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Review: Structural Racism, Children's Mental Health Service Systems, and Recommendations for Policy and Practice Change

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Abstract

Objective: Racism is a public health crisis impacting children's mental health, yet mental health service systems are insufficiently focused on addressing racism. Moreover, a focus on interpersonal racism and on individual coping with the impacts of racism has been prioritized over addressing structural racism at the level of the service system and associated institutions. In this paper, we examine strategies to address structural racism via policies impacting children's mental health services.

Method: First, we identify and analyze federal and state policies focused on racism and mental health equity. Second, we evaluate areas of focus in these policies and discuss the evidence base informing their implementation. Finally, we provide recommendations for what states, counties, cities, and mental health systems can do to promote antiracist evidence-based practices in children's mental health.

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Results: Our analysis highlights gaps and opportunities in the evidence base for policy implementation strategies including: mental health services for youth of color, interventions addressing interpersonal racism and bias in the mental health service system, interventions addressing structural racism, changes to provider licensure and license renewal, and development of the community health workforce.

Conclusion: Recommendations are provided both within and across systems to catalyze broader systems transformation.

Keywords

racism; mental health services; health equity; child; adolescent

Introduction

Racism is a public health crisis with pervasive mental health impacts that greatly affect children and continue across the lifespan into adulthood.[1–3] However, within mental health service systems, there has been little recognition of or emphasis on addressing racism as a root cause of mental health inequity.[4] Further, the few existing efforts have largely focused on addressing racial bias among individuals rather than on structural and systemic racism within the mental health service systems and the systems with which they interact.

Typically, the mental health service system has been organized as a reactive system to respond to mental health symptoms resulting from the downstream effects of racial inequality, such as intergenerational and historical trauma, family separation, and community violence.[5,6] A proactive, upstream approach to creating an antiracist mental health service system means divesting from practices, policies, and institutional norms that maintain inequity and investing in systems transformations to dismantle structural racism. Structural racism includes the ways in which societal structures and institutions establish and perpetuate policies, practices, and social norms that reify racial hierarchies, including differential access to material conditions and opportunities based on race (see Table 1).[7,8] Broadly, systems transformations can take place at the patient level (comprehensively addressing and treating the mental health effects of interpersonal and vicarious racism on families, including racial trauma), at the provider level (recognizing and engaging in efforts to eliminate interpersonal racism and bias by administrators and providers), and at the organizational and community levels (enacting and funding policies and programs to address racism and racial inequity). We suggest that there are proactive strategies at a systems level that can be mobilized to promote equity and change.

This paper examines systems-level strategies and approaches to address racism (as defined in Table 1) and its effects on family and child/adolescent mental health. Three questions are addressed: (1) what policies are currently being advanced to address structural racism and promote health equity within the children's mental health service system; (2) what is the evidence base informing implementation of these policies; and (3) what can state, county, and city mental health systems do now through their policies, contracts, trainings, and services to promote antiracist evidence-based practices that support children's mental health?

What Policies Currently Exist to Address Structural Racism and Promote Health Equity Within the Children's Mental Health Service System?

Policymakers at the federal and state levels hold the power to create and enforce laws and regulations that can push mental health providers and service systems towards addressing the impacts of racism on children's mental health. Policymakers typically apply two groups of policy instruments — material and symbolic.[19] Material policies are often introduced as bills and lead to an actual change in practice through changes to a process (e.g., creating a task force to focus on the impact of racism on children's mental health) or changes that affect the delivery of goods and services (e.g., changing state licensure requirements for mental health providers).[20] Symbolic policy instruments are often written in the form of resolutions and are typically used to raise awareness or demonstrate support for a social movement (e.g., a law that dedicates the month of May as Mental Health Awareness month).[19] State and federal governments can introduce and vote on both material and symbolic policies and an understanding of how these mechanisms lead to action is crucial to evaluating the current federal and state policy landscapes in children's mental health services.

We focused on identifying policies at the federal and state level; specifically, we identified legislative proposals or bills between January 2018 and December 2020. Federal and state bills in general contain a broad antidiscrimination statement; we focus on best practices that aim to explicitly address the role of racism, antiracism, and/or cultural competence in mental health. Federal policies were identified by searching the publicly available database at Congress.gov for keywords race, racism, racial, equity, antiracism, and/or cultural competence combined with mental health or behavioral health and youth, child, or adolescent within the 2017–2018 and 2019–2020 legislative sessions. We focused on bills related to the children's mental health service system that were passed by at least one chamber of Congress; we also give examples of bills which were not passed but have been reintroduced in 2020–2021 for consideration. Because a number of policies addressing racism were enacted via executive action beginning in January 2021, we reference several executive actions issued between January and March 2021 and identified via Whitehouse.gov using the same keywords. State legislative bills were identified via the National Conference on State Legislatures Maternal and Child Health Database,[21] limiting the search to the categories "children's mental health- services" and "children's mental health- schools" in the database and then searching for keywords race, racism, racial, equity, antiracism, and/or cultural competence in the bill title or summary. We then obtained the full text of proposals via Congress.gov, Whitehouse.gov or state legislative websites. Two authors read the bills, extracted key content regarding the actions proposed by the bills, and wrote brief descriptions with relevant quotes from each bill. For state-level bills, we further identified descriptive categories and grouped policies using these categories (see section on state policy strategies). We discussed these categories with all authors to achieve consensus, elaborate on their description, and develop relevant recommendations.

We note several limitations of our review: first, given that addressing racism as related to mental health is a reasonably new emphasis for legislative policy, we focused on providing

a conceptual overview of recent policies rather than a comprehensive review of all policies issued. Thus, there could be relevant policies not mentioned here which would be identified via a more in-depth strategy such as a policy scan.[22] Second, we limited our search to legislative proposals with additional content derived from federal executive actions issued by the White House. Our review does not capture policies and programs originating from other agencies within the executive branch of the federal government or from state-level agencies, nor does it capture judiciary decisions. Third, we focus on reviewing policies aimed to address racism or mitigate the effects of racism, and not policies that serve to perpetuate structural racism. Agénor and colleagues have published a comprehensive review of state laws related to structural racism across ten legal domains,[23] which is a resource for scholars seeking to analyze the impact of structural racism on children's mental health. Fourth, we focus on policies addressing racism, excluding other forms of discrimination (e.g., due to sexual orientation) relevant to youth mental health.

