



The Impact of Racism on Child and Adolescent Health

Maria Trent, MD, MPH, FAAP, FSAHM,^a Danielle G. Dooley, MD, MPhil, FAAP,^b Jacqueline Dougé, MD, MPH, FAAP,^c SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON ADOLESCENCE

The American Academy of Pediatrics is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. By acknowledging the role of racism in child and adolescent health, pediatricians and other pediatric health professionals will be able to proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health effects of structural, personally mediated, and internalized racism and improve the health and well-being of all children, adolescents, emerging adults, and their families.

STATEMENT OF THE PROBLEM

Racism is a “system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call ‘race’) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.”¹ Racism is a social determinant of health² that has a profound impact on the health status of children, adolescents, emerging adults, and their families.³⁻⁸ Although progress has been made toward racial equality and equity,⁹ the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear.¹⁰ Failure to address racism will

abstract

^aDivision of Adolescent and Young Adult Medicine, Department of Pediatrics, School of Medicine, Johns Hopkins University, Baltimore, Maryland; ^bDivision of General Pediatrics and Community Health and Child Health Advocacy Institute, Children’s National Health System, Washington, District of Columbia; and ^cMedical Director, Howard County Health Department, Columbia, Maryland

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Address correspondence to Maria Trent, MD. E-mail: mtrent2@jhmi.edu

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continue to undermine health equity for all children, adolescents, emerging adults, and their families.

The social environment in which children are raised shapes child and adolescent development, and pediatricians are poised to prevent and respond to environmental circumstances that undermine child health. Pediatrics as a field has yet to systematically address the influence of racism on child health outcomes and to prepare pediatricians to identify, manage, mitigate, or prevent risks and harms. Recognizing that racism has significant adverse effects on the individual who receives, commits, and observes racism,^{11,12} substantial investments in dismantling structural racism are required to facilitate the societal shifts necessary for optimal development of children in the United States. The American Academy of Pediatrics (AAP) is committed to reducing the ongoing costs and burden of racism to children, the health care system, and society.^{13,14}

Today's children, adolescents, and emerging adults are increasingly diverse. Strategies to address health and developmental issues across the pediatric life span that incorporate ethnicity, culture, and circumstance are critical to achieving a reduction in health disparities. Accordingly, pediatrics should be at the forefront of addressing racism as a core social determinant. The inclusion of racism is in alignment with the health equity pillar of the AAP strategic plan.¹⁵ In a series of workshops in 2016 during national meetings of pediatricians, 3 strategic actions were identified: (1) development of a task force within the AAP to address racism and other forms of discrimination that impact the health status and outcomes of minority youth, (2) development of a policy statement on racism, and (3) integration of evidence-based anticipatory guidance about racism into *Bright Futures*.¹⁶

The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. This policy statement will allow pediatricians to implement recommendations in practice that will better address the factors that make some children more vulnerable than others.¹³ The statement also builds on existing AAP policy recommendations associated with other social determinants of health, such as poverty, housing insecurity, child health equity, immigration status, and early childhood adversity.^{9,17-19}

RACISM AS A CORE DETERMINANT OF CHILD HEALTH

Racism is a core social determinant of health that is a driver of health inequities.²⁰⁻²² The World Health Organization defines social determinants of health as “the conditions in which people are born, grow, live, work, and age.” These determinants are influenced by economic, political, and social factors linked to health inequities (avoidable inequalities in health between groups of people within populations and between countries). These health inequities are not the result of individual behavior choices or genetic predisposition but are caused by economic, political, and social conditions, including racism.²³

The impact of racism has been linked to birth disparities and mental health problems in children and adolescents.^{6,24-30} The biological mechanism that emerges from chronic stress leads to increased and prolonged levels of exposure to stress hormones and oxidative stress at the cellular level. Prolonged exposure to stress hormones, such as cortisol, leads to inflammatory reactions that predispose individuals to chronic disease.³¹ As an example, racial disparities in the infant mortality rate remain,³² and the complications

of low birth weight have been associated with perceived racial discrimination and maternal stress.^{25,33,34}

Investments in policies to address social determinants of health, such as poverty, have yielded improvements in the health of children. The Food Stamp Program, a War on Poverty initiative first developed in the 1930s during the Great Depression and later revived in the 1960s, is linked to improvements in birth outcomes.³⁵ Efforts in education, housing, and child health insurance have also led to improved health outcomes for issues such as lead poisoning, injuries, asthma, cancer, neurotoxicity, cardiovascular disease, and mental health problems.^{20,36,37} Expansion of child health insurance has improved health care access for children, with significant gains for African American and Hispanic children in terms of access to well-child, doctor, and dental visits.³⁸ Despite these improvements, it is important to recognize that children raised in African American, Hispanic, and American Indian populations continue to face higher risks of parental unemployment and to reside in families with significantly lower household net wealth relative to white children in the United States, posing barriers to equal opportunities and services that optimize health and vocational outcomes.³⁹⁻⁴⁵

Juvenile justice involvement is also a critical social determinant of health. Because racial inequity continues to shape the juvenile justice system, this area is a modern example of race being an important determinant of short- and long-term outcomes. The AAP published a statement in 2011⁴⁶ focusing on key health issues of justice-involved youth, which was recently revised to include an in-depth discussion on racial and ethnic inequalities for this population.⁴⁷ Although the overall rates of youth incarceration have decreased, African American, Hispanic, and American

Indian youth continue to be disproportionately represented.⁴⁸ While incarcerated, youth experience additional adverse experiences, such as solitary confinement and abuse, that have the potential to undermine socioemotional development and general developmental outcomes.⁴⁹⁻⁵¹ Differential treatment of youth offenders on the basis of race shapes an individual's participation and ultimate function in society. This type of modern racism must be recognized and addressed if the United States seeks to attain health equity.⁵²

THE DEVELOPMENT OF RACE AS A CONSTRUCT

Race as a social construct is rooted in history and remains a mechanism through which social class has been controlled over time. Flawed science was used to solidify the permanence of race, reinforce the notions of racial superiority, and justify differential treatment on the basis of phenotypic differences as people from different parts of the world came in contact with each other.⁵³ Race emerged as a social classification used to assign dominance of some social classes over others.⁵³ Scientific, anthropologic, and historical inquiry further solidified race as a social construct.⁵⁴ Modern science, however, has demonstrated that there is only 1 biological race and that the clines (phenotypic differences in skin and eye color, hair texture, and bone structure) at the core of early anthropologic research were insufficient to establish different races among human beings. Dr Francis Collins, former director of the National Human Genome Project and presently the director of the National Institutes of Health, has affirmed that humans are 99.9% the same at the level of their genome.⁵⁵ Despite this, efforts to collect, organize, and categorize individuals on the basis of the plausibility of the 0.01% human variation remain a force of scientific

discovery, innovation, and medical-pharmaceutical collaborations.⁵⁶ Rather than focusing on preventing the social conditions that have led to racial disparities, science and society continue to focus on the disparate outcomes that have resulted from them, often reinforcing the posited biological underpinnings of flawed racial categories.⁵⁷ Although race used in these ways has been institutionalized, linked to health status, and impeded our ability to improve health and eliminate health disparities,^{58,59} it remains a powerful measure that must be better measured, carefully used, and potentially replaced to mark progress in pediatric health disparities research.^{60,61}

