AMERICAN MENTAL HEALTH POLICY

Racism in the Mental Health System

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The re-discovery of health disparities and continuing racism in America during the pandemic and in the aftermath of the murder of George Floyd by a policeman has reawakened concern about racism in all dimensions of American life, including mental health practice and policy.

Is the mental health system inherently racist? If so, in what ways and what can be done about it?

These questions are now being confronted by mental health organizations. For example, the American Psychiatric Association and the American Psychological Association have both issued apologies for their history of racial injustice and have begun projects to root out racism.[1,2] The National Association of Social Workers has also apologized[3] and joined with them to call for ending racism in mental health care.[4]

And they are not alone, virtually all mental health advocacy[5] and provider[6] organizations are tackling the issue. Many have introduced projects to enhance "diversity, equity, and inclusion".[7] Some have conceptualized their efforts as what is being called "**anti-racism**".

Although there are complexities to claims of racism that call for careful exploration, the racist history of mental health policy in America is clear and shameful. [8, 9, 10, 11, 12, 13, 14, 15, 16]

That the "father of American psychiatry", Benjamin Rush, believed that having black skin is a disease is—well—unbelievable.

That medical professionals in the South, and some in the North, believed that the desire to escape slavery was a disease, which they called *drapetomania*, is beyond unbelievable.

That it was widely believed that Black slaves were very unlikely to become insane (1) because to be a slave was to live a protected, stress-free life and (2) because African slaves did not have enough intelligence to lose their minds—also unbelievable.

That these beliefs were supported with erroneous data from the 1840 census should serve as a warning that data can be manipulated to appear to support bigotry.

That a psychiatrist early in the 20th century argued that Blacks had not been out of primitive state long enough in history to become civilized is also astounding and an example of how very smart people can rationalize racist beliefs.

That almost all state psychiatric hospitals were segregated, that there were state hospitals for "colored people" not just in the south but in the north as well--my mouth drops. But it's not really surprising, I guess, that the people responsible for the care and treatment of people with severe mental illness believed that their facilities should be segregated. They were men (mostly) and women* of their time and culture. Belief in the inferiority of Blacks was endemic to the American society, including among educated people. Separate but equal was a moral position. That there was no equality in segregated facilities simply escaped the notice of people—even mental health professionals—who wore the social blinders of their time.

That segregation continued until the passage of the Civil Rights Act in 1964 and the decision of the Johnson administration to deny Medicare and Medicaid payment to hospitals that were segregated is testimony to the sad fact that people often must be legally required to behave decently because they will be unmoved by moral claims and other efforts to change their attitudes and beliefs.

It may be that the profession of psychiatry deserves most of the blame for this horrible history, but those of you becoming social workers should keep in mind that beginning early in the 20th century, the profession of psychiatric social work began to emerge. Social workers were part of horrible segregation and mistreatment of Blacks and other people of color that legally came to an end in the mid-60s but arguably continue in more subtle forms today.

Apologize? That's the least the mental health professions can do. Changing the system really has become—as the "anti-racists" angrily point out—a modern moral imperative.

I confess that until the past couple of years of racial awakening I was not aware of the horrible history of the treatment of Black slaves or other non-white populations who were mentally ill. I began working in the field in 1968. The places where I worked were integrated. My first supervisor was

* Women of the time were also racists. The women who led settlement houses kept them segregated. The suffragettes who fought for the right of women to vote opposed efforts to protect voting rights of black people.

Black. On my visits to Manhattan State Hospital, I found wards that were a mix of White and non-White. I did not see the past.

But I should have. The histories I read of the treatment of people with mental illness should have dwelled on it. Instead, they gave it short shrift.* I should have wondered how slaves who went mad were treated and how Blacks with mental illness were treated during the Jim Crow era.

But—wait a minute. Even though it's true that I and other mental health professionals of the 2nd half of the 20th century were largely unaware of and insensitive about the history of out and out racism in mental health, it is simply not the case that racism has just been discovered. Racial mental health disparities have been matters of concern for at least 60 years. (Here, for example, is a reference to a book on the topic published in 1973.[17])

That people of color are disproportionately underserved in the mental health system has been known for a very long time. That, for example, Black men are more likely to be diagnosed with schizophrenia [18] and to be institutionalized or incarcerated has also been known for a very long time. So have the facts that people of color are far less likely to be providers of mental health services[19] or to be promoted into management positions or to be part of the power structure of the mental health system—on boards of directors, in high public positions, members of advisory and planning groups, etc.

