diseases, and diabetes were the major health risks and chronic conditions in African American communities, along with lack of physical activity, especially among women.⁴¹ These national trends obscure differences in morbidity rates and risk factors across minority communities.

In Richmond, REACH USA compared health data for African American adults in a small area occupying 12 census tracts in the East End with the larger population of the Richmond MMSA (metropolitan and micropolitan statistical area). The data show higher risk levels in the African American community,

Box 3. Food Access is Limited

During focus groups with East End residents, parents expressed concerns about barriers to providing healthy food for their children given limited, poor quality, and often unaffordable grocery options.

“We don’t have a grocery store. We don’t. You can go there to the market, if you can catch the bus at the right time, but that means you’re limited in what you can buy, ‘cause you can only bring so much back from the market. You can go to the [supermarket] in Mechanicsville, and people do, and you see them dragging the carts back from the store. And you think about it. You make groceries, are you going to walk two miles to bring your groceries home?”

—East End Resident

In its *Health Disparities and Inequalities Report*,¹⁵ the Centers for Disease Control and Prevention (CDC) report persistent health disparities in many areas:

AFRICAN AMERICANS HAVE HIGHER RATES OF:

- **Infant mortality.** Infants born to African American women are 1.5 to 3 times more likely to die than infants born to women of other races/ethnicities.
- **Coronary heart disease mortality.** Coronary heart disease and stroke account for the largest proportion of inequality in life expectancy between whites and African Americans, despite the existence of low-cost, highly effective preventive treatment.
- **Preventable hospitalization.** The rate of preventable hospitalizations among African Americans is more than double that of whites.
- **HIV infection.** Disparities continue to widen as rates increase among African American and American Indian/Alaska Native males but are stable or decreasing in other groups.
- **Hypertension.** Hypertension affects 42.0% of African Americans compared to 28.8% of whites.
- **Teenage pregnancy/childbirth.** Although teen pregnancy rates among African Americans have been falling or holding steady, they are still 2.5 times those of whites.
- **Homicide.** The overall homicide rate for African Americans is 23.1 deaths per 100,000, compared to 2.7 deaths per 100,000 among whites. For African American males age 20 to 24, the rate is 109.4 deaths per 100,000 population.

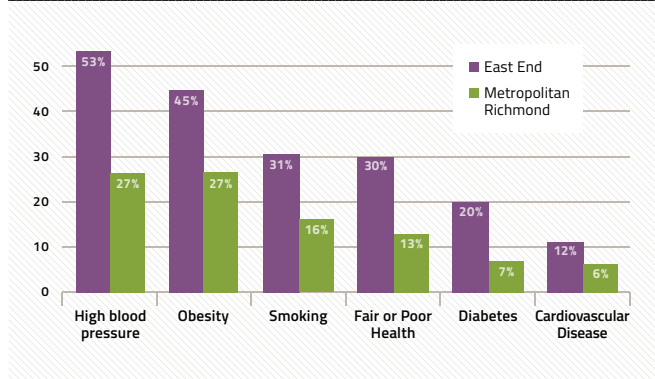
HISPANICS HAVE HIGHER RATES OF:

- **Uncontrolled hypertension.** Levels of control are lowest for Mexican Americans.
- **Teenage pregnancy and childbirth.** Although rates have been falling or holding steady, they are still 3 times those of whites.
- **Inadequate health insurance coverage.** 42% of Hispanic adults age 18 to 64 lacks coverage, compared to 15% of white adults.

NATIVE AMERICANS HAVE HIGHER RATES OF:

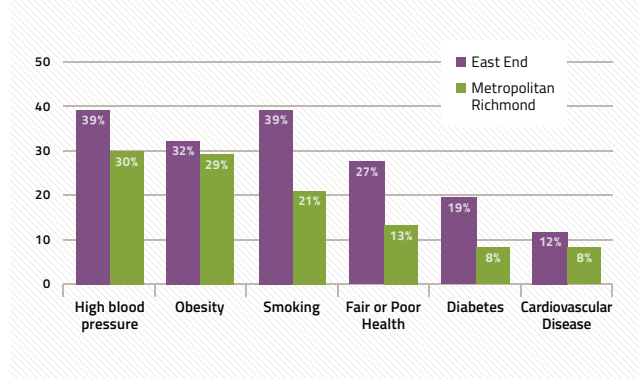
- **Motor vehicle accident mortality.** Death rates are twice as high among American Indians/Alaska Natives.
- **Suicide.** American Indians/Alaska Natives have a particularly high rate of suicide in adolescence and early adulthood.
- **HIV infection.** As noted earlier, disparities have widened as rates have increased among African American and American Indian/Alaska Native males, while rates in other groups have stabilized or declined.
- **Binge drinking.** American Indian/ Native Americans report more binge drinking episodes per month and greater alcohol consumption per episode than other groups.
- **Tobacco use.** Despite overall declines in cigarette smoking, disparities in smoking rates persist, particularly among American Indians/Alaska Natives.

Figure 4. Health Status of African American Women in Richmond's East End and Metropolitan Richmond



Source: East End: REACH U.S., 2009 Metropolitan Richmond: BRFSS data for Richmond MMSA, 2007–2009

Figure 5. Health Status of African American Men in Richmond's East End and Metropolitan Richmond



Source: East End: REACH U.S., 2009 Metropolitan Richmond: BRFSS data for Richmond MMSA, 2007–2009

including high blood pressure, cardiovascular disease, and diabetes (see Figures 4 and 5). There were also higher rates of obesity and smoking and lower access to health coverage and health services. In the previous section, we examined geographic variations in population, socioeconomic conditions, and community risk factors. Given these marked geographic disparities in community risk factors that may affect health in Richmond, it follows that health outcomes—including life expectancy—might vary sharply by neighborhood as well.

Table 6 shows the counties and cities in the Richmond metropolitan area that have been designated by HRSA as Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP). The majority of counties/cities in the metropolitan area qualify as MUAs, and two qualify as MUPs.⁴²

A needs assessment conducted by Bon Secours Health System⁴³ categorized the highest priority

community needs related to health into three areas:

- **Health Promotion and Prevention:** adult and childhood obesity, cancer early detection and screening, chronic disease prevention, and heart disease and stroke prevention
- **Access to Health Care:** heart disease and stroke treatment, behavioral health, uninsured adults and children, and dental care/oral health
- **Support Services:** maternal health, aging services and transportation

Health Status

Overall indicators of the health status of the Richmond area are mixed. According to the 2014 County Health Rankings by the Robert Wood Johnson Foundation, cities in the Richmond metropolitan area ranked poorly compared to other Virginia counties and cities: Richmond City ranked 121st of 133 counties for health outcomes, Hopewell City ranked 128th, and Petersburg City ranked last

at 133. Sussex County also ranked near the bottom at 118th. However, Hanover and Prince George counties ranked in the top 15.⁴⁴ To gain a deeper understanding of the health profile of metropolitan Richmond, we examine life expectancy and the prevalence of major diseases.

Life Expectancy

Life expectancy—how long a person born today can expect to live—is a good measure of population health. It is an average within a specific population of the predicted length of one’s life, in terms of years, based on biological, environmental, and social factors. Life expectancy is more specifically a measure of aging health, to be distinguished from infant mortality. In general, overall life expectancy has increased significantly due to social changes, public health initiatives, and medical and technological advances. In 1900, U.S. life expectancy at birth was 47.3 years; for a child born in 2010, it was 78.7 years.⁴⁵ For the developed nations, and increasingly among developing nations, infectious disease mortality has largely been replaced by chronic illnesses as a cause of mortality.

