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Examining the Impact of Institutional Racism in Black Residentially Segregated Communities

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More than 50 years have passed since the enactment of the Civil Rights Act of 1964 and a large number of Blacks in the U.S. remain marginalized and disenfranchised by public policies and public institutions (Blessett 2015). Blacks residing in residentially segregated communities across the U.S. are faced with a myriad of social, economic, environmental, and political factors that negatively affect their lives and communities alike. As a result, quality of life indicators reveal diminished educational attainment, disparaging health outcomes, limited employment opportunities, and stifled political participation for low-income Blacks. Furthermore, residentially segregated communities exemplify the ways in which institutional racism and structural inequality stifle community development. Alkadry and Blessett (2010) argued that during the time of urban development in the mid-twentieth century, millions of dollars flowed into and out of communities, however the stakeholders with the most political, social, and economic power received the vast majority of public policy benefits. The use of language (political and public discourse), public and private institutions (local development and housing authorities), and resources (tax abatements or incentives subsidized by federal and state governments) significantly aided in the perpetuation of inequality along the lines of race and class (Wilson 2007).

Collectively, these strategies resulted in multiple burdens being placed on segregated communities. These communities often have the least resources at their disposal to alter their existing realities. Whereas inequalities represent differences in outcomes between groups, inequities are the results of inequalities. Inequity is saturated throughout many facets of life for Blacks isolated in racially segregated neighborhoods. Gooden argues

> Racial inequities in the United States are largely saturated because they are cumulative and reinforcing. Racial outcomes in health, education, employment, environmental risk, occupational status, and crime are not randomly assigned. They are embedded in a historical structure where racial minorities chronically experience pervasive negative differences. These differences compound exponentially to generate a cycle of racial saturation that continues generation after generation (2014, 39).

The intergenerational effects of racial inequities are problematic for individuals, families, and communities. The inability (or unwillingness) of government officials to thoughtfully consider and implement new strategies to reverse a legacy of adverse policy outcomes legitimizes the long-standing and divergent realities for Blacks in comparison to their White counterparts.

This article begins by highlighting institutional racism as a contributory factor in the social and economic disadvantage experienced by Blacks. A discussion is presented on the role of institutional racism in maintaining the status quo, by examining the criminal justice system, housing, and health outcomes as important examples of differential outcomes experienced by Blacks. Using the social determinants of health as a conceptual model, the authors highlight Ferguson, MO as an exemplar of racial residential segregation and examine the manifestation of institutional racism in existing public policies. In conclusion, using the social determinants of health model targeted recommendations are made for reducing institutional racism across the public sector.

Understanding Saturated Disadvantage through the Lens of Critical Race Theory and Institutional Racism

Urban communities have evolved over time. Once centers of manufacturing, commerce, and bustling commercial corridors, these spaces are now characterized by disinvestment, blight, and dysfunction. To understand the changing context and dynamics of urban life, critical race theory (CRT) provides an analytical examination of the relationship between history, race, and language (Zamudio et al. 2011). CRT ultimately acknowledges that race and racism is hardwired into the social and economic landscape in American life; that racial stereotypes are ubiquitous in society and limits the opportunities of people of color; and the concept of colorblindness ostensibly serves to undermine the interests of people of color (Carbado and Roithmayr 2014). Furthermore, critical race theorists recognize that traditional scholarship and public discourse about the plight of urban communities rests on arguments about individual merit, not on the institutional practices that created disadvantage in the first place (Crenshaw et al. 1995). As science often informs policy and public opinion, Zuberi suggests that

> The knowledge produced within the social sciences is implicated in the intersection of systems of oppression within matrices of domination. The social sciences produce knowledge about "others" as "deviants" from the "norm," which is defined as White, heterosexual, bourgeois, and male (2011, 1576).

The result forces Blacks or "others" to constantly battle against the oppressive narratives that construct them and their communities in disparaging ways, ultimately justifying punitive policies outcomes.

Collectively, these practices thrive in environments where institutional racism occurs unfettered. MacPherson

defines institutional racism

> as the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes, and behavior which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people (1999, 49).

Society's acceptance of the disparity and divergent realities for Blacks in the United States is deeply rooted in institutional practice, administrative discretion, and public sentiment – all which accept discrimination as a practice when applied to nonwhite populations. Furthermore, Schneider and Ingram (1993) argued that the relationship between social construction (positive or negative) and power (high or low) is related to whether groups (e.g. advantaged, contenders, dependents, and deviants) either benefit or are burdened by public policy decisions. In many respects, the political discourse and public sentiment often characterize urban residents in a pejorative connotation, as either dependent or deviant, thus leaving them vulnerable to more degenerative policy outcomes (Schneider and Ingram 1993; Schneider and Ingram 1997). Therefore, the influence of language, role of administrators, and use of public resources (e.g. financial and bureaucratic) to sustain these divergent realities for Blacks and their White counterparts cannot be underestimated.

