# Racism and Mental Health Equity: History Repeating Itself

Michael Mensah, M.D., M.P.H., Lucy Ogbu-Nwobodo, M.D., M.S., Ruth S. Shim, M.D., M.P.H.

With a growing understanding of how racism negatively affects the mental health of patients, mental health professionals are as anxious to act as they are uncertain about the best path forward. This uncertainty persists even though thoughtful, actionable antiracist recommendations in psychiatry were made 50 years ago. Mental health professionals can take several antiracist actions, including acknowledging individual and structural racism through an examination of racist policies, to achieve mental health equity. The mental health field must take these actions collectively so that history does not continue to repeat itself.

*Psychiatric Services 2021; 72:1091–1094; doi: 10.1176/appi.ps.202000755*

George Floyd's killing mandated a reexamination of structural racism in the United States, including in malignant policing and alarming racial disparities and inequities in COVID-19 morbidity and mortality. Psychiatrists and other mental health professionals often struggle to square racial injustice with the mission and values of the profession: to improve the lives and experiences of people with mental illnesses and substance use disorders. With a growing understanding of how racism negatively affects the mental health of patients, mental health professionals are as anxious to act as they are uncertain about the best path forward.

How do we achieve racial equity and where do we start? These questions have been asked many times throughout history by coalitions demanding racial justice, but they take on new urgency considering current events. In 1970, 1 year after a group of Black psychiatrists protested institutional racism at an American Psychiatric Association Board of Trustees meeting, the *American Journal of Psychiatry* published a series of articles reflecting on racism in the field. One article, "Dimensions of Institutional Racism in Psychiatry," set out to define institutional racism, review the influence of racism on Black patients, and explore access to care along with "the professional functioning of psychiatrists" (1). Sabshin et al. made actionable antiracist recommendations for psychiatry, including creating taskforces against racism with high Black representation; increasing awareness of how everyday practice enables racism in psychiatry; and devoting publication space "to racism's origins, history, and current status in psychiatry" (1).

Almost 50 years have passed, and little has changed. Many organizations and institutions within psychiatry and the mental health profession have recently released powerful statements and antiracist recommendations; yet, again, we write this column to urge psychiatrists and other mental health professionals to consider racism's current status in psychiatry. The disappointing irony goes beyond unheeded history repeating itself. Of all sectors of health care, mental health is best equipped to stand against racism. Associations between racism and mental health are stronger than those between racism and general medical health (2). Mental health professionals' skills comprise a potentially robust antiracist armamentarium: we routinely "perspective-take," actively manage transference, and attempt to overcome structural barriers to deliver optimal mental health services. And yet, despite our good intentions, the mental health field has not adopted a professional antiracist stance. To do so, we must understand the power dynamics that sustain racism in mental health care.

**HIGHLIGHTS**

- Psychiatrists and other mental health professionals often struggle to square racial injustice with the mission and values of the profession: to improve the lives and experiences of people with mental illnesses and substance use disorders.
- Advocacy and attention are required to dismantle structural racism and to rebuild policies that support mental health equity.
- By centering racial equity as the standard of antiracism, the responsibility to pursue antiracist action is not only applicable to individuals but also scalable to mental health institutions.

## Power and Structural Racism

Since the December 1970 issue of the *American Journal of Psychiatry*, mental health treatments have greatly advanced. Several new classes of medications have made care safer. Promising neuromodulatory therapies have been developed, including deep brain stimulation, repetitive transcranial magnetic stimulation, and vagal nerve stimulation. However, policy inequities between mental and general medical health persist. The Medicaid Institutions for Mental Disease (IMD) payment exclusion—unique to psychiatry—prohibits reimbursement for many accredited inpatient psychiatric facilities. Reimbursement for outpatient mental health care trails other specialties, and few psychiatrists take insurance, including Medicaid (3). As a result, few people with mental health and substance use disorders can afford mental health care (4). Nevertheless, successful advocacy, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA), has diminished these inequities and promoted parity among general medical and mental health care.

But forces beyond mental health care—including food insecurity, income inequality, adverse early childhood experiences, and additional social factors—drive poor mental health outcomes. These social determinants of mental health are responsible for inequitable outcomes and are created by unequal distribution of opportunities and advantages in society (4). Structural racism, defined by the Aspen Institute (5) as "a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity," is the underlying mechanism that drives the unequal distribution of opportunities and advantages in society. Structural racism ties together mutually reinforcing social, economic, and legal systems that inequitably distribute power (e.g., wealth, rights, and education) (2).

Individuals who make differential, race-based assumptions about the abilities and motives of others are racially prejudiced. Actions motivated by these prejudicial racial assumptions constitute discrimination, which is the differential treatment of others on the basis of race. But unlike prejudice and discrimination, racism requires an account of power relations (6). By accounting for power differences among racial groups, structural racism explains racial group differences better than individual prejudice and discrimination alone. For example, long-standing racial inequities in educational opportunities and in the accumulation of wealth and influence between Blacks and Whites explain the overwhelmingly White representation in institutional positions of power within our health care institutions better than individual racial discrimination alone.