Life expectancy varies among nations, states, cities, and zip codes and it differs across races, genders and social class. As of 2007, the U.S. ranked 17th in life expectancy among high-income countries (80.8 years for females and 75.6 years for males in 2007). The Institute of Medicine links life expectancy to a number of factors: health systems, health behaviors, social and economic conditions, and physical environments.⁴⁶ Communities in the U.S. tend to have very diverse characteristics in all of these domains. In fact, across the Richmond metropolitan area counties, life expectancy varies by 9 years for females and 11 years for males⁴⁷ and by 20 years for males

Table 6. Richmond Metropolitan Area Counties and Cities Designated as Medically Underserved Areas (MUAs*) and Medically Underserved Populations (MUPs*)

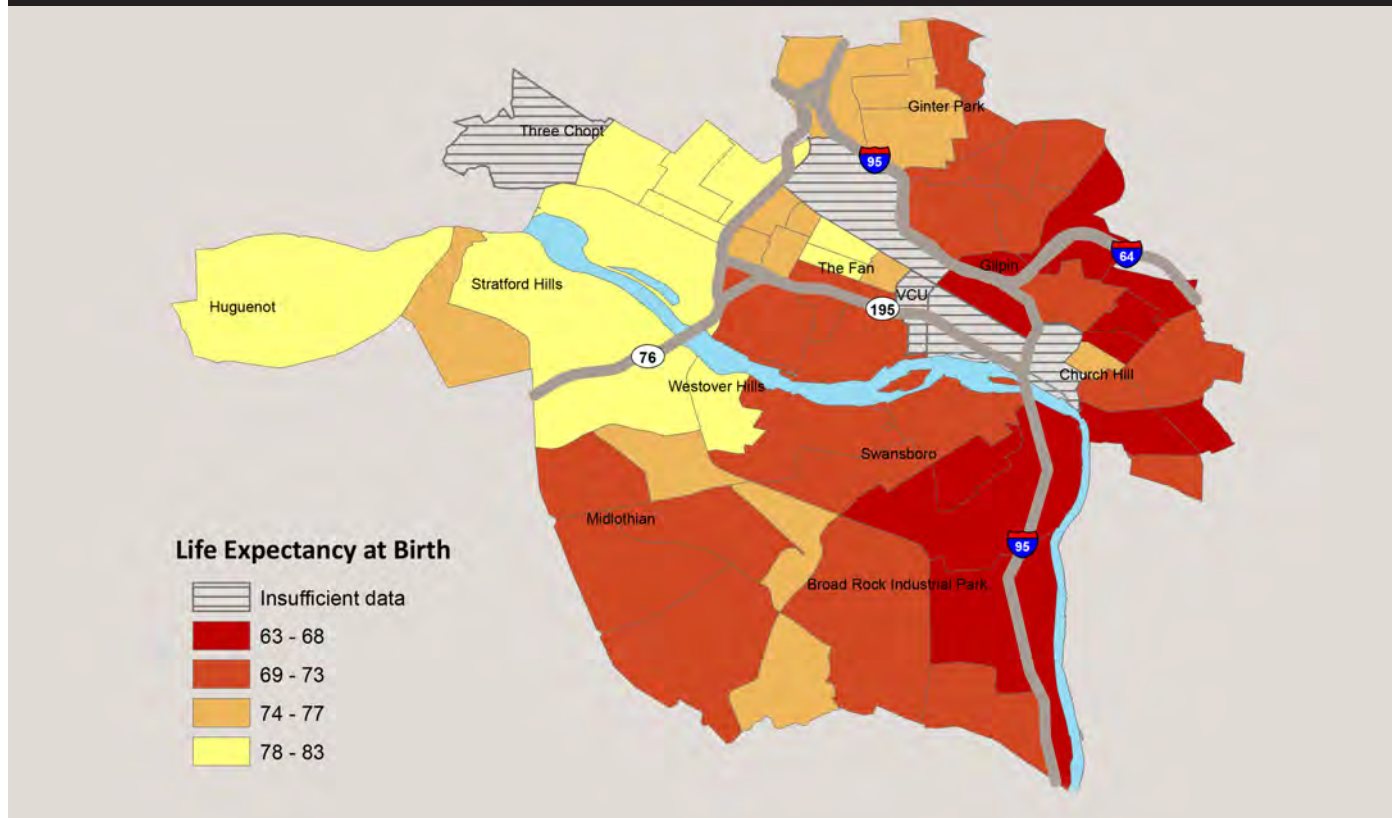
| Entire County/City | |
|-----------------------------|-----------------------|
| Amelia | King and Queen |
| Caroline | King William |
| Charles City | Louisa |
| Cumberland | New Kent |
| Dinwiddie | Petersburg City (MUP) |
| Goochland | Powhatan |
| Hopewell City (MUP) | Sussex |
| Specific Census Tracts Only | No MUA* |
| Chesterfield | Colonial Heights City |
| Henrico | Hanover |
| Richmond City | Prince George |

*MUAs: may be a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. *MUPs: may include groups of persons who face economic, cultural, or linguistic barriers to health care. Source: U.S. Dept. of Health and Human Services, Health Resources and Services Information, <http://muafind.hrsa.gov/index.aspx>.

Life expectancy variations

Across the Richmond metropolitan area counties, life expectancy varies by 9 years for females and 11 years for males and by 20 years across census tracts in Richmond City.

Map 12. Life Expectancy at Birth, Richmond City



Source: Virginia Commonwealth University Center on Society and Health, 2015

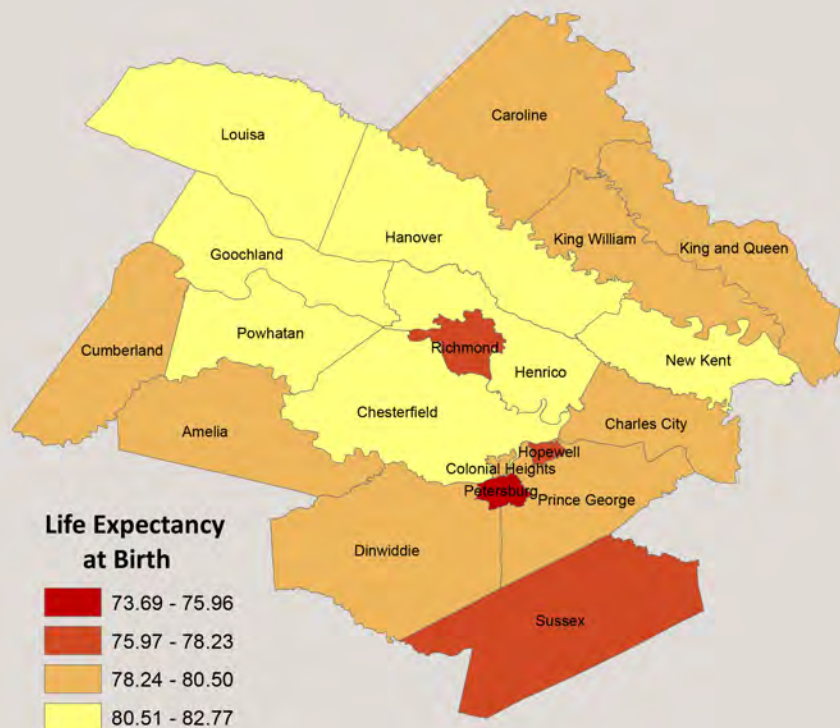
and females combined across census tracts in Richmond City. In some census tracts in Petersburg City a person born today can expect to live only about 60 years, equivalent to the life expectancy of Liberia. In other places in Richmond, a person born today might expect to live into their mid 80s, well above the national average.

Map 12 shows variation in life expectancy among Richmond City census tracts.