The privilege of whiteness is obscured by conflated language and the use of differential policy strategies that benefit groups deemed as worthy and deserving, while simultaneously ignoring the reality of Black unemployment, hyper-incarceration, disproportionate health disparities, and widespread residential segregation, based on their deviant or undeserving conception. Such difference reinforces a commitment to consistently subject people to the social constructions placed upon them, which informs how problems and solutions are conceptualized. John Restakis said, "This inability to imagine an alternative is the final triumph of ideology" (2010, 26). In this regard, it is necessary to critically examine inequity, inequality, disparity, and discrimination beyond hegemonic discourse so that urban communities can refrain from doing what O'Conner (1999) calls - "swimming against the tide."

Saturated Disadvantage

Disparities are often interpreted, as if individuals are solely responsible for creating their reality, instead of a willingness to examine the institutional practices that reinforce inequality. Public bureaucracies, for instance, are embedded with systemic practices that typically underscore neutral or colorblind policies that on the surface appear to treat all groups the same, but in reality reveal a racially disproportionate impact. Gooden (2014) identifies a model of saturated racial inequities that recognizes structural racism (e.g. policies, culture/norms, laws, social acceptance, and organizational practices) as a core factor in perpetuating disparity across many aspects of life - health, education, criminal justice, economic well-being, housing, environment. These intersections reveal inequities that are compounded and produce a cumulative effect when comprehensively considered within the context of residentially segregated communities. The result is generational disparity, particularly as the structure of society reinforces organizational practices and public sentiment about the value and worth of people and places. Therefore, regardless of how much money is funneled into communities or how much time has passed, the processes, attitudes, and behavior that created disadvantage are rarely altered in a meaningful way to bring about substantive change. In this capacity, the status quo remains.

While all of these issues deserve in-depth analysis, this paper will focus primarily on housing, the criminal justice system, and health as key factors in maintaining the legacy of disadvantage. The racially disproportionate affect these issues have on a person's quality of life cannot be understated. Further examination reveals that Blacks are disproportionately represented in homeownership and access to quality housing, over represented in the criminal justice system, and experience disparate outcomes across a broad spectrum of health indicators. A modification in processes, attitudes, and behaviors could lead to significant changes that are likely to alter the reality for low-income communities of color.

Homeownership is closely tied to the 'American dream' whereby individuals and families aspire to live in communities with diverse amenities (e.g. grocery stores, recreation facilities, and green spaces), reliable infrastructure, and high performing schools. Rhetorically, the 'American dream' is accessible to all hardworking citizens. In reality, formal and informal policies have been systematically implemented to restrict the mobility or limit residential options for nonwhite families (Bonilla-Silva 2010). Ward and Rivera (2014) subsequently acknowledge that "lending policies such as redlining and predatory lending have long defined, and hardened, the racial divide in housing affordability and accessibility, housing stock quality, and the geographic distribution of available housing in the U.S" (2014, 23). The result means that persons of color are more likely to be three times as poor as whites, live in homes valued at 35-percent less than their White counterparts, receive an inferior education, and be targets of racial profiling by police,

thus increasing likelihood of arrest, prosecution, and incarceration (Bonilla-Silva, 2010). In such destitute communities, Blessett argues

> Ultimately, the second ghetto[1] became the lifeblood of law enforcement institutions and correctional agencies in urban American communities across the country. The pipeline to prison started in the inner cities after World War II, when the prison demographic shifted from 70-percent white before World War II to 70-percent Black by 2000 (Loury 2008). The racial transformation of the prison population speaks to the concentrated efforts of political and urban elites to cooperatively disenfranchise poor minorities through punitive means. The interrelationship of poverty, race, and crime highlights a perpetual underclass that is moving from generation to generation (Blessett 2012, 121).

As Gooden (2014) ascertained, racial disparities are not randomly assigned but embedded within and across societal structures. Housing, its location and quality have a significant impact on a person's life trajectory. Therefore, to be confined to an impoverished racially segregated neighborhood is likely to increase a person's chances to have adverse interactions with the criminal justice system based on diminished educational opportunities and limited employment prospects. With respect to incarceration rates, the Sentencing Project reports, "more than 60% of people in prisons are now racial and ethnic minorities. For Black males in their thirties, 1 in every 10 is in prison or jail on any given day" (2014). Furthermore, Wald and Losen (2007) state "approximately 68% of state prison inmates in 1997 had not completed high school. Seventy-five percent of youths under the age of 18 who have been sentenced to adult prisons have not successfully passed the 10th grade. An estimated, 70% of the juvenile justice population suffers from learning disabilities and 33% read below the 4th grade level" (2007, 30).

