Structural Racism in Behavioral Health: History to Today

Understanding the Roots, Advancing Equity & Transforming Systems

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Dr. Oliver J. Johnson holds a Ph.D. in Social Work from the Whitney M. Young School of Social Work at Clark/Atlanta University and has lectured widely in a variety of forums on issues pivotal to the promotion of health and wellness among African American families.

Author's Biographical Sketch

- Dr. Johnson retired as a tenured full professor after twenty years of service at the School of Social Work at Fayetteville State University in July 2025.
- He currently provides clinical supervision and consultation with persons seeking full licensure as Licensed Clinical Social Workers and Licensed Clinical Addictions Specialists in North Carolina. He also provides clinical services through the Carter Clinic in Fayetteville, NC.
- He established Soft Ponds, LLC, an educational consulting and teaching business that will provide online classes for persons seeking to broaden and deepen their understanding of and treatment of trauma among African American families.
- He holds memberships with the National Association of Social Workers, the National Association of Black Social Workers, Alpha Phi Alpha Fraternity, Inc. and the 100 Black Men of Cape Fear Valley Region Chapter and Simon Temple AME Zion Church.

Purpose Statement

Demonstrate an appreciable and measurable degree of understanding regarding how historical periods, epochs, policies, and practices shape current disparities in behavioral health care service delivery.

Engage in course-based activities specifically intended to identify actionable and achievable steps for clinicians, researchers, and policy makers.

Defining Structural Racism in Behavioral Health

Structural racism in behavioral health care: roots of pivotal policy choices, institutions, and practices that produce and sustain egregious and covert inequities across particularly vulnerable groups.

Behavioral health care domains: DSM-V-TR mental health diagnoses, substance misuse treatment, crisis response (including law enforcement), and recovery supports.

Why It Matters

Mechanisms linking structures to primary outcomes: resource distribution, access barriers, discriminatory practices, data gaps, and implementation of policies.

Why it matters now: even with universal, or expanded coverage, inequities persist due to how systems are inherently or implicitly organized. These factors shape who gets care, the quality of care they receive, and the outcomes they experience.

Rooted in History, Present in Systems



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- Slavery and racialized understanding of mental health; pathologizing of African American grief and stress.
- Pseudoscience and the eugenics movement shaping discriminatory practices.

Rooted in History, Present in Systems (continued)



- Segregation in mental health facilities; unequal access to institutions
- Forced sterilizations and coerced treatments
- Limited autonomy for oppressed and marginalized communities

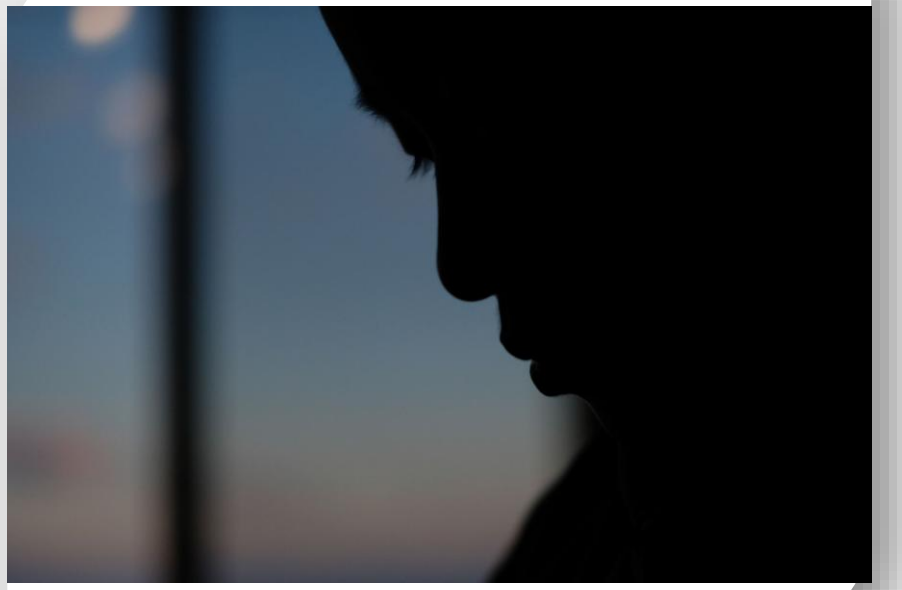
Rooted in History, Present in Systems (continued 2)



- Diminished trust due to landmark abuses (e.g., historically oppressive research practices).

Diagnostic Bias and Clinical Practice

Diagnostic bias: race-based assumptions shaping diagnoses (e.g., misattributing symptoms to psychosis or behavior rather than mood/anxiety disorders in some groups).