As such, it is important to examine the historical underpinnings of race used as a tool for subjugation. American racism was transported through European colonization. It began with the subjugation, displacement, and genocide of American Indian populations and was subsequently bolstered by the importation of African slaves to frame the economy of the United States. Although institutions such as slavery were abolished more than a century ago, discriminatory policies, such as Jim Crow laws, were developed to legalize subjugation. As the United States expanded west in North America and into Alaska and the Pacific Islands, the diversity of populations encompassing the United States also expanded. Native Hawaiian and Pacific Islander, Alaskan native, Asian American, and Latino American populations have experienced oppression and similar exclusions from society.⁶²⁻⁶⁵ Although some racial and/or ethnic groups have received reparations⁶⁶ and fared better than others over time, remnants of these policies remain in place today and continue to oppress the advancement of people from historically aggrieved groups.⁶⁷⁻⁷²

Through these underpinnings, racism became a socially transmitted disease passed down through generations, leading to the inequities observed in our population today. Although the endemic nature of racism has powerful impacts on perceived and actual health outcomes, it is also important to note that other forms of discrimination (eg, sex, religion, sexual orientation, immigrant status, and disability status) are actively at play and have created a syndemic with the potential to undermine child and family health further. It is important to address racism's impact on the health and well-being of children, adolescents, and emerging adults to avoid perpetuating a health system that does not meet the needs of all patients.⁵² Pediatricians are uniquely positioned to both prevent and mitigate the consequences of racism as a key and trusted source of support for pediatric patients and their families.

CHILDHOOD EXPERIENCES OF RACISM

Children can distinguish the phenotypic differences associated with race during infancy⁷³⁻⁷⁵; therefore, effective management of difference as normative is important in a diverse society. To identify, address, and manage the impacts of racism on child health, it is critical that pediatricians understand 3 key levels through which racism operates: (1) institutional, (2) personally mediated, and (3) internalized. The experience of race is also impacted by other identities that people have related to ethnicity, sex, religious affiliation, immigrant status, family composition, sexuality, disability, and others that must be navigated alongside race. Much of the discussion to date related to the historical underpinnings of race deals with institutionalized (or structural) racism, expressed through patterns of social institutions (eg, governmental organizations, schools, banks, and courts of law) that implicitly or

explicitly discriminate against individuals from historically marginalized groups.^{22,52,76,77} Children experience the outputs of structural racism through place (where they live), education (where they learn), economic means (what they have), and legal means (how their rights are executed). Research has identified the role of implicit and explicit personally mediated racism (racism characterized by assumptions about the abilities, motives, or intents of others on the basis of race)⁷⁸ as a factor affecting health care delivery and general health outcomes.⁷⁹⁻⁸⁶ The impacts of structural and personally mediated racism may result in internalized racism (internalizing racial stereotypes about one's racial group). A positive racial identity mediates experiences of discrimination and generates optimal youth development outcomes.^{12,87,88} The importance of a prosocial identity is critical during adolescence, when young people must navigate the impacts of social status and awareness of personally mediated discrimination based on race.⁸⁹⁻⁹¹

Although children and adolescents who are the targets of racism experience the most significant impact, bystanders are also adversely affected by racism. As an example, young adults who were bystanders to racism and other forms of victimization as youth experience profound physiologic and psychological effects when asked to recall the memory of a past anchoring event as a victim or bystander that are comparable to those experienced by first responders after a major disaster. Three core features that characterized the abusive event(s) were as follows: (1) an individual gets hurt psychologically or physically, (2) a power differential exists (eg, age, size and/or stature, or status) versus the target individual resulting in domination and erosion of the target's self-esteem, and (3) the abuse

is repetitive, causing stress levels to increase because of anticipation of future events.¹¹ Internalized negative stereotypes related to race can unconsciously erode self-perception and capacity and may later play out in the form of stereotype threat or the fear of confirming a negative stereotype of one's race.⁹¹ Stereotype threats can undermine academic and vocational attainment, key developmental milestones for the victim. Underachievement then reinforces the stereotype held by both the perpetrator and victim, further enhancing the vulnerability of the victim and the bystander to repeated acts of overt or covert victimization. These observations suggest that universal interventions to eliminate racism (experienced as a victim or bystander) from the lives of children and to engage in active societal antiracism bystander behavioral intervention may optimize well-being for all children and the adults who care for them. For individual intervention to occur, however, bystanders must identify critical situations, view them as an emergency, develop a sense of personal responsibility, have self-efficacy to succeed with the intervention, perceive the costs of nonintervention as high, and consciously decide to help.^{11,92} Research has demonstrated that racism has an effect on health across racial groups in communities reporting high levels of racism⁹³ but that racially diverse environments, such as schools, can benefit all youth by improving cognitive skills such as critical thinking and problem-solving.⁹⁴

RACISM AT THE INTERSECTION OF EDUCATION AND CHILD AND ADOLESCENT HEALTH

Educational and vocational attainment are key developmental outcomes that pediatricians monitor to assess for successful growth and development. After accounting for

sleep and time spent at home, children spend a significant portion of their time in educational settings.⁹⁵⁻⁹⁷ Educational achievement is an important predictor of long-term health and economic outcomes for children. Adults with a college degree live longer and have lower rates of chronic disease than those who did not graduate from college.⁹⁸ It is critical for pediatricians to recognize the institutional, personally mediated, and internalized levels of racism that occur in the educational setting because education is a critical social determinant of health for children.⁹⁹

Disparities in educational access and attainment, along with racism experienced in the educational setting, affect the trajectory of academic achievement for children and adolescents and ultimately impact health. Chronic absenteeism, defined as missing $\geq 10\%$ of school days in an academic year, is a strong predictor of educational achievement. Chronic absenteeism disproportionately affects children of color, children living in poverty, children with disabilities, and children with chronic diseases.¹⁰⁰ In high school, 21.2% of Hispanic, 23.4% of African American, and 27.5% of American Indian children were chronically absent in 2013-2014 compared with 17.3% of white children.¹⁰¹ Immigration enforcement and the fear of apprehension by authorities can negatively affect school attendance for Hispanic and black immigrants, thereby perpetuating inequalities in attendance.¹⁰² According to the National Center for Education Statistics, the graduation rate for white students nationally in 2015-2016 was 88% compared with 76% for African American students, 72% for American Indian students, and 79% for Hispanic students.¹⁰³ Disparities in chronic absenteeism and high school graduation rates prevent children from realizing the full benefits of educational attainment

and can increase the development of chronic disease and reduce overall life expectancy.¹⁰⁴

Although the landmark US Supreme Court case *Brown v Board of Education* banned government-sponsored segregation and laid a foundation for equal access to a quality public education, the US Department of Education continues to report institutional or structural inequality in educational access and outcomes,¹⁰⁵ even in the most diverse and well-resourced communities in the United States. Students from historically aggrieved groups have less access to experienced teachers, advanced coursework, and resources and are also more harshly punished for minor behavioral infractions occurring in the school setting.¹⁰⁵ They are less likely to be identified for and receive special education services,¹⁰⁶ and in some states, school districts with more nonwhite children receive lower funding at any given poverty level than districts with more white children.¹⁰⁷

