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Nineteenth Century Review of Mental Health Care for African Americans: A Legacy of Service and Policy Barriers

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The need to focus on service and policy barriers to mental health service delivery for African Americans remains critical. The purpose of this article is to review nineteenth century care as a method for understanding contemporary service and policy barriers. A case study strategy is used to compare the efforts of Pennsylvania and South Carolina using primary and secondary sources to document these developments through a political economy perspective. These findings suggest that the prevailing social, political and economic realities have created mental health disparities along racial lines. Existing barriers are likely rooted in this same reality.

Key words: *Mental health, African Americans; historical; service; policy; barriers*

Mental health service and policy measures often neglect the needs of African Americans. Recognized patterns of misdiagnosis, over reliance on medication and restricted forms of care and disparities in service utilization have been documented for this population (Lawson et al., 1994; Loring & Powell, 1988; Mandercheid & Sonnenshein, 1987; Neighbors, 1985; Neighbors et al., 1989; Segal et al., 1996; Snowden & Cheung, 1990; Zito et al., 1998). Such service patterns produce not only

a sense of mistrust (Brown, et al., 1999; Sussman et al., 1987), but also result in service disengagement and alternate pathways to care (Davis, 1997; Garland & Besinger, 1997). Consequently, the aggregated effect of such experiences may lead to the under-utilization of services (U.S. Department of Health and Human Services [DHHS], 2001). Given the vulnerable status of African Americans, it remains critical that we continue to focus on barriers that detract from and/or prevent access to service. In fact, widely available mental health services did not exist for African Americans until the desegregation of state hospitals in 1965, which was a requirement for funding with the expansion of the Social Security Act that provided health care to seniors (Prudhomme & Musto, 1973). Since then, although managed care has changed the landscape of mental health care, it is imperative that social workers, and all mental health providers, remain vigilant relative to potential barriers.

The nineteenth century for African Americans can be described as a period filled with contradictions. Of course, during this period most were either enslaved or disenfranchised, but some were free and thriving. As the enlightenment movement took hold, most northern states had either abandoned the lawful practice of state sanctioned slavery or at least were phasing it out. Despite these trends, southern states experienced dramatic increases in their slave holdings and thus, wealth (Johnson & Smith, 1998). As a result, the South became more dependent on slave labor and inventories of African Americans/chattel were major asset in the determination of economic wealth. Mental health care historically has always been vulnerable to the social, political, and economic environments, but for African Americans this link is magnified (Turner & Singleton, 1978). As Grob (1994) suggest, social, political, scientific and economic factors stratified service and policy practices along racial lines. Thus, the provisions of mental health care emerged as a function of the society's racial beliefs and practices (Davis, 1997; Griffith & Bakers, 1993).

A historical review of service and policy barriers can inform contemporary public policy makers and providers of potential problems associated with the *legacy of neglect* to African Americans who need mental health services (President' Commission on Mental Health, 1978). A two state case study

of 1800s mental health service and policy strategies in the states of Pennsylvania and South Carolina is presented as an expression of care through the lenses of a political economy perspective. Information was collected from primary and secondary sources in the form of published literature and *The 19th Century African American Newspaper* collection database. From this special collection, key words such as "negro", "lunatic", "asylum", "mania" and "idiocy" were used to access relevant content.

Mental Illness amongst African Americans in the 1800's

During the 19th century, the prevailing diagnostic system centered on four main syndromes, -- melancholy, mania, dementia, and idiocy; however, geography and race of clients often combined to create a different typology. In the Pennsylvania State Lunatic Hospital in Harrisburg, melancholia and acute mania were the most common diagnoses for all patients (Morrison, 1992). However, in the South an alternate taxonomy emerged that incorporated ideological thought relevant to chattel slavery within existing practice and service delivery. In 1851, Dr. Samuel A. Cartwright in the *De Bow's Review* observed two "diseases of the mind" which he associated with slaves: drapetomania and dysaesthesia aethiopica (as cited by Stamp, 1961). Specifically, drapetomania was defined as "sulky and dissatisfied" behaviors that usually resulted in slaves running away. Dysaesthesia aethiopica was a pattern of "mischief" that appeared "intentional" concerning work habits, which resulted in poor attention to their work and destruction of equipment (e.g., plow, hoe). Both diagnoses were culturally and contextually bound to the institution of slavery and reflected the intrusion of social, political, and economic views into psychiatry.

