A Critical Literature Review of African American Families' Experiences with the Behavioral Health Delivery System

Julia Radlauer-Doerfler, University of South Florida; Morgan Cooley, Florida Atlantic University; Heather Thompson, Florida Atlantic University; Robin Jimenez-Bean, Florida Atlantic University; Alicia Best, Morehouse School of Medicine; Jeff Randall, Medical University of South Carolina

Abstract

Given current disparities faced by African American families in behavioral health outcomes, the behavioral health delivery system does not appear to sufficiently meet the needs of African Americans. Existing research has identified a number of structural or systemic barriers that families may face to equitable care. The purpose of this article is to provide a critical literature review of structural factors that influence African American families' experiences with the behavioral health delivery system. Particular attention is paid to both historical and contemporary context of behavioral health services, with a focus on structural and systemic factors that influence design, delivery, and receipt of behavioral health care of African American families. The authors provide additional framing for understanding larger system or power dynamics impacting behavioral health care through discussion of social determinants of mental health, as well as cultural factors that may influence families' experiences, preferences, and needs. Finally, implications for more equitable responses in the behavioral health system for African Americans are presented. These responses include an African-centered approach and relationally-focused practices in the behavioral health system through racial equity and social capital.

Keywords: *African American and Black families, mental health, mental health treatment, training for mental health workers*

Despite increases in research and evidence-based interventions, youth mental health has been in decline (Office of the Surgeon General, 2021). Behavioral and mental health conditions affect one in five children in the United States with significant psychological or physical symptomatology (i.e., anxiety, depression, ADHD, hyperactivity, learning disorders, etc.; Caldwell et al., 2016). Existing research indicates 80% of chronic behavioral or mental health disorders begin in childhood (Reiss et al., 2017). The residual effects of childhood behavioral and mental health challenges can have adverse effects into adulthood, resulting in permanent issues (Bitsko et al., 2022). Such statistics are staggering when compounded with the World Health Organization's (WHO) 2018 prediction that by 2020, globally, childhood psychiatric (e.g., mental illness/mental health) conditions will increase by 50%. It is important to note this report was released prior to COVID-19. Such increases have consistently made childhood psychiatric (e.g., mental illness/mental health) conditions one of the five most common causes of mortality and disability among children (Agency for Healthcare Research and Quality, 2022; WHO, 2001).

For children struggling with mental or behavioral health conditions, unresolved childhood trauma, insecurities, and depression may intensify during adulthood if healthy coping strategies are not integrated while transitioning into adulthood. This is particularly true for African American youth who are twice as likely to complete suicide as white youth (Office of the Surgeon General, 2021). Black youth are more likely to receive harsher conduct-related diagnoses as compared to white youth, who are more often diagnosed with ADHD for behavioral challenges (Hoffman et al., 2023). In addition, Black

youth are more likely to experience trauma that can go undiagnosed or inappropriately diagnosed (Akubuiro et al., 2023). Negative experiences with or within mental and behavioral health systems can come from factors like insufficient access to services, living in under-resourced communities, stigma toward mental health conditions, or negative experiences with providers (e.g., Hoffman et al., 2023; Rodgers et al., 2022). Consequently, an understanding of historical and structural factors that contribute to worsened outcomes and racialized experiences regarding behavioral and mental health service utilization is crucial in addressing the needs and well-being of African American families (Akubuiro et al., 2023; Thurston & Phares, 2008). The purpose of this article is to provide a critical literature review of structural factors that influence African American families' experiences with the behavioral health delivery system.

Introduction to Behavioral Health and Mental Health and Purpose of Review

Mental health, according to the WHO (2018), "is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community." The American Medical Association (2022a) distinguishes mental health and behavioral health as distinct experiences. Mental health refers to an individual's emotional, cognitive, and psychological capacity, while behavioral health is attributed to the individual's physical response to stress and the physical symptoms that may occur (e.g., substance use disorders; AMA, 2022). Children's mental health and associated disorders are characterized by limited functioning or impairment of regulating emotions, learning capability, and appropriate behavior conduct (APA, 2022; CDC, 2025). Mental health disorders in children include anxiety, attention-deficit/hyperactivity disorder (ADHD), depression, conduct disorder, post-traumatic stress disorder (PTSD), oppositional defiant disorder (ODD), and other behavioral and cognitive disorders (APA, 2022). When children are unable to regulate their emotions or feel a sense of safety or security, they may develop adverse behavioral health conditions or behavioral health disorders, resulting in learning disorders, substance use, underage drinking, self-injurious behavior, and other maladaptive behaviors (CDC, 2023).

Mental health is an important determinant of positive relationships within a child's or adult's environment and a contributor toward overall emotional and mental well-being (CDC, 2024; Scott et al., 2011). Further, research has found the onset of mental health conditions frequently start during childhood, which can increase the likelihood of physical health challenges, high risk behavior, poor social relationships, and decreased psychological well-being in adulthood (Schlack et al., 2021; Scott et al., 2016). Further, COVID-19 amplified the disparities of mental health treatment available to racially minoritized populations (Hawks, 2023). Understanding these disparities in the context of structural racism provides an opportunity to re-create the future of behavioral and mental health treatment. However, there is relatively little research that thoroughly addresses emergent trends in mental and behavioral health services, and it is clear that the needs of African American youth have not been fully addressed by the behavioral health delivery system (Douglas et al., 2023).

The purpose of this review is to provide a historical and contemporary overview of various structural factors influencing the behavioral health system and mental health treatment for African American families. These barriers include the following: health insurance, access to care, and utilization of services; social determinants of mental health for African Americans; poverty and mental health among African American families; cultural considerations and mistrust of mental health professionals; and inequities in therapeutic relationships. Finally, potential equitable responses in the behavioral health system for African Americans will be presented. These responses include an African-centered approach and relationally-focused organizational practices in the behavioral health system through racial equity and social capital.

Historical Evolution of U.S. Behavioral Health System

The behavioral health system was initiated in 1992 when SAMHSA was created through the reorganization of four separate agencies scattered throughout the Public Health Service (National Institute of Mental Health, 2015). This reorganization moved research to the National Institutes of Health, while the treatment of mental health and substance use services was consolidated under one general system. Under SAMHSA (2020), the Center for Mental Health Services (CMHS) is responsible for working to increase the quality of and access to mental health services. In 2001, David Satcher, who was the U.S. Surgeon General, wrote a supplemental report titled Mental Health: Culture, Race, and Ethnicity that documented the need for Americans to utilize evidence-based practices to address their mental wellness. The report also recognized disparities that existed in access, availability, and utilization of formal services by African Americans (Satcher, 2001). Lack of access to services created a greater disability burden due to unmet needs, thus the report implied that it was necessary to recognize the role that culture plays in mental health.

In 2003, the New Freedom Commission on Mental Health was established to address nineteen recommendations for the mental health service delivery system, focusing on the existing continuum of services designed using the medical model, ranging from deep-end state hospital inpatient care to more prevention-oriented services (Hogan, 2003). This group reported that services for those with diagnosed mental health conditions or disabilities appeared fragmented (Hogan, 2003). Despite the need for developing mental health services and a system of care in 2003, many of the same problems exist 20 years later. In fact, disparities not only continue to exist but appear to be worsening, particularly for racialized youth (Douglas et al., 2023).

Trends and Gaps in the Behavioral Health Service System for Families in the U.S.

Behavioral health relates to how humans react to mental health symptoms and a person's behavioral response, while mental health is the biological influence upon human thinking and emotions that often influence how someone experiences or feels when they are navigating mental health challenges (Galderisi et al., 2015; Maranda et al., 2022). Behavioral health systems most frequently treat those who struggle with behavioral health disorders, such as substance use disorders (SUD) or process addictions (i.e., gambling disorder, compulsive gaming disorder, food, sexual compulsive disorder) utilizing evidence-based practices (American Medical Association, 2022b). On the other hand, mental health systems are typically composed of medical and healthcare professionals who assess, diagnose, prescribe medications, and provide psychotherapy. In the United States, the Substance Abuse and Mental Health Services Administration [SAMHSA] is the governing agency within the U.S. Department of Health and Human Services established by Congress in 1992 (SAMHSA, 2024). SAMHSA is typically responsible for the ongoing development of the national behavioral health system, as well as promoting the use of effective behavioral treatments and mental health services within communities. The continuum of care for traditional behavioral health treatment services in America follows a medical model, and more recently with the Affordable Care Act, the medical home model (Aletraris et al., 2017; Kuramoto, 2014).

