MENTAL HEALTH POLICY IN THE UNITED STATES

RACIAL MENTAL HEALTH DISPARITIES

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Abstract: In this lecture, I discuss the changing racial demographics in the United States, epidemiological data regarding prevalence of mental disorders and utilization of mental health services by people of color. This reveals substantial racial disparities in the mental health system. I then suggest a number of steps that need to be taken to overcome them. The disparities include disproportionately low use of mental health services by people of color, lower quality of care, disproportionately low provision of services by people of color, and limited participation in the power structure of the mental health system. With regard to low utilization, I focus on problems of access, engagement, and choice. With regard to quality, I focus on clinical and cultural competence. With regard to the shortage of people of color in the workforce, I focus on recruitment, lack of interest in being mental health professionals, and policies and practices regarding promotion to leadership positions. I also comment on the failure to achieve proportionate inclusion of people of color on Boards of Directors, on Advisory Groups, and in policy making.

The racial and ethnic composition of the United States is changing rapidly. The latest estimate is that by 2045 America will no longer be majority White. This change is obviously having tremendous impact, particularly on American politics. A very substantial portion of American voters appears to be terribly distressed by the impending end of America as a predominantly White, Christian nation, while another substantial portion celebrates diversity and ethnic and racial pluralism.

This divide about America becoming a racially diverse nation is, I believe, the major driving force of the political divide that has beset our nation. It has fueled intolerance across the political spectrum and our growing inability to engage in the kind of dialogue on which democracy depends.

But the purpose of this lecture is not to explore the impact of racial division on the American democracy. I mention it only to set the stage for a discussion of racial mental health disparities.

Demographics

Although changes in immigration policy could affect the growth of the population of people of color in the United States, current projections anticipate a tremendous increase over the coming decades. According to the Brookings Institute[1], **the United States will become majority minority by about 2045**. Brookings also projects that children of color under 18 are already in the majority. For older adults, reaching a majority of people of color will take place much later in the century than for the general population. They project that even by 2060, when about 45% of the overall population will be White, the older adult population will be about 55% White.

Specifically, the Brookings Institute projects that:

- The Latino population will grow from 18.3% of the American population in 2018 to 27.5% in 2060.
- The Black portion of the population will grow slightly from 12.5% in 2018 to 13.6% in 2060.
- The Asian portion of the population will grow substantially from 5.7% to 8.8 %.
- The White, non-Hispanic population will decline as a proportion of the American population from 60.5% to 44.3%.

Psychiatric Epidemiology For People of Color

According to a recent SAMHSA report, the **prevalence of mental illness among people of color is somewhat less than among whites**—19% White, 17% Black, 15% Latino, 13% Asian.[2] Given the theory that poverty and the like are social determinants of mental illness, the finding that Blacks and Latinos are less likely to be mentally ill than Whites is very surprising and questionable. Are the diagnostic system and epidemiological surveys biased in ways that result in inaccurate counts of mental illness among people of color?

Epidemiological studies also indicate that **immigrant populations have lower prevalence of mental illness than non-immigrants**, also a surprising finding because so many immigrants face tremendous economic struggles and great difficulties adapting culturally. These studies indicate that by the third generation, when immigrant families have adapted culturally and are more likely to be managing economically, both the prevalence of mental illness and utilization of services is roughly the same as for non-immigrants.[3]

Some advocates for improved mental health policy for people of color reject the finding that immigrants have better mental health status than non-immigrants. In my conversations with some of these advocates, they seem to be focused—understandably—on immigrants who do not come to America voluntarily—such as children or trafficked women—and on people detained in terrible conditions. No doubt these subpopulations of immigrants have unique and significant mental health needs. But it seems to me that people who have the courage and persistence to manage the difficulties and dangers of immigration are likely to have remarkable psychological strengths.

The SAMHSA report also indicates that **people of color with mental illness get treatment less often than whites**—whites 46%, blacks 30%, Latinos 27%, and Asians 18%. This is also true with regard to serious mental illness: whites—69%, blacks 57%, and Latinos 51%.[4]

It is worth noting that Blacks and Latinos appear to make **higher per capita use of the public mental health system**,[5] suggesting that they make far **less use of the private sector than Whites**. This should not be surprising since the SAMHSA report indicates that cost is the most common reason why people do not use mental health services. **Blacks and Latinos are less likely to have jobs that provide health insurance coverage and more likely to have Medicaid**, which is rarely accepted by private practitioners.

Why Is There Lower Utilization By People of Color?

Low utilization of mental health services by people of color reflects three very different factors. (1) Sometimes people with mental health problems want to get mental health services but encounter barriers. (2) Sometimes people get started with mental health services but do not continue.* (3) Sometimes people with mental health problems don't seek mental health services at all.