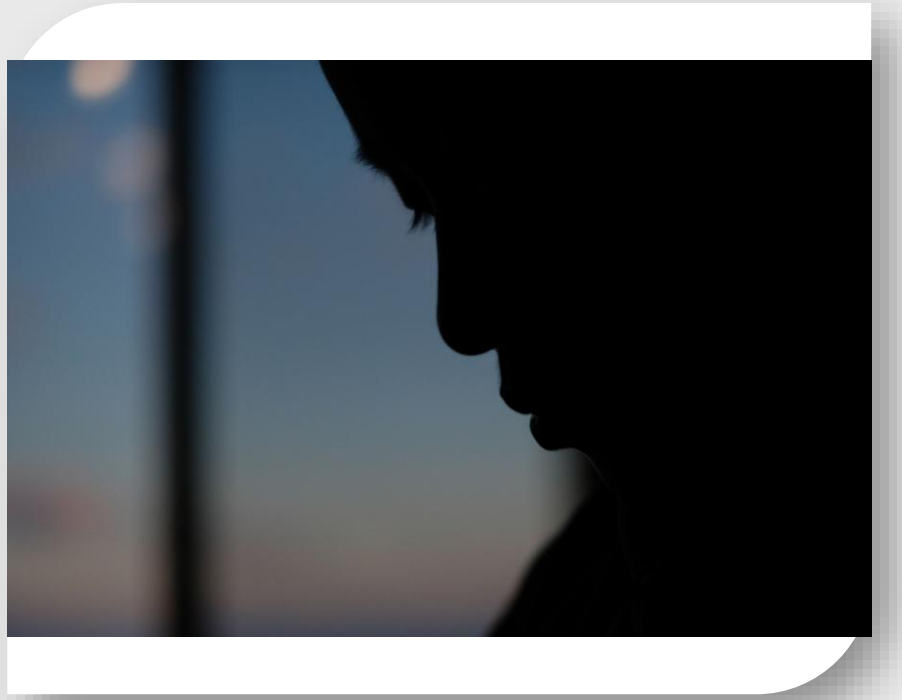


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Diagnostic Bias and Clinical Practice (continued)

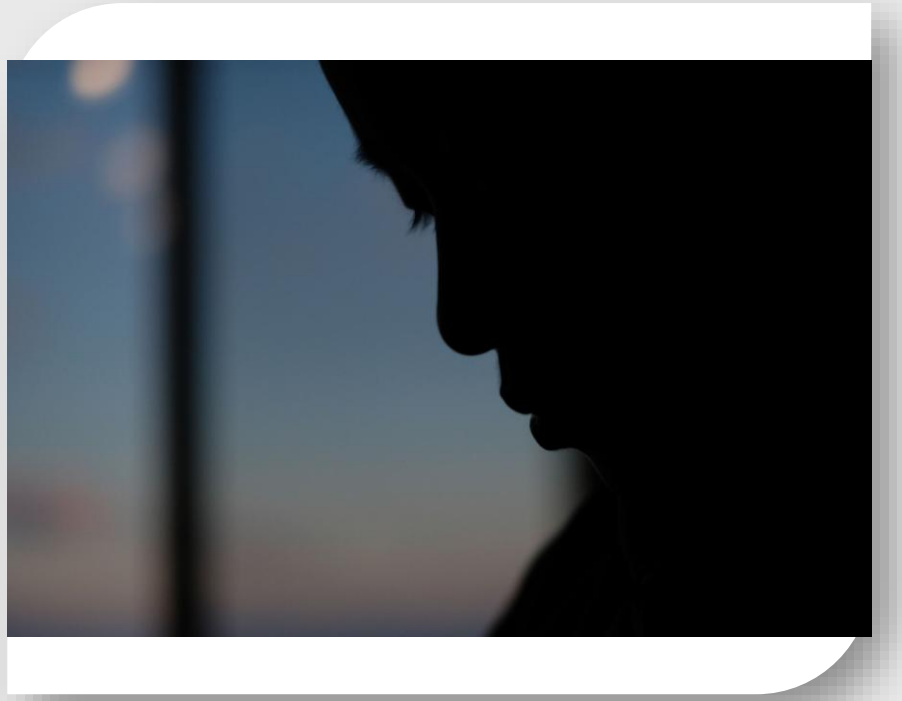
Treatment disparities: African American and Indigenous patients often receive different treatment recommendations, fewer evidence-based therapies, or shorter visits.

Access to culturally competent care and language-concordant providers remains limited.