Maps 13 and 14 show variation in life expectancy across counties for females and males. Differences in life expectancy for men and women may be explained

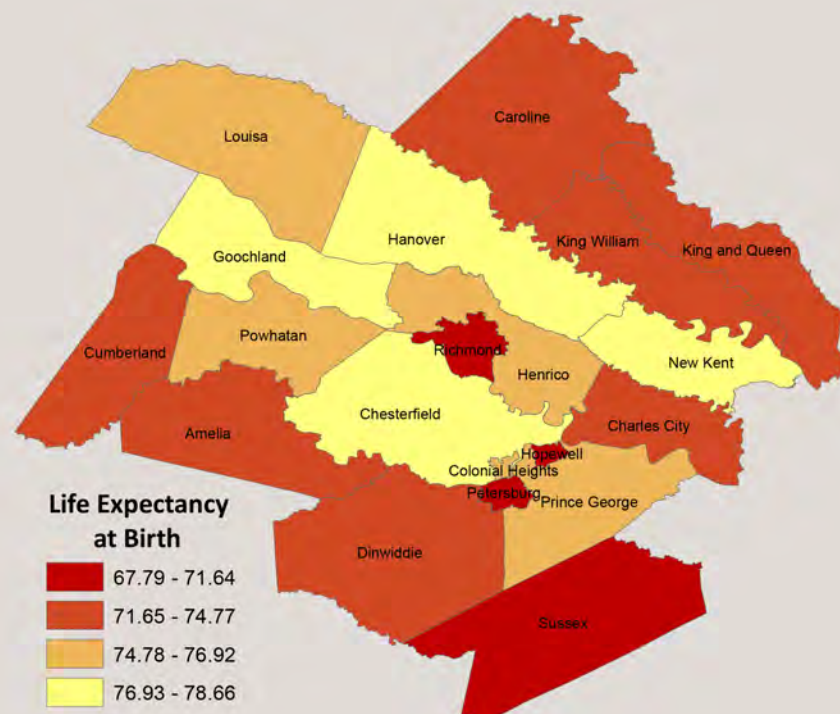
by both controllable and non-controllable factors. Biologically, men are at higher risk for heart disease than women due to the protective effects of estrogen before menopause. Controllable behavioral practices also differ between men and women, such as an increased level of health-consciousness that bring more women to see health providers than men. Behaviors, such as tobacco, alcohol, and illicit drug use also occur at higher rates among men, as do high-risk behaviors.⁴⁸ All of these behaviors are more common in lower socioeconomic communities.

Map 13. Female Life Expectancy at Birth, Richmond Metropolitan Area, 2010



Source: Institute for Health Metrics and Evaluation, 2013

Map 14. Male Life Expectancy at Birth, Richmond Metropolitan Area, 2010



Source: Institute for Health Metrics and Evaluation, 2013



Like life expectancy, death rates vary geographically across metropolitan Richmond and tend to be strongly associated with race and educational attainment at the population level. The death rate (per 100,000 persons) ranged from 655.8 in Prince George County to 1,109.9 in Hopewell City ([see Map 15](#)).

The following discussion examines some of the leading disease conditions that contribute to overall death rates.

Heart Disease

Heart disease is influenced by multiple risk factors, ranging from genetics to lifestyle. The factors that lead to the blood vessel narrowing and plaque formation responsible for coronary artery disease include diet and regular physical activity. Thus, it is clear that inequalities in the availability of community resources that promote healthy eating and exercise can determine the health outcomes of community constituents. Heart health of

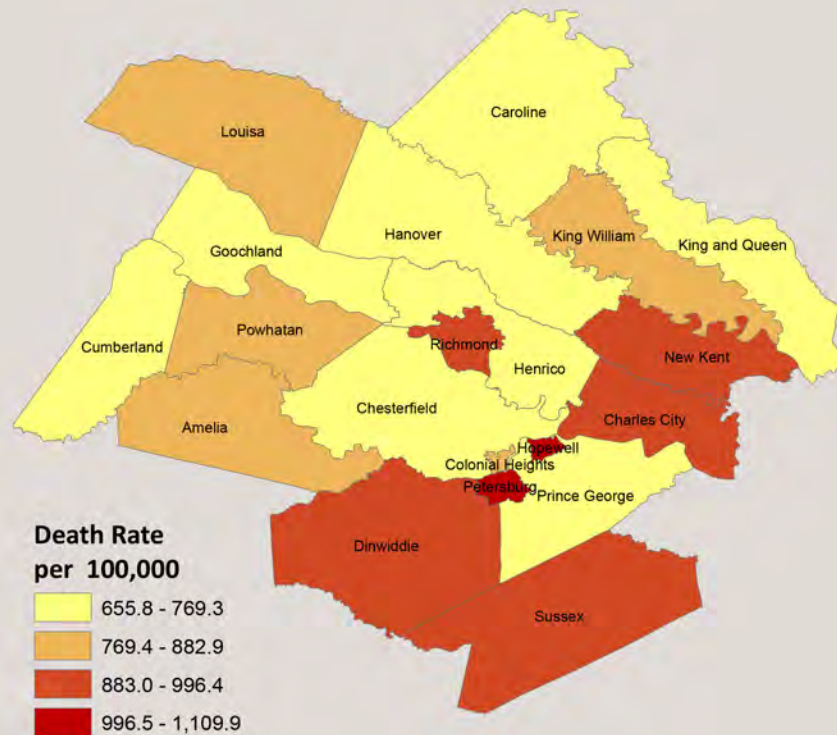
residents is compromised when local food markets only supply high-caloric low-nutrition processed foods and beverages.

According to the 2012 Virginia Atlas of Community Health, the heart disease death rate in Richmond City was 203.4 deaths per 100,000, which exceeded the state average of 157.4 deaths per 100,000. Heart disease mortality rates vary across the Richmond metropolitan area, from less than 150 deaths per 100,000 in Amelia and Goochland counties to over 220 deaths per 100,000 in Dinwiddie County, King and Queen County, and Petersburg City ([see Map 16](#)).

Diabetes Mellitus

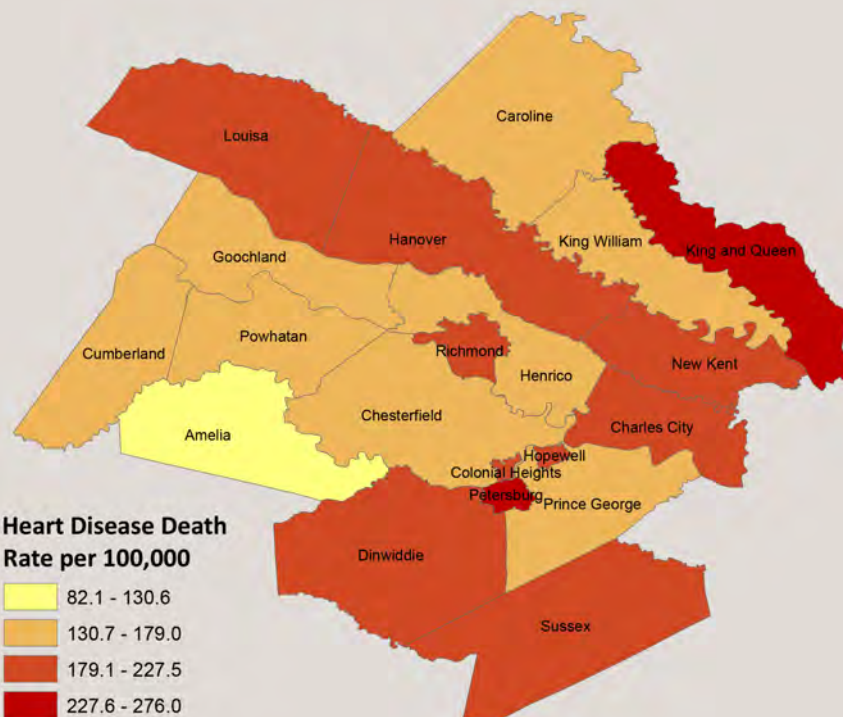
Type 2 diabetes is another major chronic medical condition that can often be controlled by eating patterns and physical activity. Studies have shown that the risk of developing diabetes can be reduced by half if at-risk patients modify their diets and physical activity levels.

