EDITORIAL

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# Editorial: Dismantling Structural Racism in Children's Mental Health Services: How Do We Do It?

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As our society becomes more sensitized to the reach and extent of structural racism embedded in our institutions, it is important that we do serious and intentional work to undo the harmful policies and practices resulting from this multicentury process. Structural racism is both endemic and epidemic in nature. As relates to children's mental health, there is literature that supports the presence of serious racial/ethnic disparities in both the quantity and quality of children' mental health services as a result of structural racism in our service system.[1,2]

The review by Alvarez *et al.*[3] identified and analyzed federal and state policies focused on racism and mental health equity, largely drawn from legislation and executive action over the past 4 years. They organized the level of actions in a practical manner, starting with Federal-level symbolic and substantive legislation, Federal executive actions, state-level policies and legislation, and actions by professional boards and organizations. They evaluated areas of focus in these policies and discussed the evidence base informing their implementation. Finally, they provide recommendations for what states, counties, cities, and mental health systems can do to promote antiracist evidence-based practices in children's mental health.

The authors are clear that this is an effort that has its own inherent limitations and challenges, although they are quire comprehensive in their work. However, an additional limitation of this review is in determining whether legislative action has been actually translated to action plans, agency policies, and practices. This limitation is actually inherent within legislative action. In addition to the inclination and level of support of the particular administration in power at the time, other important elements to ensure implementation include whether the legislation has assigned the agencies responsible for implementation, tasked them to develop action plans for implementation, and, most critically, allocated the necessary funding appropriations. It is important to point out that even well-meaning legislation that is not symbolic may not be prescriptive enough to achieve actions that can address structural racism

An example of this is the Congressional Black Caucus Emergency Task Force Report on Black Youth Suicide[4] and how it was used in the development of the Pursuing Equity in Mental Health Act,[5] a broader antiracist policy acknowledging the role of racism and discrimination on mental health. This legislation calls for funding for research in mental health disparities and program development from the National Institute of Mental Health and the National Institute on Health Disparities, but could also call for the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide funding for services development and provider training,

This review fails to point out the limitations that we face in our legislative system, particularly at this time of polarization, in pursuing effective ways of dismantling structural racism. For example, the Pursuing Equity in Mental Health Act[5] has failed to receive a vote in the US Senate. Often times, this is the result for much legislation striving to implement approaches to address structural racism. Also, in the process of achieving compromise necessary for passage, what is often watered down in legislation are the prescriptive aspects of implementation. In addition, this is now occurring during a time when governmental action is viewed with increasing skepticism as intrusive, making prescriptive solutions less palatable. It is often far easier for legislative bodies to take symbolic actions than to prescribe specific actions at the Federal and state levels to address structural racism, with funding strings attached. This adds further validity to the inclusion of Executive Orders in this review, where specific action plans are outlined and implemented. The challenge of these is that these are often valid only during the administration implementing them, with no guarantee of continuity.

In the development of specific action plans within legislation or by the executive branch, it is important for the entities drafting such policies to avail themselves of consultation by

content experts in children's mental health and culturally competent care so that the actions are focused and based on evidence. In this review, the evidence cited for effective interventions for BIPOC (Black, Indigenous, and People of Color) children and families cited is actually quite narrow. The literature on children's mental health now includes a number of systematic reviews examining the evidence of different mental health interventions with youth of color and their families not included in this review (both designed for BIPOC youth as well as culturally adapted.[6-9] Many, such as cognitive-behavioral therapy (CBT), trauma-focused CBT, interpersonal psychotherapy, brief strategic family therapy, and various parent management interventions are important in serving this important population. Where we truly have a major gap, however, are in interventions designed to address the traumatic impact of interpersonal racism and discrimination on BIPOC children and youth. The work on psychopharmacology also lags behind. Although studies suggest some degree of equivalence in pharmacological response, disparities are found around prescribing patterns and access to professionals.[10] In addition, the Communities of Care program out of SAMHSA/Center for Mental Health Services (CMHS), which began in 1994 and continues to the present, is the greatest Federal undertaking in children's mental health service and has operationalized children's systems of care programs across the nation. Their evaluation has demonstrated effectiveness in reducing racial/ethnic disparities in services access, symptom reduction, and functional outcomes such as school attendance, juvenile justice contacts, and hospitalizations, with such outcomes correlating with cultural competence measures.[11,12] However, this seminal program and its potential to reduce disparities if replicated nationally is given limited attention both by our funding agencies and even in this review.

In this important area of efficacy and effectiveness, we face similar challenges due to the biases inherent in today's philosophies of government. First, funding for services for youth in general, much less for youth of color, is rarely based on the documented need and available evidence because of myriad factors (including mistrust of science, vested interests, belief in local governmental control, and fear of central government intrusion). The United States lacks a body such as the National Institute for Health Care Excellence (NICE)[13] in the United Kingdom that guides funding for services based on evidence, and in this case population-specific evidence. Second, the retooling needed in provider training (pre-service and post-service) is also generally not well supported by our current systems.

This leads to the critical area of training, education, and certification. This review points out that state level policy has made the most strides around one of the more immediate factors in sustaining structural racism: provider attitudes and biases, as reflected in workforce development and certification. Many research and service initiatives directed at racial/ethnic disparities and structural racism are ineffective without this important element. The ultimate solution of increasing the number of providers of color is important; but, given the rapid increase in BIPOC children and youth, this is insufficient and by necessity has to include a complementary effort to retrain and retool our existing provider workforce. This needs to address pre-service education and post-service continuing education and certification/licensure (addressing updated conceptual models, clinical evidence base for BIPOC children, and attitudes/biases). Not only is this necessary for non-BIPOC providers, but also for providers of color who often face pressures to assimilate to the values and beliefs of the mainstream culture.[14]

The recommendations by Alvarez *et al.*[3] are laudable but miss a critical domain. To garner sufficient support to implement meaningful and effective actions to undo structural racism, we need to address the "hearts and minds" challenges faced with much of the now-majority European-origin population. We are seeing this challenge play out both politically and culturally, with a clear backlash fueled by fear of what is often termed "replacement" by people of color. We need to acknowledge the existential threat perceived by European-origin people as they face numerical minority status while living in an equitable pluralistic society. Addressing such fears and misconceptions, building bridges of communication and understanding, and also taking action that addresses structural racism at a basic level will make clear that this should not be a "zero sum game" (or much less a loss). For example, addressing child poverty (a major risk factor for adverse child mental health outcomes) and the overall access to children's mental health services can both address structural racism as well as address the needs of disadvantaged White persons.[2] Research and intentional efforts to address these issues are important in the goal of building an open and equitable children's mental health system that truly provides for equity and the "common good" cited in our nation's founding documents.

Accepted March 22, 2022.

Dr. Pumariega is with the University of Florida College of Medicine, Gainesville.

The author has reported no funding for this work.

Disclosure: Dr. Pumariega has received royalties from Oxford University Press for the book *Immigration, Cultural Identity, and Mental Health; Psycho-social Implications of the Reshaping of America.*

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https://doi.org/10.1016/j.jaac.2022.03.017

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