The cause and treatment of mental illnesses for African Americans were viewed differently from that of whites. Although environmental stress was widely believed to cause mental illness for the general populace, as one of the "uncivilized races", mental illness for African Americans was seen as having a different etiological premise. For example, views of biological defect, social inferiority, and political

subjugation underpinned notions of their pathology (Deutsch, 1944; Thomas & Sillen, 1972). At one extreme, some even suggested that slavery provided a "guard" against mental disorders (Dewery, 1906). This phenomenon resulted in different critiques not only about the prevalence but also causes of mental disorders among African Americans. Most notably was the perception that the regional nature of slavery caused different outcomes since it provided structured daily activities including meals and lodging, however harsh and minimal. The causes of mental illness attributed to African Americans took on a unique departure from that of their white counterparts due, in part, to the disparities uncovered in the U.S. Census of 1840.

Presumptions of low risk of mental illness were fueled by census returns and treatment rate reports to asylums. The 1840 U.S. census, for example, established disparities in rates of "insanity and idiocy" from a high rate of 1 in 14 in Maine to a low rate of 1 in 4,310 in Louisiana. In comparison, the states of Pennsylvania and South Carolina had a high of 1 in 257 to a low of 1 in 2,477, respectively (Litwack, 1961; Prudhomme & Musto, 1973). After reviewing the returns, John C. Calhoun, the Secretary of State from South Carolina advanced the notion that "science" (the tabulation of returns) had demonstrated that the *protected condition* (e.g., slavery) of blacks would decrease their risk of becoming "idiot" or "maniac" (Prudhomme & Musto, 1973). Moreover, others attributed these differences to their lack of engagement in daily routines of ordinary life and civic responsibilities (Babcock, 1895; Dewery, 1906). Following along the earlier decade, the 1850s returns found disparities in the rate of "insanity" noting 1 in 1,290 for whites, 1 in 1,350 for free African American's and 1 in 11,014 for enslaved African Americans. Before 1861, African Americans were rarely admitted into Southern asylums because they presumably exhibited "milder forms" of mental illness (Babcock, 1895) that justified lower treatment rates. These assumptions would not go unchallenged.

The black press raised concerns about both the interpretation and utilization of the census findings. In 1853, *The National Era*, a Washington, D.C. newspaper urged caution regarding the inference by suggesting there was a danger in using such

evidence as supporting oppression. It was explained that “we trust this fact will not be alleged as an argument to show the inferior organization of our race”. This critique was extended by suggestion that if “slavery” provides protection against mental disorders, then “whites would be the gainers by being reduced to slavery”.

Two claims emerged to explain disparities (lower rate) in mental illness found among African Americans. First, geography, regional differences, led to the consideration of climatic conditions as an influential factor in the prevalence of mental illness. In 1857, Bouldin, a French psychiatrist, concluded the cold climate of the North was destructive to the mental health of blacks (as cited by Prudhomme & Musto, 1973). Second, biological inferiority also fueled claims of disparity. Notably, leading social scientists of the time suggested that the lower brain functioning protected African Americans from “higher order” mental disorders, such as melancholia and mania (Babcock, 1895). This critique was consistent with the Darwinian view of the time, which suggested that Africans and their decedents were less evolved than Europeans. This alleged rarity and it’s causes justified the neglect of services to African American’s. Further analysis of the 1840 census discovered significant problems in the returns, which led to concerns regarding errors in enumeration and suspicion of fraud by proponents of slavery.

As the mental health asylum movement grew, governing bodies at the state level became concerned about the extent of mental illness in their population. In response, counties, states, and federal agencies began developing strategies to document service demands of African Americans. In 1837, the county census of almshouse residents of Philadelphia County, PA found that African Americans were more than 20 percent of those characterized as “lunatics and defective” (DuBois, 1899). Hence, they were disproportionately represented, some three times more likely to be labeled as such. In 1840, federal government enumeration efforts would constitute the first, albeit primitive, epidemiological survey to gauge the prevalence of mental illness in the country. Subsequently, the United States census returns found higher rates of “insanity and idiocy” in Northern blacks than Southern blacks, free vs. enslaved blacks,

and white vs. black populations.