Map 15. Total Age-Adjusted Death Rate, Richmond Metropolitan Area, 2010



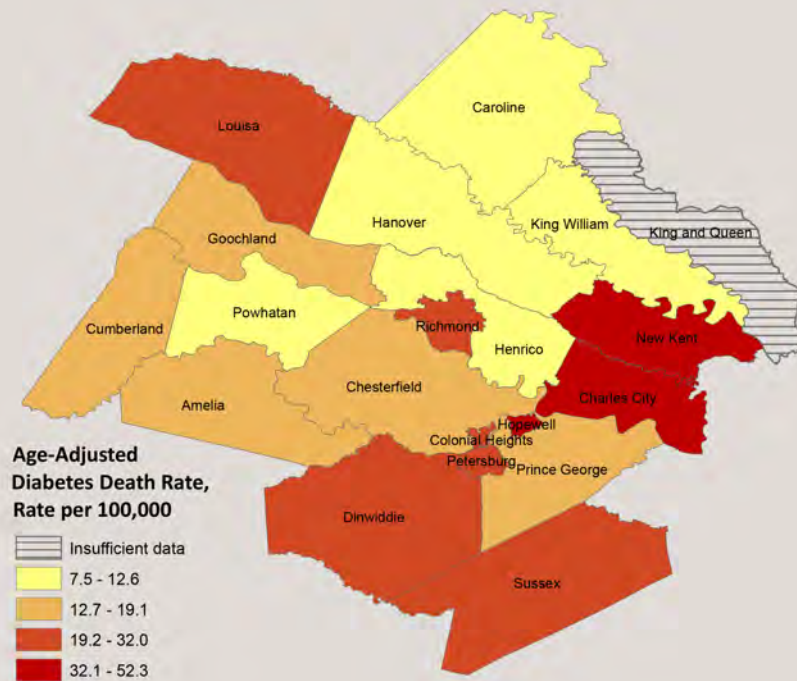
Source: Virginia Atlas of Community Health, 2012

Map 16. Total Age-Adjusted Heart Disease Death Rate, Richmond Metropolitan Area, 2010



Source: Virginia Atlas of Community Health, 2012

Map 17. Age-Adjusted Diabetes Death Rate, Richmond Metropolitan Area, 2010



Source: Virginia Atlas of Community Health, 2012

Diabetes education and awareness can be useful for decreasing diabetes-related health complications and deaths. However, there are many social and environmental barriers, as mentioned above, that make it difficult for residents of lower socioeconomic Richmond neighborhoods to eat well, exercise, and access healthcare and medications needed for care management. This puts patients with diabetes at particular risk. The lack of healthy grocery market options within reasonable distance in these communities, as well as unsafe streets that are not conducive to outdoor physical activity, only further increase the health disparities seen between neighborhoods of different socioeconomic classes.

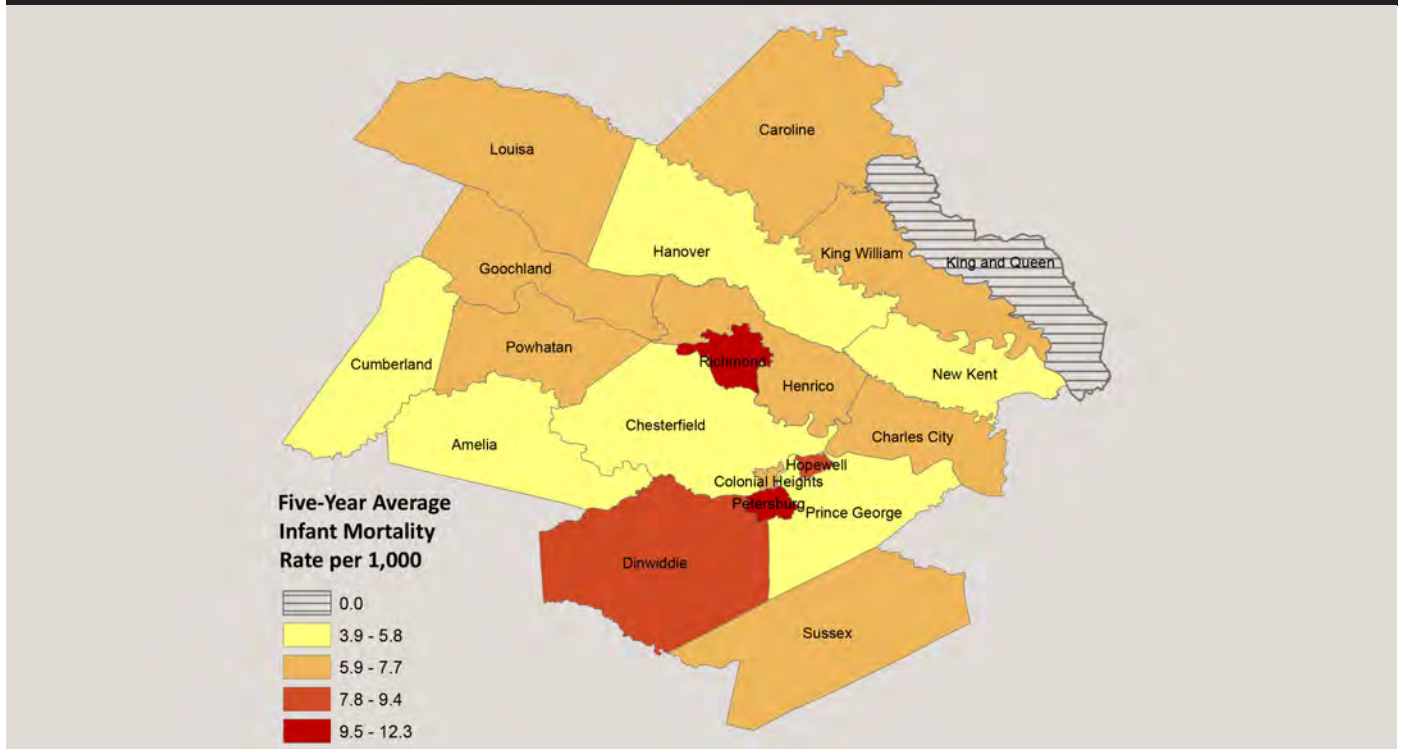
The rate of deaths from diabetes in Richmond City is 28.3 per 100,000 in 2012, which exceeds

the rate for Virginia (18.5 per 100,000). As seen in [Map 17](#), the diabetes death rate in the Richmond metropolitan area ranges from under 10 deaths per 100,000 (Caroline and King William counties) to more than 40 deaths per 100,000 (Charles City, Hopewell City, and New Kent County).

