

Improving Access to Behavioral Health Services for Racial and Ethnic Minority Youth

Victoria Bowers



Executive Summary

- Up to 20% of youth in the U.S. experience a behavioral health condition each year, yet only half receive treatment. Racial and ethnic minority youth may experience a greater burden of behavioral health conditions related to socioeconomic status, racial discrimination, adverse childhood experiences, and immigration processes.
- The COVID-19 pandemic has exacerbated and highlighted existing racial and ethnic disparities among youth, shown in the prevalence of behavioral health conditions as well as access to behavioral health services.
- Factors such as language barriers, stigma, lack of health insurance, and limited behavioral health workforce diversity may reduce access to behavioral health services for youth within racial and ethnic minority communities.
- To increase access to behavioral health services for racial and ethnic minority youth, policymakers may consider strategies that support 1) collaboration between pediatric-behavioral health systems, 2) enhanced school and community-based behavioral health services, and 3) telehealth expansion.

Behavioral health defined

The term “behavioral health” is inclusive of mental health and substance use disorders, with behavioral health services encompassing prevention efforts, inpatient and outpatient care, substance use disorder treatment, crisis response, and a variety of support services for individuals, families, and communities. Annually in the U.S., 3.4 million adolescents receive behavioral health services in an inpatient or outpatient facility, 3.2 million in an educational setting, and 700,000 in a general medical setting.¹

Washington state's public behavioral health system includes the state's youth inpatient facility, the Child Study and Treatment Center, and ten regional Behavioral Health Organizations which contract with local behavioral health agencies to provide services outlined in the Medicaid state plan.² Youth over the age of 13 in Washington state may seek inpatient and outpatient behavioral health services without parental consent.³

The Center for Health Innovation & Policy Science (CHIPS) is an interdisciplinary research center that works to improve health across communities and the lifespan through innovation, evaluation, and training in health policy and health systems science, with a focus on health equity.

Director
David Grembowski, PhD

Associate Director
Layla G. Booshehri, PhD

Introduction

Twenty percent of youth in the U.S. experience a behavioral health condition each year, with only half receiving necessary treatment.⁴ Untreated behavioral health conditions are associated with long-term effects, such as limited educational attainment⁵; reduced functioning in work and social environments^{6,7}; and an increased risk for injury, addiction, overdose, and unintended pregnancies.⁸⁻¹¹ Despite racial and ethnic minority youth experiencing a higher burden of behavioral health conditions—a burden that has been exacerbated by the coronavirus (COVID-19) pandemic—they continue to face reduced access to behavioral health services due to factors such as language barriers, stigma, lack of health insurance, and limited behavioral health workforce diversity.

Racial and ethnic disparities in the prevalence of behavioral health conditions among youth in the U.S.

The longstanding effects of historical oppression of racial and ethnic minorities increase their risk for experiencing harms, such as intergenerational trauma, racism and discrimination, adverse childhood experiences, and lower socioeconomic status.¹²⁻¹⁷ This adversity places racial and ethnic minority youth at increased risk for developing or worsening behavioral health conditions, thus contributing to racial and ethnic disparities in the prevalence of behavioral health conditions among youth in the U.S.¹⁸⁻²⁰

American Indian and Alaska Native youth

American Indian and Alaska Native (AI/AN) adolescents have the highest rates of depression²¹ and suicide²² among all racial and ethnic minority youth²³ in the U.S. Compared to white adolescents, AI/AN adolescents are also at increased risk for substance use.²⁴

Latinx youth

After AI/AN youth, Latinx youth experience the second highest rate of depression among all racial and ethnic minority groups.²⁵ Among immigrant Latinx youth, migratory²⁶ and acculturative^{27,28} stressors are associated with an increase in depression and anxiety.

Black youth

Black youth have historically lower rates of suicide compared to other races. Suicide attempts, however, among Black adolescents have increased by 73% over the last two decades,²⁹ and the suicide rate for Black youth under 13 years of age is nearly two times higher than the rate for white youth.³⁰ Additionally, nearly 90% of Black adolescents have experienced discrimination, which is significantly associated with a higher lifetime risk for depression.³¹

Protective factors and resiliency

Importantly, racial and ethnic minority communities also experience factors that protect against the negative effects of racial and ethnic adversity and promote positive behavioral health and well-being among youth.^{42,43} These protective factors include strong cultural ties, familial bonds, ethnic identity, and religious beliefs, which may be leveraged by policymakers working to increase access to behavioral health services for racial and ethnic minority youth.⁴⁴

Asian American and Pacific Islander youth

Research shows Asian American and Pacific Islander (AAPI) youth have similar rates of behavioral health conditions as white youth.³² However, additional research shows Asian American youth may experience heightened psychological distress associated with witnessing increased discrimination against their communities during the COVID-19 pandemic.³³

Washington state

In Washington state, the prevalence of depressive symptoms is reported to be highest among AI/AN and Latinx adolescents (Fig. 1), with a higher prevalence among those in rural counties.³⁴ The highest rates of suicide attempts are also found among AI/AN and Latinx youth.³⁵

COVID-19's effect on racial and ethnic disparities in the prevalence of behavioral health conditions among youth in the U.S.

With school closures and stay-at-home orders, the COVID-19 pandemic has placed all youth at increased risk for developing or worsening behavioral health conditions related to social isolation³⁶ and unstable home environments.^{37,38} Compared to March 2019, the proportion of behavioral health-related emergency department visits for children and adolescents increased by 24% and 31%, respectively, in March 2020 when COVID-19 arrived.³⁹ Additionally, racial and ethnic minority youth have witnessed disproportionately higher rates of COVID-19-related morbidity and mortality within their families and communities,⁴⁰ thus placing them at increased risk for behavioral health conditions. Compared to a non-pandemic year, child bereavement increased by 20% in the U.S. in 2020, with Black youth comprising 20% of youth who lost a parent to COVID-19 although they are only 14% of the U.S. youth population.⁴¹ These stressors may compound existing racial and ethnic disparities in the prevalence of behavioral health conditions among youth in the U.S.

