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# Bearing a Disproportionate Burden: Racial/Ethnic Disparities in Experiences of U.S.-Based Social Workers during the COVID-19 Pandemic

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While social workers have served as frontline workers responding to the needs of vulnerable populations during COVID-19 pandemic, little is known about how social work professionals themselves have been impacted. This article explored the impact of COVID-19 on social work professionals' mental health, physical health, and access to personal protective equipment (PPE). This was a cross-sectional web-based survey of social workers practicing in the United States ( $N=3,118$ ); data on demographic and workplace characteristics, physical and mental health, and safety concerns were collected between June and August of 2020. Univariate statistics were used to characterize the sample. Ordinal logistic and multinomial regression were used to achieve the research aims. The majority of participants reported either moderate or severe concerns related to mental (55 percent) and physical (55 percent) health; 36 percent of respondents indicated concerns about PPE access. Respondents' concerns differed by demographic (e.g., race, age) and workplace characteristics (e.g., setting, role, region). Social workers of color are experiencing COVID-19-related concerns of significantly greater severity relative to their White counterparts. Findings highlight an immediate need to deepen understanding of the factors that contribute to these trends and identify mechanisms to support the frontline social work workforce most impacted.

KEY WORDS: *COVID-19; quantitative methods; social work practice; social worker stress; workplace safety*

The COVID-19 pandemic has brought unprecedented strain on communities and the social work professionals who serve our most vulnerable populations. As of October 2021, there have been nearly 45 million cases and over 700,000 deaths in the United States (Centers for Disease Control and Prevention, 2021). A lack of decisive national leadership and failure to implement public health measures early contributed substantially to COVID-related morbidity and mortality—particularly among vulnerable populations (Koh et al., 2021) and communities of color (Jalali et al., 2020; Tai et al., 2020; Walter-McCabe, 2020). This has resulted in a public health emergency and social justice crisis unlike any seen in modern-day history. COVID-19 has exposed disparities rooted in structural racism (Tai et al., 2020; Yancy, 2020) and gaps in social safety nets most often filled by the

social work workforce (Abrams & Dettlaff, 2020; Banks et al., 2020). Specifically, the pandemic has shone a light on frayed social and health systems and resource scarcity, exacerbating housing and food insecurity, unemployment, and increases in mental distress, substance use, and violence (Banks et al., 2020).

Early spread of the virus was associated with greater household density, being Black, having less education, and being underinsured (Jalali et al., 2020). Black and Latinx populations in the United States comprise a greater proportion of essential workers, thereby increasing exposure among these groups (Garnier et al., 2021; Jalali et al., 2020). Efforts that mitigate COVID-19 (such as social distancing) have been weaker in counties with a greater proportion of people living in poverty and a greater proportion of essential workers (Garnier

et al., 2020). These essential workers (i.e., providers of food service, public transportation, and health services) are also less likely to have job protections (i.e., laws or regulations that protect the rights of employees, such as advance notice of termination or paid leave), which further exacerbate these disparities.

### **SOCIAL WORK AS AN ESSENTIAL WORKFORCE**

Social workers have been on the frontlines throughout the pandemic, engaged in health promotion, prevention, and intervention efforts to improve individual, familial, and community wellbeing; however, the profession is not universally recognized across states and territories as a member of the “frontline” or “essential” designated workforce (Gewirtz, 2020). Social workers, long a part of the nation’s health workforce (Ruth & Marshall, 2017), have been tasked with continuing to provide a myriad of services to vulnerable persons and communities throughout various pandemics. With respect to COVID-19, some have argued that the rapidly expanding need for social care may be further straining social work practitioners (Abrams & Dettlaff, 2020). Just as the social determinants of health (SDOH) are associated with disparate COVID-19 outcomes, these disparities may be paralleled within the social work workforce.

### **RISKS ASSOCIATED WITH FRONTLINE WORK**

#### **Mental Health and Well-Being**

The increased disparities and needs exposed by the COVID-19 pandemic have undoubtedly burdened the mental health of frontline workers, including social workers. Increased mental distress during the pandemic is associated with increased hours, more intense work environments, and poorer reported work-life balance (Mishna et al., 2020). These, coupled with lack of control, unclear workplace expectations, inadequate training/preparedness access to personal protective equipment (PPE), and lack of social support are linked to poorer mental health, particularly increased anxiety (Mishna et al., 2020; Nyashanu et al., 2020). For social workers, there are numerous professional and ethical challenges associated with providing services in a pandemic, which include fair resource allocation, continuity of client-community relationships, transitioning to telehealth, and maintaining trust, privacy, dignity, and autonomy (Banks et al., 2020).

### **Physical Health Risks and PPE Concerns**

The COVID-19 pandemic has highlighted inequities associated with remote work opportunities, including within social work. While some social workers were able to convert to working remotely (having full digital access and maintaining income), those options were unavailable for others (Abrams & Dettlaff, 2020; Yancy, 2020). It has been estimated that 32 percent of community and social service providers are exposed to COVID-19 at least once a month in the workplace, and almost 8 percent are estimated to be exposed weekly; weekly exposure rates rise to over 90 percent for individuals employed in health settings specifically (Baker et al., 2020). Due to PPE shortages, delivering social work services in-person elevates potential risk for COVID-19 exposure (Redondo-Sama et al., 2020). While in theory, restricted PPE access may be an individual risk, in practice it is one that also jeopardizes the health of family and community (Abrams & Dettlaff, 2020). It is also abundantly clear that social (physical) distancing, a core public health strategy shown to reduce COVID-19 transmission, is a privilege, as is the ability to stay at home or work remotely (Yancy, 2020).

