

# Mental Health Care Services for African Americans: Parity or Disparity?

by

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## Abstract

The social sciences have been very intentional in providing culturally responsive mental health services in the United States. Multicultural competencies and best practices have been integrated into all facets of research, training, and treatment practices. Yet pervasive ethnic and racial disparities still exist in mental health service utilization, especially for African Americans. Projected national demographic trends, federal health reformation to increase financial coverage for health care, and the decreasing stigma surrounding mental health care suggest that there will be an increased request for mental health care services. Despite empirical evidence of dissatisfactory experiences and incompetent care, little has been done to ensure parity in mental health care for the African American community. Extending the role of practitioners to include social justice and advocacy strategies is one way to remediate the disparities in mental health care.

*Keywords:* mental health care, disparity, multicultural, social justice

Psychiatry, psychology, social work, and counseling are the major professions responsible for defining emotional, psychological, and social well-being, mental illness, and treatment practices in the mental health field (Neukrug, 2012). Most of the traditional psychology and counseling theories used in mental and social healthcare were developed for and by Western-European, middle-class men. While these clinicians and researchers may not have been prejudiced, the theories, strategies, and techniques they created were based on Western European values and societal privileges not shared by all racial and ethnic populations. Most of the definitions of what constituted healthy and normal functioning and mental illness ignored the influence of sociopolitical oppression, discrimination, and systematic disempowerment which describes the life experience of many racial and ethnic minority groups in America. This resulted in barriers and challenges for individuals in need of behavioral healthcare who belonged to a minority community.

In the wake of the social initiatives birthed by the Civil Rights movement, significant changes occurred in the social sciences to address cultural variables in social and mental health care. Mental health care providers (i.e. psychiatrists, psychiatric nurse practitioners, psychologists, licensed counselors, social workers, school psychologist and counselors, marital and family therapist, certified alcohol and drug abuse counselors, and other allied professions) began to think about more effective ways to work with racial and ethnic clients whose value and worldview were different from their own. Researchers and practitioners developed theoretical approaches and strategies that addressed the cultural values and worldview of the client. Some scholars referred to these changes as the ‘fourth force’ in counseling and psychotherapy (Neukrug, 2012).

According to a report from NAMI (Carrasco, 2014), while there has been substantial progress in the development of empirically-based treatments in mental health, all Americans have not benefited from these discoveries. Further, Carrasco (2014) stated that the U.S. Surgeon General reported that people of color are less likely than whites to receive needed mental health care and when they do it is often of poorer quality. In the wake of addressing equality, serious gaps have surfaced between the quality of mental health care to Caucasians and people of color, even after adjustments are made for economic status, education levels, age and insurance coverage Carrasco (2014).

According to Safran, Mays, Huang, McCuan, Pham, Fisher, McDuffie, & Trachtenberg (2009), the Center for Disease Control and Prevention defines mental health disparity as falling into one of three categories:

- (1) disparities between the attention given mental health and that given other public health issues of comparable magnitude
- (2) disparities between the health of persons with mental illness as compared with that of those without, or
- (3) disparities between populations with respect to mental health and the quality, accessibility, and outcomes of mental health care. (p.1963)

Both the Institute of Medicine and the National Institutes of Health (NIH) have made ethnic disparities in mental health a high priority on their research agendas (Agency for Healthcare Research and Quality, 2011). The 2010 *National Healthcare Quality Report* (NHQR) and *National Healthcare Disparities Report* (NHDR) stress the importance of working harder to improve health care quality and reduce health care disparities to achieve higher quality and more equitable health care for all Americans agendas (Agency for Healthcare Research and Quality, 2011).

The census predicts that within the next 30-40 years, racial and ethnic minority groups will make up the majority of the American population (United States Census Bureau Newsroom Archive, 2012). Ignoring racial disparity in mental health care now will have devastating effects for the majority of the population of the United States in the future. The Agency for Healthcare Research and Quality (AHRQ) reported in 2009 that mental disorders ranked highest in terms of direct medical spending along with heart conditions, cancer, trauma-related disorders, and asthma in the U.S (Mental Health: Research Findings, 2009). Studies show that socioeconomic deprivation and racial discrimination have been associated with higher psychological distress (Fonseca, n.d.; Safran, et al.,2009 ). Persons with the lowest level of socioeconomic status are estimated to be about two to three times more likely to have a mental disorder than those with the highest socioeconomic level (Safran et al., 2009). Currently, racial and ethnic minority groups are more likely than non-Hispanic Whites to be of low socioeconomic status. According to NAMI, African Americans are disproportionately more likely to experience social circumstances that increase their chances of developing a mental illness (National Alliance on Mental Health, 2012).

