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Racism and Poverty are Barriers to the Treatment of Youth Mental Health Concerns

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ABSTRACT

Objective: Traditional studies of treatment moderators have focused largely on psychological factors such as clinical severity. Racial and economic inequity exert large effects on youth mental health, on treatment efficacy, and on the likelihood of receiving treatment altogether. Yet, these factors are studied less often by clinical psychological scientists.

Method: We conducted a narrative review of literature on racial and economic inequities and their impact on youth mental health.

Results: First, systemic problems such as racism and poverty increase the risk of developing complex health issues and decrease the likelihood of benefiting from treatment. Second, attitudinal barriers, such as mistrust associated with treatments provided by researchers and government agencies, decrease the likelihood that minoritized groups will engage with or benefit from evidence-based treatments. Third, minoritized and underserved communities are especially unlikely to receive evidence-based treatment.

Conclusion: Clinical psychological science has unique insights that can help address systemic inequities that can decrease treatment efficacy for youth mental health treatment. Psychological scientists can help eliminate disparities in accessing evidence-based treatment and help end violent policies in underserved minoritized communities by at the very least (1) building and supporting scalable community-based treatments as well as (2) publicly advocating for an end to violent policies that impose negative social costs.

Just as the mental health problems of young people have many different causes, there is likely no one method of improving them that is equally effective for all. Instead, interventions likely have varying degrees of effectiveness for different people. Prior studies have reviewed and summarized psychological moderators of the effects of psychological treatments for youth mental health concerns, focusing on factors such as symptom severity, comorbidity, abilities for emotion regulation, and related psychological processes (Adrian et al., 2019; Andover et al., 2020; Kraemer et al., 2006; Helena Chmura Kraemer, 2013; Musci et al., 2018; Nilsen et al., 2013; Valencia-Agudo et al., 2018). The study of such factors is important but fails to address what we believe are important social issues that have a broader impact on moderating the effects of mental health interventions and yet have not been a primary focus of research on treatment moderators. Youth mental health researchers routinely collect demographic information and socioeconomic data, such as race, income, and parental educational attainment. However, the interactions of such factors should be used more broadly to

conceptualize deeper social problems as mechanisms through which they may exert their impact on psychological treatment.

Clinical psychological science has largely ignored social problems such as systemic racism, mistrust in institutions, and lack of access to evidence-based care as potential moderators of treatment for youth mental health concerns. More importantly, the work of those who are engaged in research addressing mental health disparities among minoritized groups is not well represented in top-tier, high-impact clinical psychology journals (Adams & Miller, 2021). Racism and poverty exert an especially powerful developmental impact on minoritized and underserved youth, which include members of racial and ethnic minority groups, people at or below poverty levels, those exposed to violence, individuals experiencing homelessness, and those in the criminal justice system. Here, we discuss important social determinants that have been largely ignored in the study of youth mental health treatment. We focus our discussion on three general topic areas. First, racism and poverty – the ongoing daily life stress of inequity both exacerbate

the risk of developing complex health issues while also increasing barriers to and decreasing efficacy of evidence-based mental health treatments for those from underserved and minoritized communities. Second, attitudinal barriers – mistrust associated with treatments provided by researchers and government agencies decreases the likelihood that people from minoritized groups would engage with or benefit from evidence-based mental health treatments. Third, scarcity – minoritized and underserved communities are especially unlikely to receive evidence-based mental health treatment (Kazdin, 2018). We discuss each of these three areas in turn and end with a brief discussion highlighting concrete recommendations for addressing these current gaps referenced by those who study mental health disparities among minoritized groups.

Discussion of racism and poverty typically are not considered when reviewing treatment moderators. We therefore focus on these issues here and discuss research that motivates the consideration of racism and poverty as critically important factors when treating the mental health concerns of youth. Youth who identify with multiple stigmatized and minoritized identities are among the most vulnerable. While we do explore intersectionality, the primary focus of this work is on the broader impacts of racism and poverty.