The cumulative disadvantage of disparity is ever present in the lives of persons confined to residentially segregated neighborhoods prior to and after conviction (Blessett 2012). Through rhetoric and public policy, formerly incarcerated persons or "returning citizens" face an uphill battle if they want to successfully reintegrate back into society. This is evident when trying to secure employment, access the polls, or simply move beyond the stigma of incarceration (Blessett, 2015; Blessett and Pryor 2013). The result leaves Blacks disenfranchised and systematically marginalized in a society that has constructed them worthless. Additionally, it has been argued that the biological and psychological stress that accompanies growing up or living in dysfunctional environments is likely to restrict emotional and behavioral development (Blessett 2012). Children, in particular, who grow up in distressed environments (e.g. victims of abuse or neglect, high crime and violence) are at great risk for committing violent crimes or being the victims of crime (Children's Defense Fund 2007). Considering the sheer proportion of Blacks impacted by the criminal justice system, whole communities are being left to fend for themselves as public institutions and administrators alike legitimize their alienation.

The effects of saturated disadvantage also extend to the realm of individual and community health. Generally, health disparities represent the greater disease burden of illness, injury, disability and mortality experienced by racial and ethnic groups but may also include differences based on socioeconomic status, sexual orientation, disability, age or gender (Institute of Medicine 2003). However, as a population, Blacks disproportionately face a greater disease burden in many categories than their White counterparts. As a result, Black health disparities have broad implications for American society. According to the Institute of Medicine (IOM)

> The productivity of the workforce is closely linked with its health status, yet if some segments of the population, such as racial and ethnic minorities, receive a lower quality and intensity of healthcare, then these groups are further hindered in their efforts to advance economically and professionally (2003, 36).

Because health follows a social gradient, those in positions of power and those with greater access to services have better health and health outcomes than disadvantaged groups (Blane 2006). Thus, the unequal distribution of social and economic resources such as income, education, employment, and environment contributes to inequalities in health (Braveman, Egerter, and Williams 2011).

With few exceptions, health disparities persist across a broad spectrum of illnesses and health services. Some of the most glaring disparities are exemplified in chronic illnesses and their associated outcomes. For instance, in comparison to Whites, Blacks are twice as likely to have asthma and are three times more likely to die from asthma-related conditions (CDC 2013a). In much the same way, Blacks are 60% more likely to be diagnosed as diabetic and more than twice as likely undergo a leg, foot, or toe amputation (CDC 2013b). In addition, Blacks are 40% more likely

[1] The second ghetto substantiates the relationships of ethnic groups, the private sector, public administrators, and capital in facilitating ghetto expansion between 1940 and 1960 (Hirsch 1983).

to die from a stroke, 30% more likely to die from heart disease, and 40% more likely to die from breast cancer than Whites (CDC, 2013a). Although Blacks are nine times more likely to be diagnosed with HIV and account for nearly half of all new HIV infections (CDC 2013c), Blacks are less likely to receive antiretroviral therapy (IOM 2003). Consequently, these differences in exposure and treatment are associated with higher Black mortality rates.

Additionally, infant mortality is often cited as a good barometer of health in a community (IOM 2003). However, Black infants are more than twice as likely to die during the first year as their White counterparts (CDC 2015d). Even further, in comparison to White women, Black women are more than four times as likely to die during childbirth or from childbirth related complications (CDC 2016). According to the Institute of Medicine (2003), studies have shown that during the critical prenatal period, Black women are less likely to receive important information on smoking and alcohol cessation or receive routine screening procedures such as ultrasounds and amniocentesis. However, Black women are more likely to undergo risky invasive procedures such as cesarean section. Although Black women are three times more likely to deliver prematurely, they are only slightly more likely to receive medication to prevent the early onset of labor. "The black-white disparity in birth outcomes is largest among highly educated women. Living in a society with a strong legacy of racial discrimination could damage health through psychological pathways, even without overtly discriminatory incidents" (Braveman and Gottlieb 2014, 21).

The differential levels of treatment and quality of care experienced by Blacks contribute to these and other poor outcomes. The collective impact of saturated disadvantage reveals the pervasive and intersecting ways Black individuals and their communities experience inequity. The next section of the paper grounds the effects of saturated disadvantage within the context of health and proposes the social determinants of health as a model to help upend the effects of institutional racism.

