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**RACIAL, CULTURAL AND SOCIOPOLITICAL  
DISPARITIES IN MENTAL HEALTH ADMINISTRATION  
IN THE UNITED STATES\***

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**Abstract**

*Despite significant advances in the health care industry, recent research has revealed alarming disparities in the availability, access, and quality of health care for minorities. According to the 2001 Surgeon General's report published by the USDHHS, even if minority groups have comparable access, socioeconomic status and insurance coverage, they are still likely to receive less, or inferior care. This paper discusses the concept of culturally sensitive mental health counseling and its feasibility, in light of the monocultural manner in which cultural and criminal subgroups are typically handled.*

**Introduction**

On August 27, 2001 the U.S. Surgeon General called for a reduction in mental health service disparities among racial and

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**RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

ethnic minorities (U.S. Dept. of Health and Human Services (USHHS), 2001). This charge was based on the results of a research initiative by the Department of Health and Human Services which revealed that,

.....all [Americans] do not have equal access to treatment and services. The failure to address these inequities is being played out in human and economic terms across the nation-on our streets, in homeless shelters, public health institutions, prisons and jails... (page. 3).

The research also indicated that, “despite the existence of effective treatments for most mental disorders, minorities have less access to such services and too often receive poor quality of care when they seek it out” (page. 1).

The organization, Physicians for Human Rights (PHR) has also spoken out strongly against disparities in the availability of health interventions. At the 2001 conference of the World Conference on Racism, Race Discrimination, Xenophobia and Related Intolerance, members of PHR presented evidence that minority populations are significantly less likely to receive thorough physical examinations, to have their full medical history taken, and to receive adequate and appropriate laboratory and radiological examinations (PHR, 2001).

This state of events is not surprising. As far back as 1968 the National Advisory Commission of Civil Disorder identified disparities in health care services as one of the underlying factors of the racial crisis that existed at the time (National Advisory

Commission on Civil Disorder, 1968). In its report the Commission also pointed out that minorities suffered from higher mortality rates, higher incidences of major diseases, and lower access to, and utilization of medical services. Despite this early warning, the American Medical Association (AMA) has identified a continuing trend of minorities not being able to benefit from marked advances in medicine and health care (AMA, 1990, 2001). So the questions to be addressed are (1) Do racial and ethnic disparities in mental healthcare exist and, are they associated with worse increasing rates of recidivism? (2) If they do exist, are they related, directly or indirectly, to differences in socioeconomic status, income, education etc.? (3) Does political policy have an impact, direct or indirect, on the quality and quantity of mental health services available to racial and ethnic minorities?

### ***History***

In the 1970s the Nixon regime acknowledged, and addressed, a need for aggressive public health strategy to reduce drug use in low-income neighborhoods (Massing, 1998). State and federal officials quickly implemented formal and informal policies that were supposed to aid in the development and availability of services for the prevention and treatment of alcohol and drug abuse and dependence (Brunn et. al., 1976).

Between the mid-1970s and the mid-1990s, public intoxication was decriminalized as a result of a growing acceptance that intoxication was an illness and not a crime (Gitlow, 1973; Cahalan, 1974; Hershon, 1974; Beauchamp, 1976). Publicly funded systems

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

### *Williams*

were introduced and then expanded to address changing and emerging needs. Federal legislation and regulations were implemented through state policies, as were changes in the epidemiology of drug use (Herman, 1996). Overall, these changes were expected to lead to substantial improvements in society's ability to service the general population in treatment programs for alcohol and drug dependence.

Unfortunately, research shows that today, few of these resources are available or accessible to minorities (AMA, 2001). Not only are treatment facilities physically inaccessible because they are not located in the urban areas in which they are most needed, but, more importantly, minority populations do not have access to culture specific programs and therapeutic interventions (AMA, 2001; Blumstein & Beck, 1999; Mumola, 1999).