Some of the issues discussed here represent traditional statistical moderators (i.e., factors that influence the strength of treatment effects), but others represent factors that prevent some from receiving treatment altogether – and thus occur before questions of treatment moderators might even arise. The factors that influence whether a person receives treatment at all may not meet the traditional definition of statistical moderators in treatment studies; however, they are no less important and no less impactful on youth mental health outcomes. Young people who do not receive treatment are unlikely to benefit from it.

Racism as Policy and Determinant of Mental Health

Systems of Oppression Consume Cognitive Resources and Increase Risk of Mental Health Concerns

Structural racism is reinforced and supported by multiple social systems – the housing, labor, and credit markets as well as the education, criminal justice, economic, and health care systems (Williams et al., 2019) – and has created inequities in access to fundamental resources vital to one's well-being, such as a home, safe neighborhoods and schools, as well as jobs (Williams &

Mohammed, 2013). Lower economic status and race-related stressors particularly affect the mental health of socially disadvantaged racial and ethnic populations (Williams, 2018). In the context of Maslow's (1943) hierarchy of needs (whereby one prioritizes their basic needs above psychological and self-fulfillment needs) facing oppression on these multiple levels incentivizes people from underserved minoritized communities to prioritize securing basic resources over attending to their mental health (Kerr et al., 2017). Those who have struggled and lived in communities with pervasive poverty know just how costly it is to be poor and oppressed (Baldwin, 1960). Globally, neighborhood income inequality has been linked with poor mental health outcomes such as depression, drug overdose deaths, incidences of schizophrenia, child psychopathology, and juvenile homicides (Brown et al., 2003; Dong et al., 2004; Huffman et al., 2013; Weissman et al., 2006). Experiences that are concentrated in underserved and minoritized communities, such as resource scarcity, also occupy more cognitive resources (Mullainathan & Shafir, 2013). Hypervigilance and stereotype threat in response to experiences of discrimination and racism also constitute a bandwidth tax at the individual level (Williams, 2018).

Beyond consuming cognitive resources, experiencing systemic oppression increases mental health concerns among minoritized groups. For instance, being exposed to police brutality against unarmed Black people has adverse mental health spillovers on other Black Americans (Bor et al., 2018). This also is true for youth: being exposed to police brutality is associated with persistent decreases in GPA, lower rates of high school completion and college enrollment as well as increased incidence of emotional dysregulation (Ang, 2020). These findings were observed among Latinx and Black students and were largest for incidents involving unarmed individuals (Ang, 2020). Additionally, depictions of Indigenous culture such as racist images of American Indian (AI) peoples have been linked with lower self-esteem, community worth, and decreased academic achievement among AI youth (Fryberg et al., 2008). Historical trauma, continued colonization, and discrimination severely impact AI communities. These outcomes are relevant considering that AIs are more likely to die by suicide than any other ethnic group in the US at any age, with rates for AI youth increasing (Livingston et al., 2019). Similarly, perceived racism has been shown to have direct effects on the reported experience of suicidal thoughts and behaviors among Black youth (Walker et al., 2017).

In the current context, Black people, Indigenous people, and people of color (BIPOC) also have been dying at a higher rate due to the coronavirus (COVID-19)

pandemic. This is driven and compounded by structural racism and poverty: BIPOC are less able to work from home and more likely to be essential workers, to live in densely populated areas, reside in multigenerational households, depend on public transportation, suffer from food insecurity, have limited access to healthcare, health insurance, and financial resources – all of which put them at higher risk for contracting and dying from COVID-19 (U.S. Bureau of Labor Statistics, 2019). Stress-related mental health problems including mood and substance use disorders, which are associated with suicidal behavior, have also increased due to the COVID-19 pandemic (Panchal et al., 2021). Underserved and minoritized communities have been experiencing an overabundance of racial trauma, while simultaneously lacking resources to address public health concerns. We are facing a devastating public mental health crisis for which our underserved and minoritized communities are especially unprepared.