Barriers to getting desired services include:

- Cost and lack of adequate insurance coverage
- Inconvenient locations of services and limited transportation
- Limited hours of operation
- Language limitations
- Limited outreach and engagement efforts
- Limited availability of services in the home or in community settings such as houses of worship
- Ethnic and racial discrimination—some overt, some systemic.

* It appears that people of color are less likely than whites to continue in mental health treatment beyond a session or two.

Reasons for not continuing in service include:

- Poor engagement due to limited clinical or cultural competence
- Unpleasant settings in which services are provided
- Dissatisfaction with initial services
- Long waits to continue services after initial evaluation
- Language barriers to comfortable communication including unfortunate reliance on children to translate for their parents
- Culturally different expectations of help
- Perception of prejudice/racism.

Reasons for not seeking mental health services include:

- Denial of mental illness
- Culturally rooted alternative explanations of problems
- Belief that mental health services will not be useful
- Preference for other sources of help such as family, respected community leaders, indigenous healers, etc.
- Discomfort with providers from different cultures, classes, races, and ethnicities
- Discomfort with students and inexperienced therapists
- **Bad prior experience** with mental health providers
- Stigma, especially a sense of shame and/or embarrassment
- Lack of knowledge about the location and/or possible usefulness of mental health services.

Very importantly, different cultures follow **different pathways to help**.[6] Often it is a religious or spiritual pathway. But some cultures also rely on the family for help more than others, and some cultures turn to respected community leaders/elders for help long before considering mental health professionals, who are often seen as serving only those with severe psychotic conditions. All cultures—except perhaps highly educated liberals in major urban areas—are more likely to turn to a primary care provider than to a mental health professional.

Under-Representation Of People Of Color In The Workforce And In The Power Structure Of The Mental Health System

People of color, other than Asians, are substantially under-represented in the professional mental health care workforce.[7] (They are over-represented among the paraprofessional/direct care workforce, who have the lowest status and the lowest pay of those in the mental health workforce.)

People of color are particularly under-represented in supervisory and management positions.

In addition, they are under-represented on Boards of Directors and on the various advisory bodies that are consulted by governments in the process of making decisions regarding policies and plans for future development. And they are under-represented among policy makers and governmental leaders.

Reasons for under-representation have been hotly debated over the years. Some people strongly believe that it is due to discrimination, sometimes overt discrimination but often subtle forms of discrimination that arise from racism that is not recognized as such or from discomfort with manner of speech, points of view, etc. Some people argue that it is due to the fact that very few people of color are qualified professionals. Some argue that this reflects disparities in education; some argue that it reflects the choice of more lucrative careers by those who do get advanced education.

It seems to me that all of these perspectives are in part true. It is exceedingly hard to hire people in adequate numbers from a small pool of qualified possibilities. But it is also true that the fundamental segregation of social relationships in our nation often makes qualified people invisible to people who are responsible for hiring, who are likely to be White. No doubt it is also true that there is both overt and subtle discrimination. And being a mental health professional is just not appealing to many educated people, who generally prefer more lucrative, more respected, and personally more interesting careers.

How To Increase Utilization Of Mental Health Services By People Of Color And From Diverse Cultures

Increasing utilization of mental health services by people of color requires a multi-pronged approach that includes addressing problems of access, engagement, and choice.

Address Problems Of Access

- **Cost**

The simplest solution to the problem that mental health services are too expensive, especially for working people with limited health insurance, is to provide universal health and behavioral health coverage. Less ambitiously, it would help just to provide adequate Medicaid and Medicare rates for private practitioners.

The cost of co-pays also can be prohibitive for people with low or even middle income. Parity laws require that co-pays be no greater for mental than for physical care, but at 20% they still can be too expensive for people struggling to get by. A cap on self-pay could help.

Instituting sliding scale fees in all publicly funded programs with subsidies to programs serving large numbers of people who cannot pay and do not have coverage for full fees would also be helpful.

Although it is politically untenable in the United States, providing payment for services for undocumented as well as documented immigrants could make services available to that important sub-population.

- **Location and Hours**

Locating services where people of color live in large numbers or near public transportation could help make mental health services more accessible as could providing services evenings and weekends.

Providing services in the home and in community settings could also make it more possible for people to use services.

- **Tele-mental health**

Tele-mental health has become an effective means of providing behavioral health services. If it continues after the pandemic "emergency period", it can make mental health services much more accessible than they were before the pandemic.