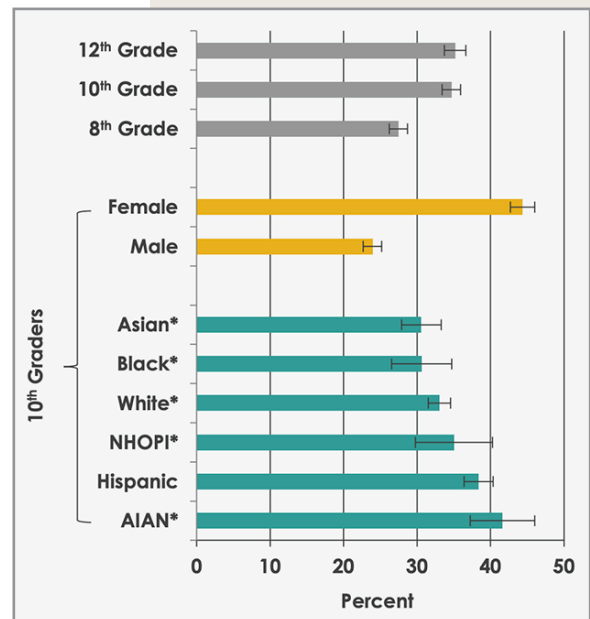
Racial and ethnic disparities in access to behavioral health services among youth in the U.S.

Access to behavioral health services

Twenty percent of all youth in the U.S. experience a behavioral health condition each year, yet only half receive treatment.⁴ Access to behavioral health services is even lower for racial and ethnic minority youth. Rates of access to all types of outpatient behavioral health services for Black and Latinx youth are nearly half the rates for that of white youth,⁴⁵ and a significantly higher percentage of Black and Latinx youth have unmet behavioral health needs compared to white youth.⁴⁶ For specialty

Figure 1

Racial and ethnic disparities in the prevalence of depressive symptoms among youth in Washington state



Washington State Department of Health. Washington State Health Assessment, 2014 and 2016 Healthy Youth Survey results combined³⁴

outpatient behavioral services—services provided by behavioral health professionals rather than general care providers, such as pediatricians—white youth are two times more likely than Latinx youth to access services.⁴⁷ Additionally, racial and ethnic minority youth covered by Medicaid or the Children’s Health Insurance Program (CHIP) are significantly less likely to access any form of behavioral health services than their white counterparts covered by Medicaid.⁴⁸ Notably, racial and ethnic disparities in rates of pediatric behavioral health-related emergency department visits in the U.S. have been increasing over the last decade⁴⁹ (Fig. 2).

Immigration, child welfare, and the juvenile correctional system

Racial and ethnic minority youth at the intersection of the immigration, child welfare, and juvenile correctional system face additional barriers to accessing behavioral health services. A significantly lower percentage of first-generation Latinx youth (18%) access behavioral health services compared to Latinx youth of U.S.-born parents (35%).⁵⁰ Significant Black-white disparities exist in access to counseling services in the child welfare system, with 35% of white youth receiving counseling compared to 24% of Black youth.⁵¹ Associations between behavioral health, race and ethnicity, and the juvenile correctional system also exist. Nearly 70% of all youth in the juvenile correctional system have a diagnosable behavioral health condition,⁵² with racial and ethnic minorities representing two-thirds of all youth in the system.⁵³

Barriers in access to behavioral health services

Behavioral health stigma

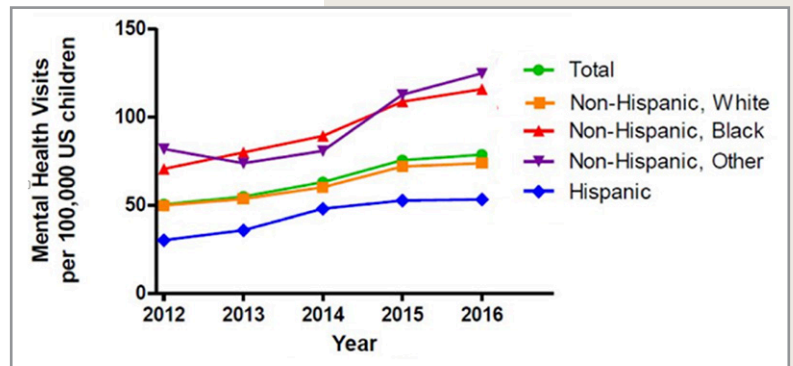
Behavioral health stigma is a negative perception of behavioral health conditions, which influences individuals or communities to fear, shame, avoid, or discriminate against those with such conditions. Such stigma deters help-seeking behavior by those who experience or perceive it.⁵⁴ Overall, research shows a higher prevalence of behavioral health stigma among racial and ethnic minority populations compared to white populations,⁵⁵⁻⁵⁷ though this varies between regions and populations.⁵⁸⁻⁶⁰

Provider shortages and limited workforce diversity

The U.S. faces a shortage of behavioral health providers, with nearly 37% of the U.S. population living in designated Mental Health Professional Shortage Areas (MHPSA).⁶¹ The country’s shortage of pediatric behavioral health providers is even more pronounced, with studies showing that the U.S. needs four times more pediatric behavioral health providers to meet the country’s current needs.^{62,63} Additionally, racial and ethnic diversity among existing behavioral

Figure 2

Trends in U.S. behavioral health-related pediatric emergency department visits, 2012-2016



Adapted from: Abrams AH, Badolato GM, Boyle MD, McCarter R, Goyal MK. Racial and Ethnic Disparities in Pediatric Mental Health-Related Emergency Department Visits⁴⁹

health providers is limited; one study found 95% of psychologists, 76% of psychiatrists, 85% of social workers, 80% of counselors, and 90% of psychiatric nurses are white, despite nearly one-third of the U.S. population being Black, AI/AN, or AAPI.⁶⁴ This lack of diversity among providers contributes to language barriers,⁶⁵ mistrust,^{66,67} and reduced cultural competency⁶⁸ in the delivery of behavioral health services to racial and ethnic minority youth.