Systemic Racism Increases Exposure to Violence

Environmental conditions that impact known moderators of treatment for youth mental health concerns, such as exposure to violence and trauma, are concentrated in minoritized and underserved communities (Johnstone et al., 2016). Children from lower socioeconomic backgrounds are more likely to have strong, frequent, and prolonged exposure to major traumatic events. Black children, in particular, have been found to be 45% more likely than white children to be exposed to a frightening or life-threatening experience (Morsy & Rothstein, 2019). Exposure to such events is also associated with lower social class status – a result of many interacting conditions including low family income, inadequate household wealth, low parental education, low parental employment status, and the intergenerational persistence of these conditions – as well as increased risk for negative behavioral and health outcomes (Morsy & Rothstein, 2019). Community violence exposure, in particular, increases the risk for mental illness (C. Clark et al., 2008), and those living in high-incarceration neighborhoods are more likely to develop severe depression and anxiety symptoms (Hatzenbuehler et al., 2015) while also experiencing emotion dysregulation (Heleniak et al., 2018). Additionally, undocumented immigrant families in low-income communities are more vulnerable to high rates of immigration raids and deportations by the U.S. Immigration and Customs Enforcement, ICE (Batalova et al., 2021; Budiman et al., 2021; Capps et al., 2018; Motivans, 2019), which has been linked to increased risk of SITBs and alcohol use among youth (Roche et al., 2020). The concentration of resource scarcity and over-policing in low-income and minority communities

is not by chance. These communities are characterized by racial segregation (Williams & Collins, 2004) – within-race segregation and between-race segregation that interacts with income (Quillian, 2012). Instead of an increase of equitable social programs aimed at psychological well-being and resilience, minoritized youth experience cycles of violence and re-traumatization in a system implementing social policies rooted in racism. Exposure and re-exposure to violent policing and incarceration are highly traumatic experiences. Psychologists have a responsibility to not only highlight the deleterious effects of violence, over policing, and incarceration on neurodevelopment and psychopathology but also advocate for social policies that can be integrated into community-based mental health treatment.

Attitudinal Barriers to Treatment

Cost-Benefit of Help Seeking

One of the most commonly reported reasons that youth and families in need of mental health treatment do not seek care is that they do not perceive that treatment is needed or will be helpful (Andrade et al., 2014). In the US, the perceived need for psychological treatment varies between race, gender, and nativity (Villatoro et al., 2018) for a variety of reasons (Goldston et al., 2008). In some cases, the cost of seeking help could be perceived as being too high. For instance, among undocumented immigrants, engaging with mental health professionals could be associated with risks of deportation, which discourages many from seeking professional services (Kaltman et al., 2014; Nicola, 2017).

Individuals who are aware of historical oppression, ongoing oppression, or who have experienced racial discrimination may develop a cultural mistrust of White institutions, including health care settings (Progovac et al., 2020; Terrell & Terrell, 1981). For example, conceptualizations of mental health concerns, such as suicide risk, fall short when applied to American Indian/Alaska Native (AI/AN) communities due to a focus on individual cognitive and affective experiences while neglecting historical trauma and sociocultural factors that may play a more significant role among AI/AN (O’Keefe et al., 2018). Here, the benefit of seeking treatment that doesn’t suit a person’s need could be perceived as being too low. Moreover, considerations of factors such as discrimination, acculturation, historical trauma, or related sociocultural issues, may contribute significantly to one’s mental health concerns; nonetheless, these topics may be perceived as difficult or inappropriate for discussion with mental health providers (Morgensen, 2012; O’Keefe et al., 2018). For example,

a study of Asian Americans found that a little over half of the sample (52%) experienced suicidal thoughts despite not meeting diagnostic criteria for a psychiatric disorder (Chu et al., 2014). Instead, those who exhibited this non-psychiatric sub-type of suicidal ideation were characterized as having stress related to discrimination, acculturation, conflict with family, and physical health issues (Chu et al., 2014). Individuals of this group were less likely to seek help from mental health providers despite having access to services (Chu et al., 2014). If people do not believe that mental health clinics are spaces to address these issues, they may not go at all, much less take their children.