### **THE CURRENT STUDY**

Understanding the experiences of social workers during the early months of the COVID-19 pandemic is critical to informing training, organization, and practice needs. Given the essential nature of social workers in this unprecedented time, the purpose of this study was to understand stressors related to mental and physical health and workplace safety among practicing social workers in the United States. Given that long-standing racial and ethnic disparities have been exacerbated by the COVID-19 pandemic, differences in social workers’ experiences by race/ethnicity are explored.

### **METHOD**

This cross-sectional survey examined associations between demographic and workplace characteristics and self-reported outcomes of physical health, mental health, and PPE access concerns among a sample of practicing social workers in the United States. The anonymous electronic survey was administered via Qualtrics (<https://www.qualtrics.com/lp/survey-platform>) and took approximately 15 minutes to complete. Respondents were not compensated for participation. All

procedures were approved by the institutional review boards at Fordham University and the National Association of Social Workers (NASW).

## Recruitment

Using snowball sampling methodology, practicing social workers were recruited for survey participation primarily through collaboration with NASW. Specifically, the NASW National Office distributed survey invitations to chapter executive directors with requests to disseminate the survey to their membership Listservs. From June through August 2020, announcements were posted on various NASW outlets (i.e., member and practice boards, social media). In addition, to solicit participation the research team distributed an email invitation and survey link to 12 professional organizations (see acknowledgments).

**Participants.** Eligibility criteria included current status as a practicing social worker either in the United States or an incorporated U.S. territory, or enrollment in a social work program. While it is not possible to report survey response rates due to the nature of the sampling strategy, a total of 4,083 responses to the electronic survey were initiated. Upon review, 964 (24 percent) responses were excluded because of absence of demographic information ( $n = 917$ ; 23 percent), international or duplicate IP address ( $n = 40$ , 1 percent), spam responses ( $n = 7$ ; less than 1 percent), and retiree status ( $n = 11$ ; less than 1 percent). The final sample resulted in 3,118 self-identifying social workers based in the United States.

## Measures

**Demographic Characteristics.** Age was collected and treated as a continuous variable in subsequent analyses. For gender, respondents selected one of five options: male, female, nonbinary, gender not represented on this list, or prefer not to disclose. For data analytic purposes, selections of nonbinary and gender not represented on this list were combined. Race and ethnicity data were collected using a choose-all-that-apply format that included the following options: American Indian or Alaska Native (AIAN), Asian American or Pacific Islander (AAPI), Black/African American, White, and Hispanic/Latinx. Respondents who selected more than a single option were categorized as multiracial. In subsequent analyses, respondents who selected a racial/ethnic identity other than White or

non-Hispanic Latinx were combined into a single category given sample constraints.

**Workplace Characteristics.** Information on social work role was collected by asking respondents to designate their role as direct care provider, student, manager/program manager, administrator/director, policy practitioner, researcher, academic, or other. Practice setting data were acquired by using a multiple-choice question initially spanning 20 areas of practice. Due to limited respondents in some categories, the following areas of practice were collapsed: academic/research, school, hospital, community health, community mental health/substance use, Children, Youth and Family Services, aging/older adults/disability services, Department of Public Health (DPH), non-DPH government agency, private practice, and other. Private practice was the largest and thus designated as the referent group. Geographic location was obtained by asking respondents to report their county and state of practice; in subsequent data analyses, state-level information was subsequently recoded to reflect membership in one of the 10 Health and Human Services designated geographic regions: Region 1 (Boston), Region 2 (New York), Region 3 (Philadelphia), Region 4 (Atlanta), Region 5 (Chicago), Region 6 (Dallas), Region 7 (Kansas), Region 8 (Denver), Region 9 (San Francisco), and Region 10 (Seattle). Region 9 was designated as the referent group, as it contained the largest number of respondents.

**Well-Being and Safety.** Dependent variables of mental health, physical health, and PPE access were assessed using a single item scored on a five-point Likert scale (1 = completely unconcerned, 3 = neither concerned nor unconcerned, 5 = very concerned). Items were subsequently recoded to reflect three categories: no concerns (response of 1, 2, or 3), moderate concerns (response of 4), and severe concerns (response of 5).

## Data Analyses

Univariate statistics were used to characterize the study sample. Categorical independent variables were dummy coded to calculate and interpret odds ratios (ORs). In addition to independent variables of demographic and workplace characteristics, a race  $\times$  gender interaction term was computed and included in initial models to detect potential interactions; nonsignificant interaction terms were removed from final models. Effects of demographic

and workplace characteristics on outcomes were examined using separate ordinal regression models for physical health, mental health, and PPE access concerns; nominal regressions were used in cases when data indicated differential slope coefficients across response categories and violated the test of parallel lines (McCullagh, 1980). Within the final sample, missing data were less than 5 percent; cases with missing data were deleted listwise. All data were analyzed with IBM SPSS Statistics (Version 26).

## RESULTS

Table 1 shows demographic and workplace characteristics of the sample. The majority of participants identified as White ( $n = 2,643$ ; 85 percent), with an average age of 46.46 years of age ( $SD = 13.79$ ; see Table 1 for all demographics). Most participants reported either moderate or severe concerns related to mental ( $n = 1,699$ ; 55 percent) and physical ( $n = 1,667$ ; 55 percent) health, while over a third of respondents indicated concerns about PPE access ( $n = 1,129$ ; 36 percent; see Table 2). Proportions of respondents who indicated presence of concerns by demographic and workplace characteristics are shown in Table 2.

Multinomial regression was used to examine dependent variables of mental and physical health concerns, as tests of parallel lines were significant [ $\chi^2(24) = 37.45, p = .04$  and  $\chi^2(24) = 40.52, p = .02$ , respectively], indicating that data in these models violated the proportional odds assumption. Results are reported in Table 3. The tests of parallel lines for models examining PPE access were not significant [ $\chi^2(24) = 26.98, p = .31, ns$ ]; thus, ordered logistic regression was used (Table 4). Significant race  $\times$  gender interactions did not emerge in any model.