Limited health insurance enrollment and coverage

In 2019, roughly 55% of youth had private insurance, 40% had public insurance, and 6% were uninsured.⁶⁹ Latinx and Black youth account for 53% of uninsured youth in the U.S.⁷⁰ despite only comprising roughly 40% of the U.S. youth population.^{71,72} Uninsured youth are less likely to access any type of behavioral health service compared to insured youth,⁷³ and uninsured youth have significantly lower treatment rates for depression than youth with private or public insurance.⁷⁴ However, health insurance coverage does not guarantee access to behavioral health services. Research shows pediatric behavioral health providers are ten times more likely to be out-of-network—and therefore more expensive—than primary care providers under commercial health insurance plans.⁷⁵

Racial and ethnic minority youth living in rural communities face additional barriers in accessing behavioral health services

Thirty-five of Washington state's 39 counties are federally designated as MHPSAs.⁷⁶ Many of these counties have large populations of Latinx agricultural workers⁷⁷ that have been disproportionately harmed by the COVID-19 pandemic. In 2020, 44% of all COVID-19 cases in Washington state occurred among Latinx individuals, despite comprising only 13% of the state's population.⁷⁸ Nearly 66% of agricultural workers in the U.S. feel the COVID-19 pandemic has undermined their mental health,⁷⁹ with rural immigrant Latinx agricultural workers reporting increased symptoms of stress and anxiety.⁸⁰ These factors may affect the behavioral health of rural Latinx youth because youth of parents with behavioral health conditions are at increased risk for developing behavioral health conditions themselves.⁸¹ Despite this increased risk, research shows rural immigrant Latinx families may be less familiar with, and have less access to, behavioral health services compared to urban immigrant Latinx families.⁸²

Rural access to behavioral health services is further limited by significant behavioral health provider shortages; 61% of MHPSAs are located in rural regions of the country.⁸³ Primary care providers and pediatricians are left to address this gap, often providing services they are not formally trained to provide.^{84,85} However, with only 9% of the nation's general physicians practicing in rural areas, pediatricians and

Provider shortages and restricted access to services contribute to behavioral health care disparities in Washington's rural communities.

primary care providers are also in short supply.⁸⁶ These challenges exacerbate racial and ethnic disparities in access to behavioral health services. Rural Black youth are half as likely to access behavioral health services compared to rural white youth,⁸⁷ and nearly half of all Indian Health Service facilities report rural locations as barriers to behavioral health service access.⁸⁸

Strategies to increase access to behavioral health services for racial and ethnic minority youth in the U.S.

Increase collaboration between pediatric-behavioral health systems

Collaborative care—that is, collaboration between primary or pediatric care providers and behavioral health providers to meet the behavioral health needs of patients⁸⁹—may improve access and outcomes associated with pediatric behavioral health services. Research shows significantly higher rates of treatment initiation (99% vs 54%), completion (77% vs 12%), and improvement in behavioral health conditions (71% vs 51%) when comparing youth under collaborative care versus traditional pediatric care.⁹⁰ In Washington state, research also shows youth under collaborative care are significantly more likely than youth under traditional care to achieve depression remission (50% vs 21%).⁹¹ Though limited, research suggests collaborative care may also reduce racial and ethnic disparities in access to behavioral health services.⁹²⁻⁹⁴

Promote community-based resources

Geographic and cultural barriers to accessing behavioral health services may be mitigated by supporting community-based resources, such as churches, school-based health centers, and community health workers and peer counselors within the broader behavioral health system. Beyond directly providing behavioral health services, these resources may connect racial and ethnic minority youth to professional behavioral health services and work to reduce behavioral health stigma within their communities.

Churches and faith-based organizations

Churches and faith-based organizations are highly trusted within Black^{95,96} and Latinx⁹⁷ communities, which may provide a foundation to improve access and outcomes associated with behavioral health services for racial and ethnic minority youth. Research shows religious social support reduces the risk for behavioral health conditions⁹⁸ and illicit substance use⁹⁹ among Black adolescents, and that faith-based mental health literacy interventions may improve treatment engagement within the Latinx community.¹⁰⁰

School-based health centers (SBHCs)

School-based health centers (SBHCs) provide integrated medical and behavioral health services to students, serving over 10,000 schools

To increase access to behavioral health services for racial and ethnic minority youth, consider:

- Collaboration between health systems
- Community-based resources
- Support of faith-based organizations
- School-based health centers
- Community health workers
- Telehealth expansion
- Increased health insurance enrollment

and 6.3 million students nationwide.¹⁰¹ SBHCs work to address geographic barriers and clinical shortages in the behavioral health field, with research showing significantly fewer racial and ethnic disparities in access to SBHCs than other behavioral health facilities.^{102,103} Notably, uninsured and publicly insured students have a higher likelihood of seeking behavioral health services from SBHCs than students with private health insurance.¹⁰⁴ Beyond improving access to behavioral health services, these centers may also improve behavioral health outcomes among racial and ethnic minority youth.^{103,105}

Community health workers (CHWs)

Community health workers (CHWs) work to mitigate behavioral health stigma and provide culturally attuned support and services to the communities they are from, which may improve access and outcomes associated with behavioral health services for racial and ethnic minority youth.^{106,107} Latinx youth engaged with Latinx CHWs—referred to as *promotores de salud* or *promotoras*—are significantly more likely to access behavioral health services than Latinx youth who are not so engaged.¹⁰⁸ Additionally, interventions implemented by AI/AN CHWs—referred to as Community Health Representatives¹⁰⁹—significantly reduce the risk for depression and illicit substance use among pregnant and postpartum AI/AN adolescents.¹¹⁰

Expand telehealth

Telehealth may increase access to behavioral health services for racial and ethnic minority youth by removing geographic and transportation barriers^{111,112} and by increasing access to linguistically and culturally competent providers.¹¹³ In addition to improving access to behavioral health services, telehealth also shows promise in significantly improving behavioral health outcomes.¹¹⁴ However, barriers to implementation include patient privacy concerns,^{115,116} limited internet access,¹¹⁷ and a lag in community clinics keeping pace with the rapid shift to telehealth initiated by COVID-19.¹¹⁸ Additionally, beginning in 2023, Washington state telehealth providers are required to have at least one in-person visit with their patients to continue to be compensated at the in-person visit rate, potentially perpetuating barriers to telehealth use within rural communities.¹¹⁹

Increase health insurance enrollment

Increasing health insurance coverage among racial and ethnic minority families may increase youth access to behavioral health services^{74,120}; research shows low-income parents who are publicly insured are more likely to also insure their children.¹²¹ Additional research shows the Affordable Care Act's health insurance expansion efforts are significantly associated with increases in behavioral health service access for Latinx and AAPI populations.¹²² Furthermore, reduced cost sharing may reduce financial barriers for families accessing behavioral health services for youth with behavioral health conditions.¹²³⁻¹²⁵ Despite legislation requiring large¹²⁶ and small group or individual¹²⁷ health insurance plans to provide behavioral health benefits on par with physical health benefits, insurers may circumvent these mandates by limiting in-network providers⁷⁵ and imposing restrictive coverage determination standards for the treatment of behavioral health and substance abuse disorders.¹²⁸

Conclusion

The COVID-19 pandemic has exacerbated and highlighted existing racial and ethnic disparities in the prevalence of behavioral health conditions as well as access to behavioral health services among youth in the U.S. and Washington state. To promote access to behavioral health services for this population, policymakers may consider strategies such as the integration of pediatric-behavioral health services, telehealth expansion, and the promotion of community-based resources in the behavioral health system to deliver timely and culturally competent care to racial and ethnic minority youth.