The Political Economy of Mental Health Service and Policy

The theoretical political economy literature has argued that service and policy formation can be modeled as the outcome of a process in which competing groups vie for the favor of policymaker. From this framework, a growing body of work has provided a better sense into how economic and political interests are translated in outcomes by the intervening political institutions (Alston & Ferrie, 1984; Becker, 1984; Brock & Mage, 1978; Collins, 2000 & Schneider & Moon Ji, 1990). However, relatively few studies in economics have explicitly examined race-specific government policy formation (Collins, 2000; Roback, 1986; Wright, 1990). Of the economics studies that have been done, most focused on the South in the early twentieth century. Few compare the regional efforts between North and South, suggesting that this area is underdeveloped. Empirical studies in political science and sociology have investigated race-specific policy formation several times, but the emphasis has been slanted toward federal legislation.

This paper expands this line of inquiry by drawing on previous works in examining the history of mental health service and policy barriers in the nineteenth century at the state level. The mental health service system was viewed as a part of the social welfare network based on the interweaving dynamics of social, political and economic influences of that time. First, a contextual overview of the social, political and economic footing of African Americans during the period is proffered.

The Confluence of Factors

Despite the promise of enfranchisement by the late eighteenth century, African American communities in Pennsylvania and South Carolina remained marginalized. The religious revivalist movement of the late 1700's and early 1800's, in part, helped direct the prevailing northern view of slavery from that of a utilitarian institution to one of moral sin. To the South, the institution of slavery was woven into the fabric of southern society. The social reform movement experienced dissention

because it failed to reconcile beliefs regarding the existence of social inequity across the country and that the loss of civil liberties dealt a blow to both free and enslaved African Americans. Many northern states eventually abandoned the practice of slavery, some abruptly and some gradually (DuBois, 1899). In contrast, the South became more dependent on slavery as a source of free labor that undergirded much, if not most of the region's wealth. These issues played out in the social, political, and economic environment of the nineteenth century. For example, although relegated to segregated/separate status in the larger society, a self-contained business and civic class emerged in some urban African American communities.

Despite the thin veil of social respectability, in Philadelphia and Charleston, African Americans lived socially on the periphery of society. These communities were relatively small and posed little threat to whites. Although a black middle class was emerging, it lacked real social clout, with few exceptions. Racial tensions erupted into violent riots in a number of areas including Philadelphia and Columbia, Pennsylvania over the issue of employment between blacks and whites and caused deep social division (Shirk, 1993). In South Carolina, where the black population was larger than that of whites, concerns were associated with the personal safety and economic security of whites at the expense of free and enslaved African Americans. In response to these tensions, communities in both states began to enact a series of ordinances that would restrict personal liberties of blacks. After becoming suspicious of municipal fires in the 1820's, the Harrisburg, Pennsylvania borough council enacted statutes developing "citizen patrols" and "requiring the registration of free people of color" (Eggert, 1991). Similarly, South Carolina, as other southern states, enacted a series of laws restricting many practices concerning African Americans' movement, emancipation, education, gatherings, religious practices, and many other activities of daily living (DuBois, 1903; Gordon, 1929). In the face of such challenges, African Americans organized mutual aid societies that would address facets of individual and communal needs (e.g., religious, churches, trade, educational) as sources of support and protection. They often targeted advertisements in black newspapers to crystallize community support, plan for and

provide respite and increase public awareness and spotlight the curtailment of rights and the punitive efforts of asylums.

As evidence in the emerging African American press suggests, both direct and indirect initiatives were made to comfort and support those suffering from "different" mental conditions. In 1848, for example, the *National Era* in Washington, D.C. carried a direct appeal, "To the Friends of the Poor Colored Orphan", for purpose of soliciting funds for support of an orphanage in Cincinnati, Ohio. The article mentioned that this method of fund raising was used in order to provide asylum care for those less fortunate. In 1851, *The North Star* of New York, New York reported the efforts of the Nightingale Minstrels in providing a concert to entertain the "inmates" of the Utica, New York Insane Asylum. The *Christian Recorder* of Philadelphia, Pennsylvania carried stories discussing the dangers of "morbid nervousness" and the efforts of the New York Asylum for Idiots in 1861 to treat the disorder. In particular, the press characterized morbid nervousness as a debilitating illness that is hastened by multiple stresses. These fund raising initiatives demonstrated both recognition and concern relevant to mental health service issues.