In an effort to address health disparities, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, together referred to as the Affordable Care Act (ACA), was signed into legislation in 2010 to make health care coverage obtainable for all Americans (HHS.gov/HealthCare, 2014; States Implement Health Reform, 2011). To ensure that individuals would have the same access to mental health care as other forms of health care, the Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted. The American Counseling Association (ACA) strongly advocated for mental health treatment coverage by identifying prevention, early intervention, and treatment of mental and/or substance use disorders as an “essential health benefit” (The Affordable care Act, 2011). Mental health treatment consists of psychological assessments, psychotherapy-or "talk therapy", and prescription assistance. Services are delivered in out-patient agencies, partial hospitalization settings (day treatment), residential mental health treatment settings, and through inpatient hospitalization by counselors, psychologists, social workers and other allied health workers.

Many of the professional organizations in the social services such as the America Counseling Association (ACA), the American Psychological Association (APA), the National Association of Social Workers (NASW), instituted significant changes to address issues of diversity in their respective professions. Because ethical codes were developed along majority culture values, many ethical codes were revised to include guidelines for culturally sensitive behavior and practice. Clinical training programs integrated multicultural perspectives into their curricula and professional development workshops. Multicultural competency standards and cultural competency checklists were developed to assess whether or not workshops, training programs, and clinicians met minimum competency standards (Neukrug, 2012). Conceptual models were, and continue to be created to describe cultural identity development and best practice methods for serving individuals and families from various racial and ethnic backgrounds.

Inadequate services, culturally incompetent providers, and dissatisfactory experiences validate the disparity in mental health care for African Americans. African American clients report feeling culturally misunderstood and dissatisfied with treatment. NAMI reports that there is some evidence to suggest that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care (Carrasco, 2014). The literature is replete with studies indicating that African Americans are less likely to utilize counseling services, and those that do seek mental health care begin treatment services at a later stage in the course of their illness than do White populations (Hatcher, 2012). They are likely to be misdiagnosed and tend to terminate counseling prematurely (Carrasco, 2014; National Alliance on Mental Health, 2012; Sanders, Vetta, Bazile, & Akbar, 2004).

Snowden (1999) conducted an extensive review of race comparative research and reported confounding conclusions concerning mental health care parity between Blacks and Whites. He attributed these findings to various methodological factors and other research design issues. For example, help-seek attitudes, the socioeconomic level of the client, service setting, type of provider, and source of payment are all factors that impact the utilization of mental health services by African Americans.

But more than a decade later, the Center for Multicultural Mental Health Research (CMMHR) reports that pervasive ethnic and racial disparities still exist in mental health service utilization and status (Center for Multicultural Mental Health Research, 2014; Fonseca, n.d.). Cultural competency guidelines were incorporated into the ethical codes of some of the largest professional organizations associated with mental health care such as the American Counseling Association (ACA), American Psychological Association (APA), and National Association for Social Workers (NASW) to ensure quality culturally competent care. Cultural competence education became mandatory in clinical training programs and checklists were used to measure knowledge and skills of practitioner trainees. Federal health reformation increased access to mental health services. Yet there are still disparities in the quality of mental health services. Benjamin Le Cook, Ph.D. M.P.H. (Alegria, Lin, Chen, Duan, Cook, Meng, 2012), highlights the fact that inadequate services are not likely to be eliminated by creating laws to expand insurance coverage. According to the National Association for Mental Illness (NAMI), there is a need for improved cultural awareness and competence in the health care and mental health workforce (Carrasco, 2014). Workforce reports published by SAMHSA also identified a pressing need for a higher level of cultural competency among new mental and behavioral health professionals. Minority clients complained that many of the providers lacked cultural and linguistic competency, regardless of their race (Carrasco, 2014). Checklists, while helpful in clinical training programs, may falsely suggest that cultural competence is a static endpoint, interpreted by trainees that they have 'mastered' culturally sensitive mental health care. They lack the realization that cultural competence is an aspiration, a life-long, personal and professional journey and therefore do not seek further training or education, engage in reflective self-awareness, or immerse themselves in diverse cultural experiences.

Practitioners indicate a growing acceptance of therapy among young African Americans and those with more education in large urban areas, says columnist Tara Barampour (2013). In an interview with columnist Keli Goff of *The Root* (2013), Dr. Jeff R. Gardere, African American psychologist, author, and highly sought after media psychologist, expressed his belief that racial-ethnic matching of therapists and clients could help to overcome the mistrust that often prevents African Americans from seeking mental health care. A study of middle-class African American women, conducted by Smith and Wermeling (2007), revealed that therapist-client racial matching may be helpful in making professional mental health services more attractive and credible for African-American with the financial means to purchase counseling services. A meta-analysis conducted by Cabral and Smith (2011), revealed that while there was little to no treatment outcomes from racial/ethnic matching of clients with therapists, African Americans very strongly preferred to be matched with African American therapists.