This is the third brief in a three-part series on health care access barriers in Washington state. CHIPS researchers are open to investigating policy questions across the public health and health policy domains.

Please contact us at uwchips@uw.edu with any inquiries.

References

1. Center for Behavioral Health Statistics and Quality. Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). The Substance Abuse and Mental Health Services Administration website. May 5, 2016. Accessed September 9, 2021. <https://www.samhsa.gov/data/>
2. Washington State Department of Social and Health Services. Behavioral Health Organizations. Washington State Department of Social and Health Services website. March 31, 2016. Accessed September 9, 2021. http://crhn.org/pages/wp-content/uploads/2015/06/BHO_Partners_FS.pdf
3. Washington State Legislature. Chapter 71.34 RCW. Washington State Legislature website. Accessed September 9, 2021. <https://apps.leg.wa.gov/rcw/default.aspx?cite=71.34>
4. Whitney DG, & Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. *JAMA Pediatr.* 2019;173(4):389-391. doi:10.1001/jamapediatrics.2018.5399
5. Kessler RC, Foster CL, Saunders WB, Stang PE. Social consequences of psychiatric disorders, I: Educational attainment. *Am J Psychiatry.* 1995;152(7):1026-1032. doi:10.1176/ajp.152.7.1026
6. Weissman MM, Wolk S, Wickramaratne P, et al. Children with prepubertal-onset major depressive disorder and anxiety grown up. *Arch Gen Psychiatry.* 1999;56(9):794-801. doi:10.1001/archpsyc.56.9.794
7. Kessler RC, Walters EE, Forthofer MS. The social consequences of psychiatric disorders, III: probability of marital stability. *Am J Psychiatry.* 1998;155(8):1092-1096. doi:10.1176/ajp.155.8.1092
8. Substance Abuse and Mental Health Services Administration. Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. November 2012. Accessed September 9, 2021. <https://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2011/NSDUHmhfr2011.pdf>
9. Centers for Disease Control and Prevention. Unintentional Poisoning Deaths --- United States, 1999-2004. Centers for Disease Control and Prevention website. February 9, 2007. Accessed September 9, 2021. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5605a1.htm>
10. Reardon DC, Coleman PK, Cogle JR. Substance use associated with unintended pregnancy outcomes in the National Longitudinal Survey of Youth. *Am J Drug Alcohol Abuse.* 2004;30(2):369-383. doi:10.1081/ada-120037383
11. The Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health (NSDUH). The Substance Abuse and Mental Health Services Administration website. Accessed September 9, 2021. <https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2003-nsduh-2003-ds0001>
12. Cerdeña JP, Rivera LM, Spak JM. Intergenerational trauma in Latinxs: A scoping review. *Soc Sci Med.* 2021;270:113662. doi:10.1016/j.socscimed.2020.113662
13. Evans-Campbell T. Historical trauma in American Indian/Native Alaska communities: a multilevel framework for exploring impacts on individuals, families, and communities. *J Interpers Violence.* 2008;23(3):316-338. doi:10.1177/0886260507312290
14. Shonkoff JP, Slopen N, Williams DR. Early Childhood Adversity, Toxic Stress, and the Impacts of Racism on the Foundations of Health. *Annu Rev Public Health.* 2021;42:115-134. doi:10.1146/annurev-publhealth-090419-101940
15. Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. *Annu Rev Public Health.* 2019;40:105-125. doi:10.1146/annurev-publhealth-040218-043750
16. Slopen N, Shonkoff JP, Albert MA, et al. Racial Disparities in Child Adversity in the U.S.: Interactions With Family Immigration History and Income. *Am J Prev Med.* 2016;50(1):47-56. doi:10.1016/j.amepre.2015.06.013
17. Bloome D. Racial Inequality Trends and the Intergenerational Persistence of Income and Family Structure. *Am Sociol Rev.* 2014;79(6):1196-1225. doi:10.1177/0003122414554947
18. Pachter LM, & Coll CG. Racism and child health: a review of the literature and future directions. *J Dev Behav Pediatr.* 2009;30(3):255-263. doi:10.1097/DBP.0b013e3181a7ed5a
19. Nyborg VM, & Curry JF. The impact of perceived racism: psychological symptoms among African American boys. *J Clin Child Adolesc Psychol.* 2003;32(2):258-266. doi:10.1207/S15374424JCCP3202_11
20. Garcia JL. Historical Trauma and American Indian/Alaska Native Youth Mental Health Development and Delinquency. *New Dir Child Adolesc Dev.* 2020;2020(169):41-58. doi:10.1002/cad.20332
21. American Psychiatric Association. Mental Health Disparities: American Indians and Alaska Natives. American Indians and Alaska Natives Fact Sheet. 2017. Accessed September 9, 2021. <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf>
22. Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003-2014. *MMWR Morb Mortal Wkly Rep.* 2018;67:237-242. doi:10.15585/mmwr.mm6708a1
23. Gary FA, Baker M, Grandbois DM. Perspectives on suicide prevention among American Indian and Alaska native children and adolescents: a call for help. *Online J Issues Nurs.* 2005;10(2):6. doi:10.3912/OJIN.Vol19No02HirshPsy01