And there have been significant efforts to address these disparities for many years. At the risk of vast oversimplification, I think of prior efforts to address racial disparities in mental health as falling into two periods—**the period of "affirmative action"** and the **period of "cultural competence".**

During the period of affirmative action, the primary goal was increasing the participation of people of color in the mental health system. This included (1) an effort to provide community mental health services to more people of color, (2) affirmative action to hire more people of color and to promote them, and (3) efforts to include them in the power structure of the mental health system.

Subsequently, there was a shift from a core concept of affirmative action to a core concept of "cultural competence". Although affirmative action did not end with the rise of the concept of cultural competence, conceptually there were major changes. The population of primary concern changed from people of color and other protected populations under the Civil Rights Act to

* For example, Gerald Grob devotes just 3 pages of his wonderful history of mental health policy, *The Mad Among Us*, to the treatment of Blacks.

people from cultures different from the dominant American culture including, for example, Russian and Iranian immigrants and, for that matter, all distinguishable ethnic and identity groups.

The concept of cultural competence shone a light on the poor quality of mental health services for many people and especially for people for whom English was not their primary language or who had limited education or were from cultures that did not turn to mental health professionals when times were tough.

Properly understood, the concept of cultural competence included more than clinical competence. Culturally competent service systems were also a significant goal. In this way the concept of cultural competence did include concern about discrimination, which is fundamental to affirmative action. But, in my opinion, it was far more concerned about insensitivity to the values, attitudes, customs, beliefs, and ways of life of different cultures than about the achievement of equity.

Equity has re-emerged as the major goal of efforts to address issues of race in the mental health system due to the revelations of disparities during the pandemic and of racially based violence in the aftermath of the murder of George Floyd. This has led to a new phase of addressing racism in the mental health system—to a phase labeled "anti-racism".

Anti-racism tends to be critical of prior efforts to address racism, seeing them as more talk than action and as failing to get to the heart of America's unjust distribution of power, which is seen as the core of systemic racism. Anti-racism, its proponents argue, is not just opposing racism; it is fighting to eliminate it. Anti-racism is not just feeble efforts to hire more people of color. It is not just about understanding their cultures. It is about recognizing that the American society is rigged against people of color and fighting to change that. It is about lingering, often invisible forms of discrimination. It is about the internalization of racism. It is about White complicity in systems that benefit Whites and disadvantage people of color, especially Blacks.

The following discussion of race and mental health provides a bit of elaboration on the three phases of mental health policy and race--(1) the phase of affirmative action, (2) the phase of cultural competence, and (3) the phase of "anti-racism", which is just getting underway.

Affirmative Action

As the expansion of the community mental health system gathered steam in the 1970s and 1980s, mental health policy concerns spread from adults with serious and persistent illness to include certain "special populations" such as

children and adolescents, people with co-occurring mental and substance use disorders, and—very importantly—people of color (who were then referred to as "minorities"). There was widespread recognition of underutilization of services and of under-representation of people of color among providers and policy makers, and this led to efforts to increase their utilization of services, representation in the workforce, and participation in the power structure. Affirmative action became a fundamental element of mental health policy.

The major goals of affirmative action were (1) to make sure that people of color had equal access to public mental health services,* (2) to make major efforts to recruit and hire people of color for professional positions, (3) to develop processes of promotion that were non-discriminatory or even gave preference to qualified applicants of color, (4) to assure that organizations licensed by and/or in contract with state departments of mental health included people of color on their Boards of Directors, (5) to include people of color on local, regional, and state planning and advisory committees, and (6) to develop initiatives to improve race relations among staff and among patients in institutions and programs operated or licensed by the state.

In New York, for example, the Commissioner of Mental Health established a Minority Advisory Committee and appointed a Special Assistant for Minority Affairs. He also established a priority for the development of new programs located in "minority" communities and focused on serving people of color in those communities. For example, in the early 1990s, when I was Director of the Hudson River Region of the Office of Mental Health, I recommended and got approval for a new clinic in Yonkers that was focused on the Hispanic population even though there was a statewide freeze on new clinic development.

Similarly, when the state's quality assurance staff from my office did site visits to re-license programs, they focused some attention on the efforts providers were supposed to be making to serve, hire, promote, and empower people of color. Did they have an affirmative action plan? How did they recruit minority staff? Did they have committees to identify and improve discriminatory practices? What was the racial composition of their professional staff? Did they have a process for improving race relations within their organizations? Did they celebrate diversity with special events for Black History Month and the like?