Federal Policy Strategies

Federal support for policies that address the impact of racism on the mental health of youth is limited. In 2019, the Congressional Black Caucus established an Emergency Taskforce on Black Youth Suicide and Mental Health and released a report to Congress in 2020 that called for several actions including: 1) increased funding for research focused on Black youth mental health and suicide, as well as funding for Black researchers to do this work; 2) evidence-based interventions and practices for providers, teachers, parents, and others who interact with Black youth; 3) development of a certification program for mental health providers and school personnel to ensure they are trained to address the mental health needs of Black youth; and 4) state and local government engagement through task forces and providing technical assistance.[24] The report from the Emergency Taskforce on Black Youth and Suicide and Mental Health aided in the development and introduction of the Pursuing Equity in Mental Health Act which passed the U.S. House of Representatives in September 2020 and was reintroduced in March 2021 (see Table 2 for details).[25] This is an example of a national antiracist policy that actively aims to address the role of racism and discrimination by explicitly acknowledging the role of race and racism on mental health within the context of the bill itself.

The STRONG Support for Children Act of 2020, a bill introduced in the House of Representatives in 2020 and reintroduced in June 2021, focuses on addressing childhood trauma via grants to health departments and to local and tribal governments.[26] This bill notably names "historical and ongoing systemic racism," structural inequities, racial profiling, and family separation policies as root causes of trauma, among other systemic forms of discrimination. The Behavioral Health Coordination and Communication Act, a bill referencing "culturally congruent care," racial and ethnic diversity in the mental health workforce, and access to mental health services, was introduced in House of Representatives in 2020 and reintroduced in February 2021.[27,41] This bill does not explicitly name racism, though it does address racial/ethnic disparities throughout, emphasizes coordination across agencies, and references the establishment of public/private partnerships. Other bills focused on health equity more broadly (e.g., Health Equity and Accountability Act of 2020, introduced but not passed) include mental health services, while several bills focused on

other service sectors include provisions for addressing racial inequity and/or culturally and linguistically appropriate services (e.g., Supporting Family Mental Health in the Child Abuse Prevention and Treatment Act, passed in the Senate and the Stronger Child Abuse Prevention and Treatment Act and Mental Health Services for Students Act of 2020, passed in the House).

Several resolutions (i.e., a proposal focused on the operation of either the House of Representatives or Senate alone or is not presented to the President for action) were also introduced in 2020. The House of Representatives[29] and the Senate[28] both introduced resolutions "declaring racism as a public health crisis." These resolutions document what is known about the impacts of structural and systemic racism on the health and well-being of U.S. citizens of color and "commits" to "dismantling systemic practices and policies that perpetuate racism" and reforming "…policies that have led to poor health outcomes for communities of color…"[28,29] Another resolution introduced in the House of Representatives urged the United States to make "historic financial investments" into mental health care in an effort to address the high prevalence rates of mental health and substance use conditions and elevate mental health care to the same priority level as physical health.[30] These resolutions can be useful in signaling legislators' investment in particular issues, outlining needed responses, and increasing public awareness; however, they do not have funding attached and are therefore unlikely to lead directly to any action.

Upon taking office in January 2021, President Biden signed several executive orders and memoranda addressing racial equity, including the Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.[31] This executive order directs all federal agencies to conduct and report results of equity assessments on select programs and policies. While not directly a mental health policy, this executive order has the potential to influence children's mental health services via its impact on federal agencies, such as the Department of Health and Human Services and Department of Education. A presidential memorandum, Memorandum Condemning and Combating Racism, Xenophobia, and Intolerance Against Asian-Americans and Pacific Islanders in the United States, was also issued. Notably, this memorandum included recognition that the Federal Government had a role in promoting xenophobic statements about Asian Americans and Pacific Islanders (AAPIs) and linked these statements to increased harassment and hate crimes. The memorandum specifically directs federal agencies to examine their "official actions, documents, and statements" to ensure that they do not "exhibit or contribute to racism, xenophobia, and intolerance against" AAPIs. This memorandum is notable for specifically naming racism and its impacts on a specific community, documenting the role of the federal government in fomenting racism through its policies and practices, and ordering federal action to address structural racism via federal agencies.

State Policy Strategies

Between 2018 and 2020, approximately 145 bills were introduced in 38 states with a focus on children's mental health services.[21] Despite efforts to create equitable access to mental health services through payment reform and school-based mental health initiatives, few bills explicitly addressed racism or racial disparities (see Table 2). Broad categories identified

were: 1) the development of a racially and culturally concordant mental health workforce, or 2) access to geographically and culturally relevant service providers in the community or 3) the development and enforcement of training on the impact of race on mental health for the mental health workforce. One of the few laws that addressed racism specifically, rather than a broader focus on cultural diversity or cultural competence, was a law in Colorado which allocated funding to expand access to mental health care in early childhood via mental health consultants.[38] In addition to allocating funding to increase availability of consultants who would match the population served in race, ethnicity, and language, the training plans were specified to include "understanding the effects of trauma and adversity, prejudice, discrimination…racism…on the developing brain" as an anticipated outcome of the program.[38]

The current sociopolitical climate is pushing policymakers to re-think the role of policy in mitigating the impacts of systemic and structural racism on children's mental health. Several state and federal policymakers have galvanized around creating equitable access to mental health services for children within minoritized groups. While increasing access to mental health services is an important goal that states should be striving to achieve, increasing access alone does not directly address racism or ensure the elimination of mental health disparities. Naming and specifically addressing racism within legislation is a first step to ensuring a comprehensive response. Furthermore, while existing bills and laws call for increased attention to domains of intervention such as culturally responsive mental health care, implicit bias training, and workforce development (see Table 2), the evidence base informing specific approaches to implementing these policies may not be clear to mental health service systems.

What is the Evidence Base Informing Policy Implementation?

Policy implementation is the process by which the objectives outlined in policies are translated into practice. In the following section, we address the evidence base and opportunities related to three state and federal policy categories: mental health services for youth of color, including culturally responsive services addressing racism; addressing structural racism in mental health services; and education and expansion of the mental health workforce.