### Mental Health Concerns

The multinomial regression model examining mental health concerns was statistically significant [ $\chi^2(48) = 252.89, p < .001$ , McFadden's  $R^2 = .04$ ] and revealed differences by race/ethnicity, age, gender, setting, role, and region. Individuals who identified as Black, AIAN, AAPI, multiracial, or Hispanic/Latinx were nearly 80 percent more likely to report severe mental health concerns compared with their White counterparts ( $B = 0.56, p < .001, OR = 1.78, 95\%$  confidence interval [CI] [1.408, 2.261]). Similarly, while significant differen-

ces in moderate mental health concerns by gender did not emerge, nonbinary respondents were over twice as likely to report severe mental health concerns ( $B = 0.78, p = .03, OR = 2.19, 95\%$  CI [1.106, 4.337]) relative to their cisgender counterparts. Results revealed an inverse relationship between age and mental health concerns; for every one-year increase in age, respondents were 3 percent less likely to report moderate ( $B = -0.03, p < .001, OR = 0.97, 95\%$  CI [0.966, 0.979]) or severe ( $B = -0.03, p < .001, OR = 0.97, 95\%$  CI [0.960, 0.976]) concerns.

Workplace characteristics of role, setting, and region also yielded significant within-group differences in mental health concerns. Compared with counterparts, direct care providers were 44% more likely to report moderate ( $B = 0.36, p = .001, OR = 1.44, 95\%$  CI [1.167, 1.776]) and over twice as likely to report severe ( $B = 0.72, p < .001, OR = 2.05, 95\%$  CI [1.574, 2.671]) mental health concerns. Social workers practicing in settings classified as "other," which included domestic violence, housing, and immigration-related settings, were 87 percent more likely to report moderate ( $B = 0.62, p = .002, OR = 1.87, 95\%$  CI [1.252, 2.780]) and 67 percent more likely to report severe ( $B = 0.52, p = .04, OR = 1.67, 95\%$  CI [1.038, 2.735]) mental health concerns. Social workers in Region 3 and Region 7 were 46 percent less likely to report moderate mental health concerns compared with those in Region 9 [ $B = -0.63, p = .001, OR = 0.54, 95\%$  CI = [0.371, 0.773]) and ( $B = -0.62, p = .006, OR = 0.54, 95\%$  CI [0.345, 0.839], respectively); however, these differences were not observed with respect to the severe category.

### Physical Health Concerns

The multinomial regression model examining associations of demographic characteristics and workplace characteristics with physical health concerns was statistically significant [ $\chi^2(48) = 150.08, p < .001$ , McFadden's  $R^2 = .02$ ] and revealed significant differences by race/ethnicity, age, setting, role, and region. Similar to the mental health patterns observed, there were no significant differences in moderate physical health concerns by race/ethnicity; however, social workers who identified as Black, AIAN, AAPI, multiracial, or Hispanic/Latinx were 70 percent more likely to experience severe concerns about their physical health ( $B = 0.53,$

**Table 1: Sample Demographics and Workplace Characteristics (N = 3,118)**

Characteristic	n	%	M	SD
Age			46.46	13.79
Race				
AIAN	21	0.7		
AAPI	116	3.7		
Black/African American	277	8.9		
Multiracial	51	1.6		
White	2,643	85.0		
Ethnicity				
Hispanic/Latinx	351	11.3		
Non-Hispanic/Latinx	2,757	88.7		
Gender				
Female	2,752	88.5		
Male	264	8.5		
Noncisgender	62	2.0		
Work setting				
Academic/research	135	4.3		
School	207	6.7		
Hospital	462	14.9		
Community health	292	9.4		
Department of Public Health	117	3.8		
Other government agency	139	4.5		
Private practice	526	16.9		
Children, Youth and Family Services	225	7.2		
Community mental health/substance abuse services	536	17.2		
Aging/older adult/disability	242	7.8		
Other	227	7.3		
Role				
Direct service provider	2,336	75.2		
Student	49	1.6		
Manager	307	9.9		
Administrator/director	208	6.7		
Policy practitioner	27	0.9		
Researcher/evaluator	40	1.3		
Academic	59	1.9		
Other	39	1.3		
Unknown	43	1.4		

Note: AIAA = American Indian or Alaska Native; AAPI = Asian American or Pacific Islander.

$p < .001$ ,  $OR = 1.70$ , 95% CI [1.356, 2.133]). For every one-year increase in age, respondents were one percent more likely to report moderate ( $B = 0.01$ ,  $p = .04$ ,  $OR = 1.01$ , 95% CI [1.000, 1.014]) and 2 percent more likely to report severe physical health concerns ( $B = 0.02$ ,  $p < .001$ ,  $OR = 1.02$ , 95% CI [1.010, 1.025]).

Associations among workplace characteristics and physical health concerns were only found for those working in hospital settings. Relative to counterparts in private practice, social workers employed in hospitals were 55 percent more likely to report moderate ( $B = 0.44$ ,  $p < .001$ ,  $OR = 1.54$ , 95% CI [1.126, 2.126]) and 47 percent more likely to report severe ( $B = 0.38$ ,  $p = .03$ ,  $OR = 1.47$ , 95% CI [1.041, 2.068]) physical health concerns. Direct care providers were over 80 percent more likely to report severe concerns compared with their counterparts ( $B = 0.59$ ,  $p < .001$ ,  $OR = 1.81$ , 95% CI = [1.406, 2.328]). DPH also reached significance; relative to counterparts, DPH practitioners were 67 percent less likely to report physical health concerns ( $B = -1.10$ ,  $p = .002$ ,  $OR = 0.33$ , 95% CI [0.168, 0.662]). Last, social workers practicing in Region 1 were 42 percent less likely to report severe physical health concerns compared with those practicing in Region 9 ( $B = -0.54$ ,  $p = .005$ ,  $OR = 0.58$ , 95% CI [0.399, 0.846]; see Table 3).