Children may also experience personally mediated racism early in their schooling, which may be internalized and ultimately affect their interactions with others.¹⁰⁸ Early teacher-child interactions are important for long-term academic outcomes. The relationship of teacher to student across ages and grade levels influences school adjustment, literacy, math skills, grade point average, and scholastic aptitude test scores.^{109–111} Given the critical nature of the student-teacher relationship, it is important to explore how racism and implicit bias affect this dynamic. Student-teacher racial mismatch can impact academic performance, with studies showing that African American children are more likely to receive a worse assessment of their behavior when they have a non-Hispanic white teacher than when they have an African American teacher.¹¹² This finding may result from racial bias in

teachers' expectations of their students, with data demonstrating that white and other non-African American teachers are more likely than African American teachers to predict that African American students would not finish high school.¹¹³ Similarly, data indicate that teachers may underestimate the ability of African American and Latino students, which can lead to lower grade point averages and fewer years of schooling.¹¹⁴ African American students who have 1 African American teacher in elementary school are more likely to graduate from high school and enroll in college than their peers who do not have an African American teacher; the proposed mechanism for this improved long-term educational outcome is the exposure to a role model early in the educational experience.¹¹⁵ These findings indicate the importance of ensuring a diverse teacher workforce, particularly as the population of students in US schools continues to diversify.¹¹⁶ School racial climate, which refers to norms, curricula, and interactions around race and diversity within the school setting, also impacts educational outcomes for students.¹¹⁷ Students who had a positive perception of school racial climate had higher academic achievement and fewer disciplinary issues.¹¹⁸ Racial inequities in school discipline begin early, and school discipline has long-term consequences for children. Although federal civil rights laws prohibit discrimination in the administration of discipline in public schools, the US Government Accountability Office found that African American and American Indian students are overrepresented among students experiencing suspension.¹¹⁹ Data from the US Department of Education confirm that a disproportionate number of African American children receive more than 1 out-of-school suspension in preschool and overall in kindergarten through grade 12 are

suspended 3 times more and expelled 1.9 times more than white students.¹²⁰ To mediate the effects of institutional and personally mediated racism in the educational setting and prevent internalized racism, studies show that a positive, strong racial or ethnic identity and parental engagement in families is protective against the negative effects of racial discrimination on academic outcomes.^{121–123}

HOW PEDIATRICIANS CAN ADDRESS AND AMELIORATE THE EFFECTS OF RACISM ON CHILDREN AND ADOLESCENTS

Pediatricians and other child health professionals must be prepared to discuss and counsel families of all races on the effects of exposure to racism as victims, bystanders, and perpetrators.^{124–126} Pediatricians can implement systems in their practices that ensure that all patients and families know that they are welcome, that they will be treated with mutual respect, and that high-quality care will be delivered regardless of background using the tenets of family- and patient-centered care.¹²⁷ To do this, it is critical for pediatricians to examine their own biases.¹²⁸ Pediatricians can advocate for community initiatives and collaborate with government and community-based organizations to help redress biases and inequities in the health, justice, and educational systems. These strategies may optimize developmental outcomes and reduce exposure to adverse events that dramatically alter the lived experiences, health, and perceived self-value of youth.^{48,129,130}

Optimizing Clinical Practice

In practice, pediatricians and other child health care providers encounter children every day who have experienced racism. There are interventions available for use in the medical home that can identify and potentially ameliorate inequities.

- Create a culturally safe medical home¹³¹ where the providers acknowledge and are sensitive to the racism that children and families experience by integrating patient- and family-centered communication strategies and evidence-based screening tools that incorporate valid measures of perceived and experienced racism into clinical practice.^{132–136}
- Use strategies such as the Raising Resisters approach during anticipatory guidance to provide support for youth and families to (1) recognize racism in all forms, from subversive to blatant displays of racism; (2) differentiate racism from other forms of unfair treatment and/or routine developmental stressors; (3) safely oppose the negative messages and/or behaviors of others; and (4) counter or replace those messages and experiences with something positive.^{137,138}
- Train clinical and office staff in culturally competent care according to national standards for culturally and linguistically appropriate services.^{139,140}
- Assess patients for stressors (eg, bullying and/or cyberbullying on the basis of race)¹⁴¹ and social determinants of health often associated with racism (eg, neighborhood safety, poverty, housing inequity, and academic access) to connect families to resources.^{9,142,143}
- Assess patients who report experiencing racism for mental health conditions, including signs of posttraumatic stress, anxiety, grief, and depressive symptoms, using validated screening tools and a trauma-informed approach to make referrals to mental health services as needed.¹⁴⁴
- Integrate positive youth development approaches,¹⁴⁵ including racial socialization,^{123,146} to identify strengths and assess

youth and families for protective factors,⁹ such as a supportive extended family network, that can help mitigate exposure to racist behaviors.¹³⁸

- Infuse cultural diversity into AAP-recommended early literacy–promotion programs¹⁴⁷ to ensure that there is a representation of authors, images, and stories that reflect the cultural diversity of children served in pediatric practice.
- Encourage pediatric practices and local chapters to embrace the challenge of testing best practices using Community Access to Child Health grants and participation in national quality-improvement projects to examine the effectiveness of office-based interventions designed to address the impact of racism on patient outcomes.
- Encourage practices and chapters to develop resources for families with civil rights concerns, including medicolegal partnerships and referrals to agencies responsible for enforcing civil rights laws.
- Encourage pediatric-serving organizations within local communities, including pediatric practices, hospitals, and health maintenance organizations, to conduct internal quality-assurance assessments that include analyses of quality of care and patient satisfaction by race and to initiate improvement protocols as needed to improve health outcomes and community trust.

Optimizing Workforce Development and Professional Education

- Advocate for pediatric training programs that are girded by competencies and subcompetencies related to effective patient and family communication across differences in pediatric populations.^{148,149}

- Encourage policies to foster interactive learning communities that promote cultural humility (eg, self-awareness, lifelong commitment to self-evaluation, and commitment to managing power imbalances)^{150,151} and provide simulation opportunities to ensure new pediatricians are competent to deliver culturally appropriate and patient- and family-centered care.^{152–155}
- Integrate active learning strategies, such as simulation¹⁵⁶ and language immersion,¹⁵⁷ to adequately prepare pediatric residents to serve the most diverse pediatric population to date to exist in the United States¹⁵⁸ and lead diverse and interdisciplinary pediatric care teams.¹⁵⁹
- Advocate for policies and programs that diversify the pediatric workforce and provide ongoing professional education for pediatricians in practice as a strategy to reduce implicit biases and improve safety and quality in the health care delivery system.^{160–162}

Optimizing Systems Through Community Engagement, Advocacy, and Public Policy

- Acknowledge that health equity is unachievable unless racism is addressed through interdisciplinary partnerships with other organizations that have developed campaigns against racism.^{163,164}
- Engage community leaders to create safe playgrounds and healthy food markets to reduce disparities in obesity and undernutrition in neighborhoods affected by poverty.
- Advocate for improvements in the quality of education in segregated urban, suburban, and rural communities designed to better optimize vocational attainment and educational milestones for all students.

