DISCUSSION PAPER

Improving Behavioral Health Services in the Time of COVID-19 and Racial Inequities

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Introduction

The emergence of coronavirus disease 2019 (COVID-19), coupled with the increasing awareness of racial inequity in the United States, as sparked by the killing of George Floyd at the hands of police officers, has led to a moment of reckoning regarding health inequities in the United States. This reckoning has also helped to shine a light on structural racism and racial inequities in the behavioral health system (i.e., the substance use disorders [SUDs] and mental health care treatment systems). In general, minoritized communities in the United States (including Black, Latinx, and Indigenous populations) experience poorer access and lower quality of care than White populations for behavioral health services [1]. These poor outcomes are compounded by the fact that mental illnesses and SUDs are more likely to be criminalized for specific populations. As a result, Black, Latinx, and Indigenous populations are more likely to receive behavioral health services in the context of systems poorly equipped to effectively manage behavioral health issues, including jails and prisons, the juvenile justice system, and the child welfare system [2].

Many individuals are aware that access to quality care for people with mental illnesses and SUDs is not equitable. However, as a society, we have not done enough to investigate how failures and breakdowns in multiple systems (e.g., health care, criminal justice, public health, and education) have a significant impact on behavioral health outcomes—with striking inequities in outcomes based on race and ethnicity—as fueled by structural racism. Structural racism is defined as "a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with 'whiteness' and disadvantages associated with 'color' to endure and adapt over time" [3]. For example, residential segregation, a structurally racist system enacted through the federal government policy of redlining, has led to lasting impacts on both physical and mental health. A recent analysis found 69 counties in the United States where Black residents had a higher likelihood than White residents of having to drive more than one mile to get to the closest COVID-19 vaccination site [4].

The failures in the management of COVID-19, coupled with greater awareness of the impact of structural racism on health, provide an opportunity to assess mistakes that were made in the past. Hopefully, this assessment will lead to charting a new path forward for transforming behavioral health services in the United States into one that provides high-quality care for all populations, emphasizing those most minoritized and oppressed. In addition, disparities in the funding of behavioral health services will also need to be reexamined through the lens of these structural biases.

The failure of the behavioral health system to meet the needs of all U.S. residents is not new. Since the advent of community mental health and deinstitutionalization in the 1950s, there have been inadequate resources to manage community health (often compounded by structurally racist policies such as residential segregation). As a result, individuals with mental illnesses and SUDs have often fallen into a safety net that is full of holes, which fails to catch most—causing the most vulnerable people to slip through these holes and into the "systems of last resort," such as the child welfare system and the criminal justice system. For instance, inequitable intervention rates for substance use must be seen in the context of two divergent paradigms for conceptualizing addiction. White people with

SUDs are more likely to receive evidence-based health treatments for these conditions, which are deemed neurobiological disorders. In contrast, Black, Latinx, and Indigenous people are more likely to receive jail and prison terms for the same conditions, which are deemed criminal behaviors. For example, White Americans are significantly more likely to receive buprenorphine, one of the three FDA-approved medications for treating opioid use disorder, than Black Americans are [5].

Moreover, while Black and White Americans use illicit drugs at roughly similar rates, Black people are imprisoned on drug charges at nearly six times the rate of White people [6]. These widely differential outcomes are a significant contributor to disparities in the US prison population, which is 33 percent Black, 30 percent White, and 23 percent Latinx, even as the U.S. population is 12 percent Black, 63 percent White, and 16 percent Latinx [6]. In the context of these long-standing structural inequities, it should come as no surprise that people of color lack trust in American institutions, including health care delivery systems.