### *Statistics*

There are several studies that document disparities in the quality of mental health services provided to racial and ethnic minorities. Specifically, the U.S. Surgeon General's report found that the administration of mental health services was "plagued by disparities in the availability of and access to its services," and that these disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender" (U.S. DHHS, 2001a, p.vi). Additional studies of racial and ethnic disparities in health care, specifically as it relates to drug use, reveal some alarming statistics. The rate of commitment to state prisons for drug arrests rose by 400% between 1980 and 1990, from 19 prison commitments per 1,000 arrests to 103 per 1,000 (Timrot, Byrne &

Finn, 1991). Additionally, the estimated time served by drug offenders in state prisons increased a full year between 1987 and 1996 while federal drug sentences rose from 17 months to 47 months (Blumstein, and Beck, 1999). By 1996, the rate of commitments per arrest had dropped to 77 per 100,000 (U.S. Dept. of Justice, Federal Bureau of Investigation (DOJ/FBI), 1998). This means that there is a greater likelihood of being sent to prison for a drug related arrest than for murder, assault, robbery, burglary, and rape (Blumstein and Beck, 1999).

Between 1980 and 1992 new court commitments to state prisons increased by 155% (U.S. Dept. of Justice, 1993). Strangely enough, violent offenders accounted for only 16% of this increase. The remaining 84% was due to increased incarceration for drug related, property and public order offenses (U.S. Dept. of Justice). In fact, research shows that the greatest single increase was 46% and this occurred in the area of drug related crimes (Mauer 1999).

The question to be asked therefore is whether a direct correlation exists between social policies, race, availability of mental health resources, and rates of incarceration? In responding to this question, some researchers argue that chemical dependency, for example, has been directly correlated to high unemployment rates, and low productivity (Hubbard & French, 1991). Additionally, a plethora of literature now exists documenting a direct relationship between chronic drug use and the propensity to commit crime (Nurco et al., 1985; Loeber et al., 1998; McBride et al., 1993; Van Den Bree, Svikis, & Pickens, 2000). Yet the availability of treatment for chemical dependency is not readily available to minorities because the assessment of their condition is all too often

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

made by a practitioner who may lack the training to understand, much less accept all the elements of their condition.

Acknowledgement of these correlations should encourage changes in the existing counseling mechanism. Unfortunately, the current trend of decreasing federal funding does not support this effort. Two-thirds of the federal drug budget is allocated to prohibition, law enforcement and supply reduction efforts. One-third is allocated to prevention, treatment and demand reduction (Clinton, 2000). So there is a greater likelihood of being sent to prison following an arrest for a drug related offense than being admitted to a treatment or counseling center (Blumstein and Beck, 1999).

### **Impact on Minority Populations**

The combined impact of new drug control policies has more than quintupled the number of black drug offenders in state prisons, rising from 14,000 to 80,000 (U.S. DOJ/FBI, 1998). Drug policies are the single most significant factor that have contributed to an increase in prison population with the number of incarcerated drug offenders rising 510% from 1989 to 1994 (Mauer, 1991, 1999). In his studies of sentencing practices Mauer (1991, 1999) revealed that the current offense and the prior record are the most significant factors considered in determining prison sentences despite obvious indications of a need for rehabilitation or counseling. He argues that public policies designed to control crime and drug abuse have in many respects contributes to the growing racial disparity in the criminal justice system and, in fact

have little or no impact on the problems they were created to address (Mauer, 1991, 1999).

### **Sociopolitical Considerations**

Interaction between politics and the community, or lack of interaction, directly impact the quality and effectiveness of the mental health services provided to minority populations. Factors such as privilege, fear, and racism have also been identified as barriers to appropriate multicultural counseling and competence (D'Andrea & Daniels, 1995; Katz, 1985; Ridley, 1995). Additionally, variables such as culture and socioeconomic status also directly impact the counseling relationship, its diagnosis, treatment plan and follow-up (Ridley et al., 1998). It has even been suggested that the practitioner's personal identity, aspects of his individual history and his background, play an important role in the development of his own worldview as well as his understanding of his client (Arredondo et al., 1996).