- Support local educational systems by connecting with and supporting school staff. The AAP Council on School Health provides resources to help physicians engage and interact with their school system and provides guidelines around the role of school physicians and school health personnel.^{165,166}
- Advocate for federal and local policies that support implicit-bias training in schools and robust training of educators in culturally competent classroom management to improve disparities in academic outcomes and disproportionate rates of suspension and expulsion among students of color, reflecting a systemic bias in the educational system.¹⁶⁷
- Advocate for increased access to support for mental health services in schools designed to help teachers better manage students with disruptive classroom behaviors and to reduce racial disparities in school expulsion.^{144,168,169}
- Advocate for curricula that are multicultural, multilingual, and reflective of the communities in which children in their practices attend school.¹⁷⁰
- Advocate for policies and programs that diversify the teacher workforce to mitigate the effects of the current demographic mismatch of teachers and students that affects academic attitudes and attainment for all students.^{115,171}
- Advocate for evidence-based programs that combat racism in the education setting at a population level.¹⁷²⁻¹⁷⁴
- Encourage community-level advocacy with members of those communities disproportionately affected by racism to develop policies that advance social justice.^{19,175}
- Advocate for alternative strategies to incarceration for management of nonviolent youth behavior.^{50,176,177}
- Collaborate with first responders and community police to enhance positive youth engagement by sharing expertise on child and adolescent development and mental health, considering potential differences in culture, sex, and background.¹⁷⁸
- Advocate for fair housing practices, including access to housing loans and rentals that prohibit the persistence of historic “redlining.”¹⁷⁹

Optimizing Research

- Advocate for funding and dissemination of rigorous research that examine the following:
 1. the impact of perceived and observed experiences of discrimination on child and family health outcomes¹⁸⁰;
 2. the role of self-identification versus perceived race on child health access, status, and outcomes⁵²;
 3. the impact of workforce development activities on patient satisfaction, trust, care use, and pediatric health outcomes¹⁶¹;
 4. the impact of policy changes and community-level interventions on reducing the health effects of racism and other forms of discrimination on youth development; and
 5. integration of the human genome as a way to identify critical biomarkers that can be used to improve human health rather than continue to classify people on the basis of their minor genetic differences and countries of origin.⁵⁵

CONCLUSIONS

Achieving decisive public policies, optimized clinical service delivery, and community change with an activated, engaged, and diverse pediatric workforce is critically

important to begin untangling the thread of racism sewn through the fabric of society and affecting the health of pediatric populations. Pediatricians must examine and acknowledge their own biases and embrace and advocate for innovative policies and cross-sector partnerships designed to improve medical, economic, environmental, housing, judicial, and educational equity for optimal child, adolescent, and emerging adult developmental outcomes.

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REFERENCES

1. Jones CP, Truman BI, Elam-Evans LD, et al. Using “socially assigned race” to probe white advantages in health status. *Ethn Dis*. 2008;18(4):496–504
2. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: a systematic review and meta-analysis. *PLoS One*. 2015;10(9):e0138511
3. Berman G, Paradies Y. Racism, disadvantage and multiculturalism: towards effective anti-racist praxis. *Ethn Racial Stud*. 2010;33(2):214–232
4. Elias A, Paradies Y. Estimating the mental health costs of racial discrimination. *BMC Public Health*. 2016;16(1):1205
5. Heard-Garris NJ, Cale M, Camaj L, Hamati MC, Dominguez TP. Transmitting Trauma: a systematic review of vicarious racism and child health. *Soc Sci Med*. 2018;199:230–240
6. 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
7. Paradies Y. Defining, conceptualizing and characterizing racism in health research. *Crit Public Health*. 2006; 16(2):144–157
8. Pachter LM, Bernstein BA, Szalacha LA, Garcia Coll C. Perceived racism and discrimination in children and youths: an exploratory study. *Health Soc Work*. 2010;35(1):61–69
9. Council on Community Pediatrics. Poverty and child health in the United States. *Pediatrics*. 2016;137(4): e20160339
10. Institute of Medicine, Committee on Improving the Health, Safety, and Well-Being of Young Adults. B: diversity and the effects of bias and discrimination on young adults’ health and well-being. In: Bonnie RJ, Stroud C, Breiner H, eds. *Investing in the Health and Well-Being of Young Adults*. Washington, DC: National Academies Press; 2015. Available at: <https://www.nap.edu/download/18869>. Accessed August 22, 2017
11. Janson GR, Hazler RJ. Trauma reactions of bystanders and victims to repetitive abuse experiences. *Violence Vict*. 2004; 19(2):239–255
12. Clark K, Clark M. The development of consciousness of self and the emergence of racial identification in Negro preschool children. *J Soc Psychol*. 1939;10:98
13. American Academy of Pediatrics. Blueprint for children. Available at: <https://www.aap.org/en-us/Documents/BlueprintForChildren.pdf>. Accessed August 22, 2017
14. Szilagyi PG, Dreyer BP, Fuentes-Afflick E, Coyne-Beasley T, First L. The road to tolerance and understanding. *Pediatrics*. 2017;139(6):e20170741
15. American Academy of Pediatrics. American Academy Pediatrics five-year strategic plan. Available at: <https://www.aap.org/en-us/about-the-aap/aap-facts/Pages/Strategic-Plan.aspx>. Accessed September 13, 2018
16. Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017
17. Council on Community Pediatrics. Providing care for immigrant, migrant, and border children. *Pediatrics*. 2013; 131(6). Available at: www.pediatrics.org/cgi/content/full/131/6/e2028
18. Council on Community Pediatrics. Providing care for children and adolescents facing homelessness and housing insecurity. *Pediatrics*. 2013; 131(6):1206–1210