Informal Versus Professional Psychological Treatment

Youth and their caretakers may consider many different options when seeking to address mental health concerns, such as relying on informal care provision or working things out on their own. In fact, statements of preference for addressing problems on their own have been observed with young adults and adolescents who chose to *not* seek treatment for a broad range of mental health issues – as well as for those who discontinued receiving care (Czyz et al., 2013; Sylwestrzak et al., 2015).

While the preference to independently address mental health concerns may be common across groups, sociocultural factors again merit consideration as to explaining why these preferences emerge and the degree to which these preferences are held. For example, Black people and other members of minoritized groups may conform to normative pressures to “be strong” and persevere without assistance as a consequence of normative beliefs that mental illness is a “White man’s issue” (Taylor & Kuo, 2018). Additionally, Latinx youth may especially feel pressure to keep things within their families (for a review, see Goldston et al., 2008). These sociocultural considerations may partially explain help-negation observed among youth with mental health concerns.

Whether youth receive professional support for mental health concerns is not solely shaped by their own perceptions of need. Adults, such as parents or guardians, may determine when, where, and how youth receive treatment. Friends, other family members, as well as school and health professionals were also often cited by youth as having influenced their decisions to seek support (Wahlin & Deane, 2012). Evidence from a recent meta-analysis suggests that stigma against mental illness is generally higher among racial and ethnic minorities when compared to majority group members (Eylem et al., 2020). Minoritized youth may be

disincentivized to seek treatment due to highly stigmatized views of mental health held by key stakeholders (such as other family members or adults).

Engagement

For those who access care, treatment engagement is essential. However, there are sociocultural factors that create attitudinal barriers that may impede treatment engagement. Those who do receive professional care may discontinue services or disengage and have less efficacious outcomes if the services are not seen as credible or appropriate. Treatment outcomes depend heavily on the credibility of the treatment to the target audience as well as the expectancies for therapeutic progress generated for any given psychological treatment (Kazdin, 1979). As such, assessment is a key opportunity to build credibility and is associated with improved engagement with care among youth receiving services (Lindsey et al., 2014, 2013).

Assessment informs care. It is therefore important to be sensitive to the differences in racial and ethnic minorities’ practice of how and when to disclose information about mental health concerns (Morrison & Downey, 2000). A study of disclosure of STBs in clinical spaces found that racial and ethnic minorities frequently chose not to voluntarily self-disclose the status of their suicidal thoughts on a form during their intake appointment, but they were willing to do so during their face-to-face assessment with a clinician (Morrison & Downey, 2000). Similar instances of non-disclosure have been observed in Black adolescents’ responses to survey items (Anderson et al., 2015). Black respondents who appeared to be at elevated risk of suicide frequently chose not to disclose whether they had attempted suicide (Anderson et al., 2015). The perceived consequences of disclosure impact whether one chooses to disclose. Concerns about involuntary hospitalization are particularly noteworthy among BIPOC, especially among people from communities that have a history of negative interactions with law enforcement. Among adults in urban areas across the U.S., negative encounters with the police are associated with increased medical mistrust, particularly among BIPOC (Alang et al., 2020). Additionally, in communities with high rates of immigration raids and deportations adults and youth report fear and mistrust of public institutions, and decreased participation in known protective activities, such as attending churches, schools, health clinics, cultural activities, and social services (Capps et al., 2007; Garcini, Chen et al., 2020; Garcini, Domenech Rodríguez et al., 2020; Hagan, 2012; Vargas, 2015). Individuals may believe that the police or related

institutions are involved in such hospitalization procedures or that the hospital would treat them poorly. Disclosing suicidal thoughts may especially be deemed to be unsafe. Such attitudes and beliefs are socially transmitted in underserved minoritized communities and directly impact youth and their caretakers.

Attitudinal barriers, such as denial, mistrust, and stigmatization of help-seeking for STBs within underserved and minoritized communities, are huge barriers to accessing and benefiting from psychological treatment. Though BIPOC with STBs experience distress and impaired functioning, it is clear the field, in its current state, is neither well-prepared nor trusted enough to address these concerns.