With the role of African Americans as a centerpiece in a national public policy debate, political tensions mounted concerning their relationship to whites. Because Pennsylvania and South Carolina were on opposing sides of the Mason-Dixon Line, both free and enslaved African American communities were exposed to similar and different dilemmas. Outcomes of the 1837 Pennsylvania Constitutional Convention represented a devastating turn away from the principles of liberty and equality. The convention ratified a 'new state constitution restricting the franchise only to white freemen (Smith, 1998). Thereby, the right of black men to vote was removed. In response to disenfranchisement, opposition was launched by two critical monographs, *Memorial of the Free Citizens of Color in Pittsburg, 1837* and *The Appeal of Forty Thousand Citizens, Threatened with Disenfranchisement, To the People of Pennsylvania, Philadelphia, 1838* (as cited by Smith, 1998). Despite protest and appeals, voting rights of African Americans would not be restored until after the Civil War. As attacks on the institution of slavery mounted, free and enslaved African Americans

became increasingly repressed politically and socially. In particular, "southern race relations required that Negroes be powerless, submissive, and dependent" (Berlin, 1974, p. 316) as their growing resistance in the courts, through the media, and via insurrection escalated tensions. The converging political protest threatened the social caste assumptions of both the North and South.

The development of the independent black church provided political leadership outside the control of whites; the African Methodist Episcopal (A.M.E) Church was launched in Philadelphia, PA in 1794 and a charter to establish a church in Charleston, SC was secured in 1810 (Berlin, 1974). This expansion to the South provided a platform to import the liberating tenets of African Methodism to free and enslaved African Americans. From 1813 to 1837, the number of A.M.E. churches grew from two to eight with almost three thousand members (Nash, 1988). After being implicated in 1822 as staging liberating activities in a failed insurrection in Charleston, the A.M.E. church was expelled from South Carolina, having become regarded as a social, economic and political threat to the status quo.

The economic implications of the demise of slavery weighed heavily, particularly in the South, on the debate concerning the future of African Americans. The north minimized the economic impact because of its reduced investment from the practice, while the South had serious misgivings because of its relationship to the institution, culture, and style of living. In some states in the South, dependence on slavery as an institution was enormous. For example, by 1860, South Carolina had established an enslaved population 30 percent larger than the free white population (Berlin, 1974). In particular, this slave population had grown from just over 146,000 in 1800 to over 402, 000 in 1860. Over the same period, the free white population grew from slightly more than 196, 000 to over 291,000. Dependence on a labor-intensive enterprise (e.g., agriculture) required a stable workforce. The investment in slavery represented a significant portion of the white population's wealth making them vulnerable to rebellions by slaves and threats by external suggestion that slave ownership was immoral and sinful. In the North, free blacks often filled lower tier jobs

usually considered less desirable by whites. An examination of the African American population in Harrisburg, PA during the 1800's reported that they primarily held lower level occupations (Eggert, 1991). Mindful of African Americans menial existence, the ability to afford and have access to asylum care is doubtful.

The Birth of Service and Policy Barriers

The North and South both recognized the need for mental health services for African Americans in the Colonial era. Services then focused around local jails and almshouses. By the nineteenth century, a new movement concerning the delivery and organization of health care dramatically changed mental health care by propelling national efforts to develop state-funded asylums for the care of the mentally ill. Notably, Virginia and Pennsylvania led others by becoming the first states to develop specialized hospitals exclusively for the care of the mentally ill in 1773 and 1813, respectively (Deutsch, 1946; Morrison, 1992). Specifically, the combined efforts of scientific developments, the social reform movement, economic demands, and the failure of communal almshouses gave rise to the innovation of institutionally based "moral treatment", which consisted of specialized care for the mentally ill.