19. American Academy of Pediatrics, Council on Community Pediatrics and Committee on Native American Child Health. Policy statement: health equity and children's rights. *Pediatrics*. 2010; 125(4):838–849. Reaffirmed October 2013
20. Gee GC, Walsemann KM, Brondolo E. A life course perspective on how racism may be related to health inequities. *Am J Public Health*. 2012;102(5):967–974
21. Gee GC. Leveraging the social determinants to build a culture of health. 2016. Available at: https://healthequity.globalpolicysolutions.org/wp-content/uploads/2016/12/RWJF_SDOH_Final_Report-002.pdf. Accessed March 19, 2019
22. Gee GC, Ford CL. Structural racism and health inequities: old issues, new directions. *Du Bois Rev*. 2011;8(1): 115–132
23. The World Health Organization. Social determinants of health. Available at: www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/. Accessed August 24, 2017
24. 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
25. Dominguez TP, Dunkel-Schetter C, Glynn LM, Hobel C, Sandman CA. Racial differences in birth outcomes: the role of general, pregnancy, and racism stress. *Health Psychol*. 2008;27(2): 194–203
26. Viner RM, Ozer EM, Denny S, et al. Adolescence and the social determinants of health. *Lancet*. 2012; 379(9826):1641–1652
27. Hogben M, Leichter JS. Social determinants and sexually transmitted disease disparities. *Sex Transm Dis*. 2008;35(suppl 12):S13–S18
28. Crosby RA, Holtgrave DR. The protective value of social capital against teen pregnancy: a state-level analysis. *J Adolesc Health*. 2006;38(5):556–559
29. Upchurch DM, Mason WM, Kusunoki Y, Kriechbaum MJ. Social and behavioral determinants of self-reported STD among adolescents. *Perspect Sex Reprod Health*. 2004;36(6):276–287
30. Slopen N, Williams DR. Discrimination, other psychosocial stressors, and self-reported sleep duration and difficulties. *Sleep (Basel)*. 2014;37(1):147–156
31. Cohen S, Janicki-Deverts D, Doyle WJ, et al. Chronic stress, glucocorticoid receptor resistance, inflammation, and disease risk. *Proc Natl Acad Sci USA*. 2012;109(16):5995–5999
32. Riddell CA, Harper S, Kaufman JS. Trends in differences in US mortality rates between black and white infants. *JAMA Pediatr*. 2017;171(9):911–913
33. Lu MC, Kotelchuck M, Hogan V, Jones L, Wright K, Halfon N. Closing the Black-White gap in birth outcomes: a life-course approach. *Ethn Dis*. 2010; 20(1,suppl 2):S2–S62–S76
34. Gadson A, Akpovi E, Mehta PK. Exploring the social determinants of racial/ethnic disparities in prenatal care utilization and maternal outcome. *Semin Perinatol*. 2017;41(5):308–317
35. Almond D, Hoynes HW, Whitmore Schanzenbach D. Inside the War on Poverty: impact of food stamps on birth outcomes. Available at: <https://www.irp.wisc.edu/publications/dps/pdfs/dp135908.pdf>. Accessed March 19, 2019
36. Robert Wood Johnson Foundation; Pew Charitable Trusts. Health Impact Assessment and Housing: opportunities for the Housing Sector. Available at: www.pewtrusts.org/~media/assets/2016/03/opportunities_for_the_housing_sector.pdf. Accessed August 29, 2017
37. US Office of the Surgeon General. *The Surgeon General's Call to Action to Promote Healthy Homes*. Rockville, MD: Office of the Surgeon General; 2009
38. Larson K, Cull WL, Racine AD, Olson LM. Trends in access to health care services for US children: 2000-2014. *Pediatrics*. 2016;138(6):e20162176
39. Matthew DB, Rodrigue E, Reeves RV; Brookings Institute. Time for justice: tackling race inequalities in health and housing. 2016. Available at: <https://www.brookings.edu/research/time-for-justice-tackling-race-inequalities-in-health-and-housing/>. Accessed September 13, 2018
40. Jones J; Economic Policy Institute. Unemployment of black and Hispanic workers remains high relative to white workers. 2018. Available at: <https://www.epi.org/publication/unemployment-of-black-and-hispanic-workers-remains-high-relative-to-white-workers-in-16-states-and-the-district-of-columbia-the-african-american-unemployment-rate-is-at-least-twice-the-rate-of-white/>. Accessed March 12, 2019
41. US Department of Labor, Bureau of Labor Statistics. Labor force statistics from Current Population Survey. 2019. Available at: https://www.bls.gov/web/empsit/cpsee_e16.htm. Accessed March 12, 2019
42. US Department of Labor, Bureau of Labor Statistics. Labor market trends for American Indians and Alaskan natives 2000-2017. Available at: <https://www.bls.gov/opub/ted/2018/labor-market-trends-for-american-indians-and-alaska-natives-2000-17.htm>. Accessed March 12, 2019
43. History D. The Native American Power movement. 2016. Available at: www.digitalhistory.uh.edu/disp_textbook.cfm?smtID=2&psid=3348. Accessed March 12, 2019
44. Dettling LJ, Hsu JW, Jacobs L, et al. Recent trends in wealth-holding by race and ethnicity: evidence from the survey of consumer finances. 2017. Available at: <https://www.federalreserve.gov/econres/notes/feds-notes/recent-trends-in-wealth-holding-by-race-and-ethnicity-evidence-from-the-survey-of-consumer-finances-20170927.htm>. Accessed March 12, 2019
45. Henderson T; Pew Charitable Trusts. The (very) few places with no black-white income gap. Stateline. 2016. Available at: www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/11/10/the-very-few-places-with-no-black-white-income-gap. Accessed March 12, 2019
46. Committee on Adolescence. Health care for youth in the juvenile justice system. *Pediatrics*. 2011;128(6):1219–1235
47. American Academy of Pediatrics, Committee on Adolescence. Health care for youth in the juvenile justice system. *Pediatrics*. 2011;128(6):1219–1235. Reaffirmed May 2015
48. Kruger DJ, De Loney EH. The association of incarceration with community health and racial health disparities. *Prog*

- Community Health Partnersh.* 2009;3(2): 113–121
49. Lambie I, Randell I. The impact of incarceration on juvenile offenders. *Clin Psychol Rev.* 2013;33(3):448–459
 50. Development Services Group I. Alternatives to detention and confinement. 2014. Available at: <https://www.ojjdp.gov/mpg/litreviews/AlternativesToDetentionandConfinement.pdf>. Accessed August 29, 2017
 51. Whitley K, Rozel JS. Mental health care of detained youth and solitary confinement and restraint within juvenile detention facilities. *Child Adolesc Psychiatr Clin N Am.* 2016;25(1): 71–80
 52. Jones CP, Jones CY, Perry GS, Barclay G, Jones CA. Addressing the social determinants of children's health: a cliff analogy. *J Health Care Poor Underserved.* 2009;20(suppl 4):1–12
 53. Sussman RW. *The Myth of Race: The Troubling Persistence of an Unscientific Idea.* Cambridge, MA: Harvard University Press; 2014
 54. United Nations Educational, Scientific and Cultural Organization. *Four Statements on the Race Question.* Paris, France: Oberthur-Rennes; 1969. Available at: <http://unesdoc.unesco.org/images/0012/001229/122962eo.pdf>. Accessed August 22, 2017
 55. Collins FS. What we do and don't know about 'race', 'ethnicity', genetics and health at the dawn of the genome era. *Nat Genet.* 2004;36(suppl 11):S13–S15
 56. Fullwiley D. Race and genetics: attempts to define the relationship. *Biosocieties.* 2007;2:221–237
 57. National Research Council. *Measuring Racial Discrimination.* Washington, DC: National Academies Press; 2004. Available at: <https://www.nap.edu/catalog/10887/measuring-racial-discrimination>. Accessed June 16, 2019
 58. Bhopal R, Donaldson L. White, European, Western, Caucasian, or what? Inappropriate labeling in research on race, ethnicity, and health. *Am J Public Health.* 1998;88(9):1303–1307
 59. Fullilove MT. Comment: abandoning "race" as a variable in public health research—an idea whose time has come. *Am J Public Health.* 1998;88(9): 1297–1298
 60. Bamshad M. Genetic influences on health: does race matter? *JAMA.* 2005; 294(8):937–946
 61. Cheng TL, Goodman E; Committee on Pediatric Research. Race, ethnicity, and socioeconomic status in research on child health. *Pediatrics.* 2015;135(1). Available at: www.pediatrics.org/cgi/content/full/135/1/e225
 62. National Public Radio. Hawaii is diverse, but far from paradise. 2009. Available at: <https://www.npr.org/templates/story/story.php?storyId=120431126>. Accessed April 5, 2019
 63. Iggiagruk Hensley WL. There are two versions of the story of how the U.S. purchased Alaska from Russia. *Smithsonian Magazine.* March 29, 2017. Available at: <https://www.smithsonianmag.com/history/why-russia-gave-alaska-americas-gateway-arctic-180962714/>. Accessed April 6, 2019
 64. US Department of State, Office of the Historian. Chinese immigration and the Chinese Exclusion Acts. Available at: <https://history.state.gov/milestones/1866-1898/chinese-immigration>. Accessed April 6, 2019
 65. Japanese Americans Citizens League. Asian American history. Available at: <https://jacl.org/asian-american-history/>. Accessed April 5, 2019
 66. Qureshi B; National Public Radio. From wrong to right: a U.S apology for Japanese internment. 2013. Available at: <https://www.npr.org/sections/codeswitch/2013/08/09/210138278/japanese-internment-redress>. Accessed April 5, 2019
 67. Robert Wood Johnson Foundation. Discrimination: experiences and views on effects of discrimination across major population groups in the United States. Available at: <https://www.rwjf.org/en/library/research/2017/10/discrimination-in-america-experiences-and-views.html>. Accessed April 5, 2019
 68. US Department of State, Office of the Historian. Indian treaties and the Native American Removal Act of 1830. Available at: <https://history.state.gov/milestones/1830-1860/indian-treaties>. Accessed August 24, 2017
 69. US Department of State, Office of the Historian. 1830-1860 diplomacy and westward expansion. Available at: <https://history.state.gov/milestones/1830-1860/foreword>. Accessed August 24, 2017
 70. Franklin JH. *From Slavery to Freedom.* 9th ed. New York, NY: McGraw-Hill; 2010
 71. Rothstein R. *The Color of Law.* New York, NY: W.W. Norton & Co; 2017
 72. Alexander M. *The New Jim Crow.* New York, NY: New Press; 2012
 73. Xiao NG, Quinn PC, Liu S, Ge L, Pascalis O, Lee K. Older but not younger infants associate own-race faces with happy music and other-race faces with sad music. *Dev Sci.* 2018;21(2):e12537
 74. Vogel M, Monesson A, Scott LS. Building biases in infancy: the influence of race on face and voice emotion matching. *Dev Sci.* 2012;15(3):359–372
 75. Sangrigoli S, De Schonen S. Recognition of own-race and other-race faces by three-month-old infants. *J Child Psychol Psychiatry.* 2004;45(7):1219–1227
 76. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health.* 2000;90(8):1212–1215
 77. Carmichael S, Hamilton CV. *Black Power: The Politics of Liberation in America.* New York, NY: Vintage Books; 1967
 78. Jones CP. Invited commentary: "race," racism, and the practice of epidemiology. *Am J Epidemiol.* 2001; 154(4):299–304; discussion 305–306
 79. Riera A, Walker DM. The impact of race and ethnicity on care in the pediatric emergency department. *Curr Opin Pediatr.* 2010;22(3):284–289
 80. Laster M, Soohoo M, Hall C, et al. Racial-ethnic disparities in mortality and kidney transplant outcomes among pediatric dialysis patients. *Pediatr Nephrol.* 2017;32(4):685–695
 81. Goyal MK, Kuppermann N, Cleary SD, Teach SJ, Chamberlain JM. Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatr.* 2015;169(11):996–1002
 82. Johnson TJ, Weaver MD, Borrero S, et al. Association of race and ethnicity with management of abdominal pain in the emergency department. *Pediatrics.*