Lack of Access to EBTs

Scarcity of Mental Health Resources Is Not Equally Distributed

Access to effective treatments for mental health concerns in underserved and minoritized communities is limited by many systemic barriers. The United States spent \$2.4 trillion on psychological treatment in 2013, with \$187.8 billion spent on substance abuse treatments (Dieleman et al., 2016). Unfortunately, these resources are not distributed equitably – there are no observed reductions in racial-ethnic disparities in access to mental health care among Black and Latinx communities (Cook et al., 2013, 2017). Additionally, rural and low-income counties have the highest levels of unmet mental health needs in the United States (Thomas et al., 2009; Walker et al., 2015; Yang et al., 2019). External factors, such as the cost of treatment services (Kazdin, 2018) and variation in insurance coverage (e.g., no insurance, public, or private) also significantly reduces access to psychological treatment (Rowan et al., 2013). Furthermore, too few providers are available to deliver treatment services (e.g., understaffing in population-dense regions; Kazdin, 2018). One example is the number of school counselors available to students across the United States. While most U.S. school districts have reduced access to school counselors, this is particularly true for low-income schools in the cities with higher rates of students that identify as BIPOC (Gagnon & Mattingly, 2016), highlighting that access to mental health care is particularly limited in minoritized communities.

Recent evidence also indicates that even if one receives an evidence-based treatment, the presence of racism is associated with decreased effectiveness of that treatment. Specifically, a recent meta-analysis revealed that Black youth show smaller benefits from treatment in communities where there is greater anti-Black racism,

an effect not seen for White youth (Price et al., 2020). Finally, racial and ethnic bias within the healthcare system can serve as a barrier to accessing treatment. For example, providers may have biased beliefs about clients' receptiveness to treatment (Snowden, 2003). Communication and cultural barriers (e.g., speaking a different language than treatment providers) can also be especially potent for immigrant communities (Wafula & Snipes, 2014). It is important to note that patients benefit from culturally sensitive clinical settings with providers that match their racial/ethnic identity (Alsan et al., 2019). Despite this, nearly 70% of all clinical psychology doctorate recipients identify as white (National Science Foundation, 2019).

Future Directions

Clinical psychological science has unique insights that can help address systemic inequities that decrease treatment efficacy for youth mental health treatments in underserved and minoritized communities. Clinical psychological scientists are also in the prime position to inform and advocate to (1) eliminate disparities in accessing evidence-based mental health treatment, (2) help eliminate violent policies in underserved minoritized communities, and (3) create scalable interventions aimed at lowering attitudinal barriers to treatment. Signaling by diagnoses of the problems (alone) are not a viable solution to the current public mental health crisis caused by systemic racism and poverty. No one can be well or seek out help when it is not made available, when it is unaffordable, or when it is unsafe to try.

Collaborations and Policy-Focused Research

Clinical psychologists, academic researchers, entrepreneurs, and policymakers can and must work together to tackle the suicide and mental health crises resulting from systemic racism and poverty. Experts can call for action and collaborate across the profit and nonprofit sectors to influence policymakers. For instance, Lord Richard Layard, an economist at the London School of Economics, and David Clark, a psychologist at the University of Oxford, collaborated on the Improving Access to Psychological Therapies (IAPT) program. They reported the effectiveness of evidence-based interventions for depression and anxiety disorders, integrated evidence-based interventions into the UK's National Health Service (NHS), highlighted the cost of not addressing the mental health problem, especially in the working class, while emphasizing the cost savings (Clark et al., 2008; Clark, 2011, 2018). Similar efforts to

use cost-effectiveness analyses were used in the promotion of the Healthy Activity Program in Goa, India (Patel et al., 2017; Weobong, 2017); and in defense of community and recreational centers, provider-initiated interventions, and social assistance in Canada (Briand & Menear, 2014; Browne et al., 2004; Torjman et al., 2004). Clinical psychological scientists in the U.S. can and must advocate for policy changes that have the potential to address our current public mental health crisis.