Mental health services for youth of color

Culturally responsive therapeutic interventions—Targeted provision of culturally responsive mental health services, including equitable access to evidence-based treatments, appears in several policies. However, a recent systematic review of evidence-based psychosocial interventions for racially/ethnically minoritized youth in the U.S. found a dearth of evidence-based interventions either developed for or tested with a large enough number of youth of color to test for moderation of intervention effects by race/ethnicity.[42] Only four interventions met the highest level of evidence (i.e., "well-established" meaning evidence of effectiveness in two randomized controlled trials conducted by separate research teams) among Hispanic/Latinx children: cognitive-behavioral therapy for anxiety, family-based interventions for disruptive behaviors, and family-based interventions for substance

use problems. Among African American youth, only multisystemic therapy for disruptive behaviors met these criteria. There were no well-established interventions for Asian American or Native American youth. These findings underscore the underrepresentation of youth of color in mental health treatment research and do so in a context in which National Institute of Mental Health funding for children's mental health services research overall has declined by 42%.[43] Scholars recommend expanding the evidence base not only by expanding the representation of youth of color in randomized controlled trials, but also by conducting implementation-effectiveness research in usual practice settings[44] and by building on approaches to train and support providers in selection, adaptation, and implementation of interventions.[45] Interventions found effective for youth of color in other settings such as schools (e.g., CBITS[46]) and primary care (e.g., brief behavioral therapy for anxiety and depression[47]) can also inform intervention strategies for mental health service systems.

Focusing on evidence-based interventions as the standard for selection of interventions may also exclude practices developed in and by communities of color. Scholars have argued for the importance of practice-based evidence, acquired through research on how treatments perform when delivered in routine clinical settings, rather than controlled settings, with relevant, heterogeneous patient populations, as a counterpoint to evidence-based practice.[48] In the California Reducing Disparities Project, the challenge of prioritizing local and community-driven knowledge was addressed by engaging service agencies representing priority populations to develop programs and conducting both statewide and local evaluations.[49] Tools to facilitate evaluation of culturally and locally specific program elements and outcomes were developed and may represent a replicable strategy for capturing the impact of practice-based evidence. Lyon and colleagues[45] further describe strategies for integrating research evidence and local knowledge in youth mental health intervention, emphasizing collaboration between researchers and clinicians in either co-design of interventions or quality improvement of existing interventions.

Interventions mitigating or addressing the effects of racism—Overall, the link between racism and health is well established[10,50], though the majority of studies have focused on adults. Reviews focused on children[1,3,12,51,52] conclude that racism impacts the physical health of young children as early as the pre-natal period and infancy (given racial disparities in infant mortality and low birth weight) and impacts mental health more so than physical health for older children and adolescents. In fact, its impact on mental health may be one of the pathways to the long-term physical health problems experienced by adults.[2] Multiple conceptual models linking discrimination to health have been advanced. Common threads in these various models include integration of stress and coping frameworks[12,52] within developmental and ecological/structural perspectives.[10,51,53] Recently, three trauma-focused models have been advanced,[6,54,55] building on earlier work documenting the impact of racial trauma on Black children and adolescents.[56]

From these models we derive implications for policy development and implementation in children's mental health service systems: a focus on addressing racism at both macro and micro levels, rooted in principles of critical race theory as applied to public health[57] with an understanding of the ways in which racism impacts children across the lifespan beginning

with prenatal exposures through adult outcomes, and via models that are strengths-based and trauma-informed. Development and testing of therapeutic approaches integrating racial-ethnic protective factors identified in past research is an important direction for individual-level interventions – for example, Jones and Neblett[58] reviewed seventeen prevention and intervention programs addressing racial identity, racial socialization, and Africentric worldview and found only one psychotherapy intervention at that time. Racial/ethnic socialization is an overarching term for the processes by which parents and caregivers communicate with their children about race and ethnicity, including socialization to their racial or ethnic group's culture and history, preparation for encountering discrimination and bias, communications about wariness or distrust of other racial/ethnic groups, and/or promoting egalitarianism or silence about race.[59] The first two processes are active coping processes that have been translated into interventions. In the area of family-based programs, the Strong African American Families Program stands out as a long-term research program focused on testing and disseminating a culturally tailored intervention, including sessions focused on encouraging racial pride and addressing racial discrimination.[58,60] However, Jones and Neblett noted in their review that racial/ethnic socialization has been developed as a target for therapeutic intervention since the early 1990s,[61] indicating that there is a gap in the translation of clinical knowledge in this area into clinical studies.

Promising interventions have since been developed and include the EMBRace five-session family-based intervention based on an expanded process-oriented model of racial-ethnic socialization termed the Racial Encounter Coping Appraisal and Socialization Theory,[54,62] the school-based Identity Project intervention focused on ethnic/racial identity development as a protective factor against the mental health effects of racism[63] and social belonging interventions.[64,65] Relatedly, the American Academy of Pediatrics recommends providing anticipatory guidance during pediatric visits on strategies to identify and resist racism and incorporating racial socialization into the assessment of youth and family strengths.[3] Integrating racial socialization into trauma-focused cognitive behavioral therapy, as recommended by Metzger et al.[66] with proposed adaptations, is another promising approach to improve the relevance and effectiveness of a widely disseminated evidence-based treatment. More research in this area is needed.

Interventions addressing interpersonal racism within the service system— Interpersonal racism also occurs within the service system, in families' interactions with mental health service providers and in the experiences of staff of color in their workplaces. Addressing racist attitudes and behaviors on the part of mental health service professionals is therefore a critical goal. A focus on cultural competence training or on addressing implicit bias has been advanced in a number of policies related to child mental health services, but the evidence base linking these interventions to improved patient outcomes is sparse. For example, implicit bias training is gaining attention as a strategy to reduce the impact of implicit bias on patient experiences and has begun to be mandated within health care professional licensure. Yet, despite this, there has been limited empirical evidence demonstrating the effectiveness of implicit bias training for long-term change in implicit preferences[67] or measuring the impact of implicit bias trainings on patient-level outcomes.[68] Drawbacks also include a unilateral focus on building awareness and a reliance

on self-report results on the Implicit Association Test. Unfortunately, building awareness alone may be motivating to providers but not lead to behavior change;[69] it may also be counterproductive if the process of building awareness incites defensiveness or avoidance among providers.[70] More promising approaches to implicit bias training include actions aimed at changing behavior and engaging actively with the process of reducing bias, including stereotype replacement, seeking common identity information with groups outside one's own, and perspective taking.[70] Some interventions that provide concrete strategies for changing behavior have demonstrated an impact on implicit biases;[71,72] a needed next step would be to measure effects of implicit bias training on health care delivery metrics such as patient satisfaction with and engagement in mental health services.