### PPE Access

The ordinal logit regression model was statistically significant [ $\chi^2(24) = 140.52$ ,  $p < .001$ , McFadden's  $R^2 = .03$ ] with respect to demographic variables of race/ethnicity and age. Individuals who identified as Black, AIAN, AAPI, multiracial, or Hispanic/Latinx were 55 percent more likely to experience moderate or severe concerns about PPE access ( $B = 0.44$ ,  $p < .001$ ,  $OR = 1.55$ , 95% CI [1.303, 1.848]). Age was inversely associated with concerns ( $B = -0.01$ ,  $p = .005$ ,  $OR = 0.99$ , 95% CI [0.986, 0.997]), indicating that for every one-year increase in age, social workers were 1 percent less likely to report PPE access concerns.

Direct care social workers were 27 percent more likely to report moderate or severe concerns about PPE access compared with their nondirect service counterparts ( $B = 0.24$ ,  $p = .01$ ,  $OR = 1.27$ , 95% CI [1.049, 1.527]). Those employed hospital settings were nearly twice as likely to report moderate or severe PPE access concerns ( $B = .66$ ,  $p < .001$ ,  $OR = 1.94$ , 95% CI [1.476, 2.550]). Similarly, social workers in aging, older adult, or specializing in disability and those in other government settings were over 75 percent more likely to report PPE concerns ( $B = 0.56$ ,  $p = .001$ ,  $OR = 1.76$ , 95% CI [1.273, 2.421] and  $B = 0.57$ ,  $p = .005$ ,  $OR = 1.77$ , 95% CI [1.187, 2.633]), respec-

**Table 2: Numbers and Proportions of Respondents Who Indicated Concerns on Outcomes of Interest by Demographic, Work Setting, Region, Role, and Work Setting Characteristics**

Characteristic	Mental Health Concerns						Physical Health Concerns						PPE Availability Concerns					
	Moderate		Severe		Any		Moderate		Severe		Any		Moderate		Severe		Any	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Age	44.08	13.15	42.99	13.06	43.68	13.13	46.20	13.64	48.18	13.97	47.03	13.81	44.66	13.05	44.82	12.77	44.73	12.93
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Race																		
AIAN	5	23.8	5	23.8	16	76.1	3	14.2	11	52.4	14	66.7	6	28.6	8	38.1	14	66.7
AAPI	42	36.2	30	25.9	72	62.1	39	33.6	30	25.9	69	59.5	32	27.6	27	23.3	59	50.9
Black/African American	97	35.0	66	23.8	163	58.8	84	30.3	71	25.6	155	56.0	69	24.9	57	20.6	126	45.5
Multiracial	16	31.4	17	33.3	33	64.7	18	35.3	17	33.3	35	68.6	11	21.6	10	19.6	21	41.2
White	918	34.4	497	18.8	1,415	53.5	844	31.9	580	21.9	1,424	53.9	537	20.3	372	20.9	909	34.4
Ethnicity																		
Hispanic/Latinx	134	38.2	91	25.9	225	64.1	99	28.2	96	20.4	195	55.6	79	22.5	66	18.8	145	41.3
Non-Hispanic/Latinx	944	18.2	530	19.2	1,474	53.5	889	32.2	613	22.2	1,502	54.5	576	20.9	408	14.8	984	35.7
Gender																		
Female	973	35.4	544	19.8	1,517	55.1	875	31.8	632	23.0	13	43.3	584	21.2	421	15.3	10	33.3
Male	76	28.8	53	20.1	129	48.9	81	30.7	58	22.0	139	52.7	49	18.6	38	14.4	87	33.0
Noncisgender	23	37.1	19	30.6	42	67.7	23	37.1	15	24.2	38	61.3	16	25.8	11	17.7	27	43.5
Work setting																		
Academic/research	42	31.1	20	14.8	62	46.5	37	20.4	24	17.8	61	45.2	25	18.1	14	10.4	39	28.9
School	79	38.2	47	22.7	126	60.9	49	23.7	52	25.1	101	48.8	42	20.3	32	15.5	74	35.7
Hospital	160	34.6	112	24.2	272	58.9	165	35.7	121	26.2	286	61.9	132	28.6	93	20.1	225	48.7
Community health	93	31.8	54	18.5	147	50.3	86	29.5	69	23.6	155	53.1	48	16.4	40	13.7	88	30.1
DPH	47	40.2	17	14.5	64	54.7	33	28.2	14	12.0	47	40.2	24	20.5	5	4.3	29	24.8
Other government agency	43	30.9	29	20.9	72	51.8	46	33.1	36	29.5	82	59.0	30	20.6	30	20.6	60	43.2
Private practice	158	30.0	18	15.4	239	45.4	155	29.5	137	26.0	292	55.5	93	17.7	59	11.2	152	28.9
CYF Services	84	37.3	47	20.9	131	58.2	87	38.7	44	19.6	131	58.2	60	26.7	34	15.1	94	41.8

(Continued)

**Table 2: Numbers and Proportions of Respondents Who Indicated Concerns on Outcomes of Interest by Demographic, Work Setting, Region, Role, and Work Setting Characteristics (Continued)**