In the practice of psychotherapy, consideration must be given to unique cultural and social environments which may affect client behavior. In the case of minority, underserved communities, practitioners must be aware of the triple stigma faced by their clients. Not only are minority offenders confronted by socio-economic discrimination, but mainstream culture perpetuates evolving myths via the media and, even within the offender's own immediate environment, particular norms of their own culture may inhibit their ability to seek help without attracting negativity from their families and their communities (King, 1996). For example,

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

African-American men in general but particularly under the age of 40, have been accused of having an aversion to counseling, whether it be mental, marriage, family life or substance abuse.

Researchers claim that many criminal acts are linked to treatable psychological problems (Blumstein & Beck, 1999; Mumola, 1999). If this is the case then it is conceivable that if the appropriate psychological treatment were made available to offenders, then perhaps recidivism rates would be considerably lower. Yet, despite the growing evidence to support this argument, policy makers have just about abandoned psychotherapy services for inmates within correctional institutions because of cost issues and a claim of poor results. But perhaps poor results are not unexpected if the psychotherapy services are culturally insensitive. In any event, there is a growing movement toward private psychological treatment provided on an outpatient basis, and as a condition of probation or parole (Blumstein & Beck, 1999). The fact that minority probationers and parolees are less likely to be able to afford private treatment is perhaps a reasonable indication that they more likely to become statistics of recidivism.

### ***Mental Health Perspective***

Recent studies have found that although chemical dependency treatment is effective in reducing addiction to illegal substances, some programs seem to be more beneficial and more effective for some racial groups than others (Institute of Behavioral Research, 2000). Moreover, continuing studies show that some minority groups do better in culturally relevant programs than in programs



that are not culturally sensitive (Rosenheck & Catherine, 1998; Longshore, Grills,& Annon, 1999). It should be obvious, therefore, that there is a greater need for culturally sensitive intervention.

Some argue that appropriate treatment (psychological, mental or otherwise) has the potential to reduce recidivism rates among offenders of all racial or ethnic background which could also be interpreted as meaning that inappropriate diagnoses directly impact the likelihood of commitment. This is in no way an indication that racial minorities commit more crimes than their white counterparts. There are many other variables which are also significant indicators of racial disparity and may be beyond the direct control of health services providers. These variables include disparities in income, wealth, insurance, housing, and environmental risk exposures (Menefee, 1996; LaVeist, 1996). With that being said, it is therefore not this author's contention that an increase in prison commitment among racial or ethnic minorities is indicative of racial bias on the part of policy makers. Notwithstanding this position, it is also important to acknowledge that In this vein, the Institute of Medicine (2002) says,

Three mechanisms might be operative in healthcare disparities from the provider's side of the exchange: bias (or prejudice) against minorities; greater clinical uncertainty when interacting with minority patients; and beliefs (or stereotypes) held by the provider about the behavior or health of minorities. (p.3)

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

With this in mind, human services researchers and practitioners have targeted drug related crimes and are suggesting revised policy initiatives as well as further changes in the epidemiology of drug abuse (Jackson, Brown, Williams, Torres, Sellers & Brown, 1996).

### ***Social Services Assessment***

Race, culture, and socioeconomic status are increasingly becoming recognized as important variables in counseling practice, mental health services, and education (Jackson, 1995; Speight et al., 1991; Sue, Arredondo, & McDavis, 1992). In fact, current literature argues that “everyone should be assessed in light of sociocultural influences” (Ridley et al., 1998, p. 851). Since historic trends “treats the process as though it is primarily the assessment of ethnic minorities by White clinicians” (p.851), many counseling and psychology professionals have identified an urgent need for the development of ethical standards and training guidelines to ensure the appropriate provision of services for an increasingly diverse population (Arredondo-Dowd & Gonsalves, 1980; Carney & Kahn, 1984; LaFromboise & Foster, 1989; Pedersen, 1989; Pope-Davis & Dings, 1995; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982).