- 2013;132(4). Available at: www.pediatrics.org/cgi/content/full/132/4/e851
83. Wickrama KA, Bae D, O'Neal CW. Black-white disparity in young adults' disease risk: an investigation of variation in the vulnerability of black young adults to early and later adversity. *J Adolesc Health*. 2016;59(2):209–214
 84. Mulia N, Zemore SE. Social adversity, stress, and alcohol problems: are racial/ethnic minorities and the poor more vulnerable? *J Stud Alcohol Drugs*. 2012;73(4):570–580
 85. Call KT, McAlpine DD, Johnson PJ, Beebe TJ, McRae JA, Song Y. Barriers to care among American Indians in public health care programs. *Med Care*. 2006;44(6):595–600
 86. Puumala SE, Burgess KM, Kharbanda AB, et al. The role of bias by emergency department providers in care for American Indian children. *Med Care*. 2016;54(6):562–569
 87. Rivas-Drake D, Seaton EK, Markstrom C, et al; Ethnic and Racial Identity in the 21st Century Study Group. Ethnic and racial identity in adolescence: implications for psychosocial, academic, and health outcomes. *Child Dev*. 2014;85(1):40–57
 88. Brody GH, Yu T, Miller GE, Chen E. Discrimination, racial identity, and cytokine levels among African-American adolescents. *J Adolesc Health*. 2015;56(5):496–501
 89. Cheng ER, Cohen A, Goodman E. The role of perceived discrimination during childhood and adolescence in understanding racial and socioeconomic influences on depression in young adulthood. *J Pediatr*. 2015;166(2):370–7.e1
 90. Muuss R. *Theories of Adolescence*. 6th ed. New York, NY: McGraw Hill; 1996
 91. Steele CM. *Whistling Vivaldi: How Stereotypes Affect Us and What We Can Do (Issues of Our Time)*. New York, NY: W.W. Norton & Co; 2011
 92. Fischer P, Krueger JI, Greitemeyer T, et al. The bystander-effect: a meta-analytic review on bystander intervention in dangerous and non-dangerous emergencies. *Psychol Bull*. 2011;137(4):517–537
 93. Leitner JB, Hehman E, Ayduk O, Mendoza-Denton R. Blacks' death rate due to circulatory diseases is positively related to whites' explicit racial bias. *Psychol Sci*. 2016;27(10):1299–1311
 94. Wells AS, Fox L, Cordova D. How racially diverse schools and classrooms can benefit all students. 2016. Available at: <https://tcf.org/content/report/how-racially-diverse-schools-and-classrooms-can-benefit-all-students/?agreed=1>. Accessed September 14, 2018
 95. National Center for Education Statistics. Schools and Staffing Survey (SASS). Available at: https://nces.ed.gov/surveys/sass/tables/sass0708_035_s1s.asp. Accessed August 25, 2017
 96. Hofferth SL, Sandberg JF. How American children spend their time. *J Marriage Fam*. 2001;63:295–308
 97. US Department of Health and Human Services, Office on Adolescent Health. A day in the life. Available at: <https://www.hhs.gov/ash/oah/facts-and-stats/day-in-the-life/index.html>. Accessed September 13, 2018
 98. Robert Wood Johnson Foundation. The relationship between school attendance and health. 2016. Available at: <https://www.rwjf.org/en/library/research/2016/09/the-relationship-between-school-attendance-and-health.html>. Accessed September 13, 2018
 99. McGill N; American Public Health Association. Education attainment linked to health throughout lifespan: exploring social determinants of health. *Nations Health*. 2016;46(6):1–19
 100. Allison MA, Attisha E; Council on School Health. The link between school attendance and good health. *Pediatrics*. 2019;143(2):e20183648
 101. US Department of Education. Chronic absenteeism in the nation's schools. Available at: <https://www2.ed.gov/dastatory/chronicabsenteeism.html#intro>. Accessed August 25, 2017
 102. Aranda E, Vaquera E. Racism, the immigration enforcement regime, and the implications for racial inequality in the lives of undocumented young adults. *Sociol Race Ethn (Thousand Oaks)*. 2015;1:104
 103. National Center for Education Statistics. Public high school graduation rates. 2018. Available at: https://nces.ed.gov/programs/coe/indicator_coi.asp. Accessed September 13, 2018
 104. Virginia Commonwealth University, Center on Health and Society. Education: it matters to health more than ever before. Available at: <https://societyhealth.vcu.edu/work/the-projects/education-it-matters-more-to-health-than-ever-before.html>. Accessed August 25, 2017
 105. US Department of Education. Equity of opportunity. Available at: <https://www.ed.gov/equity>. Accessed August 25, 2017
 106. Morgan PL, Farkas G, Hilliemiemeier MM, Maczuga S. Replicated evidence of racial and ethnic disparities in disability identification in U.S. schools. *Educ Res*. 2017;46(6):305–322
 107. White GB. The data are damning: how race influences school funding. *The Atlantic*. September 30, 2015. Available at: <https://www.theatlantic.com/business/archive/2015/09/public-school-funding-and-the-role-of-race/408085/>. Accessed September 14, 2018
 108. Derman-Sparks L, Ramsey G. *What If All the Kids Are White? Multicultural/Anti-Bias Education With White Children*. 2nd ed. New York, NY: Teachers' College Press; 2011
 109. Birch SH, Ladd GW. The teacher-child relationship and children's early school adjustment. *J Sch Psychol*. 1997;35(1):61–79
 110. Lowenstein AE, Friedman-Krauss AH, Raver CC, Jones SM, Pess RA. School climate, teacher-child closeness, and low-income children's academic skills in kindergarten. *J Educ Develop Psychol*. 2015;5(2):89–108
 111. Alvidrez J, Weinstein RS. Early teacher perceptions and later student academic achievement. *J Educ Psychol*. 1999;91(4):731–746
 112. Bates LA, Glick JE. Does it matter if teachers and schools match the student? Racial and ethnic disparities in problem behaviors. *Soc Sci Res*. 2013;42(5):1180–1190
 113. Gershenson S, Holt S, Papageorge NW. Who believes in me? The effect of student-teacher demographic match on teacher expectations. *Econ Educ Rev*. 2016;52:209–224