The medical home model, according to the Agency for Healthcare Research and Quality [AHRQ], is responsible for five important characteristics: (1) comprehensive care; (2) patient-centered; (3) coordinated care; (4) accessible services; and (5) quality and safety (AHRQ, 2022). This service array and treatment process is structured and formal, both in the type of practices or treatments as well as in

access to care. The framework for the continuum of services available in the service delivery model is provided through the federal government and then implemented at the state level (Wodarski, 2014). Every state is required to identify its service array and then guide what services should be available within the state and how those services should be provided. In the state of Florida, the Substance Use and Mental Health Program (SAMH) is a service provided through the Florida Department of Children and Families (DCF, 2023). A gap among existing services that needs further development within research is that much of what is funded are formal services offered in a professional treatment setting or driven by a transactional service delivery model where payment is often determined by government funding and insurance companies. In addition, the medical home model can leave children with mental health needs at a loss for appropriate service unless their provider has a focus or expertise in treating mental health conditions (Rast et al., 2023).

An important and emerging aspect of the behavioral health system is the inclusion of peer support, which can be described as supportive and trusting opportunities for those going through inpatient mental health or substance misuse treatment performed by individuals with lived experience (e.g., sobriety, recovery, completed substance misuse treatment, etc.; Chapman et al., 2018; Turpin & Shier, 2017). Peer support has been a component of substance use treatment for years and was recently documented as an evidence-based practice for people experiencing mental health conditions, as well as other social needs (e.g., child welfare involvement; Mental Health America, 2019; Sedivy et al., 2020). While family support groups have been added to the continuum of services above, peer support has not been officially included despite its use and availability across the United States (Mental Health America, 2019). The primary challenge with this service is not the effectiveness but rather the successful reimbursement of the service at an appropriate and timely reimbursement rate (Ostrow et al., 2017; Torres et al., 2020; Wallis et al., 2023). Among adults, the value of this service has been documented to decrease psychiatric hospital admissions, reduce inpatient days, increase outpatient treatment, and improve engagement and overall quality of life for people experiencing mental health conditions (Mental Health America, 2019; Scannell, 2021; Torres et al., 2019). Similarly, youth peer support models show immense promise, yet they lack the level of evaluation to further codify federal support and reimbursement, which is a significant gap in both practice and research (de Beer et al., 2024).

Barriers to African Americans Achieving Equitable Behavioral Health Outcomes

According to SAMHSA (2018), mental health equity refers to the right for all populations to access quality behavioral and mental health care regardless of race, ethnicity, socioeconomic status, gender, sexual orientation, where someone lives, or their social condition. Within the behavioral and mental health systems, inequity exists. Prior research determined there are a higher number of black families of color not receiving quality care versus white, non-Hispanic families who are receiving such services (Fong et al., 2014; Williams et al., 2020). Research has also indicated that African American families experience unequal outcomes as a result of not receiving such services (Williams et al., 2020). Relatedly, others have found that 49% of African American families with a child with emotional or developmental challenges delayed behavioral or mental health services for their youth and adolescents (Richmond et al., 2022). Unfortunately, despite advances in the quality of healthcare, mental health disparities have been documented across the United States, particularly among minoritized populations and people from low socio-economic communities who have less access to healthcare and less quality treatment available (Alegria et al., 2018; Mental Health America, 2023). Exposure to historical race-based adversity such as a lack

of access to healthcare, education, and economic resources results in the socioeconomic disparities among African Americans (Mental Health America, 2023). Research has recognized that socioeconomic status is strongly associated with child and adult mental health; subsequently, people living in poverty, as well as those who are incarcerated or experiencing substance use conditions, tend to report poorer mental health (Hoffman et al., 2023; Morsy & Rothstein, 2019).

Health equity means that people have equal opportunity to be as healthy as they can be. It is necessary to remove barriers to health. Some of these barriers have included poverty, discrimination, lack of access to employment, lower quality education, unsafe housing, and lack of access to health care (Braverman, 2014; Rodgers et al., 2023). In the past, African Americans have been derailed from seeking treatment and receiving quality health care due to lack of information about services, confusion regarding the meaning of mental health, spiritual reasons, hesitance or lack of ability to access behavioral health services, treatment-provider bias, and poor quality of care (Kawaii-Bogue, 2017). This is a complex challenge because African Americans have reported similar incidence rates of mental health and substance use conditions as non-Hispanic White people; however, they have a higher prevalence of serious mental health issues (NAMI, 2014). Interestingly, the difference can be partially attributed to traditional service barriers, including longer duration of illness, lower access due to transportation and location, lower utilization of behavioral health treatment, poor quality of care, and complex comorbidities typically seen in minoritized and underserved populations (Carpenter-Song et al., 2011). Broadly, the impact of mental health challenges among African Americans are a result of structural factors, including the stress of culture, racism, poverty, and discrimination as well as social determinants of health (Shim et al., 2014). Despite gains in understanding and identifying and understanding the impact of these structural barriers among both adults and youth, there has yet to be a groundbreaking solution to address barriers in youths' treatment (de Beer et al., 2024).

Paying attention to the culture, preferences, and beliefs of people experiencing mental health conditions is essential to positive outcomes, yet this research area has been relatively underexplored for African American children and families. Extant research has found that mental health disparities for African Americans are prevalent and may also be a consequence of sub-par services, inexperienced providers, and a cultural disconnect on how to treat mental health issues among different ethnic groups (Smith, 2005; Simmons University, 2017). Thus, disparities also exist due to a mental health system that is not responsive to the preferences of clients, which results in lower quality services (e.g., Le Cook et al., 2014; Panchal et al., 2024). Intersectionality refers to the way individuals are shaped by and identify with an array of cultural, structural, sociobiological, economic, and social contexts (Howard & Renfrow, 2014). Mental health disparities for African Americans are exacerbated when services are not aligned or responsive to the intersectionality of mental health conditions, social determinants of health, systemic racism in health systems, and the culture and preferences of African Americans (Smith, 2020).

While there are many contributing factors, the very nature and institutional structure of the behavioral health continuum of care has implications for the mental health of African American families. Researchers have demonstrated that African Americans may not prefer to have their mental health needs met in this way, thus perpetuating a disparity in accessing services. For example, it has been identified that disparities have persisted under four target areas: less access to mental health services, less likelihood of receiving needed services, receipt of lower quality mental health treatment, and under-representation of minoritized families in research (Satcher, 2001). Thus, African Americans are disproportionately impacted by mental health conditions partially because there are barriers to mental health treatment as well as limited utilization

of services (Chang & Downey, 2012; Panchal et al., 2024). Another potential challenge to successful mental health treatment is that African Americans have tended to seek assistance with their mental health conditions from their primary care providers rather than from professionals with mental health training; they also lack exposure to more culturally-responsive mental health care (Snowden & Pingitore, 2002; Simmons, 2023). Research has indicated that there are fewer disparities in mental health outcomes when African Americans sought mental health treatment from specialized mental health professionals, so eliminating barriers to access is essential (Rivera et al., 2021; Stockdale et al., 2008).

Health Insurance, Access to Care, and Utilization of Services

A lack of insurance has also been associated with lack of access to mental health care (American Psychiatry Association, 2017). According to the Agency for Healthcare Administration (2013), African Americans tend to be insured at a much lower rate than other populations, and studies indicate that about 11% of African Americans are uninsured compared to approximately 7% of non-Hispanic Whites (American Psychiatry Association, 2017). While the Affordable Care Act of 2010 created an opportunity for parity of mental health treatment, not all states implemented Medicaid expansion (Snowden, 2012), and for those who do not qualify for Medicaid, health insurance may be unaffordable. In addition, Medicaid spending on behavioral health services for youth has decreased (Torio et al., 2015). Even families trying to utilize private insurance for mental health treatment may still be required to pay a co-payment, which may present a financial hardship for adolescents that may keep them from seeking services (Kruse et al., 2022). There are other disparities in terms of accessibility to mental health services as well. Access to treatment is defined as the timely utilization of health services to achieve the best health outcomes (Snowden, 2012). There are several identified barriers to access, including financial needs, sociodemographic characteristics, and knowledge and beliefs about mental health treatment and provider participation (Mendenhall et al., 2011; Garney et al., 2021). Interestingly, the phenomenon of "uptake" sheds some light on sociodemographic characteristics and the knowledge and beliefs of African Americans related to access to mental health treatment (Gavin et al., 1998). Uptake refers to the utilization rates of insurance benefits to access services. African Americans historically have disproportionately low rates of service utilization, regardless of access to benefits and free service provision (Snowden, 2012). To get a better understanding of how sociodemographic factors create a barrier to accessing mental health treatment, it is helpful to examine mental health through the framing of social determinants.