During this period in NYS, there was a system to count the populations that were served by the public mental health system. At some point it became clear that Black and Latino populations were over-represented as patients in

* Virtually no attention was paid to the lack of access of people of color and other medically indigent people to private practitioners.

the system. Initially this came as a surprise because other epidemiological data indicated that Black, Latino, and Asian populations were generally underserved. But then we realized that, because they were likely to be economically disadvantaged, Blacks and Latinos usually could not use services in the private sector and were forced into the public sector.

During this period The State Office of Mental Health also pushed for the inclusion of people of color on local, regional, and state advisory bodies.

Cultural Competence

At some point in the late 1980s and early 1990s, the core concept regarding how to improve treatment of racial and ethnic minorities in the mental health system shifted from affirmative action to "cultural competence". This concept emphasizes the importance of cultural sensitivity (1) in engagement of patients/clients, (2) in diagnosis, and (3) in treatment technique. It also includes attention to (4) language and to (5) building connections with cultural communities. And there was also a growing emphasis on (6) epidemiological and clinical research that identified differences among cultures and that used research methods that were culturally sensitive.

During this period there was heavy emphasis on education about cultural differences and about how to adapt mental health services to engage, diagnose, and treat people from different cultures. For example, I hired one of the nation's leading researchers on cultural competence to provide training in the 16 counties of the region I was responsible for as well as in the five state hospitals I oversaw.

Although the push for cultural competence undoubtedly had positive outcomes with regard to clinical practice, I believe that it also had limitations with regard to confronting racism.

First, there is a fundamental difference between making cultural diversity and competence a priority and making people of color a priority. **Cultural diversity encompasses a much larger population than racial minorities**. In fact, it includes diverse White cultures as well as diverse cultures of people of color.

In addition, I believe that broadening the priority population resulted in **less attention to discrimination and civil rights** as time and effort was diverted to issues of cultural competence.

For example, the NYS Office of Mental Health's Minority Advisory Committee became the "Multi-Cultural" Advisory Committee. That is a much broader formulation—as much about Russian immigrants as about Latinos, more about language and cultural understanding than about fighting

discrimination in the location of services, in hiring and promotion, and in participation in the power structure.

Another limitation of the concept of cultural competence has to do with the goal of cultural matching. During the phase of affirmative action, the primary reason to seek more staff who were people of color was to redress the under-representation of people of color in the mental health system. Under the concept of cultural competence, the primary reason for increasing staff diversity was the belief that they are better able to understand the language and the culture of people with backgrounds like their own, and that they serve as role models. The goal, that is, was culture matching rather than equity in staffing.

In addition to the tension between the goals of equity and cultural matching, certain questions about the value of cultural matching need to be raised. For example, what is the impact of economic, educational, and status differences between clients and professionals? Do Black professionals, for example, have better understanding and have greater compassion for people of color who are poorly educated and live in poverty than do well-trained professionals who are not Black?

In my experience what is called "cultural matching" is actually color matching. For example, American Blacks and Caribbean Blacks are both Black, but they have significant cultural differences. There simply is not a single Black culture, and hiring from one Black population to serve a different Black population is not culture matching. It is color matching. The same is true for Latinos and Asians. There is not a single Latino culture or a single Asian culture. Culture matching often is an illusion.

Given these limitations, is "cultural competence" the best conceptual formulation of how to reduce disparities and enhance equity in mental health for people of color? Does it get to the heart of systemic racism?

Anti-Racism in Mental Health [20, 21, 22]

Anti-racism is based on the perception that neither affirmative action nor cultural competence went far enough in addressing issues of racism in the mental health system.

It is also based on the perception that Whites in the mental health system were not, and are not, fully committed to reducing racism. It is very important to understand that while the term "anti-racism" sounds like it means being opposed to racism, that is not what it means. In fact, those who are advocating for anti-racism make it a major point to differentiate between opposing something in sentiment, in principle, or in minor action on

the one hand and in devoting one's social activism to undoing racism on the other.

For some anti-racists, liberals who oppose racism, vote accordingly, give a little money to help disadvantaged people of color, and perhaps help a bit to racially integrate the mental health system are not anti-racists.[23] In fact, they are sometimes called racists and white supremacists because there is, according to anti-racists, no middle ground between anti-racism and racism. There are no innocent bystanders. You are either fully committed to undoing racism or you are a racist. In addition, some anti-racists believe that Whites are racists and White supremacists if they live comfortably in a society characterized, anti-racists say, by "White privilege" and "racial oppression".