Characteristic	Mental Health Concerns						Physical Health Concerns						PPE Availability Concerns					
	Moderate		Severe		Any		Moderate		Severe		Any		Moderate		Severe		Any	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
CMH/SA services	191	35.6	114	21.3	305	56.9	181	33.8	103	19.2	284	53.0	109	20.3	81	15.1	190	35.4
Aging/older adult/disability	82	33.9	52	21.5	134	55.4	80	33.1	64	26.4	144	59.5	46	19.0	54	22.3	100	41.3
Other	99	43.6	48	21.1	147	64.8	69	30.4	45	19.8	114	50.2	46	20.3	32	14.1	78	34.4
<b>Role</b>																		
Direct service provider	822	35.2	506	21.7	1328	56.8	745	31.9	581	24.9	1326	56.8	497	21.3	375	16.1	872	37.3
Student	14	28.6	15	30.6	29	59.2	16	32.7	9	18.4	25	51.0	6	12.2	10	20.4	16	32.7
Manager	102	33.2	44	14.3	146	47.6	98	31.9	45	14.7	143	46.6	76	24.8	33	10.7	109	35.5
Administrator/director	74	35.6	24	11.5	98	47.1	62	29.8	34	16.3	96	46.2	39	18.8	23	11.1	62	29.8
Policy practitioner	10	37.1	1	3.7	11	40.7	7	25.9	3	11.1	10	37.0	4	14.8	1	3.7	5	18.5
Researcher/evaluator	20	50.0	6	15.0	26	65.0	16	40.0	4	10.0	20	50.0	7	17.5	3	7.5	10	25.0
Academic	11	18.6	10	16.9	21	35.6	22	37.3	11	18.6	33	55.9	10	16.9	9	15.3	19	32.2
Other	13	33.3	7	17.9	20	51.3	8	20.5	8	20.5	16	41.0	8	20.5	6	15.4	14	35.9
Unknown	12	27.9	8	18.6	20	46.5	14	32.6	14	32.6	28	65.1	8	18.6	14	32.6	22	51.2
<b>HHS region</b>																		
Region 1-BOS	117	34.8	54	16.1	171	50.9	109	32.4	52	15.5	161	47.9	65	19.3	31	9.2	96	28.6
Region 2-NY	208	33.4	125	20.1	333	50.5	173	27.8	173	27.8	346	55.5	121	19.4	110	17.7	231	37.1
Region 3-PHL	62	27.3	45	19.8	107	47.1	74	32.6	52	22.9	126	55.5	51	22.5	34	15.0	85	37.4
Region 4-ATL	139	34.6	82	20.4	221	55.0	131	32.6	89	22.1	220	54.7	88	21.9	70	17.4	158	39.3
Region 5-CHI	103	35.8	66	22.9	169	58.7	104	36.1	61	21.2	165	57.3	64	22.2	43	14.9	107	37.2
Region 6-DAL	54	41.5	26	20.0	80	61.5	43	32.3	37	28.5	70	60.8	35	26.9	20	15.4	55	42.3
Region 7-KC	40	28.6	28	20.0	68	48.6	43	30.7	23	16.4	66	47.1	17	12.1	12	12.1	34	24.3
Region 8-DEN	33	36.3	14	15.4	47	51.6	36	39.6	13	14.3	49	53.8	23	25.3	9	9.9	32	35.2
Region 9-SF	282	38.2	157	21.2	439	59.4	230	31.1	182	24.6	412	55.8	164	22.2	124	16.8	288	39.0
Region 10-SEA	40	30.3	24	18.2	64	48.5	46	34.8	27	20.5	73	55.3	27	20.5	16	12.1	43	32.6
Overall	1078	34.7	621	20.0	1699	54.7	988	31.8	709	28.8	1697	54.6	655	21.1	474	96.2	1,129	36.3

Notes: A/AN = American Indian and Alaska Native; AAPI = Asian American and Pacific Islander; DPH = Department of Public Health; CVF = Child, Youth and Family; CMHSA = community mental health/substance abuse; HHS = Health and Human Services; BOS = Boston; NY = New York; PHL = Philadelphia; ATL = Atlanta; CHI = Chicago; DAL = Dallas; KC = Kansas City; DEN = Denver; SF = San Francisco; SEA = Seattle.

**Table 3: Multinomial Logistic Regression Models Examining Associations between Demographic and Workplace Characteristics and Outcomes of Mental (Model 1) and Physical (Model 2) Health Concerns**