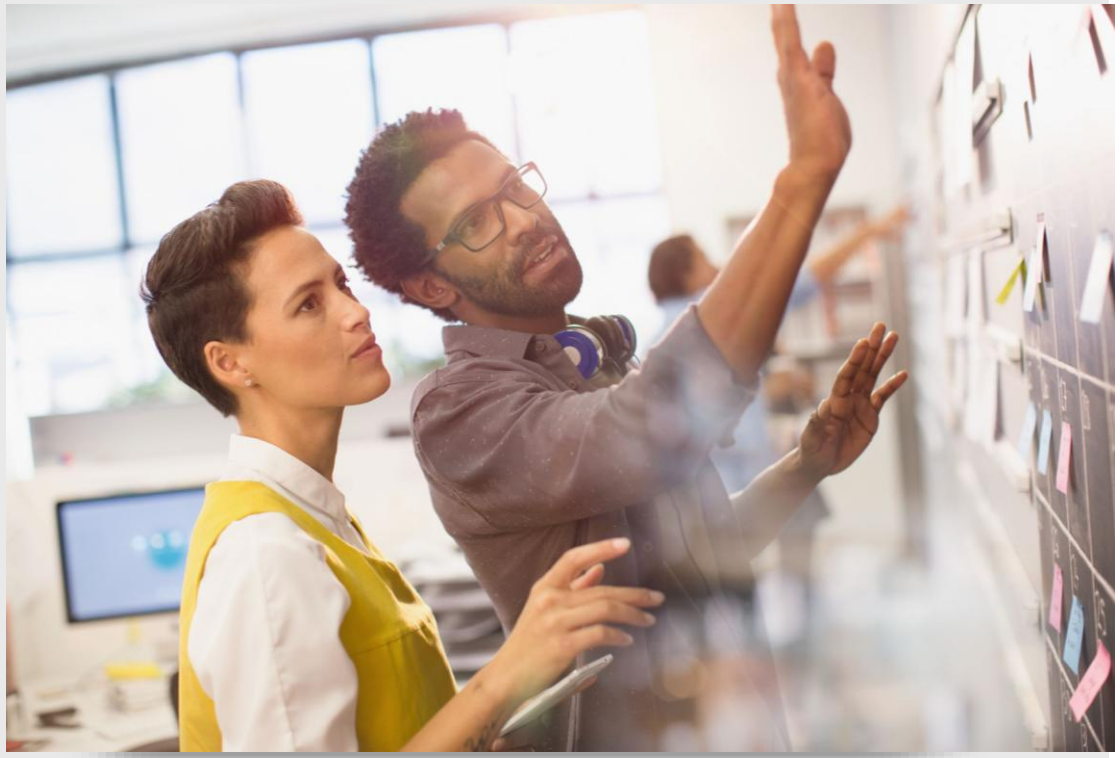


Diagnostic Bias and Clinical Practice (continued 2)

Research gaps: under-representation of racial/ethnic groups in clinical trials; data limitations hinder understanding of true disparities.