24. Centers for Disease Control and Prevention. Patterns of Polysubstance Use Among Non-Hispanic White and American Indian/Alaska Native Adolescents: An Exploratory Analysis. Centers for Disease Control and Prevention website. April 4, 2019. Accessed September 9, 2021. https://www.cdc.gov/pcd/issues/2019/18_0108.htm
25. Ramirez AG, Gallion KJ, Aguilar R, Dembeck ES. Mental Health and Latino Kids: A Research Review. Salud America! website. September 12, 2017. Accessed September 9, 2021. <https://salud-america.org/wp-content/uploads/2017/09/FINAL-mental-health-research-review-9-12-17.pdf>
26. Potochnick SR, & Perreira KM. Depression and anxiety among first-generation immigrant Latino youth: key correlates and implications for future research. *J Nerv Ment Dis*. 2010;198(7):470-477. doi:10.1097/NMD.0b013e3181e4ce24
27. Schlaudt VA, Suarez-Morales L, Black, RA. Exploring the Relationship of Acculturative Stress and Anxiety Symptoms in Latino Youth. *Child Youth Care Forum*. 2021;50:261-276. <https://doi.org/10.1007/s10566-020-09575-0>
28. Huq N, Stein GL, Gonzalez LM. Acculturation conflict among Latino youth: Discrimination, ethnic identity, and depressive symptoms. *Cultur Divers Ethnic Minor Psychol*. 2016;22(3):377-385. doi:10.1037/cdp0000070
29. Lindsey MA, Sheftall AH, Xiao Y, Joe S. Trends of Suicidal Behaviors Among High School Students in the United States: 1991-2017. *Pediatrics*. 2019;144(5):e20191187. doi:10.1542/peds.2019-1187
30. Bridge JA, Horowitz LM, Fontanella CA, et al. Age-Related Racial Disparity in Suicide Rates Among US Youths From 2001 Through 2015. *JAMA Pediatr*. 2018;172(7):697-699. doi:10.1001/jamapediatrics.2018.0399
31. Pachter LM, Caldwell CH, Jackson JS, Bernstein BA. Discrimination and Mental Health in a Representative Sample of African-American and Afro-Caribbean Youth. *J Racial Ethn Health Disparities*. 2018;5(4):831-837. doi:10.1007/s40615-017-0428-z
32. Li H, & Seidman L. Engaging Asian American youth and their families in quality mental health services. *Asian J Psychiatr*. 2010;3(4):169-172. doi:10.1016/j.ajp.2010.08.008
33. Kormendi NM, & Brown AD. Asian American mental health during COVID-19: A call for task-sharing interventions. *SSM Ment Health*. 2021;1:100006. doi:10.1016/j.ssmmh.2021.100006
34. Washington State Department of Health. Washington State Health Assessment. Washington State Department of Health website. March 2018. Accessed August 30th, 2021. <https://www.doh.wa.gov/DataandStatisticalReports/StateHealthAssessment>
35. Healthy Youth Survey. 2018 Washington State Healthy Youth Survey. Healthy Youth Survey website. Accessed September 9, 2021. <https://www.askhys.net/>
36. Loades ME, Chatburn E, Higson-Sweeney N, et al. Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19. *J Am Acad Child Adolesc Psychiatry*. 2020;59(11):1218-1239.e3. doi:10.1016/j.jaac.2020.05.009
37. Substance Abuse and Mental Health Services Administration. Intimate Partner Violence and Child Abuse Considerations During COVID-19. Accessed September 9, 2021. <https://www.samhsa.gov/sites/default/files/social-distancing-domestic-violence.pdf>
38. Centers for Disease Control and Prevention. Trends in U.S. Emergency Department Visits Related to Suspected or Confirmed Child Abuse and Neglect Among Children and Adolescents Aged <18 Years Before and During the COVID-19 Pandemic — United States, January 2019-September 2020. Centers for Disease Control and Prevention website. December 11, 2020. Accessed September 9, 2021. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a1.htm>
39. Centers for Disease Control and Prevention. Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1-October 17, 2020. Centers for Disease Control and Prevention website. November 13, 2020. Accessed September 9, 2021. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm>
40. Centers for Disease Control and Prevention. Risk of severe illness or death from COVID-19. Centers for Disease Control and Prevention website. December 10, 2020. Accessed July 20, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/disparities-illness.html>
41. Kidman R, Margolis R, Smith-Greenaway E, Verdery AM. Estimates and Projections of COVID-19 and Parental Death in the US. *JAMA Pediatr*. 2021;175(7):745-746. doi:10.1001/jamapediatrics.2021.0161
42. Marcelo AK, & Yates TM. Young children's ethnic-racial identity moderates the impact of early discrimination experiences on child behavior problems. *Cultural Diversity and Ethnic Minority Psychology*. 2019;25(2):253-265. doi:10.1037/cdp0000220
43. Neblett EW, Rivas-Drake D, Umaña-Taylor AJ. The Promise of Racial and Ethnic Protective Factors in Promoting Ethnic Minority Youth Development. *Child Development Perspectives*. 2012;6(3): 295-303. doi:10.1111/j.1750-8606.2012.00239.x
44. Suicide Prevention Resource Center. Risk and Protective Factors in Racial/Ethnic Populations in the U.S. Suicide Prevention Resource Center website. 2013. Accessed September 9, 2021. <https://www.sprc.org/resources-programs/risk-protective-factors-racial-ethnic-populations-us>
45. Marrast L, Himmelstein DU, Woolhandler S. Racial and Ethnic Disparities in Mental Health Care for Children and Young Adults: A National Study. *Int J Health Serv*. 2016;46(4):810-824. doi:10.1177/0020731416662736
46. Kataoka SH, Zhang L, Wells KB. Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *Am J Psychiatry*. 2002;159(9):1548-1555. doi:10.1176/appi.ajp.159.9.1548