Intersectional Perspective

Those who identify with multiple stigmatized and minoritized identities are among the most vulnerable. Intersectional stigma is deleterious for the health and safety of youths. Here, we did not address intersectionality and instead focused on racism and poverty as there is evidence that these issues exacerbate disparities among those with stigmatized identities – be it sexual orientation and gender identity (SOGI), disability status, and/or religion, to name just a few. For SOGI discrimination (e.g., homophobia and transphobia), disparities are exacerbated when considering race. When it comes to socioeconomic status, across sexual orientation and gender identity groups, BIPOC have shown significantly greater rates of poverty than their White counterparts (Badgett et al., 2019). It is consistently costly to identify as a BIPOC in the US. Intersectionality of stigmatized identities with a minoritized race can also be dangerous. For example, a recent study of Black youth showed that those who identified as transgender women and reported greater anti-trans experiences in school were more likely to have greater involvement with the criminal justice system – including increased odds of incarceration (Rosentel et al., 2020). Another recent study revealed that (a) transgender youth reported greater rates of physical and nonphysical victimization and (b) race-based discriminatory bullying was greater for transgender Latinx students compared with their White peers (De Pedro et al., 2019). A more careful and culturally sensitive focus on intersectional identities is needed to begin to address the many barriers to treatment and potential moderators of treatment efficacy that these youth endure.

Community-Based Collaboration

Clinical psychological science needs to reconsider the path forward in treating violence exposed youth from underserved and minoritized communities such that the resilience of communities is leveraged to their benefit

(Cicchetti, 2013; Davis et al., 2005; Hurd et al., 2013; N. M. Hurd & Zimmerman, 2010; N. Hurd & Zimmerman, 2019; McClendon et al., 2020). Social support has been found to buffer the effects of racial discrimination on stress and allostatic load among Black youth (Brody et al., 2014). Additionally, psychosocial treatments that incorporate culture (Park et al., 2021) and youth mentoring with a social justice lens (Albright et al., 2017) have shown promise in improving outcomes for youth in underserved minoritized communities. Black and Latinx youth have especially benefited from treatments targeting behavioral issues and using strategies such as discussing racism, using culturally relevant materials, having a family-centered approach to therapy, and attending to treatment engagement (Park et al., 2021). Luz Garcini's project, *Proyecto Voces* (Project Voices in English), addresses the psychological distress experienced by undocumented immigrants, helps inform community outreach initiatives, and develops advocacy projects focused on implementing policy-level changes to social programs. It is clear from the work of our colleagues that collaborative projects based in communities allow clinical scientists to improve research and treatment efforts.

Clinical psychological science has the ability to align with the Sustainable Development Goals of the United Nations and ultimately improve global mental health, but in order to do so researchers must work alongside communities, especially underserved minoritized communities (Patel et al., 2018). Community-based participatory research (CBPR) and research in low- and middle-income countries (LMICs) has helped shed light on the necessity to incorporate trusted representatives from the community into research and vice versa. In fact, barriers as well as strategies that facilitate conducting CBPR have even been identified for racial and ethnic minority groups (see Delman et al., 2019).

Clinical psychology research has largely been conducted by researchers that are not representative of underserved communities. To decolonize intervention research on mental health concerns, community members can and must play an active role in the development, implementation, and sustainability of interventions (Shelton et al., 2017). Community leaders can guide researchers in (1) assessing the needs of the community; (2) identifying culture-specific presentations of mental health concerns, which may result in adaptation of culturally-sensitive mental health measures; (3) respecting and working with established ceremonies and healing methods; and (4) identifying attitudinal barriers and finding possible solutions to engagement, such as reframing the language around mental health concerns given that stigma around mental illness is still a significant issue in many underserved communities

(Belkin et al., 2011; Chené et al., 2005; Eylem et al., 2020; De la Rosa, 1988; Lindsey et al., 2013; Stacciarini et al., 2011).