As early as 1986, researchers argued that individuals who are not “trained or competent to work with such [culturally diverse] clients should be regarded as unethical” (Casas, Ponterotto, and Gutierrez, 1986, p. 347). In fact, there is growing body of literature that equates ethical conduct with the use of multicultural counseling skills (Herlihy, Sue, Forester-Miller, Lee, & Corey, 1996;

Pedersen, 1995, 1997) and which hail the development of standardized multicultural counseling competencies is the results of an ongoing effort to operationalize the work of counselors in the area of diversity-sensitive counseling, and to meet the ethical challenge (Sue, Arrendondo, & McDavis, 1992; Sue & Sue, 1999, p.8). Since projections indicate that persons of color will constitute a numerical majority somewhere between the year 2030 and 2050, and minority groups will constitute a disproportionate number of the clients seen by mental health counselors in mental health centers and other public funded agencies (U. S. Census Bureau, 1999), this development is particularly important.

Successful practitioners have adopted and continue to use a culturally sensitive approach by selecting instruments which have the least bias with minority populations (Flaherty, Gaviria & Pathak, 1988; Paniagua, 1994, 2001). Proponents of this methodology argue that the minimum acceptable assessment instruments must not only have appropriate content and technical criteria but must demonstrate conceptual equivalence across cultures (Flaherty and Pathak, 1988). In keeping with the thought process in summarizing various assessment methods according to their degree of bias, Paniagua (2001) therefore concluded that the most effective assessments methods were those that included culturally sensitive physiological assessment, direct observation, self monitoring or self reporting scales and clinical interviews, while those that were least effective and showed the most bias included trait measure, self reports of psychopathology and projective tests (Paniagua, 1994, 2001).

It is arguable therefore, that the general guidelines for culturally sensitive assessments should include asking culturally appropriate

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

questions. Intake personnel should focus on ethnic identification rather than race and they should acknowledge socioeconomic status as a contributing factor. All parties involved in the process should be made aware that their own prejudices, biases, and stereotypes may lead to faulty conclusions about the client.

### ***Racial, Cultural, and Sociopolitical Insensitivity***

It has become increasingly obvious that there are certain populations that need a targeted approach to counseling and psychotherapy (Atkinson et al., 1989, 1993, 1998). As a result, there is a strong call for counselors and therapists to be extremely sensitive to cross-cultural issues, to the individual, to the culture of the client, and to his or her own prejudices and racism (Sue and Sue, 1990). In the absence of this targeted approach the criminal justice system may become nothing more than a catchment for individuals with mental health issues. Moreover, if traditional mental health treatment programs continue to be administered in a monocultural and insensitive manner, then the existing trend of disproportionate minority overrepresentation in the criminal justice system will continue to negatively impact minority populations. Cultural sensitivity should not only be employed in individual cases but should become an ongoing process whereby professionals continue to educate themselves about the various cultures with which they interact on a daily basis.

### ***Culture Specific Counseling***

Cultural competence has been defined as the ability of individuals to establish effective interpersonal and working relationships that

can supersede cultural differences (Campinha-Bacote, 1999). At the patient-provider level, it has been defined as the process by which the healthcare provider continuously strives to provide effective service within the cultural context of the client, regardless of cultural or racial differences (Campinha-Bacote, 1999). Given the prevalence of prejudice and discrimination in this society it is unrealistic to expect that expressions of prejudice will be any less prevalent within society's various sub-systems, specifically the mental health and criminal justice systems. To this end, dispelling the myths that relate to minorities and criminality, may be useful as part of correctional staff training.

Franklin (1982) recognized the challenge and cautioned, the counselor be vigilant and not be misled by information that is being provided. A streetwise youth might deliberately attempt to frighten or shock the counselor by describing use of drugs and sexual behaviors in graphic detail. Others might adopt a highly confrontive and aggressive stance or engage in "rapping" or telling tales as a means of "testing" out the therapist (see Sue and Sue, 1990, p. 214).

In effect, just as counselors have the ability to modify their approach based on the client's age, developmental level, intellect, and gender, the modification process should become second nature when the client's culture has a direct effect on the treatment of the specific issues for which the client is seeking help.