Addressing structural racism within mental health service systems—Arguably the most important point for intervention is at the level of structural racism,[73] but such interventions targeting children's mental health service systems are almost non-existent. Structural racism manifests in children's mental health service systems via pervasive inequities including disparities in access to and quality of care, funding and insurance disparities, and disparities in pathways to care (e.g., youth of color accessing mental health services via emergency room rather than community based services).[74,75] Structural racism also manifests in the interactions between health care and other systems including the education, justice, and immigration systems.[3,73,76] A notable example is that mental health crisis response is often the purview of law enforcement agencies and of law enforcement officers in schools, potentially exposing youth to racial trauma and criminalization in these encounters.[77,78] Related structural interventions that mental health service systems can adopt include upstream interventions impacting mechanisms produced by structural racism and impacting mental health. These include interventions to reduce poverty and address food insecurity; medical/legal partnerships supporting civil rights; community partnership and empowerment within health care; efforts to diversify the workforce and leadership ranks; and addressing disparities in access, retention, and quality of care.[3,75,79–82] The role of these efforts in dismantling racism has been hampered by a reluctance to name racism as a root cause of health inequities, even as interest in social factors impacting health has increased.[83] Thus, scholars call for a need to incorporate critical race theory and intersectionality in order to conceptualize the interlocking systems of oppression driving racial inequities.[84]

Bailey et al.[83] emphasize that "structural racism involves interconnected institutions, whose linkages are historically rooted and culturally reinforced" (p. 1454) and propose that multisector initiatives, involving action on multiple societal subsystems such as healthcare, housing, employment, welfare, education, and the carceral system, are necessary to advance health equity. Interventions addressing social determinants in the areas of education and early childhood, community development and urban planning, employment, housing, and income have shown promise in reducing health disparities, though most were not initially designed to measure health impacts.[85]

While interventions addressing social determinants may be outside the scope of the children's mental health service system, a multisector focus is entirely consistent with the prevailing model of promoting children's mental health via coordinated multi-sector services. For example, the federally funded Children's Mental Health Initiative has

demonstrated an ability to reach and engage youth of color in system of care services including wraparound planning, intensive care coordination, family and youth peer supports, and flexible funding.[86,87] Grantees in this program have been able to sustain services via Medicaid funding, including home and community-based services waivers and state plan amendments, and funding from the state mental health authority.[87] Medicaid waivers waive or expand income restrictions for Medicaid coverage and have been shown to reduce unmet mental health needs among youth with public health insurance coverage.[88] Other funding include using the Children's Health Insurance Program to provide health insurance to a greater proportion of youth, accessing the state's general revenue funds through child mental health legislation, and using community mental health block grant funding.[89] More recently, the Integrated Care for Kids (InCK) model being tested in eight states is a local service delivery and state payment model with the goal of aligning health and social service systems for Medicaid-covered children.[90] Additional options for funding programs to address social determinants of health among Medicaid enrollees are available.[91]

Multisector coalitions can coordinate and evaluate services across a range of systems and in partnership with community-based organizations, and the healthcare system can serve as a home for initiatives such as medical-legal partnerships. Partnerships with health services researchers can deepen the focus on measuring health impacts of multisector interventions, particularly given that many of these effects are unlikely to be seen in the short-term and instead require a sustained investment in evaluation.

Education and development of the mental health workforce

The role of licensure and the license renewal processes—Licensure and license renewal are leverage points for strengthening training and professional development in the clinical workforce. Priorities for improving the training of licensed providers include addressing interpersonal racism and building understanding of how structural racism has shaped the mental health system. For example, a recent proposal for graduate medical education outlines how to integrate a "core competency centered on health equity, social responsibility, and structural competency" into the existing Accreditation Council for Graduate Medical Education (ACGME) standards for practice.[92] The proposal highlights that the term systems-based practice has often focused primarily on physician navigation of the existing healthcare system, including topics such as cost containment and system policies, but has not typically addressed root causes of health and social inequities at institutional and societal levels. The authors propose adding three themes – structural competency, addressing knowledge; structural action, addressing skills; and social responsibility, addressing attitudes.[92]

In addition to this proposal for general medical education, all of the mental health specialties typically develop guidelines based on empirical research to encompass multicultural practice competencies to use as the foundation of new educational and licensure requirements (e.g., psychology,[93] social work[94]). For example, the American Academy of Child and Adolescent Psychiatry publishes the Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice[95] and has published curricular guidelines for diversity and cultural competency training.[96] However, such guidelines are not mandates for training. In

the field of psychology, for example, standards are considered mandates that psychologists must follow, while guidelines are "aspirational and informative."[97] Therefore, integration of these guidelines may vary widely by training program. In addition to satisfying training requirements through attending an accredited program, several states require that providers complete additional examinations or coursework (e.g., on ethical issues or specific topics such as child abuse assessment and reporting) to be eligible for licensure, thus creating another avenue through which workforce training could be mandated. Although addressing discrimination and racism is an ethical issue, we found that few states require additional mandatory coursework or examinations specific to discrimination and racism for mental health professional licensure and those that do offer only broad requirements.[98]

State licensing boards also oversee the licensure renewal process. Renewing one's license to practice is a legal requirement to ensure the maintenance of competence. However, requirements specific to issues of discrimination and racism in this process are rare. For instance, based on a review of requirements listed on state licensure board websites conducted in October 2020, the authors found that while all 50 states and D.C. require CE credits for licensure renewal in social work and 43 have mandated requirements for a proportion to be related to ethics, only seven had requirements related to cultural diversity, and none had requirements related to racism specifically. Because issues related to cultural diversity and race are dynamic and contextual, ongoing training in this area is important. In addition, a resource for states now exists through an online continuing medical program, Racism and Black Mental Health, which is currently available from the American Psychiatric Association.[99]

Some state licensing boards are beginning to consider mandating initial licensure coursework and CE credits specific to racism and disparities within the licensure renewal process. For example in Michigan, an Executive Directive has been signed by the governor directing the development of rules for implicit bias training as a required component of licensure for all health care professionals.[100] This change in standards would result in over 430,000 health care providers taking part in the training.[101] The training model was developed by a workgroup consisting of representatives from 86 organizations.