Changing currently inequitable behavioral health care systems must involve gaining the trust of Black, Latinx, and Indigenous communities. The health care establishment's long history of unethical and abusive treatment of Black Americans is well known and includes the Tuskegee Syphilis experiments and the unconsented sterilization and unanesthetized surgeries of Black women slaves embedded in the early history of obstetrics and gynecology. Long-standing xenophobic immigration policies have increased the risk of trauma in immigration into the United States and restricted the ability of many Latinx Americans to access health care services or to receive health care that is culturally and linguistically competent. Indigenous Americans have long experienced high rates of preventable illness and death, including SUDs and suicide, due to genocide and historical trauma. Reckoning with this past is rekindled in the context of COVID-19, with its disproportionate rates of morbidity and mortality for Black, Latinx, and Indigenous communities. Thus, health care is often avoided due to the anticipated experience of discrimination by 22 percent of Black Americans [7], 17 percent of Latinx persons [8], and 15 percent of Native Americans [9]. The expectations of minoritized populations that they might experience discrimination in health care systems co-occur with increased attention to structural racism, as evidenced by policing practices. It is imperative that the behavioral health care system adopt the many existing strategies to reduce discrimination to improve outcomes for people of color, made worse by the pandemic.

Ongoing efforts to reform the behavioral health system, in particular, have been slow, and these incremental changes have included integrating certain behavioral health conditions into primary care settings and advocating for mental health parity laws. Equal access to behavioral health care is now acknowledged by many as a civil right, and behavioral health services are viewed as essential benefits under the Affordable Care Act [10]. Unfortunately, these efforts, even though moderately successful, have not fully translated into improved care. Real and lasting change will require a significant re-conceptualization of behavioral health care through a lens of equity.

Just as communities of color experience higher rates of COVID-19-related morbidity and mortality due to structural inequities, they have also experienced behavioral health inequities as treatment systems are inadequately prepared to deliver appropriate care. Undertreatment has long been a crisis in US behavioral health, and oppressed and minoritized populations experience reduced access to already scarce resources compared to White populations. Furthermore, compared to White people, Black, Latinx, and Indigenous populations are less likely to receive services for SUDs at specialty treatment facilities [11]. Young people of color with behavioral health issues are more likely than White youth to be referred to juvenile justice systems rather than the mental health care system [12]. Policies and structures have resulted in mental health needs being separate and unequal to other health needs [13]. These policies, coupled with separate and unequal access to behavioral health care for Black, Latinx, and Indigenous populations, highlight why mental health parity is a civil rights issue.

The COVID-19 pandemic has led to a convergence of increased stigma in various sectors, including policing and enforcement of public health policies. In general, federal and state governments have not effectively prepared for worsening substance use and behavioral health problems as a result of the pandemic. Health care providers know that the social determinants of health are intimately tied to worsening outcomes in mental health—including how unemployment or job insecurity leads to depression and increased substance use and how poverty and food insecurity lead to increased suicidal ideation [14]. And yet, policies that could support U.S. residents in times of great

challenge (e.g., expanding unemployment benefits, increasing access to the supplemental nutrition assistance program [SNAP] benefits) have not been consistently implemented to improve social welfare and related behavioral health outcomes. When policies that focus on social determinants have been implemented, outcomes have improved. For example, the recent implementation of the child tax credit has led to an estimated reduction in the poverty rate in the United States from 13.7 percent to 11.3 percent [15]. In addition, an analysis of housing-related policies estimated that policies limiting evictions reduced COVID-19 infections by 3.8 percent and deaths by 11 percent in those counties that have implemented such policies. Had a federal policy regarding eviction moratoriums been implemented, it was estimated that it could have reduced COVID-19 infections by 14.2 percent and deaths by 40.7 percent [16]. Unfortunately, the Centers for Disease Control and Prevention (CDC)-implemented moratorium on evictions was recently overturned by the Supreme Court. The lack of preparation for COVID-19 has led to severe results, and behavioral health professionals and policymakers must take the opportunity to prepare for a looming behavioral health crisis by learning from the mistakes of the past and charting a bold new path forward.