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

### **Multicultural Assessment Procedure (MAP)**

In 1982, Sue et al. proposed a model of multicultural counseling standards and competencies that has become recognized and implemented in the counseling field (APA, 1992; American Counseling Association (ACA). They believe that,

[a]s mental health professionals, we have a personal and professional responsibility to (a) confront, become aware of, and take actions in dealing with our biases, stereotypes, values, and assumptions about human behavior, (b) become aware of the culturally different client's world view, values, biases, and assumptions about human behavior, and (c) develop appropriate help-giving practices, intervention strategies, and structures that take into account the historical, cultural, and environmental experiences/influences of the culturally different client. (p. 6).

MAP was introduced as a direct result of this belief and presents a comprehensive model of psychological assessment relevant to any multicultural clinician-client relationship. It incorporates current theories on multicultural counseling procedures to be used when making diagnostic decisions (Sue & Sue, 1990). The development of multicultural counseling competencies and standards was the beginning of an attempt to facilitate appropriate counseling for diverse clients in the short term and more realistic interaction between minorities and the criminal justice system in the long term.

MAP was also intended to address researcher claims that the awareness of belonging to what society identifies as a minority group with lower status and power, as well as the minority groups experiences with racial discrimination, prejudice, and stereotypes, both have a strong psychological impact on mental health services clients (Gaines & Reed, 1995; Steele, 1997).

MAP is a comprehensive model of psychological assessment relevant to any multicultural clinician-client relationship. It incorporates current theories on multicultural counseling procedures when making diagnostic decisions (Sue & Sue, 1990). One of the most valuable aspects of the MAP is that it encourages and directs practitioners to take a scientific approach to the counseling process especially where assessing clients' issues is concerned (Spengler et al,1995). This scientific approach encourages counseling professionals to initiate a self-assessment strategy while supporting attempts to evaluate professional effectiveness on a client by client basis. This procedure protects both the practitioner and the client from the biases and distorted perceptions inherent in the current evaluation process. This approach is especially significant since researchers have noted in their study of cultural and ethnic differences, that the specific factors that are thought to influence criminal behavior are rarely identified in the counseling process (Betancourt & Lopez, 1993; Phinney, 1996).

Since life experiences of diverse groups form the basis for their sociocultural and sociopolitical perspectives (Sue & Sue, 1990), a lack of enlightened perspectives on societal oppression can have a

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

negative impact on counseling and psychotherapy for all clients. There is, therefore a need for strategies that support effective professional interaction with diverse individuals, families, and groups in a counseling and psychotherapy context. So, if the propensity for criminal behavior is ignored in the counseling process because racial or cultural factors are not considered, then it is conceivable that a direct relationship exists between the quality of mental health services, specifically the degree of racial and cultural sensitivity, and the rate or recidivism for minority offenders.

### *Multicultural Counseling Competencies and Standards*

Sue and Sue (1990) also argue that minority populations tend to avoid counseling not only because of the counselor's (general) lack of cultural sensitivity but also because of a mistrust of a practice that they see as being essentially geared toward White middle-class America. They contend that,

we need to expand our perception of what constitutes mental health practices. Equally legitimate methods of treatment are nonformal or natural support systems (Brammer, 1995; J. C. Pearson, 1985) so powerful in many minority groups (family, friends, community self-help programs, and occupational networks), folk-healing methods (Padilla and DeSnyder, 1985), and indigenous formal systems of therapy (Draguns et al., 1981). Instead of attempting to destroy them, we should be actively trying to find out why they may work better than Western forms of counseling and therapy (Sue and Sue, 1990, p. 8).



As part of the ongoing process of developing a multicultural assessment model, researchers have identified certain traits that are necessary for counseling professional to successfully integrate the new assessment process with the old. Counselor self-awareness, openness, and curiosity are prerequisites to the ability to approach multicultural counseling as a science and are necessary to incorporate issues related to ethnicity, race and social class in counseling and assessment. These traits are also necessary if practitioners are to be educated as to how to phrase questions and approach potentially sensitive topics (Spengler et al., 1995). The ultimate goal, according to Brislin (1992) is to help practitioners "...to better understand their own culture, the culture of others, and how culture influences human behavior" (p.v).