There also is evidence that many evidence-based interventions are just as effective when provided by nonspecialist healthcare workers trained in the intervention (Barnett et al., 2018; Belkin et al., 2011; Raviola et al., 2019; Singla et al., 2020). Collaborative efforts to create sustainable treatment in underserved minoritized communities are desperately needed, and clinical psychologists are uniquely qualified to provide insights.

A community-based and collaborative approach to mental health can help to address some of these challenges. For instance, the Shamiri Institute is a nonprofit organization that was started to support the development and implementation of low-cost and low-stigma psychological treatment for youth in sub-Saharan Africa (Shamiri Institute, Inc.). One of the co-founders, Tom Osborn, born and raised in Kenya, is an experienced entrepreneur whose lived experience was fundamental in navigating the implementation of the Shamiri intervention in the region (Osborn, Wasil, Venturo-Conerly et al., 2020; Osborn, Wasil, Weisz et al., 2020). The Healthy Activity Program in India is another example of an intervention sustained by another organization called Sangath, which utilizes a community-based multidisciplinary approach to empower “existing community resources to provide appropriate physical, psychological and social therapies” (*Sangath*). It may also be beneficial to consider approaches taken in other public health initiatives, such as with the CBPR in Detroit – the Detroit Community-Academic Urban Research Center (Detroit URC). Community members from these projects provide feedback on the infrastructural needs of CBRP and experts help with implementation (Jones et al., 2020; Parker et al., 2020; Parra-Cardona et al., 2020). Given the pervasive impact of racism and poverty, collaborative mental health care may be an especially powerful approach in underserved minoritized communities (Lee-Tauber et al., 2018).

Diversify Clinical Research and Mental Health Care

A critical step in making real progress in these efforts is to incorporate more under-represented minority (URM) individuals into decision-making positions in higher education – including increasing URM doctoral students in clinical psychology and granting tenure to more URM scholars at top tier institutions (Galán et al., 2021). URM students are often members of the target research population and have their own lived experiences. They are in a unique position to bridge the gap between researchers and members of the community. Furthermore, BIPOC therapists are better able to use

and adapt evidence-based treatment for BIPOC families (Ramos et al., 2020). There are many challenges to sustaining interventions, such as adapting interventions to the needs of communities, maintaining funding, and working with limited staff and resources (Hailemariam et al., 2019). The sustainability of psychological treatment after research studies have been concluded may be greatly aided by better supporting URM scholars. Implementation and sustainability of evidence-based interventions have attracted the interest of researchers in the field of public health (Delman et al., 2019), which is actively increasing racial and ethnic diversity among students, graduates, and faculty in schools and programs (Goodman et al., 2020). Diversifying clinical science is a critical first step. However, we urge those in decision-making positions to ensure the safety of BIPOC scholars to thrive. Support them financially by creating more predoctoral fellowships as well as other funding opportunities; support their work by including them in productive collaboration networks and publishing their work in mainstream journals; and support their communities by promoting policies focused on equity and social justice.

Closing Remarks

As a field, we are well-versed in the directives of global mental health – capacity-building, cultural awareness, dissemination and implementation research, and ethical considerations (Ng et al., 2016) – but underperform in aligning these directives for minoritized and underserved communities in the U.S. It is important to continue to focus on traditionally studied moderators of youth mental health treatments, such as clinical severity, emotion regulation abilities, and so on, and to use these findings to improve our abilities to match youth with mental health concerns to the treatments likely to be most effective for them (Kessler et al., 2019).

We argue that an even more important direction for our field is an increased focus on the social inequities that disproportionately affect members of our communities, such as systemic racism and poverty, attitudinal barriers, and disparities in access to evidence-based mental health treatment. Advancing the understanding of how these factors impact youth mental health concerns and their treatment is an important first step. Implementation and evaluation of efforts to decrease these inequities and their impacts is also needed. There is a great deal of work for clinical psychological science to do in this domain. Shifting toward collaborative and community-based participatory approaches provides us the opportunity to address systemic inequities in our work – while bridging the gap in making psychological

treatment more accessible to and inclusive of underserved and minoritized communities.

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