- **Crisis services**

Remodeling psychiatric services in the ways currently being pursued could make a considerable difference in access to treatment. This includes the introduction of 988, the reduced use of police (especially important for people of color who may be suspicious of the police), increased use of mobile crisis services, and developing alternatives to relying on generic emergency rooms. It would also be very helpful if service providers were required to be available in some meaningful way to their patients/clients when they are in crisis outside of regular office hours.

- **Language**

Assuring that the main languages of the neighborhood are spoken in a community-based program is important. When necessary, competent translation services should be available. It is critical to have alternatives to relying on children to translate for their parents.

- **<u>Outreach and Community Linkages</u>**

Outreach into the "pathways" that people of different cultures follow to get help can make it possible to connect with people who otherwise will not find their way to the mental health system. Engaging people in and through community organizations such as community centers and houses of worship could make treatment far more accessible.

<u>Address Problems Of Engagement</u>

To improve engagement at the first contact with mental health staff, it is important to recruit staff with linguistic ability, understanding of cultural differences, and a capacity to connect with people compassionately. This is exceedingly difficult because there are shortages of qualified personnel in most of the U.S.

But programs can improve engagement by paying attention to the patient/client's experience. The ambiance of the facility makes an important statement about whether clients are valued. Welcoming, friendly staff at the point of entry also make a difference. And avoiding delays, which create a sense that clients are not valued and which can be infuriating, is exceedingly important.

Culturally competent diagnosis and treatment can be enhanced with in-service training and with quality improvement initiatives that bring staff together to address their clinical shortfalls.

<u>Address Reasons For Not Seeking Mental Health Services</u>

- **<u>Provide public education</u>** targeted to people of color including:

  - Information about what mental illness is and how it is treated
  - Information and referral services
  - Provide information in multiple languages
  - Provide information in formats that will be used by people of different cultures and levels of education.
  - Use multiple methods to provide information—print, Internet, TV, radio, signs, public meetings, etc.
  - Provide information in community settings such as houses of worship
  - Address issues of "stigma".

- **<u>Improve ambiance</u>**

  - Avoid shabby appearance of buildings where services are located and the spaces in which services are provided
  - Respect confidentiality in waiting areas as well as in treatment spaces

- Provide culturally attractive and meaningful décor.

- **Address stigma** in ways that go beyond providing information

Overcoming stigma is not just about changing people's attitudes; it is about changing their behavior in multiple ways. Effective anti-stigma efforts must go beyond providing information.[8]

It is particularly important **not** to assume that the experience of stigma reflects pure ignorance that can be corrected with rational, realistic information.

- **Improve quality**

The most important way to encourage people to seek mental health services is by improving service quality. Potential patients/clients should not be assumed to be too ignorant to tell the difference between good and poor treatment. The humanity, compassion, and cultural sensitivity of providers or lack thereof comes through loud and clear. And, when the provider is a student or very recent graduate, that is also clear and raises important questions about competence in the minds of the people they treat.

HOW TO IMPROVE THE QUALITY OF SERVICES

Use of clinically, culturally, and generationally competent staff makes a huge difference in quality. But because they are more likely to use public sector services, people of color are more likely to get treatment from students and new professionals. They need ongoing supervision from competent supervisors, which is generally made available at least nominally. They can also benefit from peer group supervision and from ongoing in-service training. Unfortunately, both supervision and training add significant costs to the operation of mental health programs.

As noted, lack of linguistic and cultural competence is widespread, even among experienced, high quality clinicians. Recruitment of multi-lingual staff requires very substantial efforts to recruit beyond the usual methods, with an emphasis on reaching out to communities of color for qualified professionals and paraprofessionals.

A fundamental issue about quality of service for people of color is that evidence-based practices generally are developed with research that includes mostly Whites. Not nearly enough is known about whether what works for middle class Whites works for other populations as well.

Cultural competence in clinical practice is critical for accurate diagnosis and for effective treatment. It is widely believed that this requires special

training. But some clinicians maintain that a skilled clinician, who listens carefully to the individuals and families they are serving, will be able to understand the issues with which **they** are struggling, which may not be the same as the issues confronting others from their culture.

It is critical to understand that for many cultures of color, problems of family members are experienced as problems for the whole family. Involving family members and providing family support can make the difference in whether there is successful engagement and treatment.

People of color are more likely than Whites to be living with problems generally referred to as "social determinants of mental health" including racism, poverty, community violence, poor education, limited access to health care, etc.[*] It is critical that providers understand that these "social" issues are real contributors to mental illness and that they need to be addressed in treatment. Therapists may not be expected to fight racism, poverty, etc., but they should certainly be expected to help their clients to deal with these very difficult problems in their own lives.