As revealed with COVID-19 and racial inequities, problems within the behavioral health care system in the United States must be reimagined with equity at the forefront. The American behavioral health system is not entirely dysfunctional—certainly, effective, evidence-based treatments are available to some. With expansion under the Affordable Care Act, an estimated 75 million people have Medicaid, which provides services, including mental health services, to low-income adults [17]. Unfortunately, fewer psychiatrists accept Medicaid compared to other medical specialties [18], and not every person eligible for Medicaid is enrolled. Others may have high-quality health insurance plans covering mental health and SUD treatment with some degree of parity, but they might have limited benefits for some services for individuals with severe and persistent conditions.

Similarly, those "non-essential workers" who have work schedules that allow prioritization of office-based care (which is often dictated not by patient availability but by office availability) can seek treatment on their terms. During the COVID-19 pandemic, from January 2020 to January 2021, the rapid expansion of telehealth services has increased access to services in mental health treatment facilities by 77 percent and in SUD treatment facilities by 143 percent [19]. However, minoritized populations (including immigrants, Black, Latinx, and Indigenous communities) often do not have access to high-quality treatments, although preliminary data suggest that telehealth service use may be greater among Black and Latinx communities [20,21]. There is an opportunity to learn from the COVID-19 pandemic about how virtual behavioral health care may address some of these access inequities. Health care providers must envision a behavioral health system that works better for all by reforming crisis care, expanding preventive services, and strengthening early intervention programs.

Given the opportunity that COVID-19 presents to re-examine and reimagine the nation's current mental health care delivery system, we propose reconfiguring delivery systems, specifically crisis care, prevention services, and early intervention programs. In so doing, the authors of this manuscript hope to re-emphasize behavioral health as a foundation for all wellness and to reprioritize evidence-based treatments in communities and health systems in order to remove barriers to access and build on the strengths of communities to support and care for one another.

Reforming Crisis Care

The National Alliance on Mental Illness (NAMI) defines a mental health crisis as "any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community" [22]. Examples include loss of any kind due to death or relocation, trauma, or exposure to violence, and stopping medication or missing doses [22]. Crises are often the access point for individuals into behavioral health services. As stated by the Substance Abuse and Mental Health Services Administration (SAMHSA), "The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks" [23]. A single crisis-care solution cannot fill the gaps in the current approach, but a reimagined and comprehensive urgent care system may address deficiencies. These current limitations are particularly critical for people of color, who often live in high-needs and low-access communities. Access to urgent care centers should be more widely available in high-need areas or places where there is a large volume of behavioral health emergency department visits and mental health- and drug-related law enforcement crisis calls.

Because a behavioral health crisis can happen at any time, centers must provide access 24/7 and must be staffed to handle a broad array of mental health and SUD needs. Patients, family members, and the community need to have confidence and trust in the urgent care center and understand when urgent care is necessary. Beyond the provision of care, centers should provide training programs for patients and family members to recognize when crisis care is needed. Ideally, the staff should reflect the ethnic and cultural diversity of the community they serve.

The urgent care center should offer various services, including a mobile crisis unit available to assist in emergent situations that require immediate support from a behavioral health clinician. Placing a mental health specialist in a 911 call center could assist with the triage process and ensure that the appropriate resource is dispatched in response to a crisis call. A new law, creating an emergency call number that individuals can use in case of a mental health crisis, 988, will go into effect on July 16, 2022. SAMHSA has explained that a national 988 number sends a message "that mental health crises and suicide prevention are of equivalent importance to medical emergencies," and "would, over time, bring needed parity and could result in additional attention and resources to improve typical local psychiatric crisis services throughout the nation" [24]. Local jurisdictions are currently planning how this call number will be implemented and what kinds of crisis services will be available, using new resources appropriated in the new legislation.

A clinical 23-hour observation/stabilization unit would help patients in crisis who do not have an immediate need for inpatient admission but whose condition could escalate if sent immediately back into the community. In addition to traditional brick-and-mortar care, the center should leverage more contemporaneous means of care delivery, such as telemental health and texting services for patients in immediate crisis who need reassurance to get care. Access to virtual or telemental care delivery is particularly important in the context of the physical distancing constraints of the COVID-19 pandemic. Telemental health and texting can also assist first responders working with individuals in crisis who do not have immediate access to a mobile crisis unit or need triaging to determine the need for a mobile unit.