Infant Mortality Rate

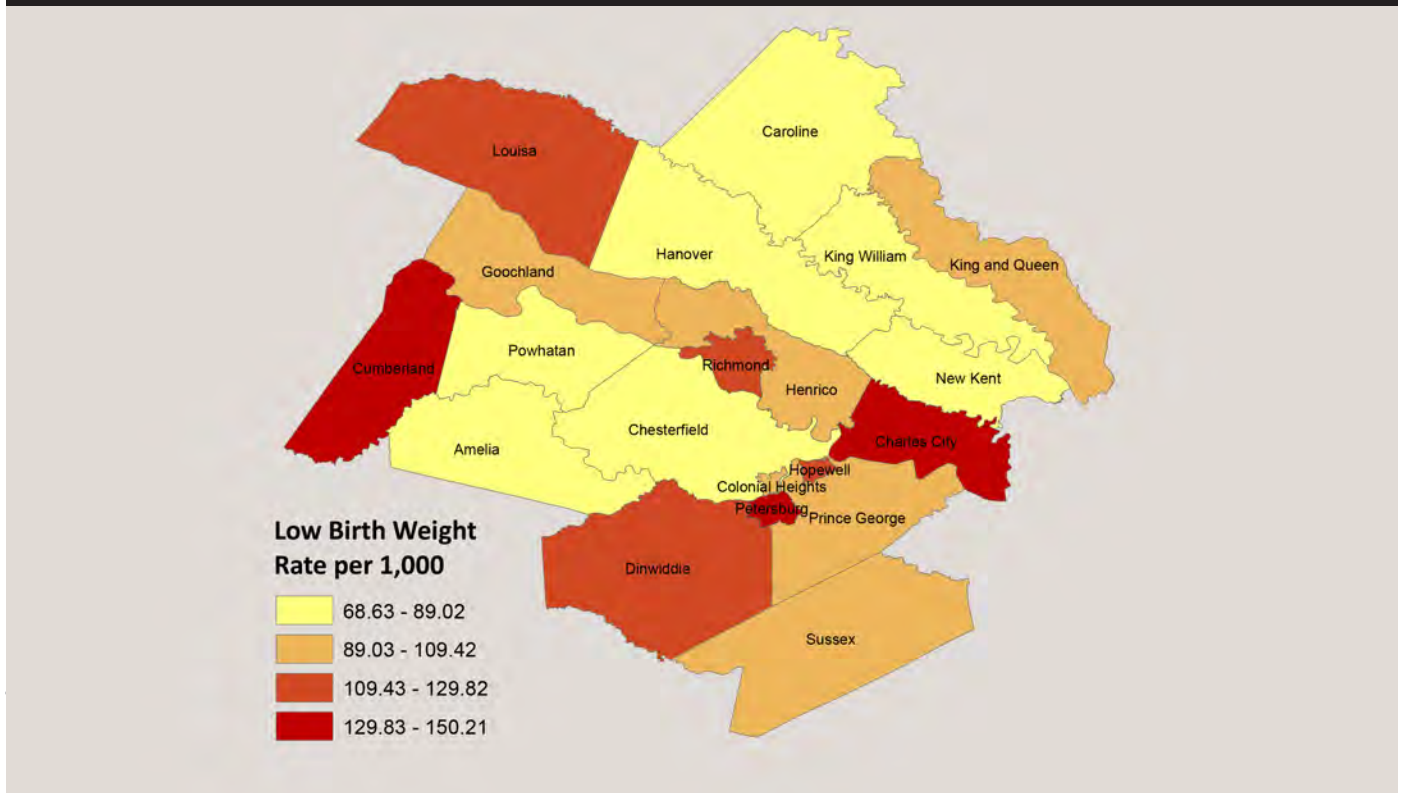
Whereas the infant mortality rate for the Commonwealth was 6.3 per 1,000 live births in 2012, it was 12.3 per 1,000 live births in Richmond City ([see Map 18](#)). Similarly high infant mortality rates (above 9 per 1,000) were reported in Petersburg City, Dinwiddie County, and Hopewell City. Many of the same social and environmental causes and risk factors for low birth weight apply to infant mortality. In Richmond City, the rate of births without early prenatal care

Map 18. Five-Year Average Infant Mortality Rate, Richmond Metropolitan Area, 2006 – 2010



Source: Virginia Atlas of Community Health, 2012

Map 19. Low Birth Weight Rate, Richmond Metropolitan Area, 2010



Source: Virginia Atlas of Community Health, 2012



was 11%, whereas the rate was 5% or lower in Chesterfield County and Powhatan County.⁵⁰

Low Birth Weight

Low birth weight is a marker for poor maternal health and adverse living conditions. Factors leading to preterm delivery (e.g., smoking, substance abuse, infectious diseases, and chronic health conditions) are some of the major contributors to low birth weight in infants. Low birth weight (defined as a weight of less than 2500 grams, or about 5.5 pounds at birth) is a major risk factor for both immediate and long-term health consequences for the child. The prevalence of low birth weight varies sharply by county ([see Map 19](#)). Darker brown areas on the map represent areas where low birth weight is most common.

Children and Adolescents

The social environment affects not only birth outcomes but the health and safety of children and adolescents. As in other metropolitan areas, homicide is the leading cause of death among youth age 15 to 24 in Richmond, but the rates are especially high. Between 1997 and 2007 the homicide rate among youths in Richmond City was 5 to 11 times the national rate. Most intentional injury deaths involved victims who were males (88%) and African American (90%).

Most homicides were firearm related.⁵¹

In the Richmond metropolitan area, the firearm homicide rate was 10.5 per 100,000 and in Richmond City it was 43.1 per 100,000.⁵² These rates exceed the average for the 50 largest metropolitan statistical areas (MSAs) in the U.S, which was 5.2 per 100,000 persons (6.8 for youth ages 10 to 19 years) per year in 2006–2007.

SUMMARY

In Part I of this report, we have examined social, demographic, and place-based factors that play a role in health disparities and health outcomes. Disparities occur locally, within cities and counties, as well as across the region. Many of the most challenging conditions faced by communities and their residents—from lack of economic and health care resources to poverty and low educational attainment—cluster together and increase the risk for poor health outcomes. In the next section we more closely examine some of the issues that community researchers have prioritized as among the most pressing issues for urban residents. They stress both the importance of community strengths and assets and a proactive approach to addressing community needs to improve health.

Richmond City: Challenges and Opportunities

Our community-based research team collected data from diverse community members about their priorities around social determinants of health through a series of 17 focus groups in Richmond’s East End,^{ix} 10 focus groups in other Richmond neighborhoods, and individual interviews. Across these focus groups and interviews, many community priorities were mentioned. Participants discussed what makes for a healthy, vibrant community, identifying both assets and concerns in their own communities. **Box 5** lists many of the issues mentioned by participants.

Our team reviewed the data from the focus groups and collaboratively engaged in priority setting exercises (asking questions regarding the themes residents identified in regard to frequency, importance, vulnerable populations, and ability to take action) and identified four top priorities: mental health, parental participation, services for children, and workforce development. These issues are discussed below.

MENTAL HEALTH

Good mental health is a foundation for increasing individual opportunities, strengthening families and the community, and giving children a stable

Box 5: Priorities mentioned by our community-based research team

- Mental health
- Workforce development/jobs
- Services/recreational spaces for children
- Parental involvement
- Unity/community events/pooling resources
- Education
- Role models/mentoring
- Environment/physical appearance and cleanliness of neighborhood/upkeep
- Financial investment in neighborhoods
- Safety/policing
- Transportation
- Access to food/supermarkets
- Access to information/communication
- Access to and sustainability of services

^{ix} The Engaging Richmond team conducted 13 focus groups with community residents (men, women, parents, seniors, the homeless, employed and unemployed persons, and residents from different areas of the community) and four focus groups with service providers (approximately 170 participants total). We also conducted individual interviews with staff from local service provider agencies.

Box 6. Mental Health Concerns Raised by East End Residents

- There is little information available about mental health issues and services in the community.
- A stigma is often associated with seeking out mental health services.
- There is a lack of available and consistent services that are culturally appropriate for different groups of people.
- Residents and service providers have weak relationships.
- Children and adults are exposed to a high level of trauma in the community.
- Residents feel alienated for a number of reasons (e.g., formerly incarcerated residents, abandoned children, etc.).
- Children's issues may be misdiagnosed.

environment in which they can thrive. The concerns about mental health raised by this community echo the larger public health implications of mental illness to the nation.⁵³ Aside from the direct emotional, psychosocial, and psychiatric burden, mental illness (e.g., major depressive disorder, substance abuse) is strongly linked to suicide and attempted suicide—the third leading cause of death among youth ages 10–24 in Virginia from 1996–2005.^{54, 55} Residents linked mental health to trauma (e.g., witnessing and experiencing violence), unemployment, alienation, incarceration, poverty, and stress. They identified lack of prevention and treatment options, along with low levels of service utilization in the community, as fostering a cycle of even greater alienation, poverty, and stress. Residents identified several key factors that shape outcomes around mental health, such as underutilization of services due to stigma related to mental health **(see Box 6)**.