Social Determinants of Mental Health

Social determinants of health are defined as "conditions in which people are born, grow, live, work and age that impact health and well-being" (Shim et al., 2014, p. 23). The origins of mental health conditions are often biologically determined; however, research has demonstrated that modifiable social, environmental, and socioeconomic contexts also play an important role in a person's mental health functioning (Alegría et al., 2018; Shim et al., 2014; Shim & Compton, 2020). Social determinants are related to both causation and the course of mental health conditions (Kirkbride et al., 2024; Wilkinson & Marmot, 2003). A public health approach to addressing social determinants of health can focus on prevention of mental health conditions by addressing the root causes of the societal factors that increase individual-level needs and enhance protective factors in communities (Marmot et al., 2008; Shim et al., 2014).

Social determinants of mental health are created or influenced by policies, which impact the opportunities available to children and families, the neighborhood, environmental surroundings, and the social landscape in communities (Compton & Shim, 2015; Shim et al., 2014). Examples of social determinants of mental health include underemployment, food insecurity, poor access to health care, educational inequity, poverty, built environments, social isolation, housing instability, and adverse life experiences

(Compton & Shim, 2015; Shim et al., 2014). African Americans are more likely to experience socioeconomic disparities, including exclusion from health, educational, social, and economic resources (Fong et al., 2014; Taylor, 2019). African American families with members experiencing behavioral health conditions coupled with complex challenges (e.g., low socioeconomic status, multi-system involvement, limited access to support services) reportedly experience poorer mental and physical health outcomes (Fitzsimons et al., 2017). However, there is even more limited research exploring families of children or adolescents navigating behavioral health conditions and social determinants of mental health.

Poverty and Mental Health Among African American Families

It is beyond the capacity and intent of this paper to explore all of the social determinants of health; however, socioeconomic status is a relevant example of how the social determinants of health impact mental health conditions. African Americans experience socioeconomic disparities due to historical adversity, including slavery and race-based exclusion from health, educational, social, and economic resources (Burkett, 2017). Socioeconomic status is associated with mental health, as people who are living in poverty, homelessness, incarceration, or have substance use conditions are at higher risk for poorer mental health (Rostain et al., 2015). Approximately 27% of African Americans live below the poverty level compared to 10.8% of non-Hispanic Whites (American Psychiatry Association, 2017). The poverty rate for rural African Americans is 40.6% while non-Hispanic White families in rural areas have a poverty rate of 13.5% (American Psychiatry Association, 2017). Further, as a result of generational poverty and systemic barriers, African American children are significantly more likely to live in single-parent families and high-poverty neighborhoods (The Annie E. Casey Foundation, 2025). Poverty goes hand in hand with unemployment, and in 2012, the African American unemployment rate was double that of non-Hispanic Whites (14% and 7% respectively; U.S. Bureau of Labor Statistics, 2013).

Researchers have recognized that poverty is associated with higher levels of stress; moreover, African American families experience what has been coined as 'culturally bound economic insecurity,' and specifically refers to the fear that families experience when their financial circumstances are impossible to overcome (Bossert & D'Ambrosio, 2013). Culturally bound economic insecurity is the never-ending sensation that one's financial situation is hopeless or helpless, and this causes a state of confusion, poorer mental health, and lower family functioning for African American families (Burkett, 2017). For example, African Americans living below the poverty level are three times more likely to report serious mental health conditions than those living above poverty (NAMI, n.d.).

When a family is struggling to have their basic needs met, accessing mental health treatment is not a priority. It has been documented that 64% of African American children live in single-parent households, which can put them at greater risk for poverty, adverse childhood experiences, and residential instability (Kids Count Data, 2025). Further, lower-income populations have less access to high-quality mental and physical healthcare as providers are not as present in low socio-economic communities (Hodgkinson et al., 2017). Ultimately, growing up in poverty greatly impacts healthy child development, which can exacerbate mental health conditions (Redd et al., 2024). For example, poverty increases the likelihood that a child will be exposed to elements that will impede brain development and result in poor academic, health, and mental health outcomes (Redd et al., 2024). Given these outcomes, it is important to understand the intersection of culture and other conditions impacting mental health treatment for African American families.

Cultural Considerations and Mistrust of Mental Health Professionals

There are many cultural considerations to consider when looking at the lower utilization of mental

health services among the African American community, such as the stigma associated with mental health conditions, lower health literacy, scarcity of culturally competent providers, mistrust of the healthcare system, and other societal factors (American Psychiatry Association, 2017; Thomas & Snowden, 2001). Both structural and institutional racism have resulted in historical trauma to many African Americans (Burkett, 2017). Historical trauma is defined as psychological and emotional damage that occurs over the life course and across generations, frequently caused by traumatic events directed specifically towards one cultural group (Mohatt et al., 2014). Historical trauma for the African American community has resulted in diminished community solidarity, compromised mental health and well-being, sustained skepticism of formal mental health treatment, and a lack of understanding of this complex trauma (Hankerson et al., 2022; Scott-Jones & Kamara, 2020). The fear of being retraumatized deters some African Americans from using formal mental health treatment (Burkett, 2017). Past research has indicated that skepticism on the part of African Americans is a healthy, resilient response to the prolonged impact of institutional racism; thus, cultural mistrust can be seen as an adaptive response (Grier & Cobbs, 1992).

Despite progress made over the years, racism continues to have an impact on the mental health of African Americans. This historical negative treatment has led to the mistrust of professionals, many of whom are seen as self-serving by the African American community (Pederson et al., 2025). Commonly, African Americans do not want professionals involved in their lives because of the perception that intervention by social service agencies will potentially lead to punitive intervention (Best et al., 2021; Breland-Noble, 2004; Thomas et al., 2023). For example, policies such as mandatory reporting require professionals to report potential abuse and neglect to authorities, but African American and Black families are inequitably reported to hotlines when compared to White families (Burkett, 2017). Cultural bias toward mental health professionals and systems is often due to prior experiences with issues such as historical misdiagnoses, inadequate or inappropriate treatment, and a lack of cultural understanding from providers that inhibits African Americans from accessing care (Hatcher et al., 2017).

There is extensive documentation that African Americans struggle to access high-quality and effective behavioral health treatment services (Summers, 2009). Past research identified that professionals' cultural biases can impact their ability to understand the functioning of African Americans (Snowden, 2002). When mental health professionals do not understand how behaviors are different among different cultures, they may function on personal assumptions that impact treatment (Gopalkrishnan, 2018). The difficulty of diagnosing a patient in combination with an ethnic-specific expression of the disorder impedes the accuracy of diagnosis and translates into decreased treatment effectiveness (Payne, 2012). For example, regarding depressive disorders, African Americans have been seen as more likely to express anger or irritability rather than hopelessness or sadness, which is seen as more typical in a non-Hispanic White person (Hankerson et al., 2015; Payne, 2012).

SAMHSA (2001) also documented that African Americans metabolize medication differently than other ethnicities, indicating that they should be prescribed lower doses of medication; however, research has demonstrated that they are typically prescribed higher doses of psychotropic medication. Others have identified that African Americans have been prescribed off-label medication and incorrect medication more frequently than their non-Hispanic White counterparts (Carpenter-Song, 2011). There is a long history of African Americans being misdiagnosed with paranoid schizophrenia by non-Hispanic White professionals, and research has indicated that misdiagnosis has been due to racial bias (Snowden, 2002). When treating African American youth, interventions tend to be ineffective because youth view being prescribed medication as a "quick fix" to their complex life challenges (Samuel, 2015). Parents of African American youth express

concern that medicalization of social problems is not the solution, but rather the need is for system change and cultural sensitivity training for professionals (Rostain et al., 2015). Researchers have also demonstrated that utilizing only Eurocentric theories to explain the behavior of African Americans is ineffective and does not value cultural differences (Harley et al., 2015).