I personally think it is a huge political mistake to use language this way if only because it alienates voters at a moment in American history when it is exceedingly important to beat back attacks on a liberal society.[24]

But it seems clear to me that anti-racist advocates are right to point out that **efforts to address racism in the mental health system until now have not gone far enough** and **not enough progress has been made regarding racism in the United States and in its mental health system**.

Fundamental elements of anti-racism

Anti-racism uses critical race theory as a theoretical framework. This theory is an outgrowth of a school of political philosophy known as "critical theory" that began with Herbert Marcuse in the mid-20th century. He developed a theory that is a very interesting amalgam of Marx and Freud and maintained that human well-being depends on "liberation", which is a combination of psychological and political freedom. Psychological liberation depends on restructuring human societies because they all have hierarchies of power that involve exploitation and oppression. Like Marxism, it is a fundamentally revolutionary point of view.[25]

According to the Encyclopedia Britannica, **"Critical race theory (CRT)**, is an intellectual and social movement and loosely organized framework of legal analysis based on the premise that race is not a natural, biologically grounded feature of physically distinct subgroups of human beings but a socially constructed (culturally invented) category that is used to oppress and exploit people of color. Critical race theorists hold that racism is inherent in the law and legal institutions of the United States insofar as they function to create and maintain social, economic, and political inequalities between Whites and nonwhites, especially African Americans. Critical race theorists

are generally dedicated to applying their understanding of the institutional or structural nature of racism to the concrete (if distant) goal of eliminating all race-based and other unjust hierarchies."[26]

Columbia School of Social Work, which is now pursuing an anti-racism plan, draws from a similar theory of social injustice, "PROP", which points to the imbalance of power in our society, an imbalance that results in oppression, especially of people of color, by Whites, who have unfair privileges.[27]

While there appears to be a very broad range of opinion about what anti-racism is, there do seem to be the following common and fundamental elements.

- Racism is systemic and embedded in American social institutions and practices, sometimes overtly but more often subtly, almost invisibly.

- Anti-racist does not mean just being opposed to racism; it means actively working to overcome it. [28]

- "Racist" means being complicit in a racist society by accepting and not challenging the advantages that White people have. [29]

- Race is a social construct rather than a biological reality. Judgements and beliefs that rest on hard and fast racial distinctions need to change.

- Changes in racist attitudes and practices depend on developing self-awareness of personal racism.

- Ending racial disparities depends on addressing social determinants of poor health and mental health such as racism, poverty, poor education, etc.

Anti-racism in the mental health system

There is a voluminous anti-racist literature developing about how to overcome racism in the mental health system. Here are a few of the recommendations in the current literature.

Address 3 levels of racism: (1) institutional racism/social determinants, (2) outright discrimination, and (3) internalization of racist attitudes leading to low self-esteem.[30]

Here are some typical recommendations, these from Jude Mary Cenat [31]

- Clinicians should develop an awareness of racial issues related to discrimination such as microaggressions and racial profiling and their potential impact on mental health.

- Clinicians should also engage in self-examination so as to become aware of their own possibly bigoted beliefs, ideas, attitudes, and privileges.

- Clinicians should not be blind to the client's skin color: "recognizing difference means recognizing both uniqueness and diversity".

- Clinicians should not believe that tests and treatment interventions are universal. For example, some screening instruments are not useful for people of color.

- Clinicians should be aware of racial and ethnic disparities in psychopharmacological treatment and acquire cultural competence in psychopharmacology. In general, prescribe only if there are no other alternatives.

- Clinicians should educate themselves on social, cultural, and racial determinants of health.

- While it is important for clinicians to become culturally competent, it is essential to realize that **communities of color are not culturally homogenous**. It is important to learn about the specific cultural background of the patient.

- Clinicians should assess factors related to microaggressions, discrimination, racial profiling, and racism as structuring, triggering, precipitating, or sustaining factors in mental health problems.

- They should also analyze hypervigilance, anxiety, or depressive symptoms as possibly related to discrimination and racism.

- They should also assess complex, intergenerational, historical, collective, and individual **trauma**. It is important to understand that the experience of racism is traumatic and needs to be taken as seriously as other forms of trauma.