Burden of Health Disparities

Decades of public health research have revealed a significant and persistent differential in health outcomes between Blacks and Whites. At every socioeconomic level, Blacks face a greater health disadvantage than their White counterparts. In fact, Blacks have higher morbidity and mortality rates, a higher prevalence of chronic conditions, and poorer health outcomes than Whites as the current majority population (IOM 2013). By definition, health disparities are the differences in health and health outcomes between population groups, which are closely linked to social, economic and environment disadvantage. Health disparities are disturbing because by their very nature they are preventable. In fact, health disparities are "directly related the historical and current unequal distribution of social, political, economic, and environmental resources" (CDC 2015e). Black health disparities undermine communities and the overall healthcare system. Thus, addressing the burden associated with health disparities cannot be isolated as a public health concern but has broad implications for the entirety of American society.

Health disparities represent a moral and ethical dilemma for healthcare professionals as healthcare is often closely linked to social justice, opportunity, and quality of life. The productivity of the individual worker is closely tied to the overall health status of the individual. When Blacks receive a lower quality of healthcare service, do not have equal access to services and fear mistreatment based on their race, their ability to improve their health status and subsequent economic and social status are impeded. From an egalitarian perspective, Americans—regardless of race or ethnicity—should expect equality in access, treatment, and services from the healthcare system. This is especially important for racial and ethnic populations who are disproportionately burdened with poor health (Shaw, Dorling, and Smith 2006).

Numerous studies have documented a persistent differential in outcomes between Blacks and Whites even after controlling for income, education and insurance status (IOM 2003). Studies presented by the Institute of Medicine conclude "Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare" (2003, 19). As a result, health disparities represent a growing concern for all Americans. With the increasing number of people of color in the U.S., health disparities lower the quality of care, reduce efficiency, and raise the cost of the overall healthcare system (Centers for Medicaid and Medicare Services 2014). According to the LaVeist, Gaskin, and Richard (2009), between 2003 and 2006, the U.S. invested nearly $1.24 trillion dollars to eliminate health disparities. This included $229.4 billion in direct medical care expenditures and $1 trillion for indirect expenses. Despite substantial spending, there has been no significant improvement in reducing overall inequalities between Black and White health outcomes (Orsi, Margellos-Anast, and Whitman 2010).

Social Determinants of Health

According to Healthy People 2020, a range of personal, social, economic, and environmental factors combine to influence health and health outcomes (Department of Health and Human Services 2015). Although a direct causal relationship has not been established, numerous studies demonstrate where an individual lives has important implications for health (IOM 2003; Marmot and Bell 2012). According to Braveman and Gottlieb

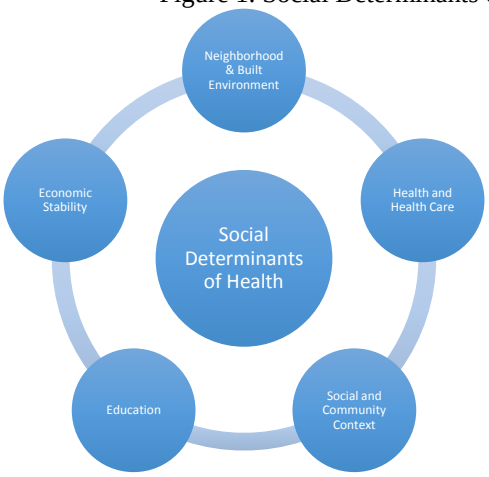
> The health impact of social factors is supported by the strong and widely observed associations between a wide range of health indicators and measures of individuals' socioeconomic resources or social position, typically income, educational attainment, or rank in an occupational hierarchy (2014, 20).

In much the same way, negative environmental factors (e.g., higher rates of violence, low social cohesion, poor educational services, greater exposure to environmental toxins, lack of access to food and other resources) have been shown to increase health risks (Williams and Collins 2001). As such, individuals residing in residentially segregated black communities are at a greater risk for poor health outcomes due to greater barriers in accessing quality healthcare services, fewer resources to obtain healthcare services, poor individual practices and health seeking behaviors, less culturally sensitive healthcare information, and greater experiences with provider bias (IOM 2003).

As a concept, the social determinants of health are "material circumstances, the social environment, psychosocial factors, behaviors, and biological factors. In turn, these factors are influenced by education, occupation, income, gender, ethnicity, and race. All these influences are affected by the socio-political, cultural and social context" (Marmot et al. 2010, 16). Differences in experiences and exposure affect population health and health risks. This is particularly true for Blacks struggling to overcome burdens associated with many of the factors that contribute to health and health status. The divergent pathway experienced by Blacks demonstrates how social determinants of health become inequalities that are deeply entrenched throughout society.