Relevant to mental health care providers, structural racism predicts which groups of patients can and will access mental health care services. Without considerable wealth, access to mental health care is limited by the paucity of mental health care providers who accept insurance, including Medicaid (3, 4). Fewer Black people have wealth, in part because of the historical exclusion of agricultural and domestic workers (who were disproportionately Black) from New Deal unemployment and retirement benefits (2). Simultaneously, the Federal Housing Administration practiced redlining, a structurally racist policy that barred Black Americans from affordable home loan financing (2). As a result, during one of the longest sustained periods of economic growth in 20th-century America, Black families often were forced to defer their dreams of homeownership—the primary vehicle of intergenerational wealth accumulation for middle-class Americans—and depend on personal, familial, and communal resources when they could not find or participate in work. In part because of these policies, the net worth of White Americans is almost 10 times that of Black Americans (7). Most U.S. residents continue to live in racially segregated neighborhoods in which economic investment, public services, schooling, exposure to environmental toxins, and access to general medical and mental health clinics favor White Americans and the neighborhoods and communities in which they most commonly reside (2). Through financial power, which enables access to mental health care, structural racism insulates more Whites than Blacks from the toxic stressors of poverty.

## Impact of Interpersonal Racism

Although structural racism is the driving force behind mental health inequities, perceived racial discrimination is also highly relevant because it is associated with increased depression, anxiety, posttraumatic stress disorder, psychological stress, negative affect, and poor sleep outcomes (2). Importantly, structural racism, through racist ideas, compels some White Americans to inflict self-harm. For example, as described in Metzl's *Dying of Whiteness* (8), many White Tennesseans resisted and rejected the ACA despite suffering from treatable, chronic, and deadly illnesses potentially curable through health care services that would have been financed through that state's Medicaid expansion. Local and state politicians repeatedly invoked the ACA as government overreach that enabled "Mexicans" and "welfare queens," leading vulnerable White people with serious health conditions to reject ACA policies that were designed to improve treatment and promote recovery (8). Similar to stigma about mental health care, racist ideas fed by structural racism and disseminated via interpersonal discrimination prevent some of the most vulnerable people from accessing life-saving care.

Advocacy and attention are required to dismantle structural racism and to rebuild policies that support mental health equity. But no MHPAEA or ACA exists for structural racism. This conspicuous absence speaks to an individual and institutional aversion to discussing racism in mental health. Many mental health professionals find race discussions uncomfortable. The risk of being labeled racist after one verbal misstep outweighs the considered benefits of dialogue. When mental health professionals do engage, they often do so

cautiously, and observed compensatory behaviors include avoiding participation through silence, defensiveness, or claims that racial perspectives are biased (6).

Unwritten norms for discussing race (and especially racial hierarchies) encourage superficial, vague, dispassionate conversation that discourages any challenges to the status quo (6). And yet, this allegiance to the status quo neglects the highest priority: our patients. Over 30% of Black people, 20% of Latinx people, and 23% of Indigenous people report avoiding medical care because of experiences of personal discrimination due to their race or ethnicity in health care settings (9). Mental health professionals have the power to heal patients, but they also have an equal responsibility to ensure that patients are not harmed when seeking care. Racial discrimination in health care settings and a lack of attention to this issue are failures to effectively care for patients with mental health and substance use disorders.

## Redefining Racism and Achieving Mental Health Equity

With an understanding of structural racism, it is evident that people are not inherently racist or antiracist but commit individual, moment-to-moment actions that can be described either as racist or antiracist (10). The emphasis on action underscores the power, consequences, and measurable impact mediating racist harm. Regardless of race, one can commit racist or antiracist actions in daily practices, decisions, and ideas (10). Under this formulation, there is no nonracist middle ground between racism and antiracism because every decision and every policy either promotes or undermines equity between racial groups. In general, all policies and actions have consequences for racial equity. By centering racial equity as the standard of antiracism, the responsibility to pursue antiracist action is not only applicable to individuals but also scalable to mental health institutions. To begin centering racial equity, mental health professionals can take several antiracist actions, described below.

*Step 1: increase awareness and acknowledge that racism exists everywhere.* Racial inequity pervades society and psychiatry. Adopting an antiracist approach in psychiatry involves interrogating power dynamics and hierarchies, not moral reputations. It is unscientific to assume that we, as mental health professionals, are not racist on the basis of our conscious feelings. Instead, we must open ourselves to the null hypothesis that any policy and any person can commit racist actions, and we must then test the hypothesis. For example, use of inpatient seclusion and restraint is employed only after assessment concludes that the risk of harm without the intervention is higher than with the intervention. However, a lack of awareness of the false, racist narratives that exist about Black dangerousness and hostility might skew this risk assessment. Clinicians who are aware of the existence of racism will acknowledge that a lower threshold exists for seclusion and restraint for Black patients than for White patients.