Characteristic	Moderate Concerns						Severe Concerns							
	B	SE	Wald	p	df	OR	95% CI	B	SE	Wald	p	df	OR	95% CI
Model 1: Mental Health														
Intercept	0.94	0.26	12.83	<.001	1	—	—	-0.07	0.32	0.05	.82	1	—	—
Age	-0.03	0.00	65.74	<.001	1	0.97	[0.966, 0.979]	-0.03	0.00	60.80	<.001	1	0.97	[0.960, 0.976]
Race/ethnicity	0.12	0.11	1.25	.25	1	1.13	[0.918, 1.397]	0.56	0.12	22.98	<.001	1	1.78	[1.408, 2.261]
Gender														
Male	-0.27	0.16	2.84	.09	1	0.77	[0.562, 1.045]	-0.01	0.18	0.01	.94	1	0.986	[0.691, 1.406]
Noncisgender	0.36	0.33	1.17	.28	1	1.43	[0.749, 2.727]	0.78	0.35	5.06	.03	1	2.19	[1.106, 4.337]
Role														
Direct care provider	0.36	0.12	11.56	.001	1	1.44	[1.167, 1.776]	0.72	0.14	28.33	<.001	1	2.05	[1.574, 2.671]
Practice setting														
Academic/research	0.08	0.25	0.09	.76	1	1.08	[0.665, 1.746]	0.04	0.32	0.02	.89	1	1.05	[0.561, 1.947]
School	0.26	0.20	1.68	.20	1	1.30	[0.874, 1.929]	0.29	0.24	1.4	.23	1	1.33	[0.833, 2.133]
Hospital	0.11	0.16	0.43	.51	1	1.11	[0.812, 1.519]	0.33	0.19	3.1	.08	1	1.39	[0.963, 2.018]
Community health	-0.06	0.18	0.12	.73	1	0.94	[0.662, 1.332]	-0.06	0.22	0.06	.80	1	0.95	[0.617, 1.451]
DPH	0.34	0.27	1.79	.18	1	1.43	[0.846, 2.419]	-0.23	0.35	0.44	.51	1	0.79	[0.398, 1.577]
Other government agency	0.01	0.24	0.00	.96	1	1.01	[0.635, 1.614]	0.21	0.28	0.57	.45	1	1.23	[0.716, 2.129]
CYF Services	-0.56	0.76	0.53	.47	1	0.57	[0.129, 1.557]	-0.36	0.94	0.14	.71	1	0.70	[0.111, 4.427]
CMH/SA Services	0.14	0.15	0.84	.36	1	1.15	[0.851, 1.557]	0.22	0.19	1.42	.23	1	1.25	[0.867, 1.798]
Aging/disability	0.15	0.19	0.64	.42	1	1.16	[0.804, 1.682]	0.31	0.22	1.93	.17	1	1.36	[0.880, 2.116]
Other	0.62	0.20	9.40	.002	1	1.87	[1.252, 2.780]	0.52	0.25	4.46	.04	1	1.67	[1.038, 2.735]
HHS region														
Region 1—Boston	-0.26	0.16	2.66	.10	1	0.77	[0.567, 1.052]	-0.25	0.20	1.58	.21	1	0.78	[0.528, 1.150]
Region 2—New York	-0.14	0.13	1.08	.30	1	0.87	[0.671, 1.130]	0.07	0.16	0.21	.65	1	1.08	[0.790, 1.463]
Region 3—Philadelphia	-0.63	0.19	11.13	.001	1	0.54	[0.371, 0.773]	-0.18	0.21	0.67	.41	1	0.84	[0.551, 1.277]
Region 4—Atlanta	-0.30	0.16	3.34	.07	1	0.74	[0.539, 1.022]	0.00	0.19	0.00	.98	1	1.00	[0.687, 1.445]
Region 5—Chicago	-0.17	0.17	0.96	.33	1	0.85	[0.610, 1.179]	0.12	0.20	0.40	.53	1	1.13	[0.771, 1.661]
Region 6—Dallas	0.07	0.22	0.11	.74	1	1.08	[0.695, 1.664]	0.01	0.27	0.00	.98	1	1.01	[0.690, 1.721]
Region 7—Kansas City	-0.62	0.23	7.48	.006	1	0.54	[0.345, 0.839]	-0.25	0.26	0.88	.35	1	0.78	[0.468, 1.308]
Region 8—Denver	-0.45	0.25	3.13	.08	1	0.64	[0.389, 1.049]	-0.58	0.33	3.10	.08	1	0.56	[0.291, 1.069]
Region 10—Seattle	-0.38	0.23	2.74	.10	1	0.69	[0.438, 1.072]	-0.21	0.27	0.57	.45	1	0.81	[0.477, 1.391]

(Continued)



**Table 3: Multinomial Logistic Regression Models Examining Associations between Demographic and Workplace Characteristics and Outcomes of Mental (Model 1) and Physical (Model 2) Health Concerns (Continued)**

Characteristic	Moderate Concerns						Severe Concerns							
	B	SE	Wald	P	df	OR	95% CI	B	SE	Wald	P	df	OR	95% CI
Model 2: Physical Health														
Intercept	-0.87	0.26	10.96	.001	1	—	—	-2.0	0.30	45.66	<.001	1	—	—
Age	0.01	0.00	4.27	.04	1	1.01	[1.000, 1.014]	0.02	0.00	19.72	<.001	1	1.02	[1.010, 1.025]
Race/ethnicity	0.12	0.11	1.21	.27	1	1.13	[0.911, 1.391]	0.53	0.12	21.13	<.001	1	1.70	[1.356, 2.133]
Gender														
Male	-0.07	0.16	.22	.64	1	.93	[0.696, 1.259]	-0.10	0.17	0.36	.55	1	.90	[0.641, 1.267]
Noncisgender	0.42	0.31	1.89	.17	1	1.53	[0.835, 2.797]	0.40	0.35	1.31	.25	1	1.49	[0.752, 2.964]
Role	0.16	0.11	2.24	.13	1	1.17	[0.952, 1.447]	0.59	0.13	21.24	<.001	1	1.81	[1.406, 2.328]
Direct care provider														
Practice setting														
Academic/research	-0.07	0.25	0.09	.77	1	.93	[0.569, 1.520]	-0.04	0.29	0.02	.89	1	0.96	[0.546, 1.688]
School	-0.29	0.21	1.80	.18	1	.75	[0.495, 1.141]	-0.02	0.22	0.01	.94	1	0.98	[0.644, 1.505]
Hospital	0.44	0.16	7.24	.45	1	1.54	[1.126, 2.126]	0.38	0.18	4.79	.03	1	1.47	[1.041, 2.068]
Community health	0.00	0.18	0.00	.98	1	1.00	[0.701, 1.440]	0.03	0.20	0.02	.89	1	1.03	[0.698, 1.513]
DPH	-0.42	0.27	2.33	.13	1	.66	[0.387, 1.126]	-1.10	0.35	9.87	.002	1	0.33	[0.168, 0.662]
Other government agency	0.22	0.24	0.88	.35	1	1.25	[0.784, 1.999]	0.26	0.26	0.98	.323	1	1.23	[0.778, 2.144]
CYF Services	0.58	0.76	0.55	.46	1	1.79	[0.388, 8.202]	0.64	0.86	0.55	.46	1	1.89	[0.349, 10.224]
CMH/SA Services	0.17	0.16	1.20	.26	1	1.19	[0.880, 1.616]	-0.10	0.17	0.32	.57	1	0.91	[0.644, 1.274]
Aging/disability	0.32	0.19	2.71	.10	1	1.37	[0.941, 2.006]	0.36	0.21	2.97	.09	1	1.43	[0.952, 2.139]
Other	0.06	0.20	0.08	.78	1	1.06	[0.711, 1.572]	-0.04	0.23	0.03	.86	1	0.96	[0.615, 1.502]
HHS region														
Region 1—Boston	-0.16	0.16	0.97	.32	1	0.86	[0.629, 1.166]	-0.54	0.19	8.02	.005	1	0.58	[0.399, 0.846]
Region 2—New York	-0.11	0.14	0.68	.41	1	0.89	[0.683, 1.168]	0.16	0.14	1.23	.27	1	1.17	[0.885, 1.549]
Region 3—Philadelphia	0.02	0.18	0.01	.91	1	1.02	[0.712, 1.466]	-0.01	0.20	0.00	.96	1	0.99	[0.664, 1.479]
Region 4—Atlanta	0.17	0.16	1.04	.31	1	1.18	[0.857, 1.630]	0.13	0.18	0.56	.46	1	1.14	[0.804, 1.628]
Region 5—Chicago	0.14	0.17	0.67	.42	1	1.15	[0.825, 1.593]	-0.04	0.19	0.05	.83	1	0.96	[0.658, 1.398]
Region 6—Dallas	0.09	0.23	0.15	.70	1	1.10	[0.692, 1.731]	0.28	0.25	1.26	.26	1	1.34	[0.814, 2.130]
Region 7—Kansas City	-0.13	0.22	0.37	.54	1	0.87	[0.568, 1.346]	-0.39	0.27	2.08	.15	1	0.68	[0.403, 1.149]
Region 8—Denver	0.15	0.25	0.35	.55	1	1.16	[0.712, 1.889]	-0.51	0.34	2.27	.13	1	0.60	[0.311, 1.169]
Region 10—Seattle	0.10	0.22	0.19	.66	1	1.10	[0.710, 1.711]	-0.16	0.26	0.39	.54	1	0.85	[0.507, 1.423]