Widely documented disparities in health experienced by African Americans^{56, 57} extend to mental illness. In 2010, African Americans had a higher rate of attempted suicide compared to the general population (0.8% and 0.5%, respectively).⁵⁸ Among those ages 12 and older, the rate of illicit drug use in the past year was also higher among African Americans than in the general population (16.8% and 15.3% respectively).⁵⁹ In general, African Americans appear to have the same or lower incidence of diagnosed mental disorders compared to other racial/ethnic groups, but this may reflect lower access to mental health services, less frequent recognition of mental health needs among African Americans by physicians,⁶⁰ and relative exclusion of vulnerable populations from

national epidemiological surveys.⁶¹ The Surgeon General's report on mental health disparities concluded that "racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their over-all health and productivity."⁶²

In 2010, African Americans with a mental illness received mental health treatment/counseling at a much lower rate than whites (27.4% versus 44.4%, respectively).⁶³ Several studies have documented lower treatment rates for depression, including the National Survey on Drug Use and Health (55% among African Americans versus 72% among whites).^{64, 65} African Americans who do seek treatment are more likely than whites to use primary care providers than mental health professionals and are less likely to seek help from informal support networks. They are also less likely to complete treatment. From 2005 to 2008, for example, African Americans who were treated for substance abuse were significantly less likely than non-Hispanic Whites to complete treatment.⁶⁷

Impact of Stigma

Mental health stigma can be held by the public or by the person with mental illness (self-stigma). Stigma may be shaped by a combination of cues (i.e., psychiatric symptoms, social-skill deficits, physical appearance, and labels), stereotypes, prejudice, and discrimination.⁶⁸ Common stereotypes related to mental illness include blame and perceptions of dangerousness. Community members who hold negative stereotypes about people with mental illness may react angrily to them, withhold help, and avoid or fear them.⁶⁹ Stigma may be experienced during interactions with members of the general

What is Stigma?

Mental health stigma is "a collection of negative attitudes, beliefs, thoughts, and behaviors that influences the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders."

Gary FA. Stigma: Barrier to Mental Health Care among Ethnic Minorities. *Issues in Mental Health Nursing*. 2005; 26: 979–999.

Addressing Mental Health Stigma in the Community

Since identifying mental health as a community priority in 2012, Engaging Richmond has worked with local stakeholders to reduce stigma and promote mental well-being among community residents. Activities to address mental health include Mental Health First Aid training, a program that teaches non-clinical community members to develop skills to de-escalate crises and to recognize symptoms of mental health disorders. To date, one Engaging Richmond team member has trained over 200 residents and service providers who work with youth in the community.

Box 8. Recognizing and Treating Children's Trauma

Service providers in the East End focused on the issue of trauma and its impact on children.

“When a child is exposed to a traumatic event, one of the first things they lose is a sense of safety.”

“A lot of kids have seen so much crime out here that they’re traumatized and they don’t even know it.”

“I think taking a step back and looking at the issue of trauma, its pervasive effects with the group of children that we serve, and what we need to understand about it in order to better serve these kids so that more kids can be successful in all the variety of programs.”

“Once you understand this kid’s coming out of trauma, there are ways to approach the children that can be much more helpful in improving the behavior and also working with that child.”

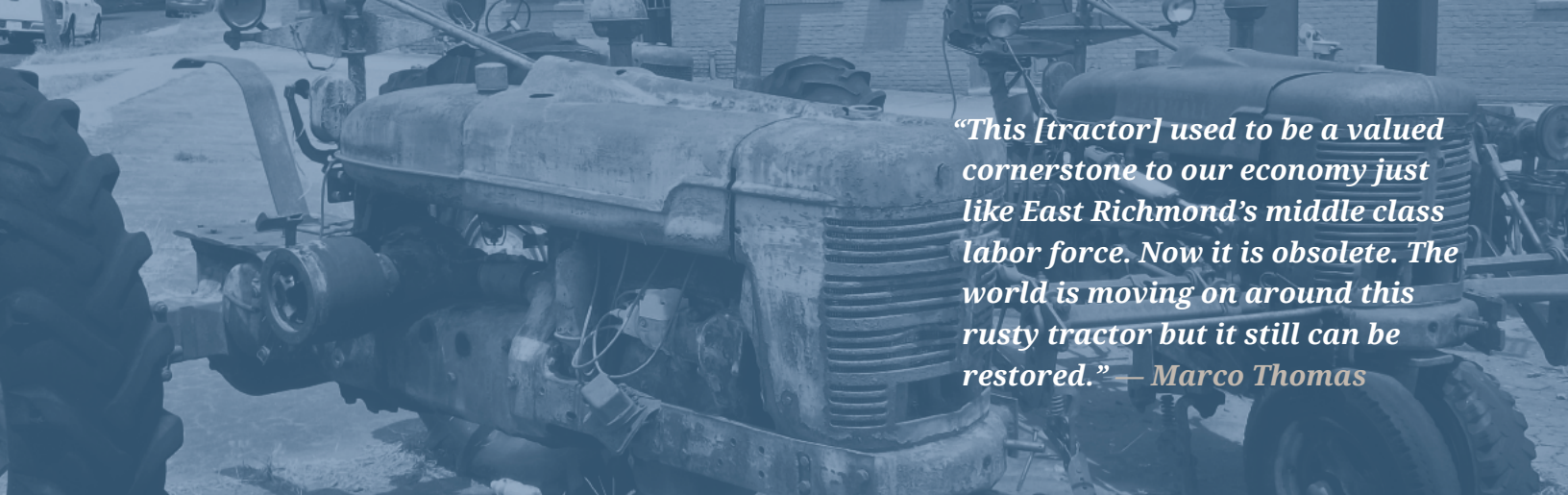
“We as youth workers among the high-risk population of children have no understanding of trauma and don’t know how to deal with the behaviors that are coming out of that and we’re diagnosing kids wrongly, but also responding to kids in ways that only make everything worse.”

community, including neighbors, people in public places, and community groups, as well as in workplaces and even among family and friends.⁷⁰

The stigma related to mental illness may prevent people from seeking help when needed. Those suffering from mental illnesses may avoid seeking help for fear of labeling, stereotyping, or discrimination.⁷¹ Stigma may reduce utilization of mental health services due to its negative effect on self-esteem and self-efficacy and by causing feelings of shame, including shame felt by family members.⁷² In addition to reducing the likelihood that individuals will seek treatment, stigma may reduce social integration and opportunities such as employment, independent living,⁷³ and access to medical care.⁷⁴ Stigma may have adverse psychological and social effects, such as low self-esteem, depressive symptoms, constricted social networks, noncompliance with treatment,⁷⁵ and stress.⁷⁶

Addressing trauma

Another theme that recurred in discussions of mental health is the concern that children and adults are exposed to a high level of trauma in the community. Children can experience trauma due to crime and violence in the community, domestic violence, and child maltreatment. Trauma that is unaddressed increases the risk for problems at school, poor mental health, and behavioral problems. Exposure to violence and adverse experiences can have a cumulative effect on children, which can affect health, development, and functioning in later life, while risk and protective factors play an important role in outcomes.⁷⁷ In **Box 8** we highlight a number of quotes from community residents and service providers on this issue.