114. Cherng H. If they think I can: teacher bias and youth of color expectations and achievement. *Soc Sci Res.* 2017;66:170–186
115. Gershenson S, Hart CMD, Lindsay CA, Papageorge NW. IZA DP No. 10630: the long run impacts of same-race teachers. Available at: <http://ftp.iza.org/dp10630.pdf>. Accessed June 16, 2019
116. National Center for Education Statistics. Fast facts: back to school statistics. 2018. Available at: <https://nces.ed.gov/fastfacts/display.asp?id=372>. Accessed March 12, 2019
117. Byrd CM. *Student Perceptions of Racial Climate in Secondary Education: Effects of Climate's Multiple Dimensions on Academic Achievement and Motivation*. Ann Arbor, MI: University of Michigan, Horace H. Rackham School of Graduate Studies; 2012
118. Mattison E, Aber MS. Closing the achievement gap: the association of racial climate with achievement and behavioral outcomes. *Am J Community Psychol.* 2007;40(1–2):1–12
119. US Government Accountability Office (GAO). K-12 education: discipline disparities for black students, boys, and students with disabilities (GAO-18-258). 2018. Available at: <https://www.gao.gov/products/GAO-18-258>. Accessed March 12, 2019
120. US Department of Education, Office on Civil Rights. 2013-2014 civil rights data: a first look. 2016. Available at: <https://www2.ed.gov/about/offices/list/ocr/docs/2013-14-first-look.pdf>. Accessed March 12, 2019
121. Wong CA, Eccles JS, Sameroff A. The influence of ethnic discrimination and ethnic identification on African American adolescents' school and socioemotional adjustment. *J Pers.* 2003;71(6):1197–1232
122. Caughy MO, O'Campo PJ, Randolph SM, Nickerson K. The influence of racial socialization practices on the cognitive and behavioral competence of African American preschoolers. *Child Dev.* 2002;73(5):1611–1625
123. Anderson AT, Jackson A, Jones L, Kennedy DP, Wells K, Chung PJ. Minority parents' perspectives on racial socialization and school readiness in the early childhood period. *Acad Pediatr.* 2015;15(4):405–411
124. Waseem M, Paul A, Schwartz G, et al. Role of pediatric emergency physicians in identifying bullying. *J Emerg Med.* 2017;52(2):246–252
125. Juvonen J, Graham S, Schuster MA. Bullying among young adolescents: the strong, the weak, and the troubled. *Pediatrics.* 2003;112(6, pt 1):1231–1237
126. Committee on Injury, Violence, and Poison Prevention. Policy statement—Role of the pediatrician in youth violence prevention. *Pediatrics.* 2009;124(1):393–402
127. Committee on Hospital Care and Institute For Patient- and Family-Centered Care. Patient- and family-centered care and the pediatrician's role. *Pediatrics.* 2012;129(2):394–404
128. Lang KR, Dupree CY, Kon AA, Dudzinski DM. Calling out implicit racial bias as a harm in pediatric care. *Camb Q Healthc Ethics.* 2016;25(3):540–552
129. Society for Adolescent Health and Medicine. International youth justice systems: promoting youth development and alternative approaches: a position paper of the society for adolescent health and medicine. *J Adolesc Health.* 2016;59(4):482–486
130. Barnert ES, Dudovitz R, Nelson BB, et al. How does incarcerating young people affect their adult health outcomes? *Pediatrics.* 2017;139(2):e20162624
131. Richardson S, Williams T. Why is cultural safety essential in health care? *Med Law.* 2007;26(4):699–707
132. Gibbons FX, Roberts ME, Gerrard M, et al. The impact of stress on the life history strategies of African American adolescents: cognitions, genetic moderation, and the role of discrimination. *Dev Psychol.* 2012;48(3):722–739
133. Landrine H, Klonoff EA. The schedule of racist events: a measure of racial discrimination and a study of its negative physical and mental health consequences. *J Black Psychol.* 1996;22(2):144–168
134. Pachter LM, Szalacha LA, Bernstein BA, Coll CG. Perceptions of Racism in Children and Youth (PRaCY): properties of a self-report instrument for research on children's health and development. *Ethn Health.* 2010;15(1):33–46
135. American Academy of Pediatrics. Engaging patients and families: providing culturally effective care toolkit. Available at: <https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/effective-care.aspx>. Accessed March 12, 2019
136. National Resource Center for Patient/Family-Centered Medical Home. What is medical home? Available at: <https://medicalhomeinfo.aap.org/overview/Pages/Whatisthemedicalhome.aspx>. Accessed March 12, 2019
137. Ward JV. Raising resisters: the role of truth telling in the psycho-logical development of African American girls. In: Weis L, Fine M, eds. *Construction Sites: Excavating Race, Class and Gender Among Urban Youth*. New York, NY: Teachers College Press; 2000:64
138. Ward JV. *The Skin We're in: Teaching Our Teens to be Emotional Strong, Socially Smart, and Spiritually Connected*. New York, NY: Free Press; 2002
139. Barksdale CL, Rodick WH III, Hopson R, Kenyon J, Green K, Jacobs CG. Literature review of the national CLAS standards: policy and practical implications in reducing health disparities. *J Racial Ethn Health Disparities.* 2017;4(4):632–647
140. US Department of Health and Human Services. National CLAS standards. Available at: <https://www.thinkculturalhealth.hhs.gov/clas>. Accessed August 29, 2017
141. Brown P, Tierney C. Media role in violence and the dynamics of bullying. *Pediatr Rev.* 2011;32(10):453–454
142. 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
143. Sampson RJ, Wilson WJ. Toward a theory of race, crime, and urban inequality. In: Hagan J, Peterson RD, eds. *Crime and Inequality*. Stanford, CA: Stanford University Press; 1995:56
144. Marsac ML, Kassam-Adams N, Hildenbrand AK, et al. Implementing a trauma-informed approach in