Coordination of care is essential for patients to reduce future crises. Therefore, administrative components should be a core function in an urgent care center. Patients need a comprehensive review of a recovery plan that includes outpatient follow-up, recovery education and tools, and, when indicated, peer support services. When applicable, patients with health care coverage will need coordination with case management staff with the health plan. Patients may also need community agency connections to address social determinants of health, which lead to mental health inequities, as patients who lack shelter, access to healthy food, and social connectedness are at greater risk for mental health issues, which can trigger a relapse [14].

Urgent care centers must have a strong alliance with inpatient facilities and emergency departments. Where available, urgent care centers should update states' inpatient psychiatric bed registries for their facility and use the registries to determine availability of beds for transfer patients. State registries were designed to allow an efficient flow of patients in crisis to the appropriate level of care by showing where beds are currently available [25]. Access to the registry by 911 dispatchers will also help divert individuals in crisis to a facility that has access to accommodate them. Additionally, emergency departments could use the registry to divert patients to the urgent care center where patients can get more immediate care with behavioral health specialists. Patients experiencing a mental health or substance use disorder crisis can spend hours or days in an emergency department waiting for care, which results in a disruption of care for the crisis patient and a disruption for other patients and emergency department staff [26]. Demographics and other social determinants of the community may be another consideration to determine optimal placement of these centers.

Access issues related to behavioral health services affect those who need treatment and (due to the pernicious effects of structural racism) put a strain on the criminal justice system. However, where available, services within the current behavioral health structure can be leveraged to increase access to much-needed services or build resiliency to prevent the need for future services. These services include medication-assisted treatment (MAT) providers, telehealth services, and other technology-based services.

Telemental health is a safe alternative to traditional outpatient services. This modality increases access to care because the behavioral health provider does not need to reside in the same location or geographic area as the patient. Telemental health also gives primary care providers and emergency departments easier access to psychiatric consultations [27]. This service is

also easier for patients who no longer need to make long trips to provider locations. However, telemental health services must be considered within the context of equity, particularly regarding how to improve access for communities that do not have adequate internet bandwidth or equipment in homes to effectively use these services.

Technology, beyond telemental health, is another method to increase access to behavioral health education and treatment. For example, apps can assist individuals with mild symptoms, which may ultimately increase overall access by addressing and resolving issues before symptoms escalate to a point where more formal or intense treatment is necessary. Other digital mental health interventions (DMHIs) include virtual reality, interactive online workbooks, and video games [28]. Researchers are still studying the effectiveness of DMHIs, but they have the potential to increase access by creating resiliency before symptoms escalate and offering an alternative form of treatment [29].

Behavioral health crisis and urgent care services are available in select communities, and technology-based services can help fill the gap in areas lacking these services. While access to these services can help relieve the burden of responding to a crisis, access is only one piece of the puzzle. The community and first responders need to know how and when to use crisis services and must have a strong alliance with crisis services providers. Increasing access to services should have a twofold effect on law enforcement: (1) available services for the community should result in a decrease in crisis calls to law enforcement, and (2) increasing access will provide an alternative to jail. In a study on mental health care and firearm violence, an association was found between increased psychiatric hospital beds and lower homicide rates [30]. Another analysis found that an increase in office-based mental health care services leads to a decrease in crime rates [31]. Arresting an individual experiencing a behavioral health crisis and confining them in jail instead of ensuring appropriate treatment is a form of discrimination that fails to address the underlying problem. In a meta-analysis of recidivism rates for offenders who received mental health treatment instead of jail, 10 out of 20 studies reported significantly lower re-arrest rates for offenders who received treatment [32].