Community health workers as mental health service providers—Expanding roles and opportunities for community health workers (CHWs) in mental health services is a strategy that can simultaneously diversify the mental health workforce (given that lay health workers tend to be more racially and ethnically diverse group than licensed providers) and address service delivery gaps.[102,103] CHWs are public health workers who are either trusted members of or are otherwise close to the communities they serve,[104] have been mobilized in mental health care,[105] and are distinct from licensed providers. There are an estimated 85,000 to 200,000 CHWs in the US[106] who are represented by 46 organizations.[107] In mental health, some commonly used titles include community health workers, family peer advocates, parent peers, peer support specialists, and outreach workers. States have advanced the role of CHWs by establishing training models, certification pathways, and professional alliances.[108,109] Certification pathways serve at least three purposes: ensuring quality of services provided, defining the roles of CHWs relative to other team members, and raising

the profile of CHWs as key members of a health care team along with their peers in other health services roles.

A major challenge facing expansion of CHW-delivered services is the marginalization of CHWs themselves. Barriers described in the literature include high turnover, lack of clarity about work roles and protocols, low quality of evidence for CHW-led interventions, fragmentation of roles via disease-specific programs, and lack of integration with and acceptance from clinicians and healthcare systems.[110] Torres and colleagues[111] critique the marginalized social location of CHWs in the US and Canada, noting that they are a workforce impacted by gender discrimination, racism, and poor economic conditions. As members of marginalized communities themselves, CHWs are further marginalized in their professional roles within the health care system. This reality not only limits career pathways for individual CHWs, but also demonstrates the necessity of transforming health systems structures and hierarchies to move towards health equity at both workforce and patient levels. However, an increasing number of states have established credentialing processes for family peer support providers, a growing workforce within the children's mental health system.[112]

Looking Forward: Recommendations for Strengthening Antiracist and Evidence-Based Practices in Mental Health Systems

Given that state, county, and city mental health systems have considerable latitude to respond to the urgency of addressing interpersonal and structural racism, we propose a series of recommendations at three levels (see Tables 3 and 4 for further details): (1) within children's mental health service systems; (2) within research communities; (3) across systems.

Recommendations for the children's mental health service system

1. Identify empirically-based interventions at all levels (i.e., state, city, and county mental health systems) that address racial stress and trauma and promote racial/ethnic socialization, and build these into existing training initiatives. Simultaneously, prioritize examining implementation barriers and strategies when considering which interventions to scale.
2. Expand training and credentialing of the lay health workforce (including family and youth peer specialists, family advocates, and community health workers) to broaden the workforce, increase diversity of staff, and improve access to services. An increasing number of states are creating credentialing processes and standards, and expansion of professionalization of this workforce is critical.
3. Strengthen the career ladders of the lay workforce so that their roles as members of health teams are clearly delineated.
4. Utilize existing mechanisms for provider licensure and licensure renewal to include standards for training in structural racism and antiracist practices, just as states have previously mandated specific training requirements in areas such as child abuse identification and reporting.

5. Expand training addressing racial bias and interpersonal racial discrimination into standard workforce development.

Recommendations for concurrent investments in research and evaluation

1. Expand federal support of research on effectiveness and implementation of evidence-based interventions with racially/ethnically minoritized youth, interventions addressing racial trauma, and systems-level approaches to reduce interpersonal and structural racism. This should become a priority for service effectiveness and dissemination and implementation research agendas within the National Institute of Mental Health and other NIH institutes (NICHD, NIMHD).

2. Invest via state, foundation and institute funding in research, evaluation, and technical assistance on racial inequities in collaboration with academic partners and form coalitions to advance research in these areas.

Recommendations across systems

1. Support and build on the federal Pursuing Equity in Mental Health Act. This bill stands out as a rare example of a comprehensive policy focused on the mental health of youth of color, building from a task force report focused on Black youth specifically. This bill can serve as a model for state and county policies in children's mental health services seeking to address all or some of the areas covered: service delivery, research, training, and education and outreach. Specific examples relevant to state-level adaptations are made in Table 4.

2. Establish multi-sector coalitions focused on children's mental health equity and antiracist practices. Multi-sector coalitions are established approaches via which children's mental health service systems can enact structural change on behalf of children and families by developing and implementing policies across systems. For these to be successful, they cannot simply be symbolic efforts, but need to have a mandate and funding to accomplish their goals. Integration of best practices in children's mental health service coalitions and racial justice and equity coalitions will be needed to advance a vision for equitable children's mental health services.

3. Establish the use of Health Equity/Racial Equity Impact Assessments for policies and practices carried out within state, county, and city mental health systems. Health Impact Assessments (HIAs) systematically appraise the impact of a particular policy or program on health via a process of screening, scoping, data collection, impact appraisal, reporting/recommendations, and monitoring/evaluation.[125] Racial equity impact assessments (REIAs) similarly engage a formal process of evaluation to analyze how a policy or budget decision will impact different racial/ethnic groups, with a process including the population(s) to be affected by a policy, the likely positive and negative impacts, and the steps needed to close racial/ethnic gaps or to address negative consequences.[127] These have been used in the United Kingdom since 2000 and have had less uptake in the US.[128] However, the landscape may be changed given the presidential executive order mandating an equity review to be conducted in all federal

agencies. Adapting this approach to children's mental health service systems and related policies would reflect similar goals to existing HIA/REIA approaches, but with a particular focus on short and long-term impacts on mental health outcomes, population health, and racial equity.

Systems transformation is dependent on enactment of new policies; implementation of programs, initiatives and interventions that support these policies; and funding to sustain and expand effective programs. Despite several decades of research on racism and its effects on health, strategies at a systems level to combat racism and its effects are only now receiving attention in federal and state policies. Systems responsible for delivering mental health services to children, adolescents and their families have considerable leverage in effecting positive change. Our review identifies promising structural approaches that are beginning to be taken by states and the federal government to attend to racism and mental health equity. These include policies and programs to address the effects of racism, to provide culturally and linguistically congruent care, to re-train the workforce, and to expand the lay workforce, including the role and function of family and youth peer support and advocacy. These developments are possible now, despite very serious deficits in research on effective therapeutic and preventive interventions, evidence-based strategies to train the workforce, and approaches to address structural racism. Concerted and coordinated attention to these issues by the research, practice and policy communities is needed to redress past inequities and promote genuine system transformation.