As a model, the social determinants of health is a "place-based" organizing framework used to examine complex relationships between interrelated factors and the manner in which they combine to create disparate outcomes. As shown in Figure 1, the Healthy People 2020 (2014) model of the social determinants of health posits individual health is affected by mediating and moderating factors involving: a) the neighborhood and built environment (e.g., quality of housing, crime, environmental conditions); b) health and health care (e.g., access to health care, health literacy); c) social and community context (e.g., social cohesion, cultural or religious institutions, economic or political structure, perceptions of discrimination and equity); d) education (high school graduation, language and literacy, early childhood education); and e) economic stability (e.g., poverty, food security, housing stability). As an open systems model, the social determinants of health framework also includes social relationships in which social hierarchy, differential treatment of social groups, and social networks contribute to differential health outcomes (Anderson et al. 2003).

Figure 1. Social Determinants of Health.



Source: Adapted from *Healthy People 2020: Social Determinants of Health*

The Social Determinants of Health in Response to Saturated Disadvantage in Ferguson, MO

Examining the burden and risks associated with residing in residentially segregated black communities provides insight into the context in which disparities occur. As such, a thorough assessment of the social and physical environment, policies and interventions is needed to understand the broad implications of residing in economically disadvantaged communities. This brief overview of Ferguson, MO calls attention to a number of risk factors creating additional burdens on Black residents. Ferguson is highlighted in this analysis based on its catapult into the national spotlight following the killing of an unarmed black teenager by a law enforcement officer in 2014. The investigation

into the Ferguson Police Department by the Department of Justice (DOJ) (2015) revealed institutional practices by City Hall, the municipal courts, and the police department that reinforced institutional racism and racial bias. Using the social determinants of health as a framework for action, the context—in which unequal and avoidable differences are allowed to play out between racial groups—is examined. In doing so, significant structural and institutional inequities are revealed. To counteract the seemingly entrenched disparities, targeted policy recommendations are identified.

Social and physical environment

Ferguson, like many jurisdictions in the United States, has a legacy of racial discrimination. St. Louis County (where Ferguson is located) has a notorious history of policies and practices that excessively burden and disadvantage Blacks. This includes unresponsive public officials, inadequate public institutions, and the unequal distribution resources (DOJ 2015). Throughout the 1960s, Ferguson was identified as a "sundown" town, which meant that Blacks were banned from the city after dark (DOJ 2015, 76). Expelling non-whites from a community before sundown was a common practice and worked as a form of terror and intimidation. Bell argues

> From 1880 and continuing until 1968, white Americans established thousands of sundown towns, most often by driving out their black community…Some jurisdictions passed ordinances preventing Blacks from owning or renting property; others simply used harassment and even murder to police violators. African Americans were not the only minorities barred from living in sundown towns and sundown suburbs. Jews, Mexicans, Chinese, and Native Americans were other groups that found their presence prohibited in such towns (2008, 541).

The consequence of this practice reinforced the idea of non-white inferiority, while simultaneously legitimizing White racist attitudes through legal and extralegal means. In this regard, institutional mechanisms were used to fortify prejudicial preferences. Collectively, these attitudes and behaviors informed policy and protocols across many aspects of societal life.

The history of racism and prejudice in the United States is long and quite telling. However, it appears that for every progressive intervention a reactionary response assured the unrelenting staying power of discriminatory practices. While the mid-20th century is known for the social movements that sought to stir the American conscious, it also resulted in the advancement of legislative initiatives (e.g. Civil Rights Act of 1964, Voting Rights Act of 1965, Fair Housing Act of 1968) designed to level the playing field for Blacks. In this capacity, Blacks would finally be afforded the same rights, privileges, and protections as their White counterparts. However despite federal intervention, state and local jurisdictions continued to use wide discretion in the implementation of these respective policies. Therefore, without appropriate oversight or accountability mechanisms, Blessett argued

> disparity persists for minorities in education, employment, morbidity, mortality, and community conditions as advantaged groups have effectively usurped public institutions and resources to undermine the efforts for achieving a true democracy. In this regard, discrimination is sanctioned under the guise of states rights, race-neutral policies, and a public discourse and policy processes that perpetuates "othering" through the use of authority, language, and policy designs (2015, 11).