Responding to individuals experiencing a behavioral health crisis requires a collaborative approach among all stakeholders, including the first responder and behavioral health care providers. The Crisis Intervention Team (CIT) model, in which law enforcement officers receive specialized training in responding to individuals with mental health problems, is one approach used by some law enforcement agencies that relies on cohesive and collaborative relationships. The CIT approach includes a change in culture for first responders, additional staffing and resources, creation of policies, training, practice guides, and relationship building with stakeholders [33]. Additional crisis response programs that divert responses away from law enforcement agencies altogether, such as Oregon's Crisis Assistance Helping Out On The Streets (CAHOOTS) model, have significantly reduced law enforcement encounters at considerable cost savings [34].

Expanding Prevention Services

Primary and secondary prevention of mental illness is not a focus for the current behavioral health system. Primary prevention focuses on preventing disease before it occurs, while secondary prevention aims to reduce the impact of a disease that has already occurred. Focusing on primary prevention requires greater attention to the social determinants of mental health, whereas secondary prevention involves more effective diagnoses, treatment, and ongoing support of individuals and families affected by behavioral health conditions. The current behavioral health care system is designed to prioritize the management of behavioral health crises, as discussed above. As a result, people often access behavioral health services when their illnesses have progressed to greater severity and chronicity, resulting in an overreliance on inpatient and emergency services and underutilization of outpatient behavioral health services, especially for people of color and people from oppressed and minoritized communities [35]. The most common reasons for not seeking services at earlier stages of illness include a lack of access to behavioral health services, increasing behavioral health care costs and fewer psychiatrists taking Medicaid insurance [36,37,18].

Shifting the focus of the behavioral health care delivery system to one that emphasizes preventive services will lead to several important gains. First, as mental health is not simply the absence of mental illness, the promotion of mental health and wellness is an important priority for improving behavioral health services. Moving toward a health care delivery model that emphasizes early interventions and prevention can lead to a system that seeks to effectively treat mental illnesses and SUDs and enables people to thrive and flourish in

life. This shift is especially important when considering the concept of behavioral health equity. Prioritizing this change requires an emphasis placed on addressing the social determinants of mental health and tackling the underlying social injustices in society that create the context for the unfair distribution of opportunities in society.

A shift toward prevention in mental health means that social determinants of mental health must be the primary focus in clinical encounters. Both primary care and mental health clinicians must ensure that patients have stable and portable health insurance, access to healthy foods, steady employment (or unemployment benefits, should they lose their jobs), opportunities to live and grow without the detrimental effects of poverty, and for children, the ability to live without adverse childhood experiences and exposure to neighborhood violence.

Interventions that address the social determinants of mental health (and thus, promote mental health and prevent mental illness) include large-scale policy interventions as well as clinical interventions. Several policy interventions that have effectively led to improving the social determinants of mental health exist. For example, Purpose Built Communities works to transform several interrelated social determinants of mental health—including neighborhood disorder, educational inequities, and area-level poverty through collaborations with community members and policymakers—resulting in improved educational outcomes, reduced crime, and increased community power in neighborhoods [38].

Clinical interventions that promote mental health include Nurse-Family Partnership, in which nurses provide home visits to young, pregnant women deemed high risk for poor post-partum outcomes. This intervention has been proven highly effective in improving many social determinants of mental health, including preventing child mistreatment and reducing interaction with the criminal justice system [39]. Also, medical-legal partnerships, in which civil service attorneys are embedded in clinical settings to protect people with mental illnesses from discriminatory acts, including evictions and loss of disability benefits, can prevent worsening of symptoms and reductions in patients' stress levels [40].

In the wake of COVID-19, emphasizing the prevention of mental illness means ensuring financial security for the 11 million children living in poverty in the United States—a higher proportion of which are Black, Latinx, and Indigenous relative to their population rates [41]. Preliminary studies suggest a rise in rates of depression during the pandemic, and an emphasis on addressing social determinants of mental health is needed [42,43]. During the pandemic, cash transfers can help sustain and prevent worsening mental health associated with financial insecurity, poverty, and income inequality [44].