- Clinicians should address low socioeconomic status, inadequate housing, segregation, mass incarceration, racial profiling, and police violence.

- It is particularly important that clinicians assess individual and collective strengths and resources such as resilience, self-efficacy, spirituality, faith, and religious values.

- It is also important to understand that collective strengths and resources such as social and religious support and community involvement can be exceedingly helpful for people coping with emotional issues and mental and/or substance use disorders.

I've included some other views and suggestions in the endnotes. [32, 33, 34]

Anti-Racist Policy Changes

The recommendations above are essentially about clinical practice. There also need to be policy changes to support anti-racist practice. What?

There are many proposals emerging in the literature. Here are a few that strike me as the core elements of proposed change:

- Everyone who works in the mental health system (especially those who are White) should go through a process of identifying their personal racism. This is regarded as a precondition of effective change.

- Clinicians should be trained to recognize and deal with the impact of racism in the lives of their clients and the racism implicit in the hierarchical clinical relationship. They should develop cultural competence and "cultural humility". And they should become what I call "racially competent" by bringing a "racist lens" to their practice.

- Access to services for non-Whites needs to be vastly improved.

- Quality of services for non-Whites needs to be vastly improved.

- Diversity of the workforce and in program, systems, and governmental leadership is essential.

- Mental health professionals should work to change elements of the American society that have a negative impact on the lives of people of color including racism, homelessness and unstable/unsafe housing, poverty and economic instability, food instability, poor education, disparate medical care, discrimination in the criminal justice system, and community and family violence.

It is striking to me that several of these key elements of anti-racism are essentially the same as the proposals that emerged during the past periods of affirmative action and cultural competence. What needs to change for these efforts to be more effective than they have been?

In addition, it strikes me that it will take a great deal of hard work to translate these general principles into laws, regulations, funding rules, accreditation standards, and other requirements.

The details will be very important.

I think particularly about funding because I believe that money drives the system. How should mental health finance be changed to pursue an anti-racist agenda? How should Medicare and Medicaid change? How should the block grants change? How should state funding be redirected? Is universal health coverage absolutely basic to achieving the goals of anti-racism? Must it be government based or can there be anti-racist funding that includes private as well as public dollars?

I also think about how the service delivery system should change. Currently, there is a mixed public-private system. Should that change? There is also a mix of providers including state psychiatric centers, general hospitals, community agencies, private hospitals and clinics, and private practitioners. How should that change? It is particularly notable, I think, that people of color have limited access to private providers. Should that change? What will that take?

What about quality assurance? We currently rely on public licensing of programs and professionals. Do these standards have racist consequences? How should they be changed? Similarly, we rely on private organizations to accredit providers and educational institutions. Those standards do much to determine the nature and quality of care provided. Do we need to change accreditation processes? Standards? And do we need to diversify the groups of mental health professionals, who currently are mostly White, who set the standards?

Does there need to be better enforcement of legal and regulatory requirements? Which?

How should planning processes change? How can the diversity of planning advisory groups be increased?

What needs to be done to improve recruitment of people of color and to make sure that there is equity or even an affirmative edge for the promotion of people of color to supervisory and leadership roles?

And how about mental health research? Does there need to be a rebalancing of biomedical, epidemiological, services, systems, and psychosocial research? Does there need to be a major effort to include people of color as research subjects? How can they be protected from dangerous research to which people of color were historically subjected?

How does the American social welfare system need to change to better protect people of color and especially children from harsh lives of poverty while also avoiding unnecessary separation of families, which is more common for people of color than for Whites? How does housing policy need to change to reduce homelessness further? How does the education system need to change? And how does the criminal justice system need to change?

Efforts to address racial disparities in mental health have always been staggeringly difficult. Pursuing an anti-racist agenda in detail and depth will be even more difficult.

Will the current strategy, which relies on the discovery and confession of personal racism among Whites with the power to bring about change actually leverage the kind of major change that is needed? What will be the impact of insisting that a person is either anti-racist, meaning actively working to overcome racism, or racist? I think that calling for confessions of racism and insisting that there is no middle ground is politically problematic in today's America. Many liberals who oppose racism are infuriated by the accusation that they are racists and white supremacists just because they are not committed to overcoming racism above all else and because they benefit from "White privilege". In my view, the anti-racist attack on liberal Whites as inescapably racists and white supremacists weakens efforts to build the kind of political coalition that will be needed to make significant inroads in racism in America. **We need practical unity not vituperative recriminations.**

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