In refining the concept of multicultural assessment, Sue et al. (1992) discussed the sociopolitical realities in counseling and asserted that racial and social forces of society affect both the client and the counselor (Sue et al, 1992). Current multicultural training, for example, focuses primarily on the ethical conduct and teaching roles, but does not address institutional or organizational development and management (Ridley et al., 1994). Perhaps a direct articulation of the personal, institutional, and professional subcontexts in multicultural counseling competence may help counseling professionals to more adequately address issues of multicultural sensitivity, sociopolitical issues, and racism.

The guidelines outlined by Sue et al. (1992) suggest that cultural awareness, knowledge, and skills are necessary for cultural competence (Sue et al, 1992). However, these three components may not necessarily ensure affective, cognitive, and proper

**RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

behavioral learning. For example, a White female counselor may be cognitively aware that her White European background gives her certain privileges in this society. She may not, however, be able to recognize and acknowledge the impact of these privileges on an affective level. Likewise, her cognitive awareness of these privileges does not necessarily guarantee a change in her professional behavior in dealing with clients she perceives as not having the same level of privileges.

***Traditional versus Multicultural counseling***

Although traditional and multicultural competencies seem conceptually interrelated, the process by which counselors are expected to become multiculturally competent is still poorly understood. Researchers are still trying to develop a better understanding of how, when, and by what process counselors can truly become multiculturally competent. How can they become aware and accepting of themselves as racial and cultural beings and become aware of their biases, preconceived notions, and personal limitations? How can they learn to appreciate and incorporate the worldviews and perspectives of their clients in therapy? And, how can they become competent in service delivery that includes alternative approaches to healing?

At one end of the spectrum is the view that mental dysfunction is largely caused by internal processes over which the client has at least some control (Dryden, 1999). At the other end of the spectrum is the belief, which is advocated by proponents of multicultural counseling, that external or environmental forces,

such as racism and oppression, are the largest significant causes of clients' emotional disturbance (Daniels, Arredondo, and D'Andrea, 2001, May; 2001, July). A mental health counselor who subscribes to an internal-processes causation model would employ different counseling strategies and outcome goals than one who subscribes to the external or environmental causation model. This raises an interesting question. Are the racial, cultural or sociopolitical undertones inherent in these opposing views and techniques counter productive to the successful application of multicultural competency theory or can both approaches be integrated for successful application?

Traditionally, counseling and psychology has been Eurocentric, that is, it is derived from a White middle-class value system (Katz, 1985; Smith, 1981). This has resulted in a professional approach that is not only ethnocentric in nature, but prone to neglect the mental health concerns of other racial groups and the socio-political injustices they may be forced to endure on a daily basis. Given this gross omission and blatant disregard by the human service professions there is an immediate and pressing need to develop different paradigms and models to allow this society's various systems to address the needs of a racially diverse population.

In one form or another mainstream psychological theory and practice has been criticized for being culturally insensitive and lacking in cross-cultural relevance (Sue, 1981; Wrenn, 1962). The argument is that "counseling approaches have been developed by and for the White, middle class person" (Atkinson, 1979, p.13). As a result counseling professionals who use theory and training based

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

on this monocultural perspective, often operate under the assumption that these theories can be applied to all populations. The result is that despite claims of being morally, politically and ethically neutral, psychology is fundamentally Eurocentric, both in theory and practice to the detriment of cultural and racial minorities, and especially as it relates to the criminal justice system.

Research have already determined that the most obvious implication of this society's ethnic growth would be the need for culture-specific models of psychopathology, assessment and treatment (Florshein, Tolan, & Gorman-Smith, 1996; Okazaki, 1997). Sue and Sue (1990), for example, see race as an integral part of one's identity, and that "those who advocate a 'color-blind' approach seem to operate under the assumption that 'Black is bad' and that to be different is to be deviant" (p. 77). However, this society's cultural differences have traditionally been regarded as deficiencies (Jones, 1985). As a result, the social interventions used by correctional counselors to assess and treat offenders tend to focus on the needs and risks presented by the offender rather than considering the various psychosocial approaches to correctional treatment.