Fast forward to 2015, Ferguson is 6.19 square miles, has a population of 21,086 people with 67% being Black, and a poverty rate at just about 24% (See Table 1). This demographic shift—Blacks being the dominant population—has been a relatively recent phenomenon that started in the 1990's. In many respects, the changing demographics quickly made Ferguson a racially segregated community. Ferguson's demographic transition from predominately White to Black has resulted in significant isolation and a loss of capital: social, political, and economic. In looking at differences in political structures, the lack of political power and engagement in Ferguson is telling. In the City of St. Louis there have been long-standing efforts to build political power, thus enabling the electorate to select Black candidates for key leadership positions in the city: Mayor, alderpersons in nearly half of the city's wards, and the Board of Estimate and Apportionment (Smith 2014). However, the same organizing capacity does not exist in Ferguson, thus resulting in a White power structure – mayor, school board (six White and one Latino), a City Council with one Black member and a 6-percent Black police force (Smith 2014). This racial mismatch is best exemplified by Smith's (2014) sentiment that Ferguson is a Black town governed by White power. Additionally, the Police Executive Research Forum (PERF 2015) report highlights

> The lower incomes of African Americans today cannot be understood in isolation from the history of pervasive housing segregation. By keeping black families out of the better off suburbs, segregation not only deprived them of the opportunity to build wealth through rising home equity, but contributed to (and was reinforced by) what some urban scholars term the 'spatial mismatch' between neighborhoods where African Americans mostly lived, and the better suburban jobs they had difficulty accessing (2015, 17).

Therefore, segregation's impact is beyond a matter of housing. Goodman and Gilbert (2013) link residential segregation with high poverty and argue that these communities have fewer public resources and are more likely to experience greater exposure to pollution and violent crime.

Table 1. Demographic Characteristics of Ferguson, MO

	Ferguson, MO	Missouri
Land Area (square miles)	6.19	68,741.52
Persons per square mile	3,423.2	87.1
Population	21,086 (2014)	6,063,589 (2014)
Black	67.4	11.5
Asian	.5	1.9
Latino	1.2	4
White	29.3	80.1
Economics		
Housing units	9,106 (2010)	2,735,742 (2014)
*% Homeownership rates	58.7	68.4
*Median value of owner-occupied homes	$93,700	$137,000
*Median household income	$38,685	$47,380

*% below poverty	24.9	15.5
Social Characteristics		
*High school graduates	88.6	87.6
*Bachelor's degree or higher	22.7	26.2

Source: U.S. Census – www.census.gov

When these issues are examined by race and geographic location, divergent realities are revealed for Blacks and their White counterparts. For example, "social and economic factors are strongly linked to health outcomes like disease, disability, and death. In fact, this set of relationships is so strong and consistent that there is a term for it: the socioeconomic gradient in health" (Purnell, Camberos, and Fields 2014, 5). This reality recognizes that structural, institutional, and environmental issues are just as, if not more significant than genetic predisposition or individual behaviors in producing adverse health outcomes. Therefore in communities plagued by violence, individuals may be limited in their choices to engage in healthy behaviors, such as exercising or actively commuting outdoors, thus affecting their ability to effectively minimize the onset of disease (Drake and Elder 2013). Within this context, Blacks are especially susceptible to chronic disease. Purnell et al. (2014) suggest that

> after accounting for genetic differences between individuals (30%), most of the contribution to premature death is made by behaviors like diet, exercise, and smoking (40%), social factors like poverty, education, and housing (15%), and exposure to physical environments that are unhealthy because of toxins, disease carrying agents, or unsafe structures (5%) (2014, 12).

This reality highlights the concentrated disadvantage imposed upon low-income groups, who are typically Black.

A report entitled "*For the Sake of All"* sought to explore the unequal distribution of health in the St. Louis region related to factors like education, income, the quality and composition of neighborhoods, and access to community resources like healthy food and safe public spaces (Purnell et al. 2014). Collectively, these factors are significant predictors of health outcomes and community conditions, in the short- and long-term. For young children, the aforementioned factors could be the difference between dropping out of school and being initiated into a life of crime or growing up and leading a healthy and productive life. Sadly for Black children in St. Louis, the former is more the rule than the exception. "In 2012, over two thousand African American 9-12 graders were classified as high school dropouts in St. Louis City and St. Louis County" (Tate 2013, 1). Education (or lack thereof) represents significant predictions in adverse life outcomes. Additionally, it has been identified as one of the strongest and most consistent predictors of health, and gaps in life expectancy between those with low and high levels of education are widening (Purnell et al. 2014).