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Table 1.

Aspects of Racism

Interpersonal racism refers to experienced racism and to vicarious exposure. The impact of vicarious exposure[9] speaks to the far-reaching impact of racism and discrimination and impacts beyond what is perceived by the individual.[2] Interpersonal discrimination has been studied far more than other forms of discrimination.[10,11]
Structural racism (also known as systemic racism and institutional racism) refers to how racism shapes the ways in which systems are structured to impact both material conditions and access to power.[7,8] Structural racism is a mechanism driving and maintaining disparities in mental health services such as access to and quality of care. Structural racism can take the form of institutional discrimination, including intergenerational experiences of institutional oppression and violence leading to historical trauma.[12]
Internalized racism refers to the impact of racism as internalized by members of minoritized racial/ethnic groups to see their own worth or that of the group they belong to as lesser than that of other groups,[8] including both consciously and unconsciously holding beliefs, values, and stereotypes (which may be seen as negative or positive) about their racial/ethnic group or about themselves due to being a member of that group.[13]
Racial trauma "refers to the events of danger associated with real or perceived experiences of racial discrimination" and includes "threats of harm and injury, humiliating and shaming events, and witnessing harm to other" people of color.[14] The effects of racial trauma are conceptualized as similar to symptoms of post-traumatic stress disorder, as well as more broadly as race-based traumatic stress.[15] Continued exposure and re-exposure to events of racial discrimination, both individually and collectively, occurs throughout the life course.[14]
Antiracism is a multifaceted concept which does not have one agreed-upon definition.[16] It can be thought of as a framework driving practices for confronting and eradicating racism that "includes a structural analysis that recognizes that the world is controlled by systems, with traceable historical roots, that batter some and benefit others."[17] In mental health care, it has been argued that "antiracist care goes beyond transcultural care; it integrates both cultural aspects and elements that allow for some form of reparation for the harm caused by racial discrimination, racial profiling, microaggressions, and racism."[18]

Table 2.

Examples of Children's Mental Health Legislation Addressing Race, Racism, or Services for Youth of Color

Name	Type	State	Status	Relevant details
Federal				
Pursuing Equity in Mental Health Act	H.R. 5469	-	Passed the House in Sept. 2020 and did not receive a vote in the Senate; reintroduced March 2021	• Focused on addressing "mental health issues for youth, particularly youth of color" by addressing gaps in mental health disparities research and developing/disseminating health professional educational programs core competencies that address mental health disparities impacting minoritized racial and ethnic groups. • States the need to design an outreach and education strategy to promote mental health and reduce stigma that "meet(s) the diverse cultural and language needs of various racial and ethnic minority groups" and "provides information on evidence-based, culturally and linguistically appropriate and adapted interventions and treatments." • Requests additional funding for the National Institute of Health, the National Institute of Minority Health and Health Disparities, and the reauthorization of the Minority Fellowship Program through the American Psychological Association.[25]
Services and Trauma-informed Research of Outcomes in Neighborhoods Grants for Support for Children Act of 2020 or the STRONG Support for Children Act of 2020	H.R. 8544		Introduced in October 2020 but did not receive a vote; reintroduced in July 2021	• Establishes two grant programs to prevent and mitigate childhood trauma and adverse childhood experiences. • Names historical and systemic racism as root causes of childhood trauma, with specific examples, and lists discrimination and racism as adverse childhood experiences. • One program awards grants to health departments to analyze data to inform interventions for prevention and mitigation of childhood trauma, and the other to local and tribal governments to establish or expand early childhood trauma-informed care coordination services. • Prohibits use of funds to inform individual case decisions, such as child removals, or to increase law enforcement presence.[26]
Behavioral Health Coordination and Communication Act of 2020	H.R.7723	-	Introduced in July 2020, but did not receive a vote; reintroduced in February 2021	• Establishes the position of Interagency Coordinator for Behavioral Health to coordinate the programs and activities of the Federal Government relating to mental health, and for other purposes. • Asks for the identification or development of best practices for "culturally congruent care" and education campaigns on mental health in all education settings and a range of populations, including "racial and ethnic minorities." • Creates a position that would be responsible for delivering a report to Congress and the President that describes: – Shortcomings in the racial and ethnic diversity of the existing mental health workforce and the projected workforce – The impact of provider and patient racial concordance on the mental health of patients – Access to community-based mental health services in communities of color.[27] • Calls for studies on the reimbursement of school-based mental health services and on the services available to children in the juvenile or criminal justice systems.

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Name	Type	State	Status	Relevant details
Declaring Racism as a Public Health Crisis	H.Res.1069; S.Res.655	-	Introduced in Congress in 2020	• Aims to document what is known about the impacts of structural and systemic racism on the health and well-being of U.S. citizens of color and "commits" to "dismantling systemic practices and policies that perpetuate racism" and reforming "…policies that have led to poor health outcomes for communities of color…"[28,29] • Discusses the impacts of racism and the disparities in health outcomes for children of color throughout the text.[28,29]
House of Representatives… [reso lution on] the high prevalence of those suffering from mental health conditions and substance use disorders	H.Res.1057	-	Introduced in House in July 2020	• Full title: "Expressing the sense of the House of Representatives that in order to effectively address the high prevalence of those suffering from mental health conditions and substance use disorders, the United States needs to make historic financial investments into mental health and substance use disorder care and finally acknowledge such care as a priority in health care equal to physical health, and for other purposes." • Calls for the adoption of a population health approach as "a tool to help address ongoing disparities in access to mental health care by youth…of color."[30]
Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government	Executive Order 13985	-		• Advocates for "an ambitious whole-of-government equity agenda" and includes the directive for the Director of the Office of Management and Budget to partner with heads of federal agencies to "study methods for assessing whether agency policies and actions create or exacerbate barriers to full and equal participation by all eligible individuals" and to "select certain of the agency's programs and policies" for an equity assessment to be reported within 200 days. • Includes sections on allocating federal resources to promote equity in the federal budget, assessing whether government contracting and procurement opportunities are available on an equal basis to eligible providers, consulting with members of communities historically underserved by the Federal Government, and establishing an equitable data working group.[31]
Memorandum Condemning and Combating Racism, Xenophobia, and Intolerance Against Asian Americans and Pacific Islanders in the United States	Memorand um	-		• Notes that the Secretary of Health and Human Services and the COVID-19 Health Equity Task Force should "consider issuing guidance describing best practices for advancing cultural competency, language access, and sensitivity towards Asian Americans and Pacific Islanders in the context of the Federal Government's COVID-19 response," considering "best practices set forth by public health organizations and experts for mitigating racially discriminatory language in describing the COVID-19 pandemic." • Directs executive departments and agencies "to ensure that official actions, documents, and statements, including those that pertain to the COVID-19 pandemic, do not exhibit or contribute to racism, xenophobia, and intolerance against Asian Americans and Pacific Islanders," which may include consultation "with public health experts, AAPI community leaders, or AAPI community-serving organizations." • Directs the Attorney General to "explore opportunities …to prevent discrimination, bullying, harassment, and hate crimes against AAPI individuals, and to expand collection of data and public reporting regarding hate incidents against such individuals."
State - Culturally relevant treatment and workforce diversity				
Adolescent Behavioral Health Care Access	WA H 1874; WA S 5904	WA	Enacted 2019	• Focuses on expanding access to adolescent behavioral health care • States that minors should "receive an appropriate continuum of culturally relevant care and treatment…" by acknowledging the importance of cultural competency in therapeutic efficacy[32]