47. Hough RL, Hazen AL, Soriano FI, Wood P, McCabe K, Yeh M. Mental health services for Latino adolescents with psychiatric disorders. *Psychiatr Serv.* 2002;53(12):1556-1562. doi:10.1176/appi.ps.53.12.1556
48. Medicaid and CHIP Payment and Access Commission. Chapter 3: Access to Behavioral Health Services for Children and Adolescents. Report to Congress on Medicaid and CHIP. June 2021. Accessed September 9, 2021. <https://www.macpac.gov/publication/access-to-behavioral-health-services-for-children-and-adolescents-covered-by-medicaid-and-chip/>
49. Abrams AH, Badolato GM, Boyle MD, McCarter R, Goyal MK. Racial and Ethnic Disparities in Pediatric Mental Health-Related Emergency Department Visits [published online ahead of print, 2020 Sep 3]. *Pediatr Emerg Care.* 2020. doi:10.1097/PEC.0000000000002221
50. Finno-Velasquez M, Cardoso JB, Dettlaff AJ, Hurlburt MS. Effects of Parent Immigration Status on Mental Health Service Use Among Latino Children Referred to Child Welfare. *Psychiatr Serv.* 2016;67(2):192-198. doi:10.1176/appi.ps.201400444
51. Wells R, Hillemeier MM, Bai Y, Belue R. Health service access across racial/ethnic groups of children in the child welfare system. *Child Abuse Negl.* 2009;33(5):282-292. doi:10.1016/j.chiabu.2008.11.003
52. Skowrya KR, & Coccozza JJ. Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice Network. December 31, 2005. Accessed September 9, 2021. <http://www.modelsforchange.net/publications/148>
53. Children's Defense Fund. The State of America's Children 2020. Children's Defense website. Accessed September 9, 2021. <https://www.childrensdefense.org/the-state-of-americas-children-2020/>
54. Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US). Chapter 2 Culture Counts: The Influence of Culture and Society on Mental Health. In: Mental Health: Culture, Race, and Ethnicity: A Supplement to *Mental Health: A Report of the Surgeon General*. Substance Abuse and Mental Health Services Administration (US); 2001. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK44249/>
55. Eylem O, de Wit L, van Straten A, et al. Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis [published correction appears in *BMC Public Health.* 2020;20(1):1326]. *BMC Public Health.* 2020;20(1):879. doi:10.1186/s12889-020-08964-3
56. Wong EC, Collins RL, Cerully J, Seelam R, Roth B. Racial and Ethnic Differences in Mental Illness Stigma and Discrimination Among Californians Experiencing Mental Health Challenges. *Rand Health Q.* 2017;6(2):6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5568160/#_ffn_sectitle. Accessed September 9, 2021.
57. Anglin DM, Link BG, Phelan JC. Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatr Serv.* 2006;57(6):857-862. doi:10.1176/ps.2006.57.6.857
58. Murry VM, Heflinger CA, Suiter SV, Brody GH. Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. *J Youth Adolesc.* 2011;40(9):1118-1131. doi:10.1007/s10964-010-9627-1
59. Turner EA, Jensen-Doss A, Heffer RW. Ethnicity as a moderator of how parents' attitudes and perceived stigma influence intentions to seek child mental health services. *Cultur Divers Ethnic Minor Psychol.* 2015;21(4):613-618. doi:10.1037/cdp0000047
60. DuPont-Reyes MJ, Villatoro AP, Phelan JC, Painter K, Link BG. Adolescent views of mental illness stigma: An intersectional lens. *Am J Orthopsychiatry.* 2020;90(2):201-211. doi:10.1037/ort0000425
61. Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). Kaiser Family Foundation website. September 30, 2020. Accessed September 9, 2021. <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
62. McBain RK, Kofner A, Stein BD, Cantor JH, Vogt WB, Yu H. Growth and Distribution of Child Psychiatrists in the United States: 2007-2016. *Pediatrics.* 2019;144(6):e20191576. doi:10.1542/peds.2019-1576
63. American Academy of Child and Adolescent Psychiatry. Workforce Maps by State. American Academy of Child and Adolescent Psychiatry website. 2021. Accessed September 9, 2021. https://www.aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx
64. University of Michigan. Factors Impacting the Development of a Diverse Behavioral Health Workforce. Ohio Department of Mental Health and Addiction Services website. February 2017. Accessed September 9, 2021. https://mha.ohio.gov/Portals/0/assets/HealthProfessionals/Training%20and%20Workforce%20Development/CareerPathways/Factors_Impacting_%20Behavioral_Health_Workforce-Diversity.pdf?ver=2019-03-13-102735-210
65. Bauer AM, Chen CN, Alegría M. English language proficiency and mental health service use among Latino and Asian Americans with mental disorders. *Med Care.* 2010;48(12):1097-1104. doi:10.1097/MLR.0b013e3181f80749
66. Sussman LK, Robins LN, Earls F. Treatment-seeking for depression by black and white Americans. *Soc Sci Med.* 1987;24(3):187-196. doi:10.1016/0277-9536(87)90046-3
67. Murry VM, Heflinger CA, Suiter SV, Brody GH. Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. *J Youth Adolesc.* 2011;40(9):1118-1131. doi:10.1007/s10964-010-9627-1
68. Bagalman E, & Heisler EJ. Behavioral Health Among American Indian and Alaska Natives: An Overview. Congressional Research Service Report. September 16, 2016. Accessed September 9, 2021.