Although there has been a long history of harassment and abuse by law enforcement and the courts, as reported by Ferguson residents and a number of nonprofit organizations like ArchCity Defenders and the PERF, no actions were taken to rectify wrongdoings until the very public mishandling of the Michael Brown killing by former police officer Darren Wilson (ArchCity Defenders n.d.; PERF 2015). The overwhelming evidence presented in the DOJ (2015), PERF (2015), and ArchCity Defenders (n.d.) reports highlight the role of Ferguson City Hall in promoting an organizational culture within the police department and courts that placed the city's financial interest ahead of public safety concerns. Officials, including but not limited to elected office holders in City Hall, law enforcement officers, municipal court judges and staff members were recognized as complicit in violating the constitutional protections of Blacks in Ferguson, in and around St. Louis City, and St. Louis County (DOJ 2015; PERF 2015). In this capacity, the City, police, and court officials worked collectively to marginalize the Black community through the disproportionate application of excessive fines and fees or with the threat of incarceration. The lack of oversight of such egregious policies and actions demonstrates how embedded discriminatory practices are within public institutions and validates the limited options Blacks have to hold public officials accountable. Another example is the *Washington v. Davis* decision, which established a doctrine that "requires plaintiffs challenging the constitutionality of a facially neutral law to prove a racially discriminatory purpose on the part of those responsible for the law's enactment or

administration" (Lawrence 1995, 236). In other words, Blacks (e.g. the plaintiffs) are required to prove racially discriminatory purpose or intent, which makes redress difficult if not impossible.

Although Blacks in and around St. Louis County had expressed frustrations with the exploitive and harassing practices of law enforcement officials, the investigative reports that followed the Michael Brown killing offered substantive credibility to long-term sentiments (ArchCity Defenders n.d.; DOJ 2015; PERF 2015). Each of the previously identified reports demonstrate the connection between degenerative institutional practices and their impact on the disparities experienced in the community. St. Louis County is made of 90 different municipalities, ranging from populations of 12 to over 5,000, of which 81 municipalities have their own police department and municipal court system (ArchCity Defenders n.d.). With decreasing income and property tax revenues, municipal governments have justified the use of fines and fees as a source of revenue generation and Blacks have been the overwhelming victims of the targeted practice. ArchCity Defenders (n.d.) reports

> We found that disproportionately stopping, charging, and fining the poor and minorities, by closing the Courts to the public, and by incarcerating people for failure to pay fines, these policies unintentionally push the poor further into poverty, prevent the homeless from accessing the housing, treatment, and jobs they so desperately need to regain stability in their lives, and violate the Constitution (n.d. 3).

Furthermore, an analysis of law enforcement statistics reveals that Ferguson residents experience harassment, abuse, and hostility at a rate greater than their White counterparts. The DOJ (2015) reports "African Americans are disproportionately represented at nearly every stage of law enforcement, from initial police contact to final disposition of a case in municipal court" (2015, 63).

Given the landscape of the environment in and around Ferguson, there are significant risk factors for Blacks as they attempt to navigate their existence within these communities. Evidence suggests institutional and structural racism on many levels in Ferguson, including: the federal highway system that routed highways through Black neighborhoods; segregation policies that used discriminatory zoning, housing, banking and insurance practices; poor education opportunities in racially segregated communities; and the lack of job creation in communities of color (Rothstein 2014). As such, many of these policies have become institutionalized and have created a system of oppression for generations of impoverished Blacks in Ferguson. Rothstein (2014) contends that improvements in the social and economic outcomes in Ferguson cannot progress without considering a century of public policies that segregated the metropolitan landscape.

Policies and Intervention

The broad disparities experienced by Blacks in Ferguson and other residentially segregated black communities are complex, dynamic and multidimensional. As a result, developing effective solutions to address seemingly entrenched disparities is similarly as complicated. By examining the social determinants of health, residents, administrators, and policy makers are provided with the broad context to identify, develop, and implement strategies to improve the quality of life for residents in disadvantaged communities. Because the root cause of many of the disparities are typically found outside of the purview of the healthcare system, solutions are only to be found by examining a broad array of social, economic, environment and political conditions that contribute to the differential outcomes. As seen in Figure 1, the five determinant areas (e.g. Neighborhood and the Built Environment, Health and Health Care, Social and Community Context, Education, and Economic Stability) reflect a number of key issues that make up the underlying factors that contribute to disparate outcomes (Healthy People 2020 2014). These areas reflect both macro- and micro-level considerations that attempt to holistically improve individual outcomes, neighborhood quality, engagement processes, and policy approaches.

Using the social determinants of health as a framework, the authors contend that concentrated efforts to address equality of opportunity in socioeconomic status, education, and the environment may have a positive impact on the health and well-being of individuals in residentially segregated black communities. Recognizing the role policies and politics play in determining individual and community outcomes is an important step in a comprehensive approach to reducing risk in disadvantaged communities. Therefore, the development of a multisectoral approach is essential to addressing fundamental issues that perpetuate disparate outcomes. Saturated disadvantage demonstrates the intersecting and cumulative effects of inequity, thus requiring an integrative and collaborative approach from public, nonprofit, and private actors is necessary to drive change.