Assessment, Insurance, and Systems Navigation Today

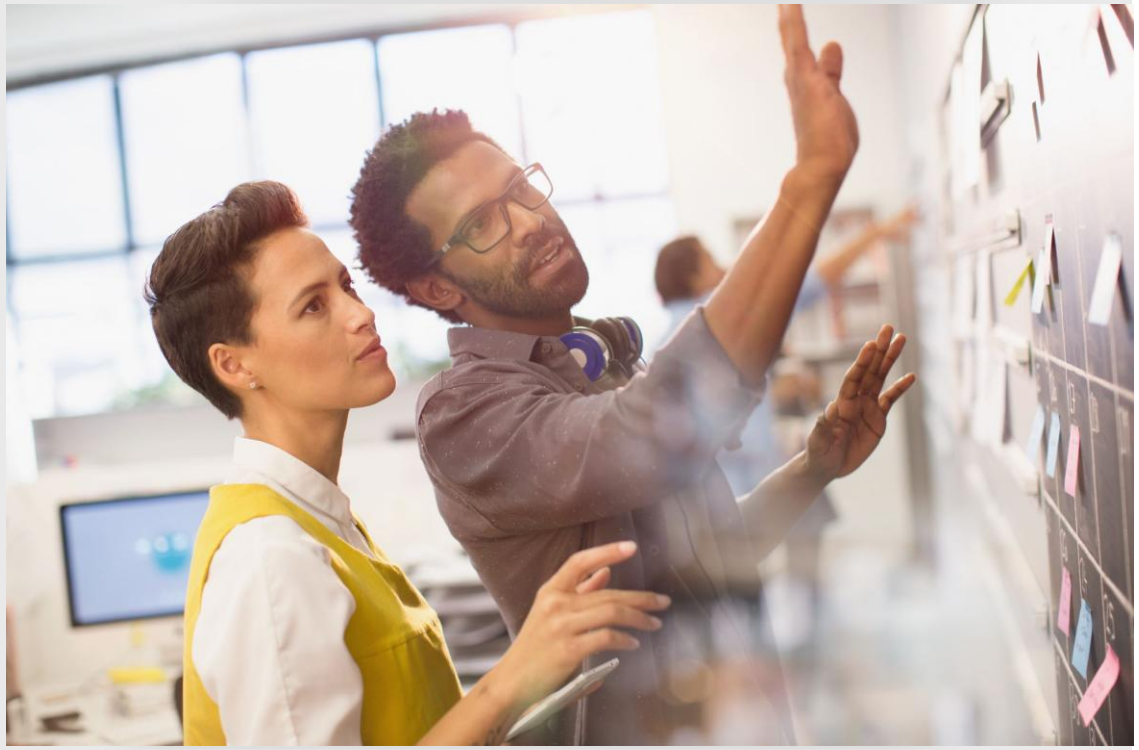


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Insurance landscapes:
Medicaid cutbacks, marketplace plans and coverage gaps affect access to services.

Provider distribution:
geographic shortages of culturally competent health providers in many communities.

Assessment, Insurance, and Systems Navigation Today (continued)



- Language barriers, literacy, and stigma impede help-seeking and engagement.
- Telehealth as both an opportunity and challenge (digital divide, privacy, trust).

Quality of Care and Outcomes in Contemporary Practice

- Persistent gaps in evidence-based care (e.g., psychotherapy access, guideline concordant pharmacotherapy).
- Trust and therapeutic alliance: historical harms influence current patient engagement and adherence.



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Quality of Care and Outcomes in Contemporary Practice (continued)

- Cultural adaptation and workplace diversity as levers for improving outcomes.
- Structural stressors (neighborhood violence, poverty) contribute to symptom burden and recovery potential.



Social Determinants of Structural Racism in Behavioral Health Care



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- Redlining and housing discrimination limited access to stable, healthy environments and quality health care.

Social Determinants of Structural Racism in Behavioral Health Care (continued)



- Under-resourced health care, food deserts, fewer mental health and addiction services, inferior schools, poor employment opportunities, unsafe housing.

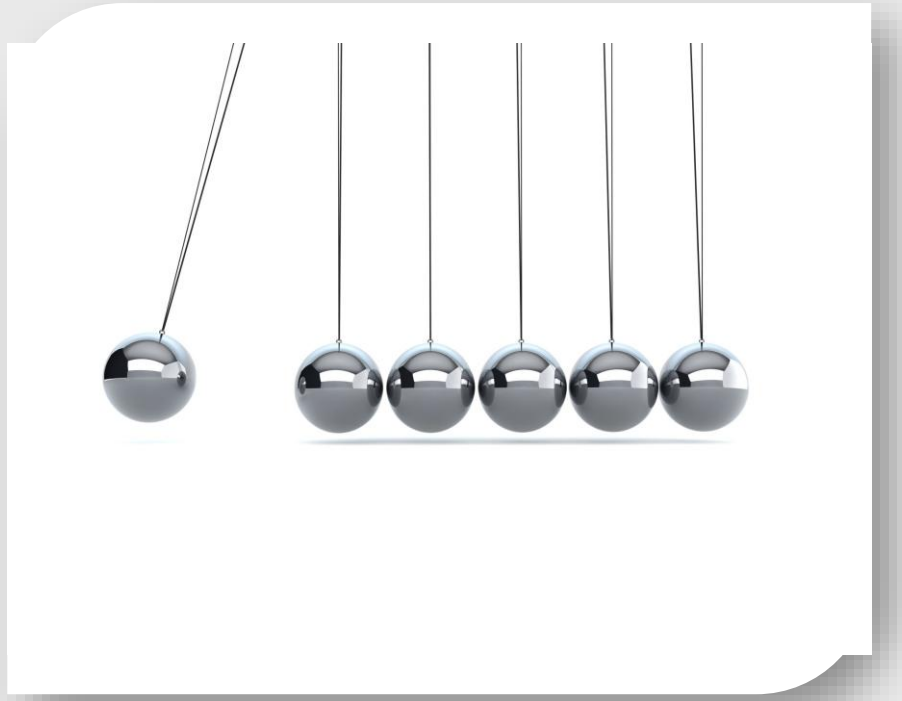
Social Determinants of Structural Racism in Behavioral Health Care (continued 2)



- Long-term stress exposure, unrelenting poverty, and limited social capital contributing to higher behavioral health risks and lower engagement in treatment.
- Contemporary linkages: ongoing geographic and economic barriers influence care-seeking behaviors and outcomes.