69. Kaiser Family Foundation. Health Insurance Coverage of Children 0-18. Kaiser Family Foundation website. 2019. Accessed September 9, 2021. <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22unit-ed-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
70. Flores G, Lin H, Walker C, et al. A cross-sectional study of parental awareness of and reasons for lack of health insurance among minority children, and the impact on health, access to care, and unmet needs. *Int J Equity Health*. 2016;15:44. doi:10.1186/s12939-016-0331-y,
71. Population Reference Bureau. Child Population, by Race/Ethnicity. Kids Data website. 2020. Accessed September 9, 2021. <https://www.kidsdata.org/topic/33/child-population-race/pie#fmt=144&loc=2&tf=110&ch=7,11,726,10,72,9,73,87&pdist=73>
72. Frey WH. The nation is diversifying even faster than predicted, according to new census data. Brookings website. July 1, 2020. Accessed September 9, 2021. <https://www.brookings.edu/research/new-census-data-shows-the-nation-is-diversifying-even-faster-than-predicted/>
73. Child Trends. Access to Mental Health Care. Child Trends website. January 2013. Accessed September 9, 2021. https://www.childtrends.org/wp-content/uploads/2013/04/Child_Trends-2013_01_01_AHH_MHAccessl.pdf
74. Olfson M, Gameroff MJ, Marcus SC, Waslick BD. Outpatient treatment of child and adolescent depression in the United States. *Arch Gen Psychiatry*. 2003;60(12):1236-1242. doi:10.1001/archpsyc.60.12.1236
75. Bowman Family Foundation. Addiction and mental health versus physical health: Widening disparities in network use and provider reimbursement. Milliman website. November 19, 2019. Accessed September 9, 2021. https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf
76. Health Resources and Services Administration. HPSA Find. Health Resources and Services Administration website. Accessed September 9, 2021. <https://data.hrsa.gov/tools/shortage-area/hpsa-find>
77. American Immigration Council. Immigrants in Washington. American Immigration Council website. August 6, 2020. Accessed September 9, 2021. <https://www.americanimmigrationcouncil.org/research/immigrants-in-washington>
78. Baquero B, Gonzalez C, Ramirez M, Chavez Santos E, Ornelas IJ. Understanding and Addressing Latinx COVID-19 Disparities in Washington State. *Health Educ Behav*. 2020;47(6):845-849. doi:10.1177/1090198120963099
79. American Farm Bureau Federation. Impacts of COVID-19 on Rural Mental Health. Farm Bureau website. December 2020. Accessed September 9, 2021. https://www.fb.org/files/Impacts_of_COVID-19_on_Rural_Mental_Health_1.6.21.pdf
80. Quandt SA, LaMonto NJ, Mora DC, Talton JW, Laurienti PJ, Arcury TA. COVID-19 Pandemic Among Immigrant Latinx Farmworker and Non-farmworker Families: A Rural-Urban Comparison of Economic, Educational, Healthcare, and Immigration Concerns. *New Solut*. 2021;31(1):30-47. doi:10.1177/1048291121992468
81. Pilowsky DJ, Wickramaratne PJ, Rush AJ, et al. Children of currently depressed mothers: a STAR*D ancillary study. *J Clin Psychiatry*. 2006;67(1):126-136. doi:10.4088/jcp.v67n0119
82. García CM, Gilchrist L, Vazquez G, Leite A, Raymond N. Urban and rural immigrant Latino youths' and adults' knowledge and beliefs about mental health resources. *J Immigr Minor Health*. 2011;13(3):500-509. doi:10.1007/s10903-010-9389-6
83. Centers for Disease Control and Prevention. Providing access to mental health services for children in rural areas. Centers for Disease Control and Prevention website. Accessed September 9, 2021. <https://www.cdc.gov/ruralhealth/child-health/policybrief.html>
84. Raval GR, & Doupnik SK. Closing the Gap: Improving Access to Mental Health Care Through Enhanced Training in Residency. *Pediatrics*. 2017;139(1):e20163181. doi:10.1542/peds.2016-3181
85. Hampton E, Richardson JE, Bostwick S, Ward MJ, Green C. The current and ideal state of mental health training: pediatric resident perspectives. *Teach Learn Med*. 2015;27(2):147-154. doi:10.1080/10401334.2015.1011653
86. Rosenblatt RA, & Hart LG. Physicians and rural America. *West J Med*. 2000;173(5):348-351. doi:10.1136/ewjm.173.5.348
87. Angold A, Erkanli A, Farmer EM, et al. Psychiatric disorder, impairment, and service use in rural African American and white youth. *Arch Gen Psychiatry*. 2002;59(10):893-901. doi:10.1001/archpsyc.59.10.893
88. Department of Health and Human Services. Access to mental health services at Indian Health Service and tribal facilities. Department of Health and Human Services website. September 2011. Accessed September 9, 2021. <https://oig.hhs.gov/oei/reports/oei-09-08-00580.pdf>
89. Advancing Integrated Mental Health Solutions. Collaborative Care. Advancing Integrated Mental Health Solutions website. Accessed September 9, 2021. <https://aims.uw.edu/collaborative-care>
90. Kolko DJ, Campo J, Kilbourne AM, Hart J, Sakolsky D, Wisniewski S. Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial. *Pediatrics*. 2014;133(4):e981-e992. doi:10.1542/peds.2013-2516
91. Richardson LP, Ludman E, McCauley E, et al. Collaborative care for adolescents with depression in primary care: a randomized clinical trial. *JAMA*. 2014;312(8):809-816. doi:10.1001/jama.2014.9259
92. Advancing Integrated Mental Health Solutions. Evidence Base for Collaborative Care. Advancing Integrated Mental Health Solutions website. 2020. Accessed September 9, 2021. https://aims.uw.edu/sites/default/files/4%20Evidence%20Base_Racial%20Ethnic%20Groups.pdf
93. Ell K, Katon W, Xie B, et al. Collaborative care management of major depression among low-income, predominantly Hispanic subjects with diabetes: a randomized controlled trial. *Diabetes Care*. 2010;33(4):706-713. doi:10.2337/dc09-1711