Notes: DPH = Department of Public Health; CYF = Child, Youth, and Family; CMH/SA = community mental health/substance abuse; HHS = Health and Human Services.

tively). Social workers in DPH were over 50 percent less likely to report concerns about access to PPE ( $B = -0.76, p = .004, OR = 0.47, 95\% CI [0.277, 0.782]$ ). With respect to region, social workers practicing in Region 1 and Region 7 were nearly a third less likely to report concerns related to PPE access compared with those in Region 9 ( $B = -0.37, p = .01, OR = .69, 95\% CI [0.520, 0.926]$ ) and  $B = -0.50, p = .02, OR = .61, 95\% CI [0.400, 0.926]$ , respectively), whereas those in Region 4 were nearly 40 percent more likely to report concerns ( $B = 0.33, p = .02, OR = 1.39, 95\% CI [1.061, 1.827]$ ; see [Table 4](#)).

## DISCUSSION

To our knowledge, this study is the largest and most regionally diverse effort to explore experiences of the U.S.-based social work workforce during the COVID-19 pandemic to date. The stress of providing services was highlighted through concerns about both mental and physical health, as well as workplace safety expressed by social work respondents. While practitioner concerns were widespread, they were not evenly distributed. Black, AIAN, AAPI, multiracial, or Hispanic/Latinx social workers were significantly more stressed across all domains assessed in this study: mental health, physical health, and PPE access. These findings provide additional empirical support for what we already know to be true: that communities of color bear a disproportionate burden of COVID-19 and its sequelae. While the phenomenon is not new, within the context of the pandemic it may be explainable through the phenomenon of a synergetic epidemic—or syndemic—of racism and COVID-19. First coined by medical anthropologist Merrill Singer in the 1990s, the term “syndemic” refers to the way in which two epidemics can overlap with one another and social and cultural problems ([Singer, 2009](#)). Use of a syndemic framework suggests a need to focus on antiracist transformations within the context of COVID-19 recovery efforts and social work specifically ([NASW, 2020](#)).

Not surprisingly, respondent concerns also differed based on workplace setting and role. Front-line social workers likely bore witness to the early days of COVID-19-related illness, death, and fear in workplaces where health and social needs are met, and where client populations include those most vulnerable ([Golightley & Holloway, 2020](#)). Likewise, PPE access concerns indicate that in set-

tings where social workers felt at risk of infectious disease exposure, they did not feel that their safety was prioritized. Discussions about the failure and need to provide safe working conditions for essential workers should extend to social work ([Lancet Editorial Board, 2020](#)).

Despite the well-known COVID-19 risks to older adults, age was protective for mental health and PPE concerns, though physical health concerns logically increased with age among respondents. It may be that this phenomenon reflected more protection through “opting out” of riskier higher-contact work among older social workers; however, it may also reflect a dimension of the “healthy worker effect,” where those long-term social workers who are used to exposures to intense and traumatic social problems have well-developed coping mechanisms for times of crisis and workplace risks ([Zelnick et al., 2013](#)).

## Limitations

While findings shed light on how Black, AIAN, AAPI, multiracial, and Latinx social workers are disproportionately impacted by the COVID-19 pandemic, there are study limitations to consider. Data were collected during first waves of COVID-19 in the United States and therefore, the disparities identified could have been present in pre-pandemic circumstances. In addition, this study launched three weeks prior to the murder of George Floyd. The survey therefore did not capture this protracted period of mass protest; these events likely impacted how stress was perceived and reported. The survey relied on self-report single-item outcomes and questions did not account for additional stressors that may have influenced respondent’s stress (e.g., family caregiving responsibilities, access to technology, and pre-COVID-19-related issues). Similarly, we were unable to compute a response rate based on our snowball sampling method, and it is possible response bias exists due to respondents’ professional organization affiliations. Future studies of the social work workforce could benefit from including independent, nonbiased measures of impact that are reliable and valid as well as utilize data drawn from sources other than self-report metrics. Finally, the cross-sectional survey design did not consider the fluctuations in the pandemic based on hot spots or new outbreaks by location. While our analysis considered regional differences, more work is needed to assess temporal variability based on how respondents perceive their community’s compliance