The Carceral Pathway and Mental Health

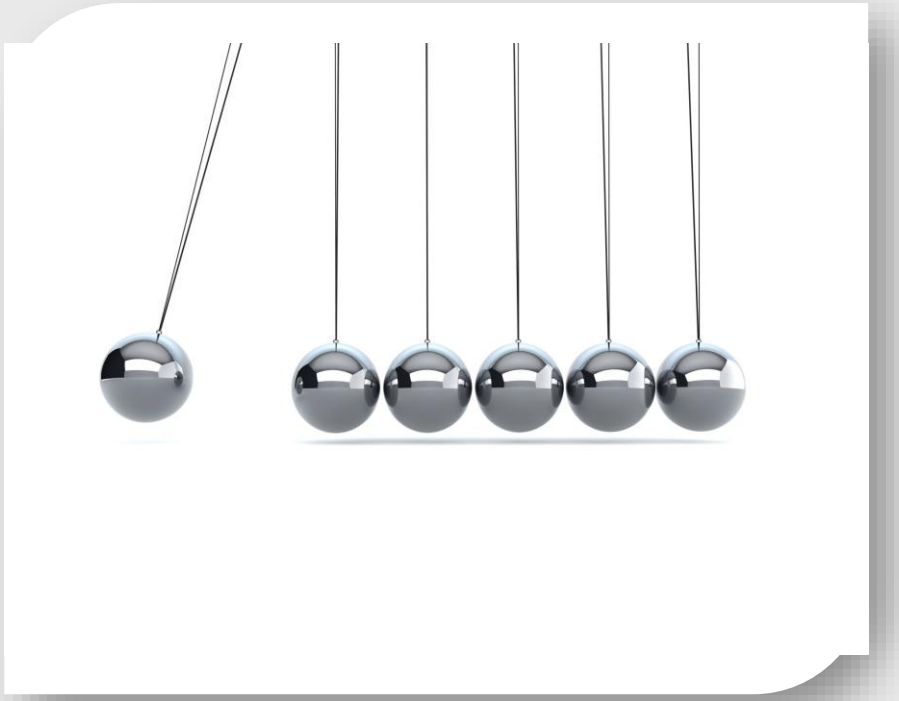
- Over-representation of racialized groups in policing, arrest, and incarceration, including, but not limited to, behavioral health crises.
- Incarceration disrupts continuity of care, increases exposure to traumatic environments, and worsens outcomes.



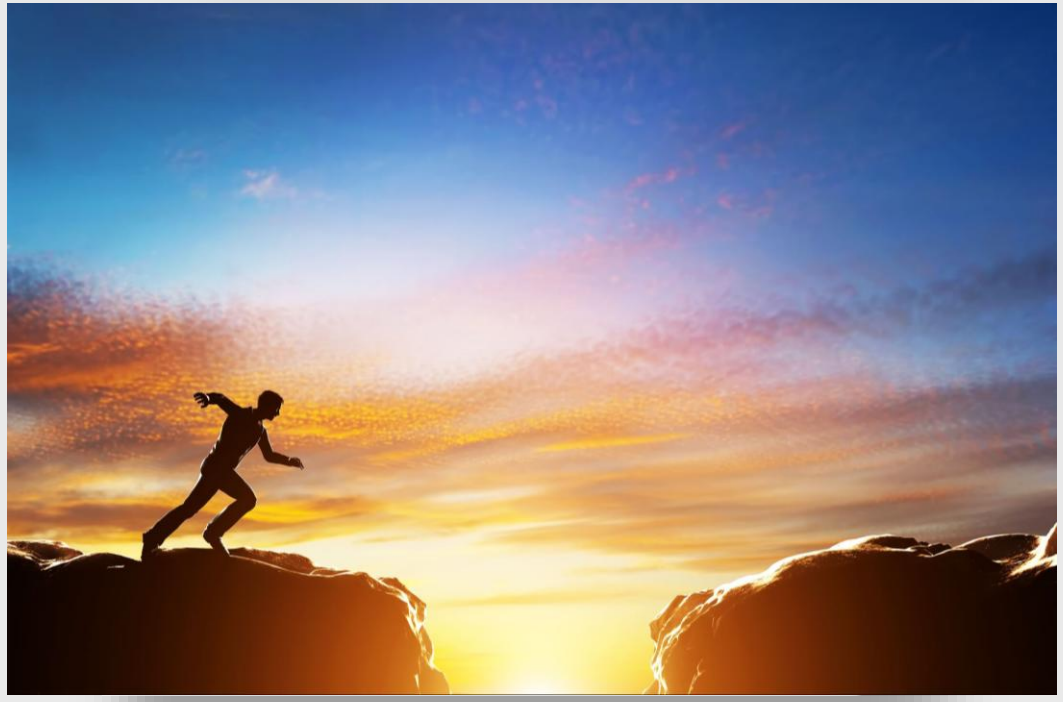
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The Carceral Pathway and Mental Health (continued)

- Mental health crises are often managed through inexperienced law enforcement personnel rather than health systems; limited access to appropriate treatment in many settings.