Unfortunately, the small number of clinicians of color in the mental health care system makes it less likely that an African American client can request or be assigned an African American clinician. According to a 2012 workforce report from SAMHSA (SAMHSA, 2013), approximately 55.8% of mental/behavioral health professionals are non-Hispanic White and 27.9% of the behavior healthcare workforce is Black/African-American. The percentage of racial and ethnic minorities across the disciplines was estimated to be as follows: 19.2% of all psychiatrists; 5.1% of psychologists; 17.5% of social workers; 10.3% of counselors; and 7.8% of marriage and family therapists. According to the NAMI African American Community Mental health Fact Sheet only 2 percent of psychiatrists, 2 percent of psychologists and 4 percent of social workers in the United States are African American (2009). These percentages are inadequate given the projected demographic growth of people of color in the United States. In addition, a more diverse workforce will be needed to meet the increased need for services caused by the Mental Health Parity and Affordable Care Acts. Collaborative efforts among behavioral healthcare professions to address the challenges in recruiting, training, and retaining a racially and ethnically diverse workforce along with intense multicultural training of White counselors can significantly decrease the disparity within mental health care.

As stated earlier, the social sciences have made great strides in the development, revision, operationalization, and training of multicultural counseling competencies. Cultural competence is considered best practices and good mental health care. There are many definitions of cultural competence. However, they all encompass the same three areas considered the foundation of cultural competency:

personal awareness-an awareness of one's own values and how they may affect others,  
specific knowledge - information about a number of culturally diverse of groups  
culturally appropriate skills and strategies – the ability to send and receive a wide variety  
of verbal and nonverbal messages accurately and appropriately. (Sue, Arredondo, &  
McDavis, 1992).

Projected national demographic trends, increased financial coverage for health care, and the decreasing stigma surrounding mental health care within the African American community will increase the need for quality, culturally competent mental health services. Clearly immediate attention is needed to the growing disparity gap within the mental health care system. Interestingly, federal policymakers at the Center for Multicultural Mental Health Research reported a lack of information and empirical data necessary to create policies to remediate the disparities in mental health care (2014). However, the social sciences are replete with research on culturally competent counseling, extending back to the early 1960s. It is possible that the lack of collaboration and intellectual exchange between federal policymakers and social sciences scholars reinforces the disparity gap within the mental health care system. Closing the disparity gap will require the combined efforts of both policymakers and those in the mental health care disciplines.

If there is going to be parity in mental health care services for African Americans, behavioral healthcare must broaden its definition of culturally competent care to include a more systemic, macro perspective. Addressing disparity in mental health care will require another paradigm shift in the history of mental health care. Social justice competency is the next step beyond multiculturalism (Vera and Speight, 2003). A key component of social justice is equity, the fair distribution of resources, rights, and responsibilities to all members of society (Crethar, Torres Rivera, & Nash, 2008). Social justice acknowledges the reality that sociopolitical oppression exists, that it negatively contributes to the mental health of our clientele, and to alleviate the mental health issues of the individual, practitioners must advocate for equity and equal access to goods and services to all members of society (Chang, Crethar, & Ratts, 2010). Social justice and advocacy must be intertwined with multicultural practices. In addition to being culturally competent, mental health practitioners must become more systemic and social justice minded.

Implementing social justice in mental health care must be a carefully crafted, multifaceted approach. It will require a paradigm shift by researchers, educators/trainers, and practitioners alike. The Center for Multicultural Mental Health Research suggests that research must be conducted to determine which strategies might simultaneously improve overall mental health care and reduce mental health care disparities (2014). Social justice competencies and best practice guidelines must be incorporated into professional ethic codes. Counseling, psychology, and social work training programs must recruit faculty and trainees from oppressed social groups, and restructure their curricula to include awareness of social injustices and knowledge of macro-level strategies, and provide opportunities to engage in social justice work (Beer, Spanierman, Greene, & Todd, 2012). Clinicians must work more collaboratively with clients to create treatment plans and goals from a contextual perspective. They must be willing to embrace the role of an environmental-organizational-institutional-change agent and sociopolitical activist (Crethar, Torres Rivera, & Nash, 2008).

The mental health profession must actively challenge societal policies or practices that threaten the emotional, social, and psychological well-being of the African American population and all racial and ethnic groups as well as diverse groups created by intersecting cultural identities. Psychiatry, psychology, social work, and counseling must broaden their one-to-one remedial model of counseling to include strategies such as consultation, outreach, prevention, advocacy, organizational development, political lobbying, public policy making, and empowering clients with the political strategies to change the cultural-environment in which they reside (Crethar, Torres Rivera, & Nash, 2008; Cutts, 2003). Advocating for equitable access to quality services and resources and insisting on institutional and societal change in addition to being culturally competent practitioners will increase the likelihood that quality mental health care will be accessible to all.

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