Social and Community Context

In Ferguson specifically, and St. Louis County broadly, residents are concentrated in an area with a legacy of differential treatment toward Blacks and Whites. Institutional racism permeates the attitudes, behaviors, and

processes of administrators and elected officials alike. This reality is evidenced by disparate outcomes in home and neighborhood location, early childhood educational development, educational access and quality, and accessibility to gainful employment for Black residents (Purnell et al. 2014). While eefforts to identify institutional and structural racism are important first steps. Addressing the broad spectrum of disparate outcomes prevalent in residentially segregated black neighborhoods will require a fundamental understanding of the root cause of disparate outcomes as well as a commitment to identifying the different levels of racism operating within various institutions and systems. Blacks in disadvantaged communities are relegated to a sort of second-class citizenship status in which improving one's social class standing or reducing one's personal risks are often difficult. In working towards eliminating disparities, efforts are needed to identify policies and systems of oppression, which have created a divergent path for Blacks in disadvantaged communities.

Neighborhood and Built Environment

Housing and neighborhood quality significantly impacts whether a person is exposed to crime and violence, environmental degradation, recreational facilities, or health care providers. As previously mentioned, individuals confined to racially segregated neighborhoods have an increased probability of arrest and incarceration, adverse health results, and poor educational outcomes. Therefore, appropriate mechanisms, such as housing subsidies and finance programs, need to be extended to Black residents so they can receive the benefits long afforded to their White counterparts. This requires enforcement by the federal government and compliance by public and private institutions to manifest the ideals of existing Fair Housing laws and Executive Orders.

Education

The infrastructure of education is an important area that could help minimize the effects of disparity in residentially segregated communities. The Ferguson Commission, a group of leaders and residents that span multiple areas of interest and expertise, was charged with developing a plan to help move the city move toward racial equity. The Ferguson Commission was comprised of several working groups: citizen-law enforcement relations, municipal courts and governance, child well-being and education, economic inequity and opportunity, and racial equity advisors. Through an interdisciplinary lens, the Ferguson Commission (2014) identified several reforms that could reduce the disparity experienced by the Black population in Ferguson: invest in early childhood education, create an innovative education hub, revise the school accreditation system, and create an education design and financing task force.

Health and Health Care

Public health policies affecting the health and welfare of individuals should be examined to determine if and how they contribute to or support disadvantage. Without identifying structural and institutionalized racism, disparities will inevitably remain in many of the institutions that service these communities. This means improving health and health outcomes will require addressing a broad array of factors and policies, including: socioeconomics, education, transportation, housing status and availability, access to services, discrimination, racism, differential treatment, provider prejudice or bias, as well as environmental and social stressors (Brunner and Marmot 2006).

Economic Stability

Gainful employment is an important step in helping someone to change their life circumstance. Recognizing the effects of differential access and opportunity, the Ferguson Commission (2014) proposed several strategies to promote financial empowerment and address employment: raise the minimum wage, end predatory lending, create universal child development accounts, create individual and family development accounts, to concentrate financial services through empowerment sites, enhance collaboration between educational institutions and employers, ensure employer-educator collaborations, and fund job training programs that demonstrate impact. Collectively, these strategies seek to address the needs of individuals, families, and the community in holistic ways.

According to Marmot, et al. (2010), reducing disparities and improving wellbeing warrant a process whereby efforts to ensure social justice, health and sustainability are central. To this end, specific policy objectives should include the following: a) the creation of fair employment and good working conditions; b) access to quality early childhood education; c) local leadership development; d) the creation and development of sustainable, safe places and communities; e) promoting a healthy standard of living and quality of life; f) developing and intensifying health prevention and promotion activities; g) enabling children, adolescents and young adults to maximize their capabilities and have better control of their lives; h) engage the utilization of technology, social media and community education to reduce stigma and build trust; and i) empower individuals to become involved in the political process and the decisions that affect their lives. All of these—coupled with ensuring equality and health equity in all policies and the development of effective evidenced-based delivery systems—will, over time, "reduce health disparities and improve

health and well-being for all" (Marmot 2010, 19).

Conclusion

Improving conditions in Black communities is paramount for a variety of reasons, including: worsening socioeconomic conditions and rising inequalities, continuing exposure of children to adverse social conditions will lead to inequalities in subsequent generations, and the threat of fiscal conservatism on the safety net programs. Furthermore, racial residential segregation denigrates the social fabric of the community and compounds negative health outcomes. The concentration of poverty must be examined to understand the historic insult of housing, lending, insurance and other policies. The legacy of the past does not have to be a predictor of the future. Improving the quality of life in racially segregated communities will require substantial investment in infrastructure, employment opportunities, and economic development. Therefore we contend that the social determinants of health model offers a holistic, multisectoral approach to meaningfully addressing the saturated disadvantage that characterize the experience of Blacks living in residentially segregated communities.

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