Although states established institutional facilities, the accessibility and quality of mental health care left considerable room for improvement. By 1849 thirteen states had initiated state-funded asylums for the care of the mentally ill (Grob, 1994). Aside from these developments, most mentally ill people remained in almshouses, which meant that their treatment options were within the framework of public welfare (Katz, 1996) and corrections. After observing the poor system of care, school teacher turned social reformer, Dorothea Dix, energized a nationwide reform effort to improve and expand institutional care for the "insane", but only for white people (Gollaher, 1995, Trattner, 1994). This effective reformer suggests that mental health care for slaves and free blacks should be the preview of black advocates. In the South, where most African Americans lived, care for the insane was generally

thought to be more deficient (Wisner, 1970), but the quality of care in the North was arguably no better (Prudhomme & Musto, 1973). With most African Americans living in bondage, this new form of care was rarely accessible; therefore, the tide of institutional reform did little to change the status of mental health.

The delivery of mental health services became increasingly more segregated during the mid 1800's, which affected the funding and public attitude toward those receiving care. The availability of moral treatment (i.e. specialized care) for the mentally ill was often limited to white citizens (Drewey, 1906, Grob, 1994), which forced alternate paths to service for most African Americans, meaning that almshouses and jails remained their primary providers of institutional care (Babcock, 1896; Prudhomme and Musto, 1973; Trattner, 1994). In 1860, Dr. Langdon of the Longview Asylum of Ohio underscored this reality. He explained that:

many of them [the colored population] pay heavy taxes, but their insane are compelled to herd with rogues and thieves and vagabonds in our county jails. This is an outrage upon justice, humanity, and common decency ... that we now almost despair of accomplishing anything in the future" (as cited in Babcock, 1895, p.178).

Segregated admissions practices developed in both the North and South. For example, the Worcester State Hospital in Massachusetts, which was organized in 1833, quickly established separate quarters for the "races" (Grob, 1994). Due to the lack of separate facilities, prior to 1848, the state Lunatic Asylum outside of Columbia, South Carolina refused to admit African Americans. Replicating the racial tensions found in the larger society as they did, asylums' provided services in keeping with what was considered to be the best treatment approach (McCandless, 1989; Prudhomme and Musto, 1973). Segregation sometimes did improve the condition of white inmates, who moved to new facilities while blacks languished in their old ones, which usually left the latter worse off than before, for once isolated in separate facilities white officials rarely bothered to improve services (Berlin, 1974). Vestiges of

denied services, as well as segregated and unequal services, remained anchored in policy practice for generations.

Regional differences provided some contrast, but did not account for major distinction in policy approaches regarding African Americans' mental health care. Local sensibilities were influential in provision of services and therefore, the context of care operated within those understood social practices. The South was not alone in its exclusionary practices; some northern states also excluded African Americans from asylum care. The states of Mississippi, North Carolina, Indiana and Ohio excluded African Americans, free or enslaved, from state financed asylum care. In 1856, these policy restraints were visibly evident-based on a legislative report. In a discussion on care, the superintendent of the Mississippi Asylum explained that there was no provisions under existing laws for the reception of slaves nor free persons of color in the asylum (as cited by Babcock, 1895).

Exclusionary practices in the South also recognized the different legal status held by African Americans. Dr. Galt of the Williamsburg Asylum explained:

the colored insane of Virginia may be divided into two classes: first, those who are free; and second, slaves ... Patients of the first class have been received into the asylum from the date of its opening [F]ree people of color ... have been ... placed upon the same footing as to the right of admission ... as white people (as cited by Babcock, 1895, p.170).

Such statements demonstrate the policy restraints placed upon the asylums by the state legislature though there is no evidence that many administrators would have delivered services even if required by law.

State mental health policy regarding admission of free and enslaved mentally ill African Americans mainly took three directions. Policy practices can be defined as exclusive, inclusive or contradictory to state's legislative mandates. With the majority of African Americans in bondage, exclusionary policy practices refer to laws that prevented their admission into mental health care. Inclusive policy practices refer to those state

policies that permitted their admission to the state asylum, which were generally the exception, not the rule; however, a number of southern and northern states were progressive in this regard. Contradictory policy practices refer to policies permitting admission, but such mandates were neutralized or not enforced.