Policy, Data, and Reform Efforts



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- Legal and policy landscape: Mental Health Parity and Addiction Equity Act (MHPAEA), Affordable Care Act provisions, and ongoing parity enforcement.

Policy, Data, and Reform Efforts (continued)



- Data and measurement: importance of capturing race/ethnic data, social determinants, and equity-relevant outcomes in EHRs and public databases.

Policy, Data, and Reform Efforts (continued 2)



- Investments and approaches: community-based participatory approaches, integrated care, workforce diversification, and culturally informed training.
- Critiques and gaps: policy often addresses access, but not root structural drivers; need for accountability and implementation science.

Toward Equity: Actionable Steps for Representatives from Different Disciplines

For clinicians:

- Adopt trauma- and culturally informed care
- Actively seek diverse perspectives
- Build trust with communities
- Use equity-focused screening

For researchers:

- Design studies that include diverse populations
- Examine structural factors
- Translate findings into actionable interventions
- Partner with communities

Toward Equity (continued): Actionable Steps for Representatives from Different Disciplines

For policy makers and funders:

- Support parity enforcement
- Support community-based services
- Support workforce development and data infrastructure
- Invest in neighborhood-level prevention and treatment access

For communities and social justice advocates:

- Engage in co-creation of care models
- Demand transparent reporting of disparities
- Support culturally resonant programs

Case Study: “Marcus's Story: When Systems Become Symptoms”

Client: Marcus J., a 32-year-old African American man

Presenting Concerns: Depression, chronic anxiety, insomnia, irritability, and symptoms consistent with post-traumatic stress following community violence and repeated exposure to racial discrimination

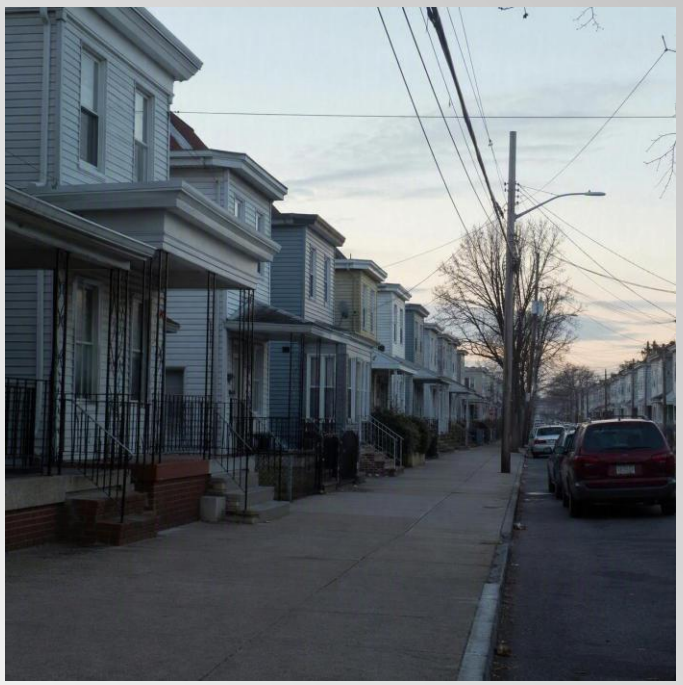
Occupation: Delivery driver and part-time community college student

Family: Single father of an 8-year-old daughter

Marcus's Story (continued): Background

Marcus grew up in an under-resourced neighborhood where schools, health care facilities, and employment opportunities were chronically underfunded. Throughout childhood, he experienced multiple adverse events, including neighborhood violence, housing instability, and the incarceration of a close family member. **Despite these challenges,** he graduated from high school and has remained steadily employed.