African American families have reported fear of being stereotyped and misunderstood, which leads to concerns that the system will not provide appropriate care (Lindsey et al., 2006). African Americans have reported that they do not receive the same quality of care, and doctors have provided less information, less supportive talk, and lower clinical performance to African Americans (Cooper & Roter, 2003). It has also been documented that African Americans report problems communicating with mental health professionals as a barrier to seeking treatment, which can result in receiving substandard care (Newhill & Harris, 2007). Alegria et al. (2008) found that African Americans with depression had significantly lower odds of receiving adequate care compared to non-Hispanic Whites with the same diagnosis. In addition, results of a national study indicated that African Americans reported poorer attitudes toward mental health treatment after receiving services compared to their attitudes prior to service provision (Diala et al., 2000).

Implications for Behavioral Health and Potential Equitable Responses in the Behavioral Health System

The research identified above regarding the mental health support preferences of African Americans is a critical piece to creating an equitable behavioral health system. Some existing frameworks, philosophies, and evidence-based practices support the identified preferences of African Americans and should be incorporated into the development of equitable mental health support for African Americans.

African-Centered Approach

There is documented research recognizing the benefits of applying an African-centered approach to mental health for African American youth and families (Hatcher et al., 2017). African Americans have been known to have deep ties to their cultural heritage, traditions, religion, and values passed down through generations. The African-centered perspective is grounded in the history, culture, and spirituality of people of African descent, so it closely aligns with these values (Asante, 1990). Asante (1998) reported that acknowledging and integrating youths' own experiences and values helps promote holistic well-being for youth and promotes self-efficacy and autonomy. Research has indicated that using an African-centered paradigm to guide interventions in mental health services is associated with more participation of African American youth (Kalonji, 2014). A more recent systematic review of African-centered interventions for Black youth identified benefits for youths' academic achievement, identity, and behavior, despite mixed findings related to the rigor of the studies (Lateef et al., 2021).

The African-centered approach focuses on cultural uniqueness, strengths, and community development rather than the deficit-based approach utilized in most of Western medicine (Graham, 1999). The approach was developed in the 1980s and has been formalized through the years. The fundamentals of the African-centered principles are described below:

- Umoja (Unity): This is the foundational principle and focuses on togetherness. Unity begins in the family, is centered on moral values, and supports conflict resolution.
- Kujichagulia (self-determination): This reaffirms the rights and responsibility of Africans to exist, speak their truth and make contributions to history.

- **Ujima (Collective work and responsibility):** Working together to solve common problems. African people believe that they are collectively responsible for failures, victories, and cooperation between families, organizations, and communities.
- **Ujamaa (Cooperative economics):** The commitment to build and maintain businesses. There is a central concept of shared wealth, self-reliance on community building, and respect for work.
- **Nia (Purpose):** The commitment to building, developing, and defending our community, its culture, and history to regain greatness as a people. It is the motivation for African Americans to make significant historical contributions.
- **Kuumba (Creativity):** The principle relates to leaving the community in a better place than it was received.
- **Imani (Faith):** Belief and commitment to a higher power and ourselves to live in a faithful manner recognizing the values to "live righteously, self-correct, support, care for and be responsible for each other" (Karenga, 1996).

Hatcher and colleagues (2017) outlined various Afrocentric principles that can be used to enhance mental health services for youth, as well as provided case scenarios to demonstrate the use and effectiveness of integrating African-centered approaches. A specific example of this intervention is through a program called Habilitation Empowerment Accountability Therapy (HEAT), which has primarily been focused on families impacted by the criminal justice system (Marlowe et al., 2018). HEAT explicitly centers spirituality as a core value throughout the program and has had successful outcomes as evidenced by substantially higher African American rates of drug court graduation (Marlowe et al., 2018). The model requires that African-centered principles be centered in all work with youth and guide cultural interactions (Karenga, 1996). It has been identified that employing African-centered principles provides a culturally relevant alternative to managing stress in the lives of African Americans (Kalonji, 2014). In addition, many of the values identified in the African-centered model closely align with research around resilience and recovery from trauma; for example, having a sense of purpose is a predictor of positive mental health (Alim et al, 2008). Additional African-centered programs showing promising results have included pregnancy prevention programming for females (Dixon et al., 2000), school and community programming to support life skills development (Flay et al., 2004), academic success and prosocial behavior (Whaley & McQueen, 2004), and a cultural knowledge and social skill-building program (Whaley et al., 2017). Although some of these programs are not explicitly about mental health, they each address important aspects of youths' social or physical well-being that influence their mental health, self-awareness, and self-advocacy.

Creating Equity in the Behavioral Health System through Racial Equity and Social Capital

Racial equity is the condition where one's racial identity no longer influences how one fares in society. This includes the creation of racially just policies, practices, attitudes, and cultural messages, and the elimination of structures that reinforce different experiences and outcomes by race (Hawn et al., 2020). Health equity is principled in committing to eliminate health disparities, which means striving for the highest standard of health for all people while giving special attention to the needs of those at risk based on their social conditions (Braverman, 2014). Current policies either create racial inequity or create racial equity, and it is necessary to examine and evaluate policies and practices in inequitable systems to achieve equity. Achieving equity requires a shift in thinking from reducing disparities once they exist to looking at the policies and practices that created the disparity in the first place (Dettlaff et al., 2020). It is time to reimagine mental health treatment in America from a system with disparate outcomes for African Americans to an equitable system that

provides mental health treatment and support for all those experiencing mental health symptoms. To achieve equity, government-funded systems may need to reconsider the notion that the only path to mental wellness is through a therapist or psychiatrist who provides guidance or medication. For example, equity could include the use of social support as a buffer against mental illness, and policies could reimburse for peer support approaches, faith-based support, or family-based intervention that engages youth and families with people in their communities to support them (Gruber, 2020).

When creating equity through social support and social capital, it is important to take into consideration the actual versus potential resources that are available in a community and to address power dynamics that affect how individuals can or cannot access social capital (Campbell, 2020). For example, not all families can afford services, have available time to engage in services due to employment or caregiving tasks, or would choose treatments that were created by outsiders. Identifying and addressing inequalities within communities is imperative for social capital interventions and health promotion. Phelan et al. (2010) warned that developing new interventions may increase social inequalities in outcomes, even if they improve individual health outcomes overall. Interventions should aim to improve mental health while also reducing inequalities, and social capital interventions should ensure that there are no unintended consequences (Umberson & Karas Montez, 2010). This can be accomplished through a policy that uses a combination of research around social capital and the heavy inclusion of community participation in the process. For example, inclusion of families or older youth who have experienced mental health challenges in the planning, analysis, or implementation of approaches can provide important information on the equity and success of a new intervention or program.

According to the Institute of Medicine's report on youth mental health, to achieve equity, it is necessary to prioritize prevention strategies rather than continuing to react to mental health issues (National Research Council (US) and Institute of Medicine, 2009). This shift should include tailoring prevention and intervention strategies specifically designed for racial/ethnic populations that address structural inequalities at the individual, organizational, and community levels (Alegria et al., 2015). In the William T. Grant Foundation's report on disparities in mental health, they lay out a framework for creating equity that includes the following: identify specific periods of developmental vulnerability and provide support during those times, address socioeconomic disparities, address childhood adversities, target family-level mechanisms for mental health disparities, improve neighborhood conditions, reduce neighborhood violence, expand access to mental health care and school opportunities, and study provider mechanisms of mental health disparities (Alegria et al., 2015). It is apparent from this list that simply providing mental health treatment services will never solve the problem of disparities in children's mental health. The framework alone will not address the mental health conditions of children; thus, it is not an either-or approach but rather a both-and approach that will level the playing field. Many of the items mentioned in the framework can be addressed by individual-level social support and community-level social capital.