### **Accomplishments and Realities**

The relationship between chronic drug abuse and crime has been constantly documented in the research literature (Loeber et al., 1998; Leukefeld, 1985; McBride et al., 1993; Nurco et al., 1985; Van den Bree, Svikis, & Pickens, 2000). In the case of chemical

dependency treatment approximately 50 % of people with mental illnesses have chemical use issues (Reiger et al., 1990). The problem with access to the appropriate mental health treatment is that unless the offender is properly screened, and assessed as needing mental health services, instead of receiving treatment the offender will be incarcerated. Additionally, even if the offender is properly diagnosed, services may not be immediately or practically available or the offender could be excluded from services due to restrictions in eligibility criteria.

Few counselors are able to modify their diagnostic procedures for the culturally different perhaps because the directions for formulating diagnoses and treatment plans provided by managed healthcare do not give them the flexibility to deviate from their usual diagnostic methods. Additionally, mental health organizations are becoming increasingly unable to address more subtle forms of discriminatory practices in health care settings (Institute of Medicine (IOM), 2002), and narrow interpretations by the courts, and the lack of adequate monitoring mechanisms for monitoring providers, also contribute to disparate levels in the availability of mental health services for minorities (Herman, 1996).

Despite these challenges attempts have been made to develop strategies for targeted populations of drug abusers. Drug abuse treatment now includes interventions developed for client with non-drug related problems which can contribute to continued drug use and affect recovery (Laudet, et al., 2000; Rachbeisel, Scott, & Dixon, 1999). Special programs have also been introduced to address victimization among drug abusing women (Logan, Walker,

**RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

Cole & Leukefeld, 2002). Targeted treatment approaches also have been developed for antisocial behavior in children and adolescents with drug problems (Henggeler & Mihalic, 1998), and social skills training has been developed for adult alcoholics with the intention of improving drug treatment approaches. These are all excellent programs which must be sensitized to encompass all sub-groups in order to be successful and effective.

Research has already determined that the most obvious implication of this ethnic growth would be the need for culture-specific models of psychopathology, assessment and treatment (Florsheim, Tolan, & Gorman-Smith, 1996; Okazaki, 1997). However, cultural differences have traditionally been regarded in this society as deficiencies (Jones, 1985). As a result, social interventions used by correctional counselors to assess and treat offenders tend to focus on the needs and risks presented by individual clients rather than considering the various psychosocial approaches to correctional treatment. It follows therefore, that the general guidelines for culturally sensitive assessments should include asking culturally appropriate questions. Intake personnel should focus on ethnic identification rather than race and they should acknowledge socioeconomic status as a contributing factor. All parties involved in the process should be made aware that prejudices, biases, and stereotypes may lead to faulty conclusions about the client.

### ***Recommendations***

The concept of multicultural counseling was prompted by the Civil Rights movement of the 1960s. It was introduced to eliminate barriers in the administration of mental services by encouraging racial, cultural and sociopolitical awareness in the practice of counseling and psychotherapy. Researchers were concerned that since the practice of counseling and psychotherapy was derived from a White middle-class value system (Katz, 1985; Smith, 1981), mainstream counseling research, theory and practice, was monocultural in nature, and tended to ignore the mental health and sociopolitical concerns of racial and cultural sub-groups.

To this end there is a call for a new code of ethics to mandate the use of assessment techniques that are appropriate to an “individual’s gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status” (American Psychological Association (APA) 1992, p.1603). Despite the fact that the proposed code has been criticized for a lack of specific guidelines for solving problems in this controversial area, it still highlights the need to consider a client’s racial, cultural or sociopolitical background in the selection of personality assessment techniques (Grey-Little, 1995; Okazaki & Sue, 1995; Velasquez, 1995).

Most practitioners agree that social relationships and public policies have a direct influence on the rehabilitation of criminal offenders as do social interventions used by correctional counselors to assess and treat offenders. For ex-offenders the issue of substance abuse is usually the culmination of a variety of other problems. Thus, to successfully address substance abuse,

**RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

comprehensive assessment and a holistic approach is the key (Menefee, 1996). The use of substandard assessment methods, techniques, and measurement instruments that adopt a non-holistic or subjective approach to the patient's life situation will inevitably produce inadequate if not faulty recommendations and decisions (Menefee, 1996). Because the recommendation of the pre-adjudication intake officer heavily affects judicial decisions, for example, it is imperative that all intake personnel are thoroughly trained in the culturally appropriate use of assessment tools.