Another area of emphasis in preventing mental illness is to ensure that everyone has access to healthy, nutritious foods. Food insecurity is associated with several poor mental health outcomes, including increased hyperactivity in children, increased suicidal ideation in adolescents, and major depressive disorder in adults [45]. Thus, ensuring access to healthy foods is crucial to promoting mental health and preventing mental illness. While food banks and charitable donations can be a starting point to support increased access to food, policy interventions at federal and local levels are needed to effectively eradicate food insecurity in the United States.

Additionally, discrimination is a powerful social determinant of mental health that can lead to many mental health problems, including alcohol use disorder, generalized anxiety disorder, and major depressive disorder [45]. Prevention of exposure to the detrimental effects of racism (and sexism, discrimination against LGBTQ populations, religious discrimination, ableism, and more) is needed to prevent severe mental illness. These efforts include examining and identifying discrimination that currently exists within the mental health care delivery system, in which Black patients are more likely to be viewed as hostile, more likely to be medicated against their will (and with higher doses of antipsychotic medications) and more likely to be secluded and restrained than White patients [46]. Anti-racist policies within mental health care settings can begin to dismantle the pernicious effects of racism and lead to the overall prevention of the development of mental illnesses and SUDs.

Finally, since good mental health does not exist without protection against other medical issues such as COVID-19, a good place to start is with implementation of equitable strategies for immunization. A recently published National Academies report titled "Framework for Equitable Allocation of COVID-19 Vaccine" acknowledges the long history of health inequities that inform the hallmark inequitable racial impacts of the

pandemic [47]. The report proposes a vaccine allocation system that includes a vulnerability index allowing resources to be focused not on specifically defined racial or ethnic categories, but on high-vulnerability areas defined by state, tribal, and local authorities. These recommendations have already been implemented successfully in many states and jurisdictions in the United States [48]. The report's vaccine allocation strategies include leveraging all levels of government to ensure equitability, focusing on care with no out-of-pocket expenses, creating a community engagement framework focused on transparency and the communication of treatment risks and benefits, launching health promotion campaigns, and developing research to identify effective new treatment strategies. These strategies are conceived with community trust in mind and can serve as guidelines for redefining equitable access to behavioral health care. Such efforts might dovetail with other proposed strategies for trust development in traditionally marginalized and oppressed communities, such as "Operation Build Trustworthiness," which emphasizes collaboration with traditionally marginalized and oppressed communities [49].

Strengthening Early Intervention Programs

While early behavioral health interventions (meaning interventions for infants, children, adolescents, and young adults) for all Americans are needed to promote robust mental health and neurobiological functioning, they have particular importance for people of color, whose experience of financial, food, and housing insecurity is associated with a wide range of behavioral and other health problems. Psychological stress experienced by young people leads to mental health problems and numerous other diseases [50]. Racial discrimination is chronic, cumulative psychological stress that is experienced across multiple settings including health care, housing, employment, and the justice system [51]. Exposures to chronic stress are the most toxic to overall health and neurodevelopment, and the chronic stress of discrimination is a well-documented determinant of poor health outcomes in communities of color [52,53,54].

The developmental and neurobiological impact of early trauma and adverse childhood experiences (ACEs) is well established [55,56], and Black, Latinx, and low-income children have much higher rates of ACEs compared with White children [57]. Young Black men are more likely to experience trauma than young White men, and they experience high rates of PTSD; yet early interventions are not routinely applied [58]. Black youth with behavioral health problems are arrested at an earlier age than comparable White youth [59]. Once young people enter the juvenile justice system, they are less likely to receive mental health interventions [60], and Black youths in the juvenile justice system have lower mental health referrals than White and Latinx youths [59]. These statistics are especially concerning given already low behavioral intervention rates for youth: though half of all adolescents are estimated to have some evidence of a mental health disorder, only 38 percent receive mental health interventions, despite known effective treatments [61]. Fortunately, some of the consequences of stress on healthy neurodevelopment can be ameliorated by known effective behavioral interventions when implemented early in the course of illness. Mental health and SUDs often have their roots in childhood and adolescent adversities, so it is appropriate for early interventions to focus there.