A Case Study of Two States Efforts

Pennsylvania

Pennsylvania's practices regarding the care of mentally ill African Americans were representative of the general practices in northern states where the African American population was small permitting such services. Because of the size of this cohort and lack of political clout, mental health service needs were of little concern for most (Grob, 1994). In 1837, the Philadelphia County, Pennsylvania, almshouses' census found that 14 percent of the residents were African Americans, while they only accounted for 7.4 percent of the population. Of these residents, more than twenty percent were characterized as "lunatics and defective" (DuBois, 1899). The conditions in almshouses throughout the state, and all of the North, were generally dismal for all occupants (Morrison, 1992). New York city and Cincinnati created separate jails and almshouses to prevent the mixing of races (Grob, 1994).

Limited details are known about the kind or range of practices in Pennsylvania regarding the delivery of asylum care to African Americans. What is known suggest some attempt at inclusion; the Friends' Asylum for the Insane in Philadelphia actively solicited admissions in the Black press. In 1851, an ad in the *National Era*, characterized the service offered by this agency as providing a family like care that combined kind and efficient moral and medical treatment. Of note is that the state asylum in Williamsburg, Virginia accepted its first African American patient considerably earlier in 1774, although such care was typically only provided to free citizens. In 1846, the Virginia legislature even permitted the treatment of enslaved individuals after a petition from the asylum's board of directors (Babcock, 1895).

South Carolina

South Carolina's policy practices regarding the care of mentally ill African Americans were contradictory. In 1821, the state passed legislation authorizing the construction of a state funded "lunatic asylum" with no exclusionary provision (Bellows, 1981). However, the lack of segregated facilities resulted in socially sanctioned denial of services to free or enslaved African Americans. It would be 1848 before the legislature approved funding for separate quarters to accommodate the needs of both the free and enslaved "insane" cohort (Bellow, 1981). Over the next ten years, Babcock (1895) recounted that thirty free African Americans were admitted to asylums, but no more than five at one time. However, those enslaved were generally expected to be provided care by their "owners", unless the latter were unable to afford care. In such cases, provisions were supposedly provided locally through general parish funds dedicated for poor people (Wood, 1974). Punitive services where "solitary confinement and near-starvation diets were the standard means of discipline were provided by Charleston's Columbus Street Almshouse; however "the needy poor refused to apply" (Eggenger, 1997). Across the South, access to almshouses was generally not available due to local policies and practices driven by the prevailing culture which neither sanctioned nor supported admission of African Americans to such institutions (Curry, 1981).

Because of the lack of constitutional protection for African Americans coupled with regional culture, customs and services, policies usually reflected the ideology of the host community. Relative to services for free African Americans, under utilization of institutional care and over utilization of almshouses and jails as "care" were the norms. Although South Carolina had laws to restrict the use of jails for the mentally insane (Babcock, 1895), the implicit policy practices suggest that they were assigned to jails for longer periods with little concern for the consequences of such action. Mentally ill slaves, as noted above, were generally the responsibility of their "owners", which signaled wide discretion for "treatment" options (Drewery, 1906) that ranged from contracting services to local physicians to employing corporal punishment to control behavior. Tom Whiteside, a slave owner from

South Carolina, hanged an old slave woman who had “loss her mind” after exhibiting bizarre behaviors and burning down the barn (Botkin, 1973). In cases where slaves displayed symptoms of drapetomania, owners were advised to identify and remove those who were discontent. When no cause for certain behavior was determined, “whipping the devil out of them” was the appropriate “preventive” service against progression of the illness (Stampp, 1961).

A number of state policy mandates were contradictory regarding these earlier practices. South Carolina first expressed concerns for “lunatic” slaves in the Negro Act of 1751 which required local parishes to make provisions to relieve poorer slave owners for the cost of confining and maintaining “slaves that may become lunatic” (Wood, 1974). Similarly, the states of Virginia, Kentucky, Maryland, Tennessee, and also the District of Columbia had policies that permitted asylum-based services; however, social practices restrained any substantial delivery of care. In 1821, the South Carolina legislature authorized the building of a state funded “lunatic asylum” (Bellows, 1981). Although service access was denied by laws due to requirement of separate facilities, by no means did the legislation negate the need for care. In 1848, appropriations were made available for separate facilities, but the failure to account for a significant increase in services for African Americans raises serious doubt if care was made available. At other times, policy practices emerged that provided care *only* when accommodations for all mentally ill white citizens was secured (Wisner, 1970).

