

Thesis: DSM-Based Model's Utility and Differential Benefits in the Two-Track System

Despite validity flaws, the DSM, as a framework with practical utility, provides standardization for diagnoses, assessments, and interventions in mental health and child welfare contexts. This is evident in identifying symptom clusters for treatment planning, facilitating parental evaluations, and enabling structured care pathways. Within the “two-track” system, White youth disproportionately access comprehensive, community-based referrals (e.g., psychotherapy, outpatient support), correlating with improved outcomes such as symptom reduction, functional enhancement, and better life-course trajectories like educational success and emotional stability. These benefits are framed as extending beyond mere avoidance of harms like overmedication or confinement, suggesting the model's capacity for positive impacts when equitably applied, particularly in mitigating distress through early, non-punitive interventions.

Antithesis: Systemic Harms, Inequities, and the Primacy of Social Determinants Over DSM Efficacy

Opposing this, the DSM-based biomedical model is pseudoscientific, depoliticizing inequalities and exacerbating harms, especially for ethnic and racial minorities in child welfare. Diagnoses medicalize poverty, trauma, and place-based deprivation as individual pathologies, leading to biased assessments, family separations, stigma, and punitive tracks (e.g., medication-heavy or correctional pathways) with minimal evidence of healing or improved outcomes. International critiques from the WHO and UN amplify this, urging a shift from coercive, overmedicalized practices toward rights-based, socially oriented alternatives that address root causes like discrimination and adversity. The two-track system's disparities are attributed not to DSM treatment superiority but to structural racism, where BIPOC youth face amplified “pile-up” of adverse experiences (ACEs), including higher baseline trauma from inequities and additional harms from restrictive pathways, resulting in materially worse experiences and intergenerational cycles.

Synthesis: Reframing Outcomes as Adversity Mitigation, Not Significant Benefits From DSM-based treatments

Integrating these perspectives reveals that the DSM model's apparent utility is illusory and contingent, overshadowed by its failure to confront social determinants, which drive disparities more than any intrinsic treatment efficacy. The synthesis posits a transformative paradigm: holistic, equity-focused systems that prioritize preventing adversity accumulation over diagnostic labeling, aligning with WHO/UN calls for community-led, trauma-informed care that dismantles coercion and biases. Differences in two-track outcomes stem predominantly from preventing or reducing exposure to hardships, discrimination, and high adversity levels for White youth, rather than substantial impacts from DSM-based treatments. Evidence shows that while DSM interventions offer modest symptom relief when accessed, racial gaps persist due to minorities' compounded traumas (e.g., racism-induced ACEs clustering in high-adversity profiles), with equivalent efficacy

across groups when barriers are removed, highlighting that “benefits” for Whites are protective against further harms rather than proactive gains from the model. This dialectic culminates in advocacy for reforms targeting structural roots—anti-racist policies, cultural responsiveness, and social investments—to achieve universal healing, rendering the current framework obsolete and equitable outcomes attainable beyond its limitations.

Sustaining and Expanding “Access” to the DSM-Based Mental Health System We Is Not Our Best Public Policy Option; It Is at Best Better Than The Race-Biased Two-Track System We Have

Sustaining and increasing access to the DSM-based biomedical system as the primary treatment model—despite its documented cumulative harms, including the medicalization of social distress, perpetuation of place-based and structural inequalities, and amplification of racial biases—is not the best public policy choice available, particularly in light of WHO and UN contributions from 2023 to 2025 that advocate for transformative, rights-based alternatives focused on human rights, social determinants, and equity. These international recommendations provide evidence-based pathways for reform that prioritize holistic, community-centered approaches over individual pathology, offering superior outcomes in terms of access, quality, and justice while addressing the very biases and harms embedded in the current system.

The WHO’s March 2025 guidance on transforming mental health policies explicitly calls for urgent shifts away from outdated institutional and biomedical models, which often rely on diagnostic frameworks like the DSM that emphasize symptom clusters without adequate consideration of contextual factors, leading to gaps where up to 90% of people with severe conditions receive no care in some countries. This guidance critiques coercive practices and overmedicalization, recommending instead a framework aligned with human rights standards, including holistic interventions that integrate lifestyle, psychological, social, and economic supports; addressing social determinants like employment, housing, and education; and empowering individuals with lived experience in policy design. It identifies five reform areas—leadership/governance, service organization, workforce development, person-centered care, and tackling structural determinants—to create equitable systems, building on the WHO QualityRights initiative for recovery-oriented, rights-based care.

Similarly, the joint WHO-OHCHR 2023 guidance on mental health, human rights, and legislation—referenced in UN Human Rights Council reports as late as February 2025—urges countries to adopt laws mandating rights-based mental health systems that transform services, promote equality, and respect dignity, explicitly moving beyond coercive and biomedical-dominant approaches to support community thriving and recovery. The UN System Mental Health and Well-being Strategy for 2024

and beyond complements this by emphasizing policy mainstreaming of mental health, stigma reduction, and addressing structural biases (e.g., discrimination, workload inequities) through participatory, data-driven plans that prevent risks and promote inclusive support, rather than relying on traditional diagnostic models. These documents collectively highlight that current systems exacerbate racial and place-based disparities—such as disproportionate overdiagnosis and punitive interventions for minorities—by individualizing societal issues, and they propose alternatives like school-based prevention programs, integrated services, and equity-focused reforms as more effective policy options.

In contrast to sustaining the DSM-based system, which research links to ongoing harms like family separations in child welfare, overrepresentation of BIPOC youth in correctional pathways, and depoliticization of inequalities, the WHO and UN frameworks offer a superior policy pathway: they are flexible, context-specific, and evidence-informed, with proven progress in initiatives like the WHO Special Initiative for Mental Health across diverse countries. Implementing these would reduce cumulative harms by prioritizing prevention, social justice, and human rights, making them the optimal public policy choice for equitable mental health outcomes.