Effective early interventions that address childhood trauma and other ACEs include a range of individual and group cognitive behavioral therapies (CBTs) [62]. One such example is Cognitive Behavioral Intervention for Trauma in Schools (CBITS), which has provided school-based mental health care to racially and ethnically diverse populations [63]. While other CBT-based approaches are probably or possibly effective, some are experimental [62] and should be used with caution. Another effective early intervention for trauma is the Attachment, Self-Regulation, and Competency (ARC) framework [64,65]. Additionally, Family Check-Up (FCU) is an early intervention that reduces conduct problems in children and improves parental engagement, particularly in social and economic risk factors [66,67]. Other therapeutic interventions in early childhood that promote mental health include Child-Parent Psychotherapy (CPP), Attachment and Biobehavioral Catch-Up (ABC), and Circle of Security (COS) [68]. Finally, early interventions for parents that reduce the impact of stress and mental illnesses on children include interpersonal therapy (IPT) and CBT, as well as numerous evidence-based medication treatments [69].

Evidence-based interventions that could be further expanded include numerous other approaches. For example, collaborative care models are shown to expand access to treatment for opioid and alcohol use disorders, both of which are sources of significant morbidity and mortality in the United States. This model is

associated with abstinence from alcohol and opioids [70]. Unfortunately, other effective early interventions do not have sufficient reach: Head Start and Early Head Start reach only 31 percent and 7 percent of eligible enrollees, respectively [71]. In addition, implementation barriers exist for many evidence-based interventions that might benefit marginalized and traumatized communities [72].

A 2019 National Academies report titled "Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda" notes that while these and other effective evidence-based interventions are available, almost none are implemented widely and sustainably [69]. This and three other recent reports by the National Academies argue for expanding access to evidence-based interventions, especially early interventions [73,74,75]. The report's early intervention recommendations include mobilizing more than care providers and health systems. It emphasizes the need for cross-sector change to promote mental health and lifelong wellness by advocating for the creation of a "Decade of the Child." This proposed initiative would focus on healthy child development in multiple sectors including health, business, advertising, and education. It acknowledges that cross-sector contributions and data sharing are needed to improve access to effective early mental health interventions, from screening and monitoring to scaffolded care at local, state, and national levels. In addition, the initiative would strengthen basic necessities—including safe and affordable housing, access to food, and reduced exposure to environmental toxins such as air pollutants and lead—all of which support early and lifelong mental health. As a step to advance the evolving attention to racial inequities, the report also calls for stopping ineffective punitive and disciplinary practices experienced inequitably by communities of color. A sea-change is needed in community and business support, financing, and political will to support effective and equitable needs-based early interventions.

Congress has demonstrated some political will through actions promoting mental health in the context of the COVID-19 pandemic and related national attention to mental health concerns. For example, in September 2020, the US House of Representatives passed the Mental Health Services for Students Act of 2020 (H.R. 1109) which would expand SAMHSA's Advancing Wellness and Resilience in Education Project (Project AWARE) to increase school-based comprehensive mental health programs [76]. The same month, the US House passed the Suicide Prevention Act (H.R. 5619), establishing grant programs expanding screening for self-harm [77]. While the Senate did not pass these proposed laws during the 116th Congress, the Mental Health Services for Students Act of 2021 (H.R. 721) was introduced during the 117th Congress in February 2021 [78]. These early intervention supports take on additional meaning in the context of renewed attention to the individual, family, and societal impacts of police killings of Black Americans and the separation of Latinx families at the U.S.–Mexico border.

Conclusion

Recent protests against murders of Black Americans at the hands of police, coupled with the COVID-19 pandemic, have helped spur calls for change in society. There is now an unprecedented opportunity to use this energy to advance change within the behavioral health system. With a focus on reforming crisis care, expanding prevention services, and strengthening early intervention programs, significant transformation of the US behavioral health care system can lead to greater equity for all. In addition, investing in minoritized communities, coupled with accountability to achieving equity, can improve outcomes for people experiencing mental illnesses and SUDs.

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