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Name	Type	State	Status	Relevant details
Postsecondary education: mental health counselors	S.B. 968	CA	Vetoed by Governor in 2018	• Focuses on expanding the mental health workforce in postsecondary education • States that students of color face mental health challenges due to additional stressors like discrimination and would require that "where possible" mental health counselors should reflect the diversity of the student body they are serving.[33]
School resource officers and school security officers; training standards	VA H 1419; VA S 171	VA	Enacted 2020	• Targets implicit bias in school-settings by requiring minimum training standards for the certification and recertification of individuals hired as school security officers and law-enforcement officers working with students in a school environment • Mandates that standards address "awareness of cultural diversity and implicit bias," "working with children with mental health needs," and "mediation and conflict resolution."[34]
State - Increasing access to community-based or school-based services				
Education finance: education omnibus budget trailer	CA S 75	CA	Enacted 2019	• Focuses on building mental health partnerships between the county mental or behavioral health departments, offices of education and school districts through a competitive grant program • Awards over $50 million dollars over a four-year grant cycle to help increase access to mental health services in locations that are easily accessible to students.[35]
School Code	IL S 1941	IL	Enacted 2019	• Establishes the Safe Schools and Healthy Learning Environments grant program through which schools can apply for additional financial resources to implement evidence-based "restorative interventions," hire additional school staff to provide socio-emotional services or to offer training to school staff on "trauma-informed approaches" and "addressing the effects of toxic stress."[36]
Mental Health Services in Schools	NE L 619	NE	Enacted 2019	• Focuses on increasing access to mental health services in schools by making it illegal for insurers to deny coverage or payment for mental health services solely on the basis that the services were delivered in a school-setting.[37]
State - Developing or continuing education in the mental health workforce				
Early Childhood Educator Workforce Support	CO H 1053	CO	Enacted 2020	• Allocates funding for early childhood "mental health consultants" and expanded access to mental health services in child care, schools, and various healthcare settings.[38] • Allocates funding for a model of consultation "rooted in diversity, equity, and inclusion," through standards and guidelines that aim to increase the availability of bilingual or multilingual health consultants and 2) ensuring the mental health consultants match the diversity of the children and families being served.[38] • Requires that training plans include information on "an understanding the effects of trauma and adversity, prejudice, discrimination…racism…on the developing brain" as an anticipated outcome of the program.[38]
Mental Health Services Consultation Program	WA S 6452	WA	Enacted 2018	• Expands technical assistance in children's mental health services and establishes a "Children's Mental Health Evidence-based Practices Institute" at University of Washington to serve as a "statewide resource" to help children's mental health providers adapt evidence-based practices to better serve "ethnically or culturally diverse children."[39]

Name	Type	State	Status	Relevant details
Emotional Learning and Development for Children	ME S 287	ME	Enacted 2019	• Funds an early childhood consultation program to train early care and education teachers and providers working with children.[40] • Develops a plan for training community-based licensed mental health professionals on "cultural competence to ensure [they] understand the needs of the ethnically diverse communities they may be serving and how to form relationships to provide the unique services needs to support these populations."[40]

Note: Based on the National Conference of State Legislatures- Maternal and Child Health Database using search topics "Children's Mental Health-Schools" and "Children's Mental Health- Services."

Table 3.

Recommendations within the service system and for research and evaluation

	Recommendation	Context and rationale
	Within the children's mental health service system	
1.	Identify empirically-based interventions at all levels (i.e., state, city, and county mental health systems) that address racial stress and trauma and promote racial/ethnic socialization, and build these into existing training initiatives. Simultaneously, prioritize examining implementation barriers and strategies when considering which interventions to scale.	• There are promising interventions for which training could be offered in partnership with intervention developers. • States should work with communities to adapt evidence-based mental health practices for youth of color and incorporate racial justice and equity goals into trauma-informed practices.
2.	Expand training and credentialing of the lay health workforce (including family and youth peer specialists, family advocates, and community health workers) to broaden the workforce, increase diversity of staff, and improve access to services. An increasing number of states are creating credentialing processes and standards, and expansion of professionalization of this workforce is critical.	• Nineteen states have invested in their lay health workforce by offering credentialing of providers who offer support services. • This approach standardizes training competencies, ensures high quality of services, and addresses the severe workforce shortages that most states are experiencing, especially providers serving children and families. • Early evidence from New York indicates virtual trainings are as effective as in-person trainings; family peer advocates trained virtually had equal knowledge gains compared to those trained in person.[113]
3.	Strengthen the career ladders of the lay workforce so that their roles as members of health teams are clearly delineated.	• In healthcare, people of color are often in entry-level, lower-paid positions rather than in leadership positions.[114] • Rather than simply diversifying the workforce, efforts should focus on addressing inequities in leadership, compensation, career pathways, and valuing of multiple forms of experience within the workforce via structural and long-term change.
4.	Utilize existing mechanisms for provider licensure and licensure renewal to include standards for training in structural racism and antiracist practices, just as states have previously mandated specific training requirements in areas such as child abuse identification and reporting.	• Training and licensure requirements should include explicit reference to racism and discrimination and build upon the substantial work previously accomplished by professional organization task forces and guideline committees on antiracism and culturally congruent care.[93–95] • Changes in training and licensure processes will require coordination among several entities including state licensing boards, professional organizations, and academic institutions. • Continuing education mandates could include already developed material such as the Racism and Black Mental Health continuing education program available from the American Psychiatric Association.[99] • Racism and discrimination towards trainees of color by faculty takes place within academic training programs[115,116] and perpetuates a system that impedes the advancement of racially and ethnically minoritized faculty into senior roles in health care.[117] Changes to training and licensure therefore also require structural and interpersonal changes at the levels of leadership and administration.
5.	Expand training addressing racial bias and interpersonal racial discrimination into standard workforce development.	• Evidence indicates that a focus on short-term implicit bias training will not be sufficient to make long-term changes in workplace climate and patient-provider interactions. • System transformations must include avenues to address racism and bias perpetuated by staff and administrators. Ongoing consultation and coaching will be key to behavior change, as well as promoting institutional champions who