- pediatric health care networks. *JAMA Pediatr.* 2016;170(1):70–77
145. Ginsburg KR, Kinsman SB. *Reaching Teens: Strength-Based Communication Strategies to Build Resilience and Support Healthy Adolescent Development.* Elk Grove, IL: American Academy of Pediatrics; 2014
 146. Gaskin A; American Psychological Association. Racial socialization: ways parents can teach their children about race. 2015. Available at: www.apa.org/pi/families/resources/newsletter/2015/08/racial-socialization.aspx. Accessed March 12, 2019
 147. High PC, Klass P; Council on Early Childhood. Literacy promotion: an essential component of primary care pediatric practice. *Pediatrics.* 2014; 134(2):404–409
 148. Sectish TC, Zalneraitis EL, Carraccio C, Behrman RE. The state of pediatrics residency training: a period of transformation of graduate medical education. *Pediatrics.* 2004;114(3): 832–841
 149. Carraccio C, Burke AE. Beyond competencies and milestones: adding meaning through context. *J Grad Med Educ.* 2010;2(3):419–422
 150. Cross T, Bazron B, Dennis K, Isaacs M, eds. *Towards a Culturally Competent System of Care.* Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center; 1989
 151. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved.* 1998;9(2):117–125
 152. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. *J Natl Med Assoc.* 2008;100(11):1275–1285
 153. Saha S, Korthuis PT, Cohn JA, Sharp VL, Moore RD, Beach MC. Primary care provider cultural competence and racial disparities in HIV care and outcomes. *J Gen Intern Med.* 2013;28(5): 622–629
 154. Ho MJ, Yao G, Lee KL, Hwang TJ, Beach MC. Long-term effectiveness of patient-centered training in cultural competence: what is retained? What is lost? *Acad Med.* 2010;85(4):660–664
 155. Paez KA, Allen JK, Beach MC, Carson KA, Cooper LA. Physician cultural competence and patient ratings of the patient-physician relationship. *J Gen Intern Med.* 2009;24(4):495–498
 156. Maguire MS, Kottenhahn R, Consiglio-Ward L, Smalls A, Dressler R. Using a poverty simulation in graduate medical education as a mechanism to introduce social determinants of health and cultural competency. *J Grad Med Educ.* 2017;9(3):386–387
 157. Barkin S, Balkrishnan R, Manuel J, Hall MA. Effect of language immersion on communication with Latino patients. *N C Med J.* 2003;64(6):258–262
 158. Federal Interagency Forum on Child and Family Statistics. America's children in brief: key national indicators of well-being, 2018. Available at: <https://www.childstats.gov/americaschildren/demo.asp>. Accessed August 25, 2017
 159. Katkin JP, Kressly SJ, Edwards AR, et al; Task Force on Pediatric Practice Change. Guiding principles for team-based pediatric care. *Pediatrics.* 2017; 140(2):e20171489
 160. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health.* 2015; 105(12):e60–e76
 161. Committee on Pediatric Workforce. Enhancing pediatric workforce diversity and providing culturally effective pediatric care: implications for practice, education, and policy making. *Pediatrics.* 2013;132(4). Reaffirmed October 2015. Available at: www.pediatrics.org/cgi/content/full/132/4/e1105
 162. The Joint Commission. Implicit bias in healthcare. 2016. Available at: https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_23_Apr_2016.pdf. Accessed March 12, 2019
 163. Jee-Lyn Garcia J, Sharif MZ. Black lives matter: a commentary on racism and public health. *Am J Public Health.* 2015; 105(8):e27–e30
 164. American Public Health Association. Racism and health. Available at: <http://www.apha.org/topics-and-issues/>
 165. Devore CD, Wheeler LS; Council on School Health; American Academy of Pediatrics. Role of the school physician. *Pediatrics.* 2013;131(1):178–182
 166. Council on School Health. The role of the school nurse in providing school health services. *J Sch Nurs.* 2008;24(5): 269–274
 167. van den Bergh L, Denessen E, Hornstra L, Voeten M, Holland RW. The implicit prejudiced attitudes of teachers: relations to teacher expectations and the ethnic achievement gap. *Am Educ Res J.* 2010;47(2):527
 168. Mendelson T, Tandon SD, O'Brennan L, Leaf PJ, Jalongo NS. Brief report: moving prevention into schools: the impact of a trauma-informed school-based intervention. *J Adolesc.* 2015;43: 142–147
 169. Gilliam WS, Maupin AN, Reyes CR. Early childhood mental health consultation: results of a statewide random-controlled evaluation. *J Am Acad Child Adolesc Psychiatry.* 2016;55(9):754–761
 170. Southern Poverty Law Center. Perspectives for a diverse America. Available at: www.tolerance.org/sites/default/files/general/Perspectives%20for%20a%20Diverse%20America%20User%20Experience.pdf. Accessed August 26, 2017
 171. Gershenson S, Dee TS; Brookings Institute. The insidiousness of unconscious bias. 2017. Available at: <https://www.brookings.edu/blog/brown-center-chalkboard/2017/03/20/the-insidiousness-of-unconscious-bias-in-schools/>. Accessed March 12, 2019
 172. Kirwan Institute, Ohio State University. Interventions to address racialized discipline disparities and school “push out.” Available at: <http://kirwaninstitute.osu.edu/wp-content/uploads/2014/05/ki-interventions.pdf>. Accessed November 24, 2017
 173. Southern Poverty Law Center. Teaching tolerance. Available at: <https://www.splcenter.org/teaching-tolerance>. Accessed August 26, 2017
 174. National Child Traumatic Stress Network. Addressing race and trauma in the classroom: a resource for educators. 2017. Available at: <https://>

- www.nctsn.org/resources/addressing-race-and-trauma-classroom-resource-educators. Accessed March 12, 2019
175. Boyd RW, Ellison AM, Horn IB. Police, equity, and child health. *Pediatrics*. 2016;137(3):e20152711
176. The Pew Charitable Trusts/Research & Analysis. Re-examining juvenile incarceration: high cost, poor outcomes spark shift to alternatives. 2015. Available at: <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2015/04/reexamining-juvenile-incarceration>. Accessed March 12, 2019
177. Chamberlain P, Reid JB. Comparison of two community alternatives to incarceration for chronic juvenile offenders. *J Consult Clin Psychol*. 1998; 66(4):624–633
178. Bostic JQ, Thurau L, Potter M, Drury SS. Policing the teen brain. *J Am Acad Child Adolesc Psychiatry*. 2014;53(2): 127–129
179. Mitchell B, Franco J. *HOLC “Redlining” Maps: The Persistent Structure of Segregation and Economic Inequality*. Washington, DC: National Community Reinvestment Coalition; 2018. Available at: <https://ncrc.org/holc/>. Accessed April 5, 2019
180. Heard-Garris N, Williams DR, Davis M. Structuring research to address discrimination as a factor in child and adolescent health. *JAMA Pediatr*. 2018; 172(10):910–912

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