*Step 2: take an honest individual and institutional inventory.* We must look honestly within ourselves and our organizations for racial inequity, then boldly commit substantial resources and capital toward racial equity. We should employ racial equity analyses to implement antiracist policies and practices in clinical and educational settings. This step includes multimodal analyses of organizations to better illustrate inequitable structures, and these analyses should include all stakeholders. For example, while most institutions aim to increase representation among mental health practitioners, this same intentionality does not always include actively engaging practitioners and ancillary staff to increase inclusivity in clinical settings. To dismantle structurally racist practices, mental health care institutions must engage, respect, and compensate stakeholders for their feedback and recommendations on increasing inclusivity.

*Step 3: apply a racial equity lens to mental health advocacy.* To dismantle structural racism, advocacy is needed to undo harmful policies and practices. This requires that mental health professionals take a stand on issues seemingly unrelated to mental health care, including mass incarceration, residential segregation, and the overrepresentation of Black, Latinx, and Indigenous people within correctional populations. For example, as the population of imprisoned people has grown, spurred by the incarceration of Black, Latinx, and Indigenous people who were disproportionately arrested during the War on Drugs, the number of mental health beds per capita has decreased by more than 90% (10). The U.S. correctional system, which incarcerates the largest proportion of the population of any country in the world, has been transformed into both a system of mental health care and a promoter of structural racism (2). Yet racism is seldom mentioned in mental health care when discussing this problem. To change racist power dynamics and advocate for antiracist mental health care, we must make explicit the racist policies that pervade our mental health care services delivery system.

## Conclusions

Acknowledging individual and structural racism by examining racist policies and implementing antiracist policies is the first step toward achieving mental health equity. We have advanced the clinical science of mental health care and engaged multiple sectors over several decades to address other social determinants of mental health but have failed to identify racism as a determinant of mental health with comparable intensity, despite its profound impact on patients. This neglect stems from an aversion to honest dialogue about race and racism.

To paraphrase writer and activist Audre Lorde, our silence will not protect us. Race, as a form of caste system, empowers White patients and mental health professionals at the expense of patients and mental health professionals of color. The result is a fragmented mental health care system that does not

effectively serve most people, regardless of racial identity. In response, mental health professionals must take an active stance to implement antiracist policies and examine power structures. The mental health field—and psychiatry in particular—must take these actions collectively so that in 2070, our profession will not again need to address racism by asking simply for its acknowledgment.

## AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry and Biobehavioral Sciences, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles (Mensah); Massachusetts General Hospital, and Department of Psychiatry McLean Hospital, Harvard Medical School, Boston (Ogbu-Nwobodo); Department of Psychiatry and Behavioral Sciences, University of California, Davis (Shim). Drs. Mensah, Ogbu-Nwobodo, and Shim are editors of this column. Send correspondence to Dr. Shim (rshim@ucdavis.edu).

Dr. Mensah has received honoraria from the American Medical Association and National Center for Healthcare Leadership. The other authors report no financial relationships with commercial interests.

Received October 10, 2020; accepted October 27, 2020; published online January 12, 2021.

## REFERENCES

1. Sabshin M, Diesenhaus H, Wilkerson R: Dimensions of institutional racism in psychiatry. Am J Psychiatry 1970; 127:787–793
2. Bailey ZD, Krieger N, Agénor M, et al: Structural racism and health inequities in the USA: evidence and interventions. Lancet 2017; 389:1453–1463
3. Bishop TF, Press MJ, Keyhani S, et al: Acceptance of insurance by psychiatrists and the implications for access to mental health care. JAMA Psychiatry 2014; 71:176–181
4. Miranda J, Snowden LR, Legha RK: Policy effects on mental health status and mental health care disparities; in The Palgrave Handbook of American Mental Health Policy. Edited by Goldman HH, Frank RG, Morrissey JP. Cham, Switzerland, Palgrave Macmillan, 2020
5. 11 Terms You Should Know to Better Understand Structural Racism. Washington, DC, The Aspen Institute, 2016. https://www.aspeninstitute.org/blog-posts/structural-racism-definition. Accessed Oct 10, 2020
6. DiAngelo R: White Fragility: Why It's So Hard for White People to Talk About Racism. Boston, MA, Beacon Press, 2018
7. McIntosh K, Moss E, Nunn R, et al: Examining the Black-White Wealth Gap. Washington, DC, Brookings, 2020. https://www.brookings.edu/blog/up-front/2020/02/27/examining-the-black-white-wealth-gap. Accessed Oct 10, 2020
8. Metzl J: Dying of Whiteness: How the Politics of Racial Resentment Is Killing America's Heartland. New York, Basic Books, 2019
9. Discrimination in America. Washington, DC, National Public Radio, Robert Wood Johnson Foundation, Harvard TH Chan School of Public Health, 2018. https://www.rwjf.org/en/library/research/2017/10/discrimination-in-america–experiences-and-views.html. Accessed Oct 10, 2020
10. Kendi IX: How to Be an Antiracist. New York, One World, 2019