# Black Mental Health in the USA: Nothing for Us without Us 1

## The impact of racism on Black American mental health

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This is the first in a **Series** of three papers about Black Mental Health in the USA. All papers in the Series are available at www.thelancet.com/series/black-american-mental-health

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**Black individuals in the USA experience disparities in mental health that lead to unfavorable health outcomes and increased morbidity from mental illness due to centuries of racism. We emphasize the need to understand the roots of racial injustice to achieve racial equity. Historical factors such as European imperialism, enslavement, the myth of Black inferiority, and scientific racial classification have all perpetuated disparities, leading to the current underestimation, misdiagnosis, and inadequate treatment of mental illness in Black populations. Many of the issues discussed herein apply to Black people globally; however, our focus is on Black Americans and the inequities that result from the current US mental health system. We discuss the limitations of using the DSM-5 classification system and common epidemiological surveys, which do not capture or call for a comprehensive analysis of the systems producing mental health issues, to understand mental illness among Black Americans.**

### Introduction

Throughout history, several salient points have shaped the understanding of race and contributed to racial inequalities, leading to the disparities in Black mental health seen today. Although these disparities extend beyond the USA, the focus of this Series will be those seen among Black Americans. In the 17th century, the enslavement of Africans for economic gain established a system in which Black individuals were treated as property, rather than as humans deserving of equal rights and protection.[1] In the 18th century, the myth of Black inferiority was developed, with political and intellectual leaders asserting that people of African descent were naturally inferior and best suited for slavery.[1] In the 19th century, the belief that peoples conquered by European powers were physically inferior solidified the racial worldview, with White populations seen as superior, and non-White populations, particularly those racialized as Black, considered the least deserving of humanity.[1] In the 20th century, so-called objective measures were used to support racist claims, such as the use of metrical descriptions to foster typological conceptions of human group differences. These seemingly scientific approaches contributed to the perpetuation of racial disparities and inequalities.[1]

In 1971, the National Survey on Drug Use and Health (NSDUH), designed to assess patterns of mental health in the US population, affirmed a path for scientific conceptualizations and analysis of mental illness and race to inform public policy directly, which laid the groundwork for pathologizing Blackness, and the underestimation, misdiagnosis, and inadequate treatment of mental illness among Black Americans.[2] These data have been used as evidence in congressional hearings and have indirectly informed how race and ethnicity are considered in US federal legislation. The proportion of White individuals using illicit drugs is reported as lower than the proportion of Black individuals using illicit drugs; however, the survey focuses disproportionately on urban areas where Black people are more likely to live, with higher rates of poverty, as compared with suburban or rural regions that were undersampled and where the population is predominantly White.[3] This discrepancy in sampling leads to a misrepresentation of substance use rates between racial groups. The survey findings that drug use is more prevalent among Black individuals than White individuals could be due to oversampling of individuals from low-income communities, meaning that the difference in rates of substance use is the result of socioeconomic disparities, