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REGULAR ARTICLES

Conceptualizing Community Mental Health Service Utilization for BIPOC Youth

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ABSTRACT

Historically, children and adolescents who identify as Black, Indigenous, and other people of Color (BIPOC) have had inequitable access to mental healthcare, and research shows that they are significantly less likely than their white American counterparts to utilize available services. Research identifies barriers that disproportionately impact racially minoritized youth; however, a need remains to examine and change systems and processes that create and maintain racial inequities in mental health service utilization. The current manuscript critically reviews the literature and provides an ecologically based conceptual model synthesizing previous literature relating to BIPOC youth barriers for service utilization. The review emphasizes client (e.g. stigma, system mistrust, childcare needs, help seeking attitudes), provider (e.g. implicit bias, cultural humility, clinician efficacy), structural/organizational (clinic location/proximity to public transportation, hours of operation, wraparound services, accepting Medicaid and other insurance-related issues), and community (e.g. improving experiences in education, the juvenile criminal-legal system, medical, and social service systems) factors that serve as barriers and facilitators contributing to disparities in community mental health service utilization for BIPOC youth. Importantly, we conclude with suggestions for dismantling inequitable systems, increasing accessibility, availability, appropriateness, and acceptability of services, and ultimately reducing disparities in efficacious mental health service utilization for BIPOC youth.

A significant amount of research documents racial and ethnic disparities in mental health access and service utilization among children and adolescents (Alegría et al., 2015; Cook et al., 2017; Holm-Hansen, 2006). The existing literature in clinical psychology describes barriers that youth and families who are Black, Indigenous, and People of Color (BIPOC) face in accessing mental health services (Planey et al., 2019), and primarily focuses on client (e.g., stigma) and provider (e.g., cultural humility) barriers. However, more attention should be drawn to historical and systemic factors (i.e., institutional and structural racism) that uphold barriers and maintain inequities in mental health access and utilization. Thus, the purpose of the present article is to critically review the literature to provide a conceptual framework for examining the barriers and facilitators to BIPOC mental health service utilization that encompasses not only client and provider factors, but also barriers and facilitators related to structural, organizational, and community factors.

Broadly, structural (i.e., systemic) racism is defined as the way in which policies, practices, cultural representation, and other norms work together across society to reinforce racial inequity (Aspen Institute, 2004; Jones, 1972). More proximally, institutional racism is defined as the rules and regulations that block BIPOC individuals from resources and penalize them disproportionately within organizations (Thompson & Carter, 1997). As such, to conceptualize the current state of mental health service utilization for BIPOC youth and families, we view disparities through a lens that includes consideration of structural and institutional racism in the mental health system. It is through this understanding and subsequent work that we can begin to dismantle inequitable systems and improve access to and utilization of mental health services for BIPOC youth and families.

To understand mental health service utilization among BIPOC youth, it is important to acknowledge their sociopolitical, historical, and current racialized experiences in the United States. Individual racial and ethnic communities have unique histories related to racial marginalization and oppression. These experiences have historically been used as a defining factor

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to prohibit BIPOC communities from access to basic resources such as housing, health care, and education (Pounder et al., 2003). As such, proximity to blackness has historically and contemporarily shaped experiences of racism for communities of Color in the United States. People of Color do share similar narratives regarding race-related subjugation and discrimination. Some historical examples include the enslavement of Black people,the genocide of Indigenous people, Asians who faced the Chinese Exclusionary Act and the Hart-Celler Act, internment camps (e.g., Japanese individuals and communities), colonization and Latinx groups who experienced displacement and racial harassment due to exclusionary immigration and migration policies.

Despite current legislation that prohibits discrimination based on race, systems of oppression that lead to race-based trauma for BIPOC are still in existence. For example, whiteness, defined as the "...overt and subliminal socialization processes and practices, power structures, laws, privileges, and life experiences that favor the white racial group over all others" (Helms, 2017, p. 717) acts as the driving force behind white supremacy (Tyler et al., 2022). A White supremacy (i.e., the political, cultural, and economic system that both creates and sustain White dominance in society through systemic and institutional hegemony; Ansley, 1997) in tandem with other systems of oppression work together in a matrix of domination operates structurally to effect systemic exclusion, oppression, and erasure of BIPOC communities. Such exclusion and oppression continues to subjugate BIPOC children and families, contribute to declines in mental health and wellbeing, and influence the resources and services that BIPOC youth are able to access (Bailey et al., 2017). As such, for the purpose of the current paper and conceptualization, we reference BIPOC youth and families because we recognize that individuals of African, Latinx, Asian, Pacific Islander, and Indigenous American descent, as well as other communities of Color, have been historically marginalized in ways that similarly impact their service utilization. Ultimately, we aim to elucidate reasons for service utilization and offer a common conceptualization that can lead to systemic and structural change to benefit these underserved groups.

Although the field of mental health is traditionally perceived as a helping profession, psychology and psychiatry have contributed to upholding systems of oppression, including racism, dating back to the early 1800s (see Medlock et al., 2019). Historically, enslaved Blacks were often sold to physicians as experimental subjects, experienced inhumane treatment and deception, and much of this early research sought to establish the false notion that Black individuals were dysfunctional, deficient and inferior (Medlock et al., 2019; Turner, 2019). Such treatments were widespread in the field of health care and continued after the formal end of chattel slavery in the United States (e.g., the Tuskegee Experiment). Research underscores the urgent need to enact policy and societal-level changes to dismantle racist social structures and prevent their continued manifestations in the lives of BIPOC youth and families (Turner & Turner, 2021; Turner et al., 2019).

Purpose of Current Review

BIPOC youth are at increased risk for mental health and behavioral problems due to the compounding effects of systemic and institutional racism, as well as, direct and vicarious racial stressors (Yusuf et al., 2022). Most youth navigate stressors with guidance and support from their families and peers, or tap into community services designed to foster positive mental and behavioral health and healing from life's stressors, including community mental health programs (Lindsey et al., 2006; Turner et al., 2016). However, BIPOC youth are less likely to access mental health treatment and are also less likely to benefit from services when they are available. The current review provides a conceptualization of barriers to and facilitators to accessing community mental health services that contribute to disparities for BIPOC youth and families. Although there are existing models of service utilization, there are few that are specific to racially and ethnically minoritized youth that also account for institutional and systemic factors that contribute to disparities (Alegría et al., 2015). As such, the current paper synthesizes prior literature with regard to barriers to service utilization and provides recommendations for facilitators of improved service utilization that span beyond individuals and neighborhoods to include changes to structures and organizations. In doing so, our conceptual model acknowledges client, provider, structural/organizational, and community-level factors that prevent or encourage service utilization among BIPOC youth and families, through a sociohistorical lens. We conclude with a summary and brief considerations to assist clinical psychologists in dismantling inequitable systems, thereby increasing access to and reducing disparities in efficacious mental health services for BIPOC youth and their families.

Conceptual Model of Mental Health Service Utilization for BIPOC Youth and Families

Scholars have identified factors that promote and impede the use of community mental health services (Planey et al., 2019; Thompson et al., 2013; Turner et al.,

2016). To highlight the impact of accessibility, availability, appropriateness, and acceptability on treatment seeking and engagement, the Model of Treatment Initiation (MTI) explores barriers that contribute to mental health disparities among diverse populations (Turner, 2019; Turner et al., 2019): a) accessibility factors representing structural variables that influence an individual's ability to access treatment, b) availability factors that determine access to culturally appropriate services, c) appropriateness factors related to whether individuals view mental health problems as requiring treatment, and d) acceptability factors that encourage or hinder individuals from seeking treatment, such as stigma and cultural mistrust of health professionals. Building upon the MTI, the current conceptualization discusses barriers and facilitators to BIPOC youth and families' mental health service utilization while considering accessibility, availability, appropriateness, and acceptability.

The provided conceptualization is modeled after the ecological systems theory (Bronfenbrenner, 1979). Figure 1 depicts client (individual), provider (microsystem), structural/organizational (mesosystems), and community (exosystem) barriers and facilitators to community mental health services for BIPOC youth and families. Although our introduction discusses historic factors that contribute to disparities in service utilization (depicted in the figure by dashed lines), the focus of our conceptualization is on proximal and malleable targets as possible points of intervention. Below, we review the barriers and facilitators included in this model, at both the client, provider, structural, and community levels.

Barriers to Mental Health Service Utilization

Client Level Barriers

According to Bronfenbrenner (1979), individual level factors are critical to understanding human behavior. Although individual or client barriers may be similar across racially and ethnically minoritized groups, some studies identify individual concerns that are important to consider (Grandbois, 2005; Rhee et al., 2003; Turner et al., 2016). When examining client barriers to community mental health, we must seek to mitigate the

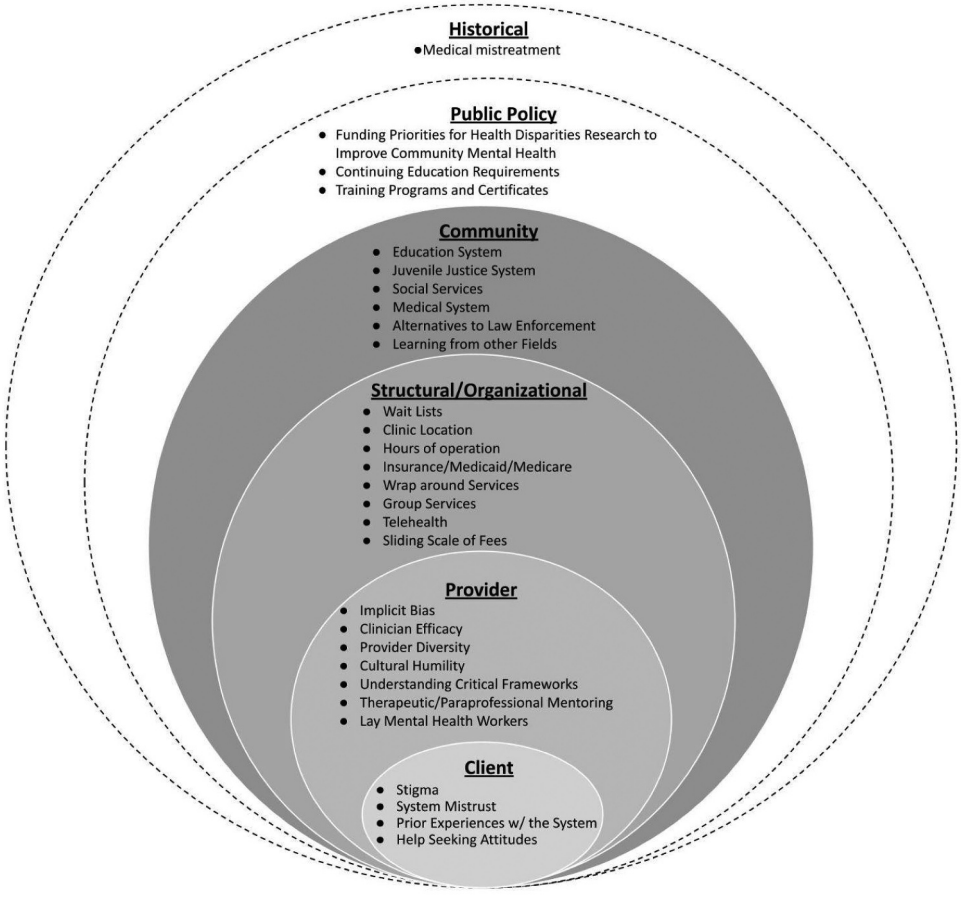

Figure 1. Conceptual model of mental health service utilization for BIPOC youth and families.

impact that these barriers have on service utilization among BIPOC youth. The following sections provide an overview of common barriers to mental health services among this population.

Stigma

Stigma, or the perceived labeling, disapproval of, and shame attached to utilizing mental health services persists as a consistent barrier for BIPOC youth and their families due to historical and current patterns of discrimination and abuse from medical and psychological institutions. Additionally, literature suggests client ideologies and beliefs are consistent barriers. For example, Asian American and African American caregivers report not seeking mental healthcare due to worries about their children being perceived as "sick" or "crazy" (Blank et al., 2002; Ling et al., 2014; Turner et al., 2019). Among American Indian and Alaska Native (AI/AN) communities, the systematic erasure of AI/AN cultural values and cultural insensitivity within medical institutions may serve as a barrier to treatment seeking (Grandbois, 2005).

System Mistrust

An important client barrier is mistrust of the mental health system and other systems responsible for upholding racism and oppression in American society (Whaley, 2001a). Among Black youth and families, studies consistently show that mistrust of service providers, as well as, suspicion and hesitancy related to seeking treatment decreases acceptability of mental health services (I. Metzger et al., 2023; Samuel, 2015; Turner et al., 2019; Whaley, 2001a, 2001b). Similar findings have been identified regarding mistrust among BIPOC communities, which are consistent with historical and modern medical racism, abuse within government institutions, and mismatches between cultural values and values endorsed by psychology (e.g., Tuskegee experiment; sexual assault in immigration detention centers; focus on talk therapy and emotionality as incongruent with some Asian and African cultures). For example, historical invalidation and incongruence of traditional healing practices in Western psychotherapy have led to mistrust among AI/AN communities and impacted service utilization (Doria et al., 2021).

Prior Experience with the System

Studies show that past experiences (e.g., perceived mistreatment) with mental health systems impact future utilization (Hodgkinson et al., 2017; Lindsey et al., 2013; Turner et al., 2016). BIPOC youth and their families often report experiencing discrimination and receiving poor quality mental healthcare in comparison to their non-Hispanic white peers (Kataoka et al., 2002; Kugelmass, 2016; Miranda & Cooper, 2004). Prior experiences within the system also impacts the type and quality of services that BIPOC youth and their families access. For instance, compared to their white counterparts, BIPOC families are more likely to seek treatment for mental health issues though the emergency room (ER) rather than available community services (Chow et al., 2003). This may be due to parents' negative experiences or their preferences to manage crises without the need for an ongoing relationship with a therapist or mental health professional. For example, one study noted BIPOC families are more likely to seek crisis intervention through the ER compared to outpatient therapy (Snowden et al., 2009).

Help Seeking Attitudes

As noted, attitudes and beliefs play a significant role in help-seeking behaviors. Studies show that parents' perceptions and expectations about mental health services predict utilization (Lindsey et al., 2013; Turner & Liew, 2010). For example, Black parents report more negative help-seeking attitudes and are less likely to engage in services compared to other racial/ethnic groups (Kataoka et al., 2002; Turner et al., 2015). Internalizing culturally specific values and beliefs that emphasize strength, perseverance, and the ability to handle stressors (e.g., Strong Black Womanhood, John Henryism) may negatively influence help seeking attitudes and service utilization for BIPOC youth and their families (Watson-Singleton, 2017; Woods-Giscombé, 2010). These values, while beneficial for intrinsic motivation and resilience, can be detrimental if they result in attitudes that reduce mental health service utilization and promote a sense of shame about seeking help.

Overall, stigma, system mistrust, prior experiences with the system, and help-seeking attitudes serve as critical barriers to service utilization. When considering the MTI, it is apparent that accessibility and acceptability have long played a role in BIPOC clients' prior experiences within the system. This may reduce their current willingness and ability to utilize available community mental health services.

Provider Level Barriers

The ecological systems theory posits that the proximal environments that individuals are embedded in can shape current and future behavior (Bronfenbrenner, 1979). With regard to mental health service utilization, the responsibility to secure competent mental health services should not fall solely on the individual or client-(s). Practitioners (microsystems) also have the

opportunity to act as advocates and allies. This may build trust, and increase accessibility, availability, appropriateness, and acceptability of available services for BIPOC youth, both by decreasing barriers and increasing facilitators of service utilization.

Implicit Bias

Implicit bias is defined as prejudice that occurs outside of an individual's awareness and at times, may contrast their conscious values or beliefs (Devine & Sharp, 2009). Implicit bias has been found to predict discriminatory actions (Gilliam et al., 2016; Hoffman et al., 2016; Okonofua & Eberhardt, 2015). Implicit biases left unexplored and unchecked may be disruptive to the therapeutic alliance and may also have serious consequences for whether BIPOC children receive appropriate diagnoses and treatment, internalize narratives of inferiority that are suggested through implicit prejudice, and result in racial trauma as a result of harm caused during the therapeutic process (Shim et al., 2018). Without sufficient pedagogical tools and infrastructure to disrupt implicit biases that providers may hold, such prejudice will continue to contribute to mental health inequity among BIPOC youth.

Clinician Efficacy

Given limitations to multicultural training in mental health graduate education, as well as, the realities of racial socialization in whiteness (Helms, 2017), white clinicians may not be equipped or familiar with interacting with BIPOC youth on issues concerning ethnicity, culture, and racism. Thus, in addition to lack of familiarity with diverse cultural norms, white providers often lack awareness of structural and environmental discrimination that BIPOC youth, their families, and their communities experience (Chang & Yoon, 2011; Rosen et al., 2019). These clinicians may be naïve to the ways environmental factors (e.g., racial discrimination) may negatively impact BIPOC mental health, and thus are less likely to consider these factors in diagnostic and treatment processes (Ieva et al., 2021; Naz et al., 2019). Some providers may be reluctant to discuss issues of race and discrimination due to fear, denial of White privilege, color blindness, or expressing discomfort around talking about race (Sue et al., 2010). Limited awareness of cultural norms and values, structural factors, and strategies for coping also may lead to inappropriate therapeutic interventions for psychological distress among BIPOC youth. Additionally, some white clinicians may interact with BIPOC youth in ways indicative of a "savior complex" (Cammarota, 2011) that occurs when a clinician benefits from being perceived as an ally without risking their existing privilege and power (Helms, 2017).

Structural/Organizational Barriers

Moving beyond client and provider factors, according to Bronfenbrenner (1979), structural/organizational barriers can have a compounding impact on BIPOC clients' experience in the system due to demographic and social characteristics (Leong & Lau, 2001). Due to structural racism that has resulted in significant economic disadvantage, BIPOC youth and their families are disproportionately represented within lower socioeconomic backgrounds. As such, some families may not have insurance or may deal with barriers related to being undocumented. Thus, community organizations are in a unique position to address the structural/organizational barriers that BIPOC clients may encounter when seeking mental health services.

Wait Lists

Long waitlists may be the first barrier BIPOC clients face when accessing mental health services (Meredith et al., 2009). Research indicates that the average wait time to see a child mental health provider is 9.9 weeks (Children's Hospital Association Survey, 2018). This long wait time is a significant barrier to initial onboarding for treatment, as long wait periods have been significantly and positively associated with clients failing to appear at initial appointments, increased symptomatology, and decreased motivation to seek treatment (Brown et al., 2002). Having timely access to mental health services is critically important for treatment among youth with mental health conditions (Sherman et al., 2009).

Clinic Location

Long distances and inadequate access to transportation are additional barriers to mental health access among BIPOC children and families that providers are responsible for considering (I. Metzger et al., 2023; Planey et al., 2019; Turner et al., 2019). Transportation barriers lead to rescheduled or missed appointments resulting in delayed care, as well as, increased health costs and poorer outcomes (Syed et al., 2013). This is particularly concerning for youth who are also on medication to manage their mental health symptoms, as missing an appointment can disrupt the continuum of care and compromise client outcomes. As such, organizations should be situated in urban, low-income, otherwise under-resourced and underserved communities. When this is not possible, community organizations should accept Medicaid in order to keep costs low, and hire

staff that will facilitate clients' attendance through connecting them to the Medicaid van, offering bus tokens, or reimbursing for private transportation. Overall, when considering the location of community mental health facilities, it remains critically important that BIPOC youth and families can physically access available services.

Hours of Operation

Parents or caregivers can participate in treatment with their child, but they often express difficulty attending appointments that are scheduled during business hours (I. Metzger et al., 2023; Ofonedu et al., 2017). Thus, it may be important to expand hours of operation to include evening and weekend availability for parents who may not have flexible work schedules that accommodate therapy attendance. This structural barrier prevents many families from accessing care, particularly when weekday appointments quickly fill. Such flexibility is also likely to benefit caregivers who have limited control over their work schedules, provide care for elders or other dependents, and youth limited by school and extracurricular schedules. When considering the MTI, increasing an organization's office hours increases its availability, accessibility, and acceptability, and thus also increases families' opportunities to utilize services.

Insurance/Medicaid

Insufficient insurance and the cost of services have contributed to disparities in mental health access (Sheffield et al., 2004). As BIPOC youth and their families are more likely to come from a low socioeconomic background, this may increase their likelihood of not having insurance (Holm-Hansen, 2006). Although Medicaid has somewhat improved access, insurance barriers such as a lack of in-network providers or not being able to find a provider that accept' one's insurance plan are still commonly reported (National Alliance on Mental Illness, 2020). Even for insured individuals, differences in policy may reduce the quality or comprehension of coverage for BIPOC youth (Holm-Hansen, 2006). Insurance coverage for mental health should not only continue to be expanded, but organizations should also work toward accepting all insurance, including Medicaid, as this would create more equitable access to mental healthcare.

Community Level Barriers

Lastly, exosystems such as the education system, the juvenile criminal-legal system, social services, and the medical system encompass factors that influence behaviors and development (Bronfenbrenner, 1979). BIPOC youth encounter and are disproportionately represented within these systems, albeit underserved. Additionally, they face a combination of client, provider, and structural barriers that are maintained within these institutions and further prevent equitable access to mental health services, as discussed below.

Education System

Most children and youth receive mental health services in schools (Rones & Hoagwood, 2000). Although schools are a common place for youth to receive mental health services, a study conducted by Wang et al. (2020) on barriers to mental health help at school found that Asian and Latinx adolescents reported structural barriers (time and cost) that schools and mental health institutions can help offset. Additionally, one study that examined teachers' perceptions of barriers for school mental health reported that the primary barriers for supporting youth mental health needs were an insufficient number of school mental health professionals, lack of adequate training for dealing with children's mental health needs, and lack of funding to support school mental health services (Reinke et al., 2011).

Juvenile Criminal-Legal System

Although BIPOC youth with mental health conditions are often underserved, youth involved with the juvenile criminal-legal system (otherwise known as the juvenile justice system) are often more underserved than those who have not had contact with this institution (Masi & Cooper, 2006). Though the rate of detained youth living with a mental health condition is high, these young people are less likely to use mental health services both within institutions of incarceration and in their communities. For example, Abram et al. (2008) examined detained youths' perceptions of barriers to mental health services, and many reported believing that their mental health condition would go away, resolve on its own, that they did not know where to receive help, or that finding help was too difficult.

Social Services

Black and Latinx children are disproportionately represented in the child welfare system, and scholars have found that youth who enter the child welfare system are more likely to be diagnosed with emotional and behavioral disorders (Havlicek et al., 2013). Despite a desire to support these young people, case managers have reported macro level barriers that make it difficult to facilitate care, such as a lack of funding to provide basic needs for the families with whom they work. Moreover, some expressed concerns about the dearth of timely,

culturally appropriate services and providers' limited availability to serve the many BIPOC youth in the welfare system (DeNard et al., 2017).

Facilitators to Mental Health Service Utilization

Given disparities in treatment, it is necessary that we not only identify barriers to treatment seeking, but also recommend pathways to improve service utilization and clinical care for BIPOC youth. As such, the following section identifies factors that clinical psychologists can address in order to support increased access and use of mental health care among BIPOC youth and their families. Similar to our identification of barriers, we identify factors that will facilitate service utilization at the client, provider, and community levels.

Client Level Facilitators

Recent scholarship has demonstrated that client and family recognition of symptom severity and declines in mental health functioning may facilitate treatment seeking. For example, a systematic review found that African American mothers who observed severe behavior in their child were more inclined to secure mental health services for them (Planey et al., 2019). This finding is consistent with research on BIPOC mental health that documents that externalizing behavior is more likely to result in help seeking compared to internalization of distress (Cho et al., 2007; Lindsey et al., 2013). To facilitate treatment, psychoeducation around emotional, physical, behavioral, and social symptoms may support BIPOC families in their ability to identify signs of distress and thus, seek support for their children.

Parents' personal experiences with mental health services may also facilitate seeking treatment for BIPOC youth (Murry et al., 2011; Turner & Liew, 2010). Numerous studies with African American families report that parents' positive experiences with mental health treatment, prior use of psychiatric medication, or current involvement in treatment facilitates openness to seek mental health services for their child (Planey et al., 2019; Turner & Liew, 2010). Furthermore, BIPOC youth and their families bring individual and cultural strengths that enhance engagement with mental health providers and can improve their experience of services. I. W. Metzger et al. (2021) suggest that clinicians should build upon these resiliencies and use evidence-based treatments modified to incorporate cultural values and highlight cultural and community strengths (e.g., racial socialization). Such customization will improve mental health outcomes, as well as., better engage and retain BIPOC youth in treatment.

Provider Level Facilitators

Community mental health providers have a responsibility to work toward, and advocate for improvement of provider-client interactions, to decrease barriers to service utilization. Given that BIPOC clients often report a lack of clarity regarding the roles of the staff that they encounter in mental health settings, providers should prioritize fundamental skills related to establishing relationships with clients (I. Metzger et al., 2023). This includes a formal introduction to the role(s) they hold, the scope of work they will engage with clients, and any required contact with third parties regarding treatment planning, service utilization, and mandated reporting. Additionally, providers play an instrumental role in cultivating culturally-responsive environments for BIPOC clients. Providers should ensure that they are aware of and are advocating for the multitude of factors that speak to the needs of BIPOC youth. Such factors range from individual client considerations to awareness of organizational and community resources available to increase utilization and provision of care. Continuing in our discussion of our conceptual model, below we discuss additional provider level facilitators that have been identified in the literature.

Provider Diversity

Despite a growing number of BIPOC clinicians entering mental health professions, related training programs enroll and graduate an overwhelming majority of white practitioners (American Psychological Association [APA], 2018). As such, the values, principles, and practices of the institution of mental health are largely guided by white cultural values and practices. Other factors such as racial and gendered socialization, racial privilege, lack of familiarity with patients' and families' life and experiences, and cultural worldviews may negatively impact clinical judgment among white-identified clinicians. This ultimately may reduce clinical efficacy and the degree to which BIPOC youth experience relief from the psychological distress for which they sought support (Tervalon & Murray-García, 1998). One remedy may be the intentional recruitment and retention of BIPOC providers in community mental health centers. Purposeful focus on expanding racial and ethnic diversity within community mental health is likely to improve mental health access and equity for BIPOC youth and their families due to familiarity with BIPOC clients' race, ethnicity, and cultural values (Turner et al., 2019; Wintersteen et al., 2005). This may be particularly important in the wake of the 2020 racism syndemic as BIPOC youth and their parents may be especially interested in working with therapists who understand their lived experience.

Cultural Humility

Cultural humility is a disposition through which mental health providers focus on maintaining an "other-oriented interpersonal stance" to prevent making assumptions about clients' cultural identities and the meaning they assign to such identities (Hook et al., 2013). Cultural humility encourages providers to: 1) engage in ongoing learning and self-reflection; 2) mitigate traditional power differentials between themselves, their clients, their colleagues, and the communities served; and 3) engage in institutional advocacy (Tervalon & Murray-García, 1998). For example, providers should not assume that all clients with whom they share cultural identities will have the same lived experiences. Providers should seek continuing education to learn about cultural factors related to treatment and not rely on clients to teach them about their culture. Further, they should prioritize treating BIPOC youth and their families as experts in their worldview, and avoid defensiveness when microaggressions occur in the therapeutic setting (Ofonedu et al., 2023).

Despite its usefulness in facilitating cultural openness and curiosity, some researchers posit that cultural humility fails to challenge the cultural hegemony of whiteness that is characteristic of the discipline (Ahmed, 2007). As such, practitioners should acknowledge the ways in which psychology maintains whiteness through pedagogy, ethical guidelines, and multicultural training (Martin, 2014; Rentería et al., 2020). All providers should seek training, engage in consultation, and practice personal reflection in order to move toward cultural humility and reduce implicit bias within the treatment space. Such critical reflection and education may facilitate acknowledgment and mitigation of the power and privilege that influences white clinician's provision of services in ways that may cause harm to BIPOC children, their families, and their communities.

Understanding Critical Frameworks

When working with BIPOC children, an other-oriented stance must be accompanied by knowledge, awareness, and skills suggested in cultural competency training, in addition to antiracist and abolitionist frameworks that both acknowledge and challenge the ways that BIPOC children have historically been harmed by structural and interpersonal racism embedded within the institution of mental health (Flynn et al., 2020; Love, 2019). Cultural humility and critical knowledge must be accompanied by a deep commitment to, and ongoing practice of meaningful exploration of one's racial identity, privilege, and values (Helms, 2017; Thomann & Suyemoto, 2018). Integrating these frameworks and practices in clinical work is likely to facilitate trust of service providers and BIPOC youth's engagement with mental health services. Maintaining an open interpersonal stance with regard to culture creates space to explore youths' experiences and the formation of identity. Simultaneously, critical frameworks (e.g., antiracism, critical race theory, critical whiteness studies) that honor the experiences of BIPOC youth can act to decenter whiteness in clinical science by validating the impact of structural oppression and environmental factors on psychological distress, as opposed to dominant individual-level analyses of psychological functioning. The integration of cultural humility and competency-based knowledge may reduce inequities as therapists are challenged to acknowledge the realities of racism and its pervasiveness in the structures that make up the culture of psychotherapy.

Inequitable Pathways to Licensure and Paraprofessional Mentoring

The demand for services outweighs the number of available child mental health providers across the United States. The number of mental health providers who are trained to meet the developmental and cultural needs of BIPOC youth is even smaller. According to a national survey, only 6% of mental health providers identify as Hispanic and 4% as Black (APA, 2022), and this may be due to gatekeeping and costly, elitist policies that make it difficult for racially and ethnically minoritized individuals to pursue professional degrees in healthcare (Wilcox et al., 2022). To reach a broad range of BIPOC youth, the field of mental health can benefit from reframing how it prepares and certifies those who provide direct services.

Professional training and mentoring of therapeutic paraprofessionals are models that are being explored more often. Given research (Buchbinder, 2003) that demonstrates that paraprofessionals, with appropriate training and support, can deliver effective clinical interventions, greater utilization of paraprofessionals may reduce delays to treatment. Further, expenses associated with years of graduate training for mental health professionals would be reduced. This also creates increased opportunity to facilitate entry of a diverse professional workforce to improve access to mental health support and dissemination of treatments for BIPOC youth. Most importantly, clinicians can advocate against policies that gatekeep and prevent historically marginalized individuals from licensure (e.g., costly licensure exam fees; requirement of GRE and other standardized exams for graduate school entry).

Lay Mental Health Workers

An alternative way to increase access to mental health services is through tasking shifts, or shifting the delivery of treatment interventions to lay mental health workers in BIPOC communities. Research shows that trusted community members such as preachers/pastors, coaches, teachers, or barbers/hair stylists can ameliorate BIPOC youth mental health (Dorsey et al., 2020; Jemmott et al., 2017). Currently, there are limited examples of lay mental health workers delivering evidence-based treatments in the United States (Barnett et al., 2018), despite evidence that BIPOC individuals rely on these community members for social, emotional, and spiritual wellbeing. Future research should continue to explore the potential health impact of training lay mental health workers to deliver mental health services and its impact on BIPOC youth and families' community mental health service utilization.

Structural/Organizational Facilitators

Sliding Scale of Fees

Even when individuals are insured, costs may still be a barrier in securing mental health care. Offering a sliding scale of fees allows for community-based organizations to charge based on family income, current stressors, household size, and other factors that impact one's ability to utilize available services. Rather than charging a fixed fee per hour, offering a sliding scale allows for clients to get the services they need at an affordable rate thereby increasing accessibility to mental health services. Although the literature on mental health organizations offering a sliding fee scale for mental health services is sparse, it is important to consider that cost is one of the most common barriers reported by clients. With this knowledge, offering a sliding scale fee may increase the accessibility to mental health services for BIPOC youth and families (Smith et al., 2016).

Wraparound Services

Wraparound services can play a critical role in increasing outpatient treatment utilization and reducing disparities in treatment outcomes, particularly for BIPOC youth (Blizzard et al., 2017). Wraparound services focus on addressing youths' mental health needs by connecting families with collaborative care through multiple settings such as community mental health, schools, foster care, and the juvenile criminal-legal system (Carney & Buttell, 2003; Hunter et al., 2018; Weiner et al., 2011). Rather than sending youth to intensive inpatient facilities, like treatment centers or psychiatric hospitals, wraparound services allow youth to stay in their community. When implemented with fidelity, this approach results in better outcomes for youth, and at a lower cost (Coldiron et al., 2017). Despite this finding, racially and ethnically minoritized communities often face disparities in how frequently these wraparound services are implemented (Olson et al., 2021). We posit, here, that increased awareness and availability of wraparound services will also improve mental health service utilization for BIPOC youth and families.

Group Services

It is important to also consider group therapy and the benefit of serving more clients than can be served in individual therapy. Group therapy has many advantages including being less expensive, normalizing and validating individuals' experiences, and facilitating creation of a support system. Additionally, group therapy is equally as effective as individual therapy (Flannery-Schroeder et al., 2005). To this end, group therapy is a viable way to offer additional mental health services to BIPOC youth and their families.

Telehealth

Telehealth can also improve access to mental health care, specifically where there are physical barriers to utilization. Scholarship related to telehealth has demonstrated strong evidence of satisfaction and acceptability among youth and their parents (Goldstein & Glueck, 2016), in addition to resulting in treatment outcomes similar to in-person therapy for various mental health concerns (Gloff et al., 2015). Telehealth may be critically necessary and useful for BIPOC youth that may live in rural or underserved areas, or lack access to transportation- solving some of the barriers discussed earlier.

Community Level Facilitators

Given BIPOC youth frequency access primary health care services and school-based mental health treatment, increased collaboration between systems is one of the most important considerations to facilitate community mental health services. Within communities, organizations should facilitate communication, transparency, referrals, accommodations, and advocacy. Here, we consider additional ways that community-based systems can serve as facilitators of service utilization for BIPOC youth and their families.

Medical System

Although much of our review of the literature on historical and systemic abuse of BIPOC youth and families has considered the impact of the medical

system, it is important to note the ongoing intrinsic involvement of primary care in service provision. Although marginalized, low-income, and BIPOC youth are less likely to utilize community mental health services, these families still encounter regular wellness checks, physicals, and even emergency room visits that serve as sites of early prevention, assessment, and brief intervention (Snowden & Pingitore, 2002). As such, practitioners operating in these capacities have the opportunity to mitigate common barriers families experience (e.g., lack of awareness of available services) by addressing culturally specific stressors and strengths and empowering families to seek and utilize additional resources in their communities.

Alternatives to Law Enforcement

It is important to note the negative relationship that Black people and other racially minoritized communities have with law enforcement. Many police officers are not trained to address mental health or substance use issues and their interventions have often led to a person in crisis being placed in jail, killed, or not getting the treatment they need (Ramasamy et al., 2022). Therefore, in addition to establishing trust and communication between and within systems, communities that face systemic marginalization and criminalization may benefit from alternative community interventions for mental health concerns that do not include law enforcement (Shivaram, 2021). Some cities have created alternative response teams made up of social workers, counselors, and other helping professionals to assist people with mental health or substance use issues. For local communities that do not have a formal alternative response team established, there are often other trusted individuals and organizations (e.g., transformative justice practitioners, domestic violence organizations, pastors) who are able to de-escalate potentially harmful situations before calling law enforcement.

Learning from Interdisciplinary Scholarship and Practice

The field of clinical psychology can learn from other fields including social work, intervention and prevention science, and public health, as well as, subdisciplines within psychology including community and counseling psychology. These fields move beyond focusing on individual level factors and examine larger, more distal macro levels factors to improve the mental health of BIPOC clients. For example, clinicians can work with clients to help address social and environmental determinants of mental health including access to healthcare, childcare, housing, transportation, and employment. These fields and sub-disciplines also often engage and collaborate with racial and ethnically minoritized communities to conduct outreach and to identify and address common concerns. Clinicians in community mental health centers, though delivering shorter-term individual and group services, can learn from these similar fields to better serve and encourage service utilization for BIPOC youth and families.

Conclusion

Historically, racially and ethnically minoritized children and adolescents have experienced greater deficits with regard to support for their mental health needs. Inadequate mental health and subsequent mental health difficulties among BIPOC youth has contributed to poor mental health outcomes, as well as, higher healthcare burdens on their families, communities, and on mental health institutions. As such, this paper builds on existing literature to conceptualize points of intervention to improve access to mental health services for BIPOC youth. Specifically, this paper provides a robust review of current literature with regard to barriers facilitators to mental health services among BIPOC youth and their families.In doing so, we posit a comprehensive conceptual model that outlines these barriers and facilitators at the client, provider, structural/organizational, and community levels, and that addresses acceptability, accessibility, availability, and appropriateness of services (Turner & Turner, 2021; Turner et al., 2019). It is our intention that this review and conceptual model builds on previous literature (Alegría et al., 2015; Turner et al., 2019), to bring attention to historical and contemporary individual and community factors that lead to mental health disparities among BIPOC youth and their families, and to facilitate greater access and improved health. Ultimately, mitigating the disparities in treatment seeking and utilization in this population is an act of racial justice in which clinical psychologists and other mental health clinicians can practically engage.

Research in the fields of psychology and psychiatry documents how historical mistreatment, oppression, and unethical behavior have led to medical mistrust and reluctance to utilize community mental healthcare (Fisher et al., 2002; Medlock et al., 2019; Turner et al., 2016). Although there have been improvements in training and policy to reduce mistreatment and discrimination, there remains a need to eradicate racism in the mental health field and in society. Implementing anti-racist practices and strengthening clinician efficacy in psychology requires mitigation of barriers to treatment at the client, provider, organizational and

community levels. In removing these barriers, mental health providers and institutions become more culturally responsive in their service delivery and ultimately increase help seeking behavior, improve treatment outcomes, and reduce further harm of BIPOC youth (e.g., misdiagnosis of BIPOC youth) and families in mental health systems (Turner et al., 2016). Thus, our review and recommendations are a significant contribution to literature related to mental health disparities largely determined by experiences of structural and systemic racism.

Looking forward, it is necessary to continue dialogue around how racism within the field of psychology serves as a barrier to treatment seeking. In order to facilitate treatment among BIPOC youth, the field of child psychology can play a critical role in advancing science and practice by illuminating discrimination in training and clinical settings. Practitioners must also acknowledge how systems have continued to disproportionately impact BIPOC clients through the lack of racially conscious and culturally-responsive providers and implicit biases. These issues are critical to reducing disparities and improving clinical care.

It is therefore important to identify and address how structural variables can impede the use of mental health services for BIPOC youth and their families (Turner & Turner, 2021). One way to do so is through engaging public policy. Within the child mental health field, advocacy is necessary to realize policy changes that will reduce barriers and promote facilitators to treatment for BIPOC youth. Advocacy at the local and national levels is required to urge policymakers to support bills that will directly reduce discrimination in mental healthcare and increase funding opportunities to continue finding solutions to continue understanding and creating solutions to disparities in mental health. For example, as more individuals seek teletherapy, policy efforts need to address insurance coverage of online mental health services, as expansions in coverage to include teletherapy may directly increase access to care. Additional ways that public policy can improve access to mental healthcare services for BIPOC youth and families include increasing access to wraparound services, increasing racial representation in the field, and training more mental health advocates and paraprofessionals (Coldiron et al., 2017; Jemmott et al., 2017).

Finally, as we continue to advance the field of clinical child psychology, it is important to continue expanding the ways that we approach our understanding of barriers and facilitators. Consideration should be given to integrating theories that have emerged out of disciplines such as sociology, public health, and legal studies (e.g., critical race theory; Delgado, 1998) as interdisciplinary scholarship and practice enhance BIPOC youth's overall wellness through collaboration and the creation of innovative solutions that are multidisciplinary and justice-oriented. As we acknowledge growing individual and cultural diversity within youth and families, psychology- in both training and practice- must play catch up to meet the multicultural needs of those we serve.

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