94. Yeung A, Shyu I, Fisher L, Wu S, Yang H, Fava M. Culturally sensitive collaborative treatment for depressed Chinese Americans in primary care. *Am J Public Health*. 2010;100(12):2397-2402. doi:10.2105/AJPH.2009.184911
95. Brewer LC, Williams DR. We've Come This Far by Faith: The Role of the Black Church in Public Health. *Am J Public Health*. 2019;109(3):385-386. doi:10.2105/AJPH.2018.304939
96. Taylor RJ, Chatters LM, Brown RK. African American Religious Participation. *Rev Relig Res*. 2014;56(4):513-538. doi:10.1007/s13644-013-0144-z
97. Aguilar-gaxiola S, Loera G, Méndez L, Sala M, Latino Mental Health Concilio, Nakamoto J. Community-defined Solutions For Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report. 2012. https://health.ucdavis.edu/newsroom/pdf/latino_disparities.pdf
98. Hope MO, Assari S, Cole-Lewis YC, Caldwell CH. Religious Social Support, Discrimination, and Psychiatric Disorders among Black Adolescents. *Race Soc Probl*. 2017;9(2):102-114. doi:10.1007/s12552-016-9192-7
99. Marcus MT, Walker T, Swint JM, et al. Community-based participatory research to prevent substance abuse and HIV/AIDS in African-American adolescents. *J Interprof Care*. 2004;18(4):347-359. doi:10.1080/13561820400011776
100. Caplan S, & Cordero C. Development of a Faith-Based Mental Health Literacy Program to Improve Treatment Engagement Among Caribbean Latinos in the Northeastern United States of America. *Int Q Community Health Educ*. 2015;35(3):199-214. doi:10.1177/0272684X15581347
101. Love HE, Schlitt J, Soleimanpour S, Panchal N, Behr C. Twenty Years Of School-Based Health Care Growth And Expansion. *Health Aff (Millwood)*. 2019;38(5):755-764. doi:10.1377/hlthaff.2018.05472
102. Cummings JR, Ponce NA, Mays VM. Comparing racial/ethnic differences in mental health service use among high-need subpopulations across clinical and school-based settings. *J Adolesc Health*. 2010;46(6):603-606. doi:10.1016/j.jadohealth.2009.11.221
103. Knopf JA, Finnie RK, Peng Y, et al. School-Based Health Centers to Advance Health Equity: A Community Guide Systematic Review. *Am J Prev Med*. 2016;51(1):114-126. doi:10.1016/j.amepre.2016.01.009
104. Amaral G, Geierstanger S, Soleimanpour S, Brindis C. Mental health characteristics and health-seeking behaviors of adolescent school-based health center users and nonusers. *J Sch Health*. 2011;81(3):138-145. doi:10.1111/j.1746-1561.2010.00572.x
105. Kataoka SH, Stein BD, Jaycox LH, et al. A school-based mental health program for traumatized Latino immigrant children. *J Am Acad Child Adolesc Psychiatry*. 2003;42(3):311-318. doi:10.1097/00004583-200303000-00011
106. Pumariega AJ, Rogers K, Rothe E. Culturally competent systems of care for children's mental health: advances and challenges. *Community Ment Health J*. 2005;41(5):539-555. doi:10.1007/s10597-005-6360-4
107. Barnett ML, Gonzalez A, Miranda J, Chavira DA, Lau AS. Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved Populations: A Systematic Review. *Adm Policy Ment Health*. 2018;45(2):195-211. doi:10.1007/s10488-017-0815-0
108. Urban Institute. An Evaluation Of The Latin American Youth Center's Promotor Pathway Program. April 2016. Accessed September 9, 2021. https://www.urban.org/sites/default/files/publication/79726/2000742-solutions-for-youth-an-evaluation-of-the-latin-american-youth-centers-promotor-pathway-program_2.pdf
109. Indian Health Service. Community Health Representative (CHR). Indian Health Service website. Accessed September 9, 2021. <https://www.ihs.gov/oklahomacity/programs/services/chr/>
110. Barlow A, Mullany B, Neault N, et al. Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: a randomized controlled trial. *Am J Psychiatry*. 2013;170(1):83-93. doi:10.1176/appi.ajp.2012.12010121
111. Benavides-Vaello S, Strode A, Sheeran BC. Using technology in the delivery of mental health and substance abuse treatment in rural communities: a review. *J Behav Health Serv Res*. 2013;40(1):111-120. doi:10.1007/s11414-012-9299-6
112. Gloff NE, LeNoue SR, Novins DK, Myers K. Telemental health for children and adolescents. *Int Rev Psychiatry*. 2015;27(6):513-524. doi:10.3109/09540261.2015.1086322
113. Stewart RW, Orengo-Aguayo RE, Gilmore AK, de Arellano M. Addressing Barriers to Care Among Hispanic Youth: Telehealth Delivery of Trauma-Focused Cognitive Behavioral Therapy. *Behav Ther (N Y N Y)*. 2017;40(3):112-118.
114. Fortney JC, Bauer AM, Cerimele JM, et al. Comparison of Teleintegrated Care and Telereferral Care for Treating Complex Psychiatric Disorders in Primary Care: A Pragmatic Randomized Comparative Effectiveness Trial. *JAMA Psychiatry*. Published online August 25, 2021. doi:10.1001/jamapsychiatry.2021.2318
115. National Conference of State Legislatures. Telehealth Policy Trends and Considerations. National Conference of State Legislatures website. 2015. Accessed September 9, 2021. <https://www.ncsl.org/research/health/telehealth-policy-trends-and-considerations.aspx>
116. Health Affairs Blog. Addressing Privacy Concerns Central To Success Of Telehealth Use Among Undocumented Immigrants. Health Affairs website. Accessed September 9, 2021. November 23, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20201118.621497/full/>
117. Pew Research Center. Internet/Broadband Fact Sheet. Pew Research website. April 7, 2021. Accessed September 9, 2021. <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?menulitem=3109350c-8dba-4b7f-ad52-a3e976ab8c8f>

118. Health Affairs Blog. How The Rapid Shift To Telehealth Leaves Many Community Health Centers Behind During The COVID-19 Pandemic. Health Affairs website. June 2, 2020. Accessed September 9, 2021. <https://www.healthaffairs.org/doi/10.1377/hblog20200529.449762/full/>
119. Washington State Hospital Association. Audio-Only and Other Telemedicine Law Changes to Take Effect. Washington State Hospital Association website. July 15, 2021. Accessed September 9, 2021. <https://www.wsha.org/articles/24328/>
120. Szilagyi PG, Shone LP, Klein JD, Bajorska A, Dick AW. Improved health care among children with special health care needs after enrollment into the State Children's Health Insurance Program. *Ambul Pediatr*. 2007;7(1):10-17. doi:10.1016/j.ambp.2006.09.006
121. Center on Budget and Policy Priorities. Coverage of parents helps children, too. Center on Budget and Policy Priorities website. October 20, 2006. Accessed September 9, 2021. <https://www.cbpp.org/research/coverage-of-parents-helps-children-too#:~:text=The%20studies%20also%20indicate%20that,number%20of%20periods%20without%20insurance.>
122. Creedon TB, & Cook BL. Access To Mental Health Care Increased But Not For Substance Use, While Disparities Remain. *Health Aff (Millwood)*. 2016;35(6):1017-1021. doi:10.1377/hlthaff.2016.0098
123. Barry CL, & Busch SH. Do state parity laws reduce the financial burden on families of children with mental health care needs?. *Health Serv Res*. 2007;42(3 Pt 1):1061-1084. doi:10.1111/j.1475-6773.2006.00650.x
124. Kennedy-Hendricks A, Epstein AJ, Stuart EA, et al. Federal Parity and Spending for Mental Illness. *Pediatrics*. 2018;142(2):e20172618. doi:10.1542/peds.2017-2618
125. Chatterji P, Decker SL, Markowitz S. The effects of mandated health insurance benefits for autism on out-of-pocket costs and access to treatment. *J Policy Anal Manage*. 2015;34(2):328-353. doi:10.1002/pam.21814
126. Centers for Medicare and Medicaid Services. The Mental Health Parity and Addiction Equity Act (MHPAEA). Centers for Medicare and Medicaid Services website. Accessed September 9, 2021. https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet
127. Assistant Secretary for Planning and Evaluation. Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans. Assistant Secretary for Planning and Evaluation website. February 19, 2013. Accessed September 9, 2021. <https://aspe.hhs.gov/reports/affordable-care-act-expands-mental-health-substance-use-disorder-benefits-federal-parity-protections-0>
128. Manatt. Level-of-Care Criteria Ruled Inconsistent with Accepted Medical Standards. April 17, 2019. Manatt website. Accessed September 9, 2021. <https://www.manatt.com/insights/newsletters/health-update/level-of-care-criteria-ruled-inconsistent>