Further, there is documented research focusing on models such as structural competency, which is designed to promote awareness of forces that influence health outcomes at the institutional or community level (Metzl, 2014). The argument for the model is that if people experience stigma at the institutional level rather than only at the individual level, these structural causes of stigma must also go away at the institutional level. The way to address the needed changes is through clinical training at the individual, organizational, institutional, and policy levels, as well as through neighborhoods and cities (Metzl, 2014). Structural competency consists of training in five core competencies: recognizing the structures that shape clinical interactions; developing an extra-clinical language of structure; rearticulating "cultural" formulations in structural terms; observing and imagining structural interventions; and developing structural humility (Metzl, 2014). ■

About the Authors

Dr. Julie Radlauer-Doerfler *is a leading expert in the social influences of mental health and uses her experience to create impact within communities, systems, organizations, and individuals. Her approach is collaborative, creative, and curious as she strives to educate utilizing unique avenues including media, stage production, video production, podcasting and writing. She has extensive experience in behavioral health, public health, and organizational development for more than 25 years. She speaks internationally, is a keynote speaker, has spoken at the United Nations and TEDx Miami on social support, and social connectedness. Her research on structural racism in the behavioral health field has led to the development of a national curriculum designed to create more equitable systems. She is passionate about addressing behavioral health challenges in communities and speaks widely on the topic.*

Dr. Morgan Cooley *earned her PhD in Marriage and Family Therapy in 2014 and MSW in Social Work in 2009 from Florida State University in Tallahassee, Florida. She taught as an Assistant Professor between 2014-2018 at the University of Tennessee at Chattanooga. Currently, Dr. Cooley is a social work faculty member at Florida Atlantic University. She is a licensed clinical social worker with practice experience in couple and family therapy, working with child welfare involved families, mental health and trauma, and also those who identify as LGBT+. Dr. Cooley's research is greatly influenced by a background in both social work and family science and focuses on examining the relationships between child mental health and family system or child welfare context. Specifically, she is interested in the relationship quality between foster children and foster parents, the influence of fostering experiences and child behavior on foster parent well-being, and what factors are associated with improved foster child mental health. Her ultimate career goal is to enhance the preparation and training of both relative and non-relative foster families to support youth who have to be placed into foster care, particularly youth who are dealing with mental health challenges.*

Dr. Heather Thompson *earned her PhD in Marriage and Family Therapy and MSW in Social Work from the Florida State University in Tallahassee. She taught as an Adjunct Professor at Florida Agricultural & Mechanical University after the completion of her PhD. She has several years of experience in the child welfare system in Florida, working in a range of roles from a front line staff to an administrator at the lead child welfare agency of North Florida. Additionally, as a Licensed Clinical Social Worker, Dr. Thompson has provided counseling services, including individual, couple and family counseling, as well as parenting interventions to at-risk families involved in the foster care and juvenile justice systems. She is also a Qualified Supervisor for registered interns in Social Work and Marriage and Family Therapy. Her area of research expertise is in child welfare, specifically identifying protective factors for adolescents and their families in long-term foster care. Her secondary area of research focuses on identifying best practices for child welfare professionals.*

Robin Jimenez-Bean *received her Master's in Social Work from Florida Atlantic University and currently works as the Office of Undergraduate Research and Inquiry as the Program Coordinator. She has a rich history and experience with undergraduate and master's-level research and her interests revolve around the child welfare system, foster care, and post-traumatic growth of foster care youth.*

Dr. Alicia Best *is an Associate Professor in the Department of Public Health Education at the Morehouse School of Medicine where she teaches, advises and mentors graduate public health students and medical residents. Her research expertise lies at the intersection of health communication and health equity, with a primary focus on identifying, understanding, and contextualizing social and cultural factors (e.g. religiosity, health literacy, etc.) that influence cancer-related and other health disparities; and designing, implementing, and evaluating health communication interventions to address these disparities. Dr. Best has been principal investigator or co-investigator on multiple internally and externally funded research projects collectively aimed at reducing health disparities. Additionally, she has over 10 years of practical public health program implementation and evaluation experience, along with a strong proficiency in both qualitative and quantitative methodologies.*

Dr. Jeff Randall *completed his Ph.D. in clinical and health psychology at Virginia Tech, and a post-doctoral fellowship at the University of Pittsburgh. He is a professor at the Medical University of South Carolina. He has published over 70 articles and is associated with disseminating 700 programs in 40 states and 20 countries.*

Conflict of Interest Statement

The authors have no conflicts of interest to disclose.

References

Agency for Healthcare Research and Quality (2022). *2022 national healthcare quality and disparities report*. Author. https://www.ncbi.nlm.nih.gov/books/NBK587174/

Akubuiro, S., Clay, W., Nelson, S., & Cowan, A. E. (2023). Addressing Structural Racism in Child and Adolescent Psychiatry in Psychotherapy. *Innovations in Clinical Neuroscience*, *20*(10-12), 29–34. https://pmc.ncbi.nlm.nih.gov/articles/PMC10773604/

Alegría, M., NeMoyer, A., & Falgàs Bagué, I. (2018). Social determinants of mental health: Where we are now and where we need to go. *Current Psychiatry Reports, 20*, 95. https://doi.org/10.1007/s11920-018-0969-9

Aletraris, L., Roman, P. M., & Pruett, J. (2017). Integration of care in the implementation of the Affordable Care Act: Changes in treatment services in a national sample of centers treating substance use disorders. *Journal of Psychoactive Drugs, 49*(2), 132-140. https://doi.org/10.1080/02791072.2017.1299263

Alim, T. N., Feder, A., Graves, R. E., Wang, Y., Weaver, J., Westphal, M., Alonso, A., Aigbogun, N. U., Smith, B. W., Doucette, J. T., Mellman, T. A., Lawson, W. B., & Charney, D. S. (2008). Trauma, resilience, and recovery in a high-risk African American population. *American Journal of Psychiatry, 165*(12), 1566-1575. https://doi.org/10.1176/appi.ajp.2008.07121939

American Medical Association (AMA). (2022a). What is behavioral health? https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health

American Medical Association (AMA). (2022b). Mental health. https://www.ama-assn.org/search?search=mental+health

American Psychiatric Association (APA). (2022). *Diagnostic and statistical manual of mental disorders (5th ed.). Text Revision*. https://doi.org/10.1176/appi.books.9780890425787

Asante, M. K. (1990). *Kemet, Afrocentricity and knowledge*. Africa World Press. https://archive.org/details/kemetafrocentric0000asan/page/n6/mode/1up

Asante, M. K. (1998). *The Afrocentric idea (Rev. ed.)*. Temple University Press. https://www.jstor.org/stable/j.ctt1bw1kjr

Best, A. L., Fletcher, F. E., Kadono, M., & Warren, R. C. (2021). Institutional Distrust among African Americans and Building Trustworthiness in the COVID-19 Response: Implications for Ethical Public Health Practice. *Journal of health care for the poor and underserved*, *32*(1), 90–98. https://doi.org/10.1353/hpu.2021.0010

Bitsko, R. H., Claussen, A. H., Lichstein, J., Black, L. I., Jones, S. E., Danielson, M. L., Hoenig, J. M., Davis Jack, S. P., Brody, D. J., Gyawali, S., Maenner, M. J., Warner, M., Holland, K. M., Perou, R., Crosby, A. E., Blumberg, S. J., Avenevoli, S., Kaminiski, J. W., & Ghandour, R. M. (2022). Mental health surveillance among children- United States, 2013-2019. *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, 71*(2), 1-42. http://dx.doi.org/10.15585/mmwr.su7102a1

Experiences with the Behavioral Health Delivery System

Bossert, W., & D'Ambrosio, C. (2013). Measuring economic insecurity. *International Economic Review, 54*(3), 1017-1030. https://www.jstor.org/stable/24517074

Braverman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports, 129*(1), 5-8. https://doi.org/10.1177/00333549141291S203

Burkett, C. A. (2017). Obstructed use; Reconceptualizing the mental health (help-seeking) experiences of Black Americans. *Journal of Black Psychology, 43*(8), 813-835. https://psycnet.apa.org/doi/10.1177/0095798417691381

Caldwell, C. H., Assari, S., & Breland-Noble, A. M. (2016). The epidemiology of mental disorders in African American children and adolescents. In: Breland-Noble, A., Al-Mateen, C., Singh, N. (eds) *Handbook of Mental Health in African American Youth. Springer Series on Child and Family Studies*. Springer. https://doi.org/10.1007/978-3-319-25501-9_1

Campbell, C. (2020). Social capital, social movements and global public health: Fighting for health-enabling contexts in marginalized settings. *Social Science & Medicine, 257*, 112-153. https://doi.org/10.1016/j.socscimed.2019.02.004

Carpenter-Song, E., Whitley, R., Lawson, W., Quimby, E., & Drake, R. E. (2011). Reducing disparities in mental health care: Suggestions from the Dartmouth-Howard collaboration. *Community Mental Health Journal, 47*(1), 1-13. https://doi.org/10.1007/s10597-009-9233-4

Centers for Disease Control and Prevention. (2025). *Children's mental disorders*. https://www.cdc.gov/children-mental-health/about/index.html

Centers for Disease Control and Prevention. (2024). Mental health. https://www.cdc.gov/healthy-youth/mental-health/index.html#:~:text=Why%20it's%20important,youth%20develop%20good%20mental%20health.