	Recommendation	Context and rationale
		are supported by clear mandates from leadership (including organizational support, protected time, and resources to accomplish this work).
	Research and evaluation	
1.	Expand federal support of research on effectiveness and implementation of evidence-based interventions with racially/ethnically minoritized youth, interventions addressing racial trauma, and systems-level approaches to reduce interpersonal and structural racism. This should become a priority for service effectiveness and dissemination and implementation research agendas within the National Institute of Mental Health and other NIH institutes (NICHD, NIMHD).	• The combination of the underfunding of priorities related to racism and health disparities and the significant underfunding of children's mental services research[43] leads to a major gap that requires a concerted focus on advancing evidence-based practices for youth of color. • The National Institute on Minority Health and Health Disparities, the institute within NIH explicitly addressing some of these priorities, receives lower total funding relative to many other NIH institutes[118] and as a result has the lowest percentage of R01 proposals (9.1%) that receive funding among them.[119] • Increasing research funding for these priorities is one of the provisions of the federal Pursuing Equity in Mental Health Act; absent an increased level of funding, prioritization of research funds should take these gaps into account. • A recent NIH funding announcement on "understanding and addressing the impact of structural racism and discrimination on minority health and health disparities" is a step in this direction.[120]
2.	Invest via state, foundation and institute funding in research, evaluation, and technical assistance on racial inequities in collaboration with academic partners and form coalitions to advance research in these areas.	• Presence of state policies supportive of evidence-based treatments is predicted in part by investment in research centers working with state mental health agencies.[121] • Only a quarter of legislators and half of state mental health agency officials report turning to universities for behavioral health research.[122] • These partnerships can: (1) evaluate the quality of trainings provided; (2) address whether these systems changes have impact on longer term children's mental health outcomes; (3) provide data on the effectiveness of specific interventions on the mental health of youth of color; and (4) link structural interventions, including those impacting the social determinants of health, to health and mental health outcomes.

Table 4.

Cross-systems

Recommendation	Further details
Support and build on the federal Pursuing Equity in Mental Health Act.	• The bill proposes grant funding to establish interprofessional health care teams that provide behavioral health care in settings serving a high proportion of racially and ethnically minoritized patients, low-income patients (via the Federally Qualified Health Center program), or rural patients, and notes that services provided "shall be scientifically based, taking into account the most recent peer reviewed research available." States could similarly model their integrated care expansion efforts. • It provides funding for a national study on mental health disparities, including specific focus on the impact of exposure to community violence, adverse childhood experiences, and structural racism; such studies could be conducted at the state level. • This Act provides for development and dissemination of best practices and core competencies in training mental health providers and certifying community health workers • It endorses partnerships with advocacy and behavioral health organizations serving racially and ethnically minoritized groups to develop and implement outreach and education strategies that meet "diverse cultural and language needs" and engage consumers and community members in development and implementation of strategies. While beneficial at the federal level, the regional diversity and expertise represented throughout the country also makes this an important priority at the state level. • It bans the use of federal funds for conversion therapy, meaning any practice or treatment seeking to change an individual's sexual orientation or gender identity, and withholds SAMHSA funds to states that fund conversion therapy. This provision demonstrates the importance of policy provisions to end use of non-evidence-based treatments that are actively harmful to children and adolescents.
Establish multi-sector coalitions focused on children's mental health equity and antiracist practices.	• Examples of successful multisector coalitions in children's mental health established by state policy include the New York State Children's Plan and the Connecticut Children's Behavioral Health Plan. • In the area of racial justice and equity, King County, Washington has advanced multisector work in a long-term process beginning with an Equity and Social Justice Initiative established by a county executive in 2008, followed by the County Council affirming a commitment within their countywide strategic plan and Equity and Social Justice ordinance, and culminating in the launch of the 2016–2022 Equity and Social Justice Strategic Plan.[123] • This plan relied on quantitative and qualitative data, including input from over 700 employees and 100 organizations, with a defined framework focused on public health and upstream causes. The plan defines how practices promoting equity will be integrated and implemented into county functions including leadership, operations, services, plans, policies, and budgets.[123]
Establish the use of Health Equity/Racial Equity Impact Assessments for policies and practices carried out within state, county, and city mental health systems.	• HIAs can promote trust between community and government entities while also informing the distribution of resources promoting health.[124] • Recommendations to strengthen HIAs with a specific focus on health equity include: (1) being explicit about the underlying values guiding the proposal, (2) taking into account context-specific equity considerations, (3) identifying the root causes of health inequity at all levels, (4) incorporating consideration of power differentials, and (5) building capacity for the processes needed to conduct and use health impact assessments.[125] • Seattle's Race and Social Justice Initiative has used a racial equity toolkit in budget and policy decisions since 2012. Their toolkit includes five steps: (1) set outcomes; (2) involve stakeholders and analyze data; (3) determine benefit and/or burden; (4) develop strategies to advance opportunity or minimize harm; and (5) evaluate over time, raise racial awareness, and be accountable to continuing to involve stakeholders and resolve issues.[126]