Over the past year, Marcus has reported increasing hopelessness, panic attacks, nightmares, emotional numbing, and difficulty trusting others. After encouragement from his church pastor, **he seeks behavioral health treatment.**



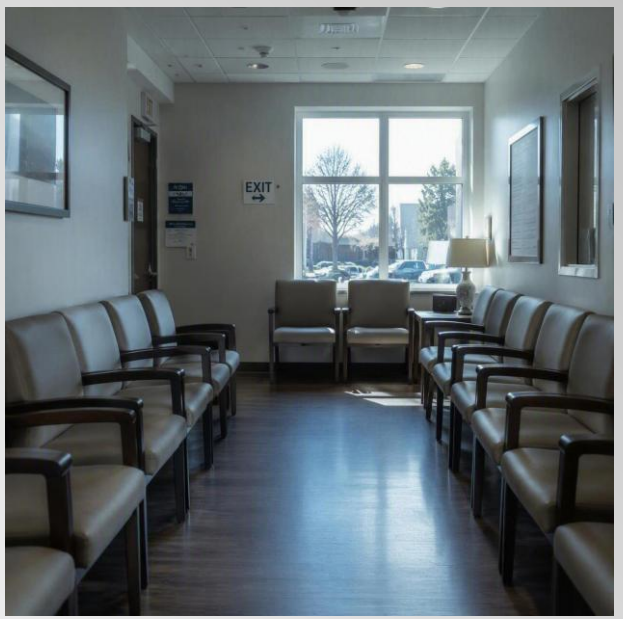
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Marcus's Story (continued): Initial Contact with the Behavioral Health System

Marcus contacts a local mental health clinic but is informed that the **earliest available appointment is three months away**. The clinic serving his neighborhood has experienced longstanding staffing shortages, while clinics in wealthier communities nearby have significantly shorter wait times.

When Marcus finally attends his intake appointment, **the clinician spends only 30 minutes** with him due to scheduling pressures. His guarded demeanor and reluctance to discuss traumatic experiences are interpreted as resistance rather than understandable caution. His descriptions of anger and hypervigilance are emphasized, while his **history of trauma and racial stress receives little exploration.**

He is diagnosed with an unspecified mood disorder and prescribed medication, but **no trauma-focused psychotherapy or culturally responsive assessment** is offered.

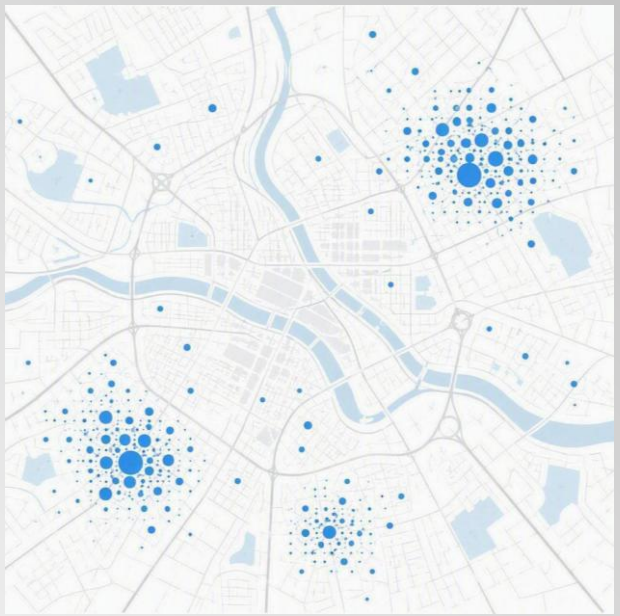


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Marcus's Story (continued): Structural Factors Affecting Care

Several systemic issues contribute to Marcus's experience:

- **Unequal access to care:** Mental health resources are concentrated outside his community, resulting in prolonged delays.
- **Under-recognition of racial trauma:** Experiences of discrimination, chronic vigilance, and cumulative stress are not assessed as clinically meaningful contributors to his symptoms.
- **Implicit bias in assessment:** Expressions of frustration are interpreted as aggression rather than distress, influencing diagnostic impressions.



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Marcus's Story (continued): Structural Factors Affecting Care (continued)

- **Insurance limitations:** His insurance covers brief medication visits more readily than specialized trauma therapy.
- **Lack of cultural representation:** Marcus never encounters a provider who discusses the impact of racism, historical disadvantage, or community context on mental health.
- **Over time,** Marcus stops attending appointments, believing that “therapy isn't for people like me” and that clinicians do not understand his experiences.