Centers for Disease Control and Prevention. (2023). *What is children's mental health?* https://www.cdc.gov/children-mental-health/about/?CDC_AAref_Val=https://www.cdc.gov/childrensmentalhealth/basics.html

Chapman, S. A., Blash, L. K., Mayer, K., & Spetz, J. (2018). Emerging roles for peer providers in mental health and substance use disorders. *American Journal of Preventive Medicine, 54*(6), 267-274. https://doi.org/10.1016/j.amepre.2018.02.019

Chang, E. C., & Downey, C. A. (2012). *Handbook of race and development in mental health*. Springer. https://www.psicopolis.com/psicvaribox/psichtr/EChangracedev.pdf

Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus*, *13*(4), 419-425. https://doi.org/10.1176/appi.focus.20150017

De Beer, C. R. M., Nooteboom, L. A., Van Domburgh, L., De Vreugd, M., Schoones, J. W., & Vermeiren, R. R. J. M. (2024). A systematic review exploring youth peer support for young people with mental health problems. *European Child & Adolescent Psychiatry*, *33*(8), 2471-2484. https://doi.org/10.1007/s10995-023-03652-1

Dettlaff, A. J., Weber, K., Pendleton, M., Reiko, B., Bettencourt, B., & Burton, L. (2020). It is not a broken system, it is a system that needs to be broken: The upend movement to abolish the child welfare system. *Journal of Public Child Welfare, 14*(5), 500-517. https://doi.org/10.1080/15548732.2020.1814542

Diala, C., Muntaner, C, Walrath, C. Nickerson, K. J., LaVeist, T. A., & Leaf, P. J. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry, 70*, 455-464. http://dx.doi.org/10.1037/h0087736

Dixon, A. C., Schoonmaker, C. T., & Philliber, W. W. (2000). A journey toward womanhood: Effects of an Afrocentric approach to pregnancy prevention among African-American adolescent females. *Adolescence, 35*(139), 425–425 https://pubmed.ncbi.nlm.nih.gov/11130588/

Douglas, C. M., Richardson, L., & Evans, Y. N. (2023). Utilization of mental health services among black adolescents during the COVID-19 pandemic: A narrative review of the literature. *Current Pediatrics Reports*, *11*(1), 7-12. https://doi.org/10.1007/s40124-023-00282-7

Fitzsimons, E., Goodman, A., Kelly, E., & Smith, J.P. (2017). Poverty dynamics and parental mental health: determinants of childhood mental health in the UK. *Social Science and Medicine 175*, 43-51. http://dx.doi.org/10.1016/j.socscimed.2016.12.040

Flay, B. R., Graumlich, S., Segawa, E., Burns, J. L., Holliday, M. Y., & Aban Aya Investigators (2004). Effects of 2 prevention programs on high-risk behaviors among African American youth: a randomized trial. *Archives of Pediatrics & Adolescent Medicine*, *158*(4), 377–384. https://doi.org/10.1001/archpedi.158.4.377

Florida Department of Children and Families. (2023). *Substance abuse and mental health*. https://www.myflfamilies.com/services/substance-abuse-and-mental-health

Fong, R., McRoy, R. G., & Dettlaff, A. J. (2014). *Disproportionality and disparities*. Encyclopedia of Social Work. https://doi.org/10.1093/acrefore/9780199975839.013.899

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231-233. https://doi.org/10.1002%2Fwps.20231

Garney, W., Wilson, K., Ajayi, K. V., Panjwani, S., Love, S. M., Flores, S., Garcia, K., & Esquivel, C. (2021). Social-Ecological Barriers to Access to Healthcare for Adolescents: A Scoping Review. *International journal of environmental research and public health*, *18*(8), 4138. https://doi.org/10.3390/ijerph18084138

Gavin, N. I., Adams, E. K., & Hertz, E. J. (1998). The use of EPSDT and other health care services by children enrolled in Medicaid: The impact of OBRA '89. *Milbank Quarterly, 76*(2), 207-250. https://doi.org/10.1111/1468-0009.00087

Gopalkrishnan N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in public health*, *6*, 179. https://doi.org/10.3389/fpubh.2018.00179

Graham, M. J. (1999). The African centered worldview: Developing a paradigm in social work. *British Journal of Social Work, 29*(2), 251-267. https://www.jstor.org/stable/23714959

Grier, W. H., & Cobbs, P. M. (1992). *Black rage*. Basic Books. https://archive.org/details/blackrage0000grie_i5u3

Gruber, J. (2020). *Flattening the mental health curve is the next big coronavirus challenge*. The Conversation. http://theconversation.com/flattening-the-curve-is-the next-big-coronavirus-challenge-139066

Experiences with the Behavioral Health Delivery System

Hankerson, S. H., Moise, N., Wilson, D., Waller, B. Y., Arnold, K. T., Duarte, C., Lugo-Candelas, C., Weissman, M. M., Wainberg, M., Yehuda, R., & Shim, R. (2022). The intergenerational impact of structural racism and cumulative trauma on depression. *The American Journal of Psychiatry*, *179*(6), 434–440. https://doi.org/10.1176/appi.ajp.21101000

Hankerson, S. H., Suite, D., & Bailey, R. K. (2015). Treatment disparities among African American men with depression: implications for clinical practice. *Journal of health care for the poor and underserved*, *26*(1), 21–34. https://doi.org/10.1353/hpu.2015.0012

Harley, D., Hunn, V., Elliot, W., Elliot, W., & Canfield, J. (2015). Photovoice as a culturally competent research methodology for African Americans. *Journal of Pan African Studies, 7*(9), 31-40. https://jpanafrican.org/docs/vol7no9/7.9-5-Jackson-Harley.pdf

Hawks J. L. (2023). Editorial: The Impact of the COVID-19 Pandemic on Racial Disparities in Pediatric Mental Health. *Journal of the American Academy of Child and Adolescent Psychiatry*, *62*(4), 398–399. https://doi.org/10.1016/j.jaac.2022.12.015

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics*, *139*(1), Article e20151175. https://doi.org/10.1542/peds.2015-1175

Hogan, M. F. (2003). New freedom commission report: The president's new freedom commission: Recommendations to transform mental health care in America. *Psychiatric Services, 54*(11), 1467-1474. https://doi.org/10.1176/appi.ps.54.11.1467

Hook, J. N., Farrell, J. E., David, D. E., DeBlaere, C., Van Tobgeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. Journal of Counseling Psychology, 63(3), 269-277. https://doi.org/10.1037/cou0000114

Howard, J. A., & Renfrow, D. G. (2014). Intersectionality. In J.D. McLeod, E.J. Lawler, & M & Schwalbe (Eds.), *Handbook of the social psychology of inequality*, 95-121. Springer. https://doi.org/10.1007/978-94-017-9002-4

Kalonji, T. (2014). The Nguza Saba & Maat, a path for self-reconstruction and recoveredness: Exploring a Kawaida paradigm for healing addiction in the Black community. *Journal of Pan African Studies, 7*(4), 195-210. https://jpanafrican.org/docs/vol7no4/7.4-8-Kalonji-Community%20The%20Nguzo%20Saba.pdf

Karenga, M. (1996). The Nguzo Saba (the seven principles): Their meaning and message. In M.K. Asante & A.S. Abarry (Eds.), *African intellectual heritage* (pp.5430554). Temple University Press.