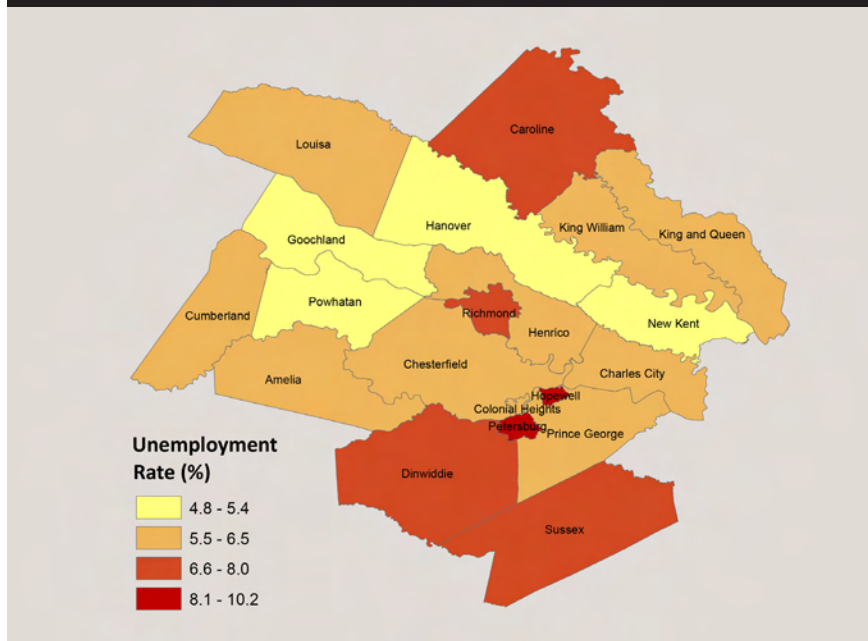
“This [tractor] used to be a valued cornerstone to our economy just like East Richmond’s middle class labor force. Now it is obsolete. The world is moving on around this rusty tractor but it still can be restored.” — Marco Thomas

WORKFORCE DEVELOPMENT

The Engaging Richmond team collaboratively identified workforce development as one of the most pressing issues for the community. Areas such as Richmond’s East End have experienced a period of growing blight, dilapidated housing, increased levels of poverty and crime, multi-generations of pregnant teens, and high school dropouts. The commercial corridor serving the neighborhood is now dilapidated with few businesses. Unemployment is exacerbated by high levels of poverty, many single parent households, inadequate social support, and low high school graduation

rates. Some Richmond neighborhoods have higher levels of unemployment, particularly those with a high density of public housing, racial segregation, and physical isolation from employers. According to the 2008–2012 American Community Survey (ACS), for example, approximately half (47%) of the residents age 16 and older in parts of Richmond’s East End (where the Creighton, Whitcomb, Fairfield, and Mosby housing projects are located) did not work at all in the past 12 months. Median household income was under \$16,000 in most of these census tracts.

Map 20. Unemployment Rate, Richmond Metropolitan Area, March 2012



Source: U.S. Dept of Labor, Bureau of Labor Statistics Unemployment Rates by County in Virginia, March 2013

Above: photo and quote by Marco Thomas

“I think it’s because we live in this community, we’re ignored, because they think that the average person that lives in the projects don’t want nothing out of life, don’t have an education, can’t find a job. So it’s like a systematic way that they view us and it hurts us.”

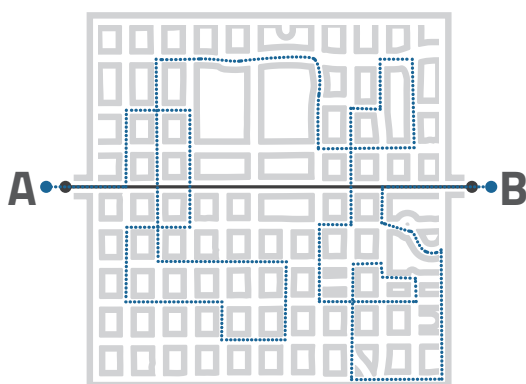
— East End resident

Residents of disinvested neighborhoods are cut off from job opportunities in the following ways:



Lack of local employers

Some residential areas of Richmond are geographically isolated from employers, such as areas of the East End that are made up almost exclusively of low-income housing projects and rental units. There are very few employment opportunities in the vicinity and the area is encircled by interstate highways that isolate it from neighboring urban areas with more job opportunities.



Lack of transportation to employers outside the immediate area

Geographic isolation is compounded by lack of access to reliable transportation. The majority of low-income households, particularly those that currently rely

on public benefits, lack their own vehicles and must rely on public bus service to access jobs and services that are not within walking distance. Throughout Richmond City, 7% of workers rely on public transportation to get to work. In geographically isolated, low-income neighborhoods of Richmond City's East End, 32% of workers rely on public transportation.⁷⁸ However, bus schedules are limited, particularly during evenings and weekends. Without a regional transportation system, Richmond City does not operate buses with connecting service that enable commuters to reach employment opportunities outside the city limits.

Low educational attainment and lack of job skills

Unemployment rates in 2013 were highest in Petersburg City (10.2%), Hopewell City (8.7%), Sussex County (8.0%), Richmond City (6.7%), and Dinwiddie County (7.0%)⁷⁹ (see [Map 20 on previous page](#)). The high school graduation rate in Richmond is 13 percentage points lower than the state average.⁸⁰ In particularly disadvantaged areas, such as the East End neighborhood described above, 42% of the population age 25 and older did not have a high school diploma, according to 2008–2012 American Community Survey (ACS) data, and 31% had a high school diploma or GED as their highest level of educational attainment. According to the City Department of Economic and Community Development, many blue-collar jobs go unfilled for lack of skilled workers. Despite a growing job market⁸¹ for certain population groups in Richmond, residents who are under-educated, inexperienced, and geographically isolated face formidable barriers to stable employment and are not

competitive to work for the financial, health, and retail industries that are the top employers in the area. According to the *Richmond Times Dispatch*, among the top 20 employers in Richmond City are banks/financial products (Capital One, SunTrust, Wells Fargo, Bank of America, Federal Reserve Bank of Richmond, Genworth Financial), medical and health services providers (VCU Medical Center, HCA Virginia Health System, Bon Secours Richmond Health System, Wellpoint, Southside Regional Medical Center), retail (Walmart, Food Lion, Kroger), utilities (Dominion Resources, Verizon Communications), and manufacturers (Altria, Dupont), freight services (UPS), and education (University of Richmond). Across the region, education and health services are still among the largest employers, along with government and defense.^{x,82}



Residents of low-income neighborhoods in Richmond City described several challenges in the search for employment and made recommendations for improving residents' prospects. Among the challenges were criminal records, lack of computer access and knowledge, and business skills, such as resume preparation (see [Box 9 for additional concerns raised by East End residents](#)).

x Industries with the greatest number of new hires (with average weekly wages) were (in order): administrative and support and waste management (\$609), accommodation and food service (\$299), health care and social assistance (\$914), and retail trade (\$508). The largest long-term projected growth industries, by percent growth, are professional, scientific and technical services, health care and social assistance, arts, entertainment and recreation, construction, and educational services

If We Miss The Bus

Photos and Story by Marco Thomas

It's dark outside at 5:30 am, a mother's purse is slung over her shoulder, her toddler in her arms and her 5- year-old daughter holding her hand. She's thinking:

"I had to get up, get the kids ready and fed, now I'm walking 10 minutes to get to this first bus stop on time, because if I miss this bus the next one isn't coming for an hour. I'm standing at this stop in the dark and gloom during prime dope hours. Someone could be hiding in this corner, or coming around the next—someone might shoot or rob me. But I got to drop-off my kids at my mom's and get to work—I hope for happy customers today—I don't need this; I don't know how much more I can take."



Box 9. Workforce Development Concerns Raised by East End Residents

- The current job market is weak.
- Residents do not feel adequately prepared for the current job market.
- Access to good jobs and skills training is limited because of difficulties with transportation, child care, and access to technology and information.
- Residents experience racial and class prejudice and discrimination; employers' perceptions lead to discrimination against hiring people living in public housing and in the East End neighborhood generally.



SERVICES FOR CHILDREN

During focus groups, we heard frequently from parents about the services their children need and those they receive. Parents felt positively about many of the services that their children receive but were also critical of services that fell short of expectations or were difficult to access in their neighborhoods. Many lamented cuts in programs that were important to the community. Some programs that were popular with parents in the East End included Early Head Start, Richmond Healthy Families, Richmond Healthy Start Initiative, and the after school program at Fairfield Elementary School.