Enduring Vestiges of the 1800’s Mental Health Care

Although major socio-political, scientific, policy advances and service delivery have occurred in the mental health care into the millennium, care for African Americans continues to be plagued by barriers that emanate from their precarious history. This circumstance begs the question: What vestiges of the nineteenth century mental health care system for African American still exist – even into the 21st century? Arguably, remnants of mental health service and policy barriers found in the 21st century for African Americans are manifest in the form of on-going service disparities as well as the lack of access to

care that resulted in substantial gaps in many dimensions.

Despite improvements, the marginal socio-political status of African Americans impacts access to care. African Americans today exercise more political power than ever before with more than 8,000 elected and appointed officials nationwide (Smith, 1999). Major Civil Rights victories of the 1950s and 60s supported increased access to health care through the expansion of public insurance (Prudhomme & Musto, 1973), but African Americans' continuing underutilization of mental health care is associated with their family income and level of wealth (Brown, Ahmed, Gary, & Milburn, 1995; Corenlius, 2000; DHHS, 2001; Lowe & Hopps, in press, U.S. Census Bureau, 2000). Disparities also continue to persist in the form of overrepresentation of African Americans as crime victims, under "state supervision", such as in prison, on probation (Federal Bureau Investigation, 2004; William & Jackson, 2000) reflective of past asylum care. As a result, public funded health programs like Medicare, Medicaid and other state supported efforts are critical components in the response to address service barriers. In particular, on-going socio-cultural, political and economic practices continue to underpin service and policy practices that mimic their early predecessors.

Claims of African Americans' racial inferiority permeate our popular culture, as structural barriers often mask this reality. Racial prejudice currently looms as an overarching reality in the delivery of psychiatric care for African Americans (Corrigan, 2004; Gary, 2005; Hollar, 2001). Findings from the Epidemiologic Catchment Area and the National Co-morbidity Survey studies in 1980s and 1990s, respectively, found that African Americans were less likely than whites to suffer from major depression and more likely to suffer from phobia (DHHS, 2000; Zhang & Snowden, 1999). Studies also have documented consistent patterns of misdiagnosis (that is, over-diagnosis of schizophrenia and under-diagnosis of depression) and disparities in quality mental health care for African Americans (Barnes, 2004; Lawson et al., 1994; Loring & Powell, 1988; Neighbors, 1985; Neighbors et al., 1989; Segal et al., 1996; Snowden, 2003; Snowden & Cheung, 1990; Strakowski, Hawkins, Keck, et al., 1997; Zito et al., 1998; Zhang & Snowden, 1999). These ongoing disparities are complicated

by socio-cultural and economic realities that suggest African Americans, who are in need of mental health care and are less likely to receive the necessary help. This phenomenon parallels the effort found in the nineteenth century (Cohen, 2002).

Discussion

Given the marginalized status of African Americans during the 1800s, the caliber of mental health care provided them emerged as a function of barriers relative to their position in society. The political economy perspective suggests that social, political and economic factors underpinned prevailing service and policy practices that disproportionately shaped, developed and inhibited access to mental health care. These interlocking factors also contributed to racial stratification, which continues to persist. Mental health providers and social scientists participated in aiding the development of a "scientific" rationalization (or "scientific racism") of oppression. Prevailing views of mental health illness among African Americans were predicated on co-relative assumptions of White supremacy and Black inferiority that retarded the development of adequate care. Although the institutional care movement created an improved system of care for many suffering from mental illness, it failed to cause significant changes in the quality and level of mental health care for African Americans. The context of their mental health services were relegated to the county almshouses and jails; neither of which provided substantive "care", often meaning the absence of any such service.

This review demonstrates that arguably barriers are ultimately based in American social culture. It follows that such barriers to mental health care are *human* in origin and only by moving away from the notion of the faceless "system" as the perpetrator of policy and service barriers can we ever expect to address enduring problems. If this assumption has currency, two strategies come to mind: first, owning the history of policy and service disparities and second, attacking any remaining vestiges of racism and unprofessionalism in policy and practice via education, values clarification and cultural competence. This can quicken the pace of substantive improvements in the mental health care of this population, along with

others, thereby reducing disparities and providing hope for an even better legacy at the turn of the next decade—instead of the next century.

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