Kawaii-Bogue, B., Williams, N. J., & MacNear, K. (2017). Mental health care access and treatment utilization in African American communities: an integrative care framework. *Best Practices in Mental Health, 13*(2), 11-29. https://psycnet.apa.org/record/2017-45092-003

Kids Count Data Center. (2025). *Children in single parent families by race*. https://datacenter.aecf.org/data/tables/107-children-in-single-parent-families-by-race-and-ethnicity#detailed/1/any/false/2545,1095,2048,1729,37,871,870,573,869,36/8223,4040,4039,2638,2597,4758,1353/432,431

Kirkbride, J. B., Anglin, D. M., Colman, I., Dykxhoorn, J., Jones, P. B., Patalay, P., Pitman, A., Soneson, E., Steare, T., Wright, T., & Griffiths, S. L. (2024). The social determinants of mental health and disorder: evidence, prevention and recommendations. *World psychiatry: Official journal of the World Psychiatric Association (WPA)*, *23*(1), 58–90. https://doi.org/10.1002/wps.21160

Kruse, M., Olsen, K. R., & Skovsgaard, C. V. (2022). Co-payment and adolescents' use of psychologist treatment: Spill over effects on mental health care and on suicide attempts. *Health Economics*, *31*, 92-114. https://doi.org/10.1002/hec.4582

Kuramoto, F. (2014). The Affordable Care Act and integrated care. *Journal of Social Work in Disability & Rehabilitation, 12*(1-2), 44-86. https://pubmed.ncbi.nlm.nih.gov/24329106/

Lateef, H., Amoako, E. O., Nartey, P., Tan, J., & Joe, S. (2022). Black youth and African-centered interventions: A systematic review. *Research on Social Work Practice*, *32*(1), 3-12. https://doi.org/10.1177/10497315211003322

Le Cook, B., Zuveka, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Services Research, 49*(1), 206-229. https://doi.org/10.1111/1475-6773.12095

Maranda, M. J., Lee-Easton, M. J., & Magura, S. (2022). Variations in definitions of evidence-based interventions for behavioral health in eight selected U.S. states. *Evaluation Review, 46*(4), 363-390. https://doi.org/10.1177/0193841X221100356

Marlowe, D. B., Shannon, L. M., Ray, B., Turpin, D. P., Wheeler, G. A., Newell, J., & Lawson, S. G. (2018). Developing a culturally proficient intervention for young African American men in drug court: Examining feasibility and estimating an effect size for Habilitation Empowerment Accountability Therapy (HEAT). *Journal for Advancing Justice, 1*, 109-128. https://advancejustice.org/wp-content/uploads/2018/06/AJ-Journal.pdf

Marmot, M., Friel, S., Bell, R., Houweling, T. A. J., & Taylor, S. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet, 372*(9650), 1661-1669. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61690-6/abstract

Mendenhall, A. N., Demeter, C., Findling, R. L., Frazier, T. W., Fristad, M. A., Youngstrom, E. A., Arnold, L. E., Birmaher, B., Gill, M. K., Axelson, D., Kowatch, R. A., & Horwitz, S. M. (2011). Mental health service use by children with serious emotional and behavioral disturbance: results from the LAMS study. *Psychiatric services*, *62*(6), 650–658. https://doi.org/10.1176/ps.62.6.pss6206_0650

Mental Health America. (2019). *Peer support: Research and reports*. https://mhanational.org/peer-support-research-and-reports/

Mental Health America. (2023). *Black and African American communities and mental health*. https://africanamericanbehavioralhealth.org/ResourceMaterials/Black%20and%20African%20American%20Communities%20and%20Mental%20Health%20_%20Mental%20Health%20America.pdf

Metzl, J. (2010). *The protest psychosis: How Schizophrenia became a Black disease*. Beacon Press. https://psychiatryonline.org/doi/epdf/10.1176/ps.62.8.pss6208_0979a

Experiences with the Behavioral Health Delivery System

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science & Medicine, 106*, 128-136. https://doi.org/10.1016/j.socscimed.2014.01.043

Morsy, L., & Rothstein, R. (2019). Toxic stress and children's outcomes. Economic Policy Institute. https://www.epi.org/publication/toxic-stress-and-childrens-outcomes-african-american-children-growing-up-poor-are-at-greater-risk-of-disrupted-physiological-functioning-and-depressed-academic-achievement/

National Alliance on Mental Illness. (n.d.). *ADHD and adults: a look at cultural differences*. https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/ADHD

Newhill, C. E. & Harris, D. (2007). African American Consumers' perceptions of racial disparities in mental health services. *Social Work in Public Health, 23*, 107-124. https://doi.org/10.1080/19371910802151861

National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions, O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK32775/

Office of the Surgeon General (OSG). (2021). *Protecting youth mental health: The U.S. Surgeon General's Advisory*. US Department of Health and Human Services. https://pubmed.ncbi.nlm.nih.gov/34982518/

Ostrow, L., Steinwachs, D., Leaf, P. J., & Naeger, S. (2017). Medicaid reimbursement of mental health peer-run organizations: Results of a national survey. *Administration and Policy in Mental Health and Mental Health Services Research, 44*, 501-511. https://doi.org/10.1007/s10488-015-0675-4

Panchal, N., Hill, L., Artiga, S., & Hamel, L. (2024). *Racial and ethnic disparities in mental health care: Findings from the KFF survey of racism, discrimination and health.* Kaiser Family Foundation. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/#:~:text=Findings%20from%20the%202023%20KFF,among%20mental%20health%20care%20providers.

Payne, J. S. (2012). Influence of race and symptom expression on clinicians' depressive disorder identification in African American men. *Journal of the Society for Social Work and Research, 3*(3), 162-177. https://doi.org/10.5243/jsswr.2012.11

Pederson, A. B., McLaughlin, C., Hawkins, D., Jain, F. A., Anglin, D. M., Yeung, A., & Tsai, A. C. (2025). Medical Mistrust and Willingness to Use Mental Health Services Among a Cohort of Black Adults. *Psychiatric Services*, *76*(4), 318-325. https://doi.org/10.1176/appi.ps.20240016

Phelan, J. C., Link, B. G. & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: Theory, evidence and policy implications. *Journal of Health and Social Behavior, 51*(1), 28-40. https://doi.org/10.1177/0022146510383498

Rast, J. E., Roux, A. M., Connor, G., Ezeh, T. H., Shea, L., Turchi, R. M., & Shattuck, P. T. (2023). The medical home and mental health services in children and youth with special health care needs. *Maternal and child health journal*, *27*(6), 1097–1106. https://doi.org/10.1007/s10995-023-03652-1

Redd, Z., Thomson, D., & Moore, K. A. (2024). *Poverty matters for children's well-being, but good policy can help*. Child Trends. https://www.childtrends.org/publications/poverty-matters-childrens-well-being-policy

Reiss, M., Greene, C. A., & Ford, J. D. (2017). Is it time to talk? Understanding specialty child mental healthcare providers' decisions to engage in interdisciplinary communication with pediatricians. *Social Science & Medicine, 175*, 66-71. http://doi.org/10.1016/j.socscimed.2016.12.036

Richmond, J., Adams, L. B., Annis, I., Ellis, A. R., Perryman, T., Sikich, L., & Thomas, K. C. (2022). Rapid and deferred help seeking among African American parents of children with emotional and behavioral difficulties. *Psychiatric Services, 73*(12), 1359-1366. https://doi.org/10.1176/appi.ps.202100553

Rivera, K. J., Zhang, J. Y., Mohr, D. C., Wescott, A. B., & Pederson, A. B. (2021). A narrative review of mental illness stigma reduction interventions among African Americans in the United States. *Journal of mental health & clinical psychology*, *5*(2), 20. https://pmc.ncbi.nlm.nih.gov/articles/PMC8496896/

Rodgers, C. R., Flores, M. W., Bassey, O., Augenblick, J. M., & Lê Cook, B. (2022). Racial/ethnic disparity trends in children's mental health care access and expenditures from 2010-2017: Disparities remain despite sweeping policy reform. *Journal of the American Academy of Child & Adolescent Psychiatry*, *61*(7), 915-925. https://pubmed.ncbi.nlm.nih.gov/34627995/

Rostain, A. L., Ramsay, J. R., & Waite, R. (2015) Cultural background and barriers to mental health care for African American adults. *Journal of Clinical Psychiatry, 6*(3) 279-283. https://doi.org/10.4088/jcp.13008co5c

Samuel, I. A. (2015). Utilization of mental health services among African American male adolescents released from juvenile detention: Examining reasons for within-group disparities in help-seeking behaviors. *Child and Adolescent Social Work Journal, 32*(1), 33-34. https://doi.org/10.1007/s10560-014-0357-1

Satcher, D. (2001). *Mental health: Culture, race and ethnicity- A supplement to mental health: A report of the Surgeon General. U.S. Department of Health and Human Services*. https://doi.org/10.13016/JELA-CKXW