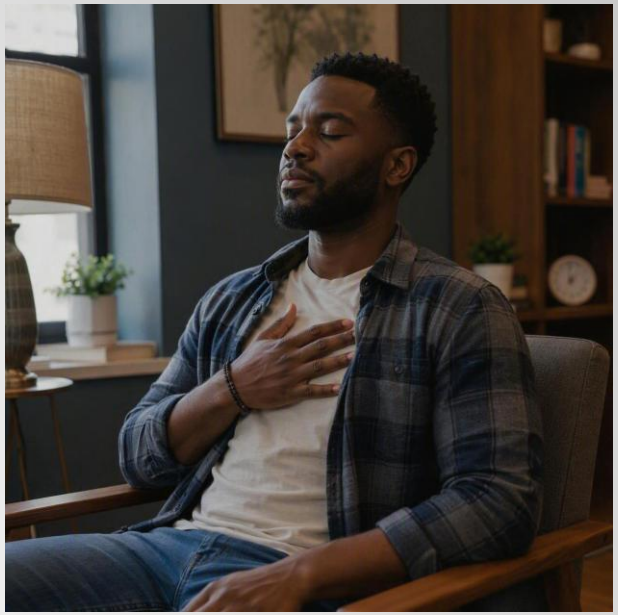
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Marcus's Story (continued): Re-Engagement Through Culturally Responsive Care

Months later, Marcus enrolls in another clinic that explicitly practices **trauma-informed and culturally responsive care**. During intake, the clinician explores not only symptoms but also experiences of discrimination, historical stressors, family strengths, spirituality, and community resilience.

The clinician validates that chronic exposure to racism and inequitable systems can contribute to depression, anxiety, and trauma-related symptoms without defining Marcus solely by those experiences. Marcus participates in **evidence-based trauma treatment** while incorporating:

- Psychoeducation about chronic stress and trauma.
- Skills for affect regulation and emotional awareness.
- Strength-based exploration of identity, family, and resilience.



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Marcus's Story (continued): Re-Engagement Through Culturally Responsive Care (continued)

- Collaboration with community supports, including his church and peer network.
- Practical assistance addressing transportation and scheduling barriers.



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Marcus's Story (continued): Outcome

Within several months, Marcus reports:

- **improved sleep**
- **fewer nightmares**
- **stronger relationships with his daughter**
- **renewed hope about the future**



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Marcus's Story (continued): Teaching Points for Clinicians

This vignette illustrates that **structural racism in behavioral health care** often operates through policies, institutional practices, and unequal resource distribution rather than overt prejudice alone. Its effects may include delayed access, incomplete assessment, diagnostic bias, fragmented treatment, and reduced engagement.

For behavioral health professionals, key strategies to counter these patterns include:

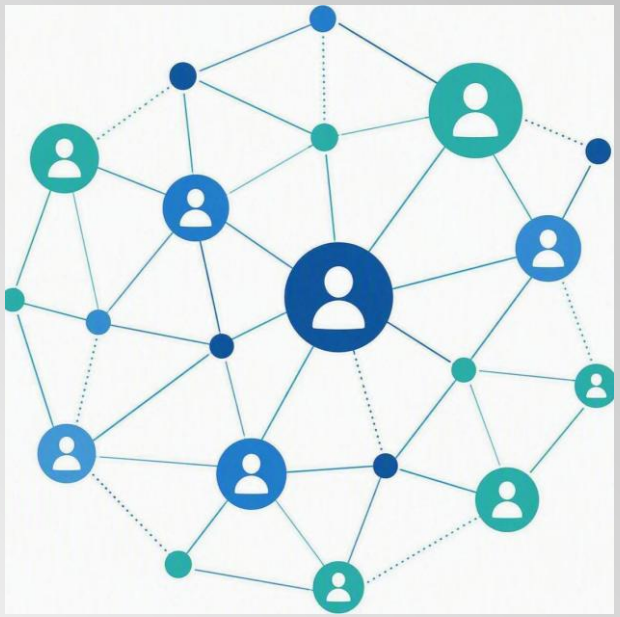
- Conduct comprehensive assessments that consider trauma, social determinants of health, and experiences of discrimination.
- Avoid pathologizing culturally shaped expressions of distress or adaptive survival behaviors.



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Marcus's Story (continued): Teaching Points for Clinicians (continued)

- Use evidence-based interventions while adapting care to the client's cultural context and lived experiences.
- Build partnerships with families, faith communities, and trusted local organizations when appropriate.
- Advocate for equitable access to high-quality behavioral health services and reduce barriers related to transportation, insurance, and workforce shortages.



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Discussion Questions

- At what points did structural factors—not individual prejudice alone—shape Marcus's care?
- How might implicit bias have influenced diagnostic decisions?
- What additional assessments should have been completed during the initial evaluation?
- How can trauma-informed and culturally responsive practices improve engagement and outcomes?
- What policy or organizational changes could reduce inequities similar to those experienced by Marcus?
- This case can be used in graduate social work education, psychology, counseling, psychiatry, or continuing education workshops to stimulate discussion about how systemic inequities influence assessment, diagnosis, treatment engagement, and recovery in behavioral health settings.



You have completed the course:

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Thank you!

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