HOW TO ADDRESS UNDER-REPRESENTATION OF PEOPLE OF COLOR AS PROVIDERS AND AS PART OF THE POWER STRUCTURE

Recruitment, Hiring, and Promotion:

Because there is a vast shortage of people of color who are mental health professionals—with the exception of Asians, who are over-represented in all health professions—it is difficult to recruit staff who are both people of color and qualified professionals, and it is very difficult to retain them when they have so many competitive opportunities. Creating incentives for people of color to enter the field of mental health has long been discussed and attempted to some extent. Scholarships and loan forgiveness are the prime examples. But it may well be that limited promotional and leadership opportunities create strong disincentives to enter the field.

It is possible, of course, that discrimination is at work in hiring and promotional decisions, not necessarily overt discrimination but more subtle judgments based on manner, language, etc. Training in non-discriminatory, culturally sensitive hiring and promotion might alleviate this problem to some extent.

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[*] The expression "social determinants of mental health" is very misleading. Poverty and other difficult circumstances are not determinants; they are contributors or "drivers" but do not determine the outcome of people's lives. In addition, poverty and the like are contributors to mental illness not to mental health. There are social conditions that promote mental health, but they are the opposite of those that contribute to mental illness.

It is also important to recruit beyond the usual arenas. Anyone who has done hiring knows that many hires come from recommendations from friends and trusted colleagues, who very often are from the same communities that we are. Someone who I worked with years ago and who did a terrific job of shifting his organization from almost all White to very diverse, told me that his approach was to turn to people of color already in his organization and ask them to recruit from their personal networks. The point is that outreach into communities of color is essential for successful diverse recruiting.

Promotion to the highest levels of organizations, especially CEOs, are often decisions made by Boards of Directors, who tend not to be diverse and may not have a strong commitment to diversity in leadership. (See below).

Empowerment in the field of mental health

Like all fields, mental health is hierarchical.

Boards of Directors: Community agencies and hospitals are legally led by Boards of Directors. Their responsibilities are to establish policy and strategic direction for their organizations, to hire and fire the CEO and sometimes other leadership staff, and to contribute and raise funds to supplement the income of their organization. Lack of diversity or policies of diversity at the Board level can affect diversity within the organization. Board training on diversity may be helpful, but including people of color and people from the community that is served is, in my view, more important. That not only guards against Boards made up almost exclusively of White and wealthy people; it also may provide a voice for people of color and the community served. But incorporating people of color onto Boards of Directors is complicated by the fact that the traditional role of Boards of not-for-profit organizations includes, as I noted above, substantial personal financial donations and fundraising. Even if financial expectations are loosened, diversification of board leadership is not an easy matter.

Oversight: Mental health providers are subject to oversight by governmental and accreditation bodies that historically are also dominated by White people. Inclusion of people of color in these very important roles can help to assure that standards allow flexibility for cultural differences.

Planning and Advisory Groups: In addition, there are numerous planning and advisory groups to all levels of government with regard to key mental health policy questions. What should the goals of the mental health system be? What services should be in place? What populations are the highest priority? What organizations should be licensed and funded? Etc. Obviously, these groups can have significant impact on the nature, quantity, and quality of mental health services. Diversity on these groups has been a major goal of

those attempting to make the mental health system more diverse, equitable, and inclusive.

Governmental Officials: Finally, both elected and appointed public officials tend to be White. Racial equity in elections is a major political issue of the moment. And to achieve racial equity in the mental health and other service systems, more governmental officials will need to be appointed who reflect the racial and ethnic mix of America.

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[1] Frey, WH (2018). "The U.S. Will Become Minority White in 2045, Census Bureau Projects". The Brookings Institute.

[2] The SAMHSA Chartbook. February 2015.

[3] Allegria, M et al (2007). "Prevalence of Psychiatric Disorders Across Latino Subgroups in the United States" in *American Journal of Public Health*, January 2007.

[4] SAMHSA Chartbook. Op cit

[5] New York State Office of Mental Health (2011). *Unmet Needs Assessment Report Statewide Assessment of Treatment Gaps for Racial/Ethnic Groups in Need of Mental Health Services*.
https://www.omh.ny.gov/omhweb/cultural_competence/reports/unmet_needs.pdf

[6] Rogler, LH and Cortes, DE (1993). "Help-Seeking Pathways: A Unifying Concept in Mental Health Care" in *American Journal of Psychiatry*, April 1993.

[7] Zippia. (2022) Therapist Demographics and Statistics in the U.S.
https://www.zippia.com/therapist-jobs/demographics/

[8] Friedman, M.(2006). "Stigma" in *Mental Health News,* Winter 2006)