**Table 4: Ordinal Logistic Regression Model Examining Associations between Demographic and Workplace Characteristics and PPE Availability Concerns**

Characteristic	PPE Availability Concerns						
	<i>B</i>	<i>SE</i>	<i>Wald</i>	<i>p</i>	<i>df</i>	<i>OR</i>	<b>95% CI</b>
Age	−0.01	0.00	7.89	<b>.005</b>	1	0.99	[0.986, 0.997]
Race/ethnicity	0.44	0.09	24.21	<b>&lt;.001</b>	1	1.55	[1.303, 1.848]
Gender							
Male	−0.12	0.14	.71	.40	1	0.89	[0.678, 1.168]
Noncisgender	0.34	0.26	1.77	.18	1	1.41	[0.851, 2.330]
Role							
Direct care provider	0.24	0.10	6.02	<b>.01</b>	1	1.27	[1.049, 1.527]
Practice setting							
Academic/research	−0.01	0.23	0.003	.96	1	0.99	[0.627, 1.555]
School	0.12	0.18	0.35	.56	1	1.11	[0.781, 1.582]
Hospital	0.66	0.14	22.56	<b>&lt;.001</b>	1	1.94	[1.476, 2.550]
Community health	−0.08	0.17	0.23	.634	1	0.92	[0.667, 1.280]
DPH	−0.76	0.26	8.36	<b>.004</b>	1	0.47	[0.277, 0.782]
Other government agency	0.57	0.20	7.85	<b>.005</b>	1	1.77	[1.187, 2.633]
CYF Services	−0.08	0.70	0.01	.91	1	0.93	[0.235, 3.657]
CMH/SA services	0.18	0.14	1.73	.19	1	1.20	[0.914, 1.580]
Aging/disability	0.56	0.16	11.79	<b>.001</b>	1	1.76	[1.273, 2.421]
Other	0.13	0.18	0.54	.46	1	1.14	[0.801, 1.630]
HHS region							
Region 1–Boston	−0.37	0.15	6.16	<b>.01</b>	1	0.69	[0.520, 0.926]
Region 2–New York	0.12	0.11	0.86	.35	1	1.11	[0.889, 1.391]
Region 3–Philadelphia	0.06	0.16	0.13	.72	1	1.06	[0.776, 1.447]
Region 4–Atlanta	0.33	0.14	5.70	<b>.02</b>	1	1.39	[1.061, 1.827]
Region 5–Chicago	−0.02	0.15	0.02	.90	1	0.98	[0.737, 1.307]
Region 6–Dallas	0.08	0.19	0.17	.68	1	1.08	[0.741, 1.580]
Region 7–Kansas City	−0.50	0.21	5.39	<b>.02</b>	1	0.61	[0.400, 0.926]
Region 8–Denver	−0.18	0.24	0.56	.46	1	0.84	[0.530, 1.330]
Region 10–Seattle	−0.18	0.21	0.77	.38	1	0.84	[0.560, 1.248]

Notes: DPH = Department of Public Health; CYF = Child, Youth and Family; CMH/SA = community mental health/substance abuse.

with necessary social (physical) distancing and other pandemic mitigation measures (e.g., mask wearing). Despite these limitations, findings provide a beginning understanding of some of the concerns of social workers during the first year of the pandemic.

### IMPLICATIONS FOR THE FUTURE

While vaccination in the United States is underway, the ramifications of the pandemic are far from over. Its effects will last long into the future, even after the United States and other nations collectively begin to “flatten the curve” of COVID-19 infection and mortality rates. While social workers will continue to respond to meet the needs of vul-

nerable populations postpandemic (Abrams & Dettlaff, 2020), the future requires social work leaders to consider the continued disparate burden experienced by U.S.-based Black, AIAN, AAPI, multiracial, and Latinx social workers and actively work to redress the inequities that perpetuate it. Our findings suggest that, as a profession, social work must take immediate action to develop and disseminate large-scale initiatives that systemically prioritize the physical, mental, and financial health and well-being of U.S.-based social workers of color. The dearth of such initiatives poses a substantial threat to specific members of the social work profession as well as the sustainability and ef-

fectiveness of the social work workforce. In addition to national organizations such as NASW, the Council on Social Work Education, and the Society for Social Work and Research, schools of social work are well positioned to allocate resources to develop, launch, and maintain profession-specific initiatives.

While profession-specific initiatives that prioritize the health and well-being of social workers of color are necessary, they alone are not sufficient. It is well established that health disparities are rooted in inequities facilitated by institutional and systemic mechanisms that organize the distribution of resources and power differentially across lines of race/ethnicity, class, and gender; it is the unequal allocation of these resources that manifests in unequal social, economic, and environmental conditions—SDOH—that fundamentally drive these inequities (Weinstein et al., 2017). Although many U.S.-based health and social service organizations (including schools of social work) have taken up workplace-based diversity, equity, inclusion, and justice initiatives from which social workers may benefit, these alone will do little if they focus only on awareness-raising and interpersonal aspects of antiracism without redistributing power and resources within the organization. They will do even less in the absence of large-scale policy changes that redress SDOH inequities that manifest across multiple systems and institutions and affect the general population. To effectively address pandemic-related sequelae and other challenges of the future, social work must act now. In particular, the continued racial disparities in the United States and within the U.S.-based social work workforce warrant a renewed call to activism to collectively build organizational infrastructure and change the political landscape. Implementing antiracist policies and practices that not only reallocate resources at the organizational level (both in social and health service organizations and in schools of social work), but also redress inequities in housing, health care, education, child welfare, and public safety evident at local, state, and national levels is critical to sustaining the health of the social work workforce and the nation. **SW**

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