We talked with East End community residents and service providers who expressed concern that children were not adequately involved in a range of quality services, including early childhood services, sports, mentoring, and enrichment. Opinions ranged widely,

however, as to why many children were not enrolled in these programs. Some residents felt that programs were too restrictive (e.g., focusing only on kids with special needs) or that parents were not given an opportunity to get engaged and thereby develop trust in the programs. Some residents felt that the problem was not the availability of quality programs but parents' lack of access to clear, comprehensive information about what is available and lack of motivation or incentive to enroll children. There was widespread agreement that children who are not involved in quality activities may spend too much time on the street, fall behind academically, miss out on opportunities to enjoy childhood activities, and lack exposure to a range of experiences.

Above Left: Middle School Student Learning Video Skills in Art180 After School Program. Photo credit: Art180 **Above Right:** Girl in Baseball Uniform. Photo credit: Art180



Peter Paul Development Center, an outreach and community center serving Church Hill and neighboring communities in Richmond's East End, provides youth services to help students attain success in school and prepare them for life after high school graduation. The Center's intensive, individualized Youth Program supports East End students ages 7 to 18 through its After School Learning Immersion Program and its Summer Promise program. These programs are designed with clear expectations of regular attendance, academic performance, and good behavior. In addition to the primary academic focus, students participate in enrichment activities, are fed healthy meals, and receive transportation to and from the Center and all activities.

The Importance of Mentoring

Informal and formal mentoring by adults other than parents was often mentioned as an important component in helping vulnerable children succeed.

“We do need more services for our kids... And definitely for our teens, definitely for our older kids because, believe it or not, we are losing them and I’m sick to the stomach... But when you can look at somebody’s child and see some potential in them... It’s not gonna hurt a breath out your body to say ‘Boy, I see something in you. Girl, I see something in you. Go back to school. Put that cigarette down. Get out of the streets.’ ... But if you’re saying something positive to them, it’s not gon’ hurt them and we might could just make that change in that child’s life.”

—East End Resident

The Need for Children’s Services

The issue of scope and quality of activities for children was a strong theme in many focus groups with residents as well as service providers. Recreation, child care, tutoring, and mentoring were key themes.

“We got to get the kids back outdoors and into active things”

—East End Resident

“They ain’t got nowhere to go. They ain’t got no recreation or nothing. If they try to go on the basketball court to play basketball, the police come and mess with them. So you’ve got to put some activities in the neighborhood.”

—East End Resident

“The point is why all these kids is doing so much violence. They doing so much violence because of the fact that they ain’t got nothing to do.”

—East End Resident

Middle School Renaissance

Middle School Renaissance 2020 is a collaborative community initiative designed to engage Richmond Public School’s middle school students in meaningful after-school activities. As part of a pilot program for Middle School Renaissance, Engaging Richmond completed focus groups in the spring of 2014 with 13 parents of middle school students to gather feedback and make recommendations for services for the 2014–2015 academic year. Parent leaders expressed a strong desire for out-of-school activities to be fun, engaging, and promote self-expression.



PARENTAL INVOLVEMENT

Parental involvement, not just in schools but in overall child development, was expressed as a strong priority by East End residents. Parental involvement in children's education can have many benefits, from enhancing children's behavior and school performance to improving parental self-confidence and teacher morale. Barriers to parental involvement may involve competing demands, such as jobs, but they may also have to do with lack of understanding about what schools expect of parents and how parents can contribute to their child's education. A school culture of collaboration can help foster parental involvement, as can clear and consistent school policies.⁸³

Parental involvement in education and child development tends to be higher among families with greater socio-economic resources. However, research evidence indicates that parental investment in educational involvement and the parent/child relationship can be an important mediator between economic disadvantage during childhood and later positive outcomes. Various aspects of parental involvement include time spent with children, shared activities, discussions, monitoring, relationship quality, and contact with the school system or parent-teacher organizations.⁸⁴

Above: Photo credit: Art180



Box 13. Parental Involvement Concerns Raised by East End Residents

- Parents want to learn how to encourage their children to do well in school so that they can have a successful future.
- Parents want to be involved in their children's lives in ways that help their children and themselves.
- Some parents in the community feel alienated for reasons that include substance abuse, mental health issues, or transitioning from environments such as prison.
- There is limited access to information about how parenting affects child development.
- Some parents lack the resources and support that would enable them to become involved, especially fathers and young mothers.
- Parents have skills and talents they could use to mentor children in the community, but they do not know about opportunities for mentorship.

Parental involvement is a challenge from both perspectives—engaging parents in available opportunities and creating meaningful engagement mechanisms that promote involvement and foster trust. Some parents also expressed the need for opportunities to learn and strengthen their own parenting.

“We recently had a PTA meeting and we didn’t have a parent to show up. So I think it’s important that we find a way to get our parents to support their children to be more proactive about their education.”

“[We need] education for the parents as well as the kids to help them be better parents. A lot of them can’t be parents because they don’t know how... if you would teach us how to be fathers, we could be better fathers.”

“When we was little, we had all types of sports that we was participating, and our moms and fathers was out there... but they don’t do none of that no more.”

Conclusion

It is well-documented nationwide that minority populations have worse health outcomes than whites, and the data presented here suggest that Richmond is no different. Richmond fares poorly in a number of health outcomes measures, notably life expectancy and death rates. African-Americans from the East End show greater risk of developing several preventable diseases, including high blood pressure, cardiovascular disease, and diabetes, and also exhibit higher rates of obesity and smoking and lower access to health coverage and health services. Death rates from heart disease and diabetes exceed the state average in Richmond City. The poorest neighborhoods of Richmond City have high rates of infant mortality and low birth weight babies, both of which are associated with poor overall health and living conditions.

African American residents comprise the predominant race in Richmond City, but they have been largely segregated into the city's poorest neighborhoods due in part to historically discriminatory housing policies. Many African American

neighborhoods have subsequently fallen prey to neglect and blight. Residents living in public housing report facing class-based discrimination in the job market, which could contribute to continued poverty in these neighborhoods. Moreover, Richmond City appears to have worse housing conditions overall than the rest of the metropolitan area, with the lowest percentage of owner-occupied housing and the highest rates of overcrowding. Many poor neighborhoods are also located in food deserts where the available foods are more likely to be highly processed with high sugar and calorie content, contributing to the preventable diseases discussed above.

The high violent crime rate in Richmond City could contribute to lower life expectancy, lower high school graduation rates, and higher prevalence of mental health disorders. Growing up in high crime areas has implications for the mental health of children and adults, especially those who experience or witness traumatic events. Unsafe school environments could be a factor in the growing problem of under-education for the city's minorities.

High school dropout rates appear to be highest in disadvantaged areas such as the East End. Low educational attainment limits qualifications for work in the financial, health, and retail industries that are the top employers in Richmond. High unemployment rates in the East End are exacerbated by residents being further cut off from the job market by geographical isolation and lack of transportation to employers.

Under-education, unemployment, racial and class discrimination, segregation and poor housing in Richmond City all converge on arguably the most important social determinant of health: poverty. Poverty levels in Richmond City are higher than either the metropolitan area or the state. Moreover, the rate of extreme poverty (incomes below 50% of the national poverty level) is two to three times higher in Richmond City compared to the metropolitan area, and African Americans and Hispanics are far more likely than whites to live in poverty. Even within Richmond City, however, there is an emerging wealth gap, with median

household income just over \$10,000 per year in the poorest census tract and more than \$175,000 per year in the wealthiest. Given the wealth gap, it does not come as a surprise that life expectancy varies by 20 years for males and females combined across census tracts in Richmond City, with wealthier areas having higher life expectancies.

Suggestions for community priorities were provided by residents of the East End and other areas of Richmond City. Greater focus on mental well being and access to mental health services were top priorities. Parents feel that children's services and reliable information about them are lacking in the East End, and mentoring and after-school programs could play a role in keeping kids off the streets and in school. Programs to enhance parental involvement could also increase children's success. Investment in other factors contributing to concentrated poverty, such as housing, job training, transportation, and educational programs would likely also increase wealth and improve health outcomes for the Richmond community.

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