More importantly, systems must be put in place to monitor and target discrimination in health care, access to services, quality of health care - specifically diagnosis and treatment - and health outcomes. Society must be prepared to identify and end racist and discriminatory practices that interfere with prevention and treatment. Whether the disparity is caused by treatment decisions, differences in income and education, sociocultural factors, or flaws within the medical profession, it is detrimental to society's advancement and must be addressed. Physicians must routinely examine their own practices to ensure that racial prejudice is not a determining factor in the clinical judgment used in the administration of medical care.

A larger issue in rehabilitation is whether the standard "core program" run for mainstream offenders throughout the prison system (anger management, domestic violence, sex offender treatment, cognitive skills, drugs and alcohol etc.) needs to be adapted for prisoners from different cultures. There may be a need to have culture specific groups so that the important cultural



values, norms, beliefs and practices can be incorporated within the rehabilitation program.

With reference to the comprehensive reports which summarize the clinical findings of the evaluation, the expectation is that emerging practices will enable them to be more likely to present conclusions, based on reasonable psychological certainty, regarding any connection between the identified psychological problems and the individual's criminal activity. The multiculturally diverse professional will be more competent to make specific recommendations for treatment, and will present a prognosis regarding the likelihood of repeat offenses in the future, without regard for race or socioeconomic status and without the influence of counselor prejudices.

### ***Conclusion***

Despite evidence of ineffective public policy, there are some encouraging signs of progress. Some state legislatures are already beginning to consider making radical changes to their mandatory sentencing laws in the hope of restoring judicial discretion and flexibility and encouraging the use of alternatives to incarceration. The number of drug courts and the ability to require substance abuse treatment for addicted offenders as opposed to incarceration, is increasing exponentially and there is renewed attention to the obvious need for more substance abuse treatment centers in highly populated urban areas.

## **RACIAL, CULTURAL AND SOCIOPOLITICAL DISPARITIES IN MENTAL HEALTH ADMINISTRATION IN THE UNITED STATES.**

*Williams*

Although multiculturally cognizant counseling experts are beginning to accept the fact that external and environmental forces such as racism and oppression are perhaps the largest cause of clients' emotional disturbance, some attention must be given to the apparent use of race as a biological marker. Several studies claim that this is typical of those who have documented race-associated differences in health and illness behavioral patterns (Daniels, Arrendondo, and D'Andre, 2001). These researchers have made it clear, however, that the results of such studies are inappropriate and can lead to erroneous conclusions about the role that race plays in the existence of disparities in health status. As such they are engaged in continuous attempts to discover universal processes that will encompass race, culture, and socioeconomic status in the evaluation process.

The key to achieving the highest attainable standard of health is a willingness to recognizing that racism, racial discrimination and related intolerance are the main factors that impair the health of millions of people. It is imperative that this society work toward eliminating disparities in health status based on such factors as race and ethnicity. Statutory mandates must be implemented with specific targets and strategies in mind. Laws and policies must be reviewed and genuine efforts made to identify those that accept or support racism or discrimination in health services, and legislation must be immediately enacted to prohibited discrimination based on race, gender, ethnicity, nationality or health status.

Finally, minority patients must prepare themselves for, and expect high-quality, sensitive health care by adopting patient-empowerment skills. Yes, it is a reasonable argument that their may be disparities in the quality of mental health services

administered to minorities. However, it is also arguable that minorities must accept responsibility for educating themselves about their basic rights. They must be able to adequately express themselves and demand the respect of their service provider. Physicians must learn to be more culturally-sensitive, and society must allow, encourage and support development of health policies and agendas to improve African-American health status. As the Surgeon General so eloquently puts it, "...we need to embrace the nation's diversity in the conduct of research, in the education and training of our mental health service providers and in the delivery of services" (United States Surgeon General Press Release, 2001).

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