Schlack, R., Peerenboom, N., Neuperdt, L., Junker, S., & Beyer, A. K. (2021). The effects of mental health problems in childhood and adolescence in young adults: Results of the KiGGS cohort. *Journal of health monitoring*, *6*(4), 3–19. https://doi.org/10.25646/8863

Scott, J. G., Mihalopoulos, C., Erskine, H. E., Roberts, J., & Rahman, A. (2016). Childhood mental and developmental disorders. *Disease control priorities,*, *4*, 145-161. https://www.ncbi.nlm.nih.gov/books/NBK361938/

Sedivy, J. A., Rienks, S., Leake, R., & He., A. S. (2020). Expanding our understanding of the role of peer support in child welfare workforce retention. *Journal of Public Child Welfare, 14*(1), 80-100. https://doi.org/10.1080/15548732.2019.1658020

Scannell, C. (2021). Voices of hope: Substance use peer support in a system of care. *Substance Abuse: Research and Treatment, 15*. https://doi.org/10.1177/11782218211050360

Scott-Jones, G., CAADC, Kamara, M. R., & PE (2020). The traumatic impact of structural racism on African Americans. *Delaware Journal of Public Health*, *6*(5), 80–82. https://pmc.ncbi.nlm.nih.gov/articles/PMC8352535/

Scott, K. M., Von Korff, M., & Angermeyer, M. C. (2011). Association of childhood adversities and early-onset mental disorders with adult-onset chronic physical conditions. *Archives of General Psychiatry 68*(8), 838-844. https://pubmed.ncbi.nlm.nih.gov/21810647/

Shim, R. S., & Compton, M. T. (2020). The social determinants of mental health: Psychiatrists' roles in addressing discrimination and food insecurity. *Focus*, *18*(1), 25-30. https://doi.org/10.1176/appi.focus.20190035

Shim, R., Koplan, C., Langheim, J. P., Manseau, M. W., Powers, R. A., & Compton, M. T. (2014). The social determinants of mental health: an overview and call to action. *Psychiatric Annals, 4*(1), 22-26. https://doi.org/10.3928/00485713-20140108-04

Simmons University. (2017). *Racial disparities in mental health treatment: Blog*. https://online.simmons.edu/blog/racial-disparities-in-mental-health-treatment/

Simmons, V. (2023). Evaluating the relationship between ethnicity and attitude toward seeking mental health services. *Journal of Graduate Education Research*, *4*(1), 7. https://scholarworks.harding.edu/cgi/viewcontent.cgi?article=1040&context=jger

Smith, L. (2005). Psychotherapy, classism and the poor: Conspicuous by their absence. *American Psychologist, 60*(7), 687-696. https://doi.org/10.1037/0003-066X.60.7.687

Smith, K. M. (2020). *Discrimination and racism in the history of mental health care*. https://www.nami.org/african-american/discrimination-and-racism-in-the-history-of-mental-health-care/

Snowden, L. R. & Pingitore, D. (2002). Frequency and scope of mental health services delivery to African Americans in primary care. *Mental Health Services Research, 4*(3), 123-130. https://doi.org/10.1023/a:1019709728333

Snowden, L. R. (2012). Health and mental health policies' role in better understanding and closing African American-White American disparities in treatment access and quality of care. *American Psychologist, 67*(7), 524-531. https://doi.org/10.1037/a0030054

Stockdale, S. E., Lagomasino, I. T., Siddique, J., McGuire, T., & Miranda, J. (2008). Racial and ethnic disparities in detection and treatment of depression and anxiety among psychiatric and primary health care visits. *Medical Care, 46*(7), 668-677. https://doi.org/10.1097/mlr.0b013e3181789496

Substance Abuse and Mental Health Services Administration. (2024). *Frequently asked questions*. https://www.samhsa.gov/about/faqs

Taylor, J. (2019). *Racism, inequality, and health care for African Americans*. The Century Foundation. https://production-tcf.imgix.net/app/uploads/2019/12/19172443/AfAmHealth_Jamila_PDF.pdf

The Annie E. Casey Foundation. (2025). *Child welfare and foster care statistics*. https://www.aecf.org/blog/child-welfare-and-foster-care-statistics

Thomas, K. C., & Snowden, L. R. (2001). Minority Response to Health Insurance Coverage for Mental Health Services. *The Journal of Mental Health Policy and Economics*, *4*(1), 35–41. https://pubmed.ncbi.nlm.nih.gov/11967464/

Thurston, I. B., & Phares, V. (2008). Mental health service utilization among African American and Caucasian mothers and fathers. *Journal of Consulting and Clinical Psychology, 76*(6), 1058-1067. https://doi.org/10.1037/a0014007

Torio, C. M., Encinosa, W., Berdahl, T., McCormick, M. C., & Simpson, L. A. (2015). Annual report on health care for children and youth in the United States: National estimates of cost, utilization and expenditures for children with mental health conditions. *Academic Pediatrics*, *15*(1), 19-35. https://doi.org/10.1016/j.acap.2014.07.007

Torres, M. E., Brolin, M., Panas, L., Ritter, G., Hodgkin, D., Lee, M., Merrick, E., Horgan, C., Hopwood, J. C., Gewirtz, A., De Marco, N., & Lane, N. (2020). Evaluating the feasibility and impact of case rate payment for recovery support navigator services: A mixed methods study. *BMC Health Services Research, 20*, 1004. https://doi.org/10.1186/s12913-020-05861-8

Turpin, A., & Shier, M. L. (2017). Peer support and substance use disorder treatment: Benefits and barriers for intra-personal development in longer-term treatment programs. *Journal of Groups in Addiction and Recovery, 12*(2-3), 117-134. https://doi.org/10.1080/1556035X.2016.1258683

Umberson, D., & Karas Montez, J. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior, 51*(1), S54-S66. https://doi.org/10.1177/0022146510383501

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Service. (2001). *Mental health: Culture, race and ethnicity: A supplement to mental health: A report of the Surgeon General.* https://www.ncbi.nlm.nih.gov/books/NBK44243/

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2013). *National healthcare disparities report*. https://archive.ahrq.gov/research/findings/nhqrdr/nhdr13/index.html#fig231

U.S. Department of Health and Human Services, National Institute of Mental Health. (2015). *Important events in NIMH history*. https://web.archive.org/web/201507051311833/http://www.nih.gov/about/almanac/archive/1998/organization/nimh/history.html

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2022). *Defining the PCMH*. https://www.ahrq.gov/ncepcr/research/care-coordination/pcmh/define.html

Wallis, R., Signorelli, M., Linn, H., Bias, T., Allen, L., & Davis, S. M. (2023). Lessons learned from employing Medicaid-funded peer recovery support specialists in residential substance use treatment settings: An exploratory analysis. *Journal of Substance Use and Addiction Treatment, 154*, 136-209. https://doi.org/10.1016/j.josat.2023.209136

Whaley, A. L., & McQueen, J. P. (2004). An Afrocentric program as primary prevention for African American youth: Qualitative and quantitative exploratory data. *The Journal of Primary Prevention, 24*(2), 253–269. https://doi.org/10.1023/B:JOPP.0000042389.22212.3a

Whaley, A. L., McQueen, J. P., & Oudkerk, L. (2017). Effects of Africentric socialization on psychosocial outcomes in Black girls: The critical role of gender. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(4), 289–306. https://doi.org/10.1080/15313204.2017.1344945

Wilkinson, R.G. & Marmot, M.G. (2003). *Social determinants of health: The solid facts*. World Health Organization. https://iris.who.int/handle/10665/326568

Experiences with the Behavioral Health Delivery System

Williams, M., George, J.R., & Printz, D.M.B. (2020). Behavioral health service delivery with African Americans. In Benuto, L.T., Gonzalez, F.R., Singer, J. (eds) *Handbook of Cultural Factors in Behavioral Health*. Springer, Cham. https://doi.org/10.1007/978-3-030-32229-8_9

Wodarski, J.S. (2014). The integrated behavioral health service delivery system model. *Social Work in Public Health, 29*(4), 301-317. https://pubmed.ncbi.nlm.nih.gov/24871769/

World Health Organization. (2001). *World health report: 2001: Mental health: New understanding, new hope*. https://iris.who.int/handle/10665/42390

World Health Organization. (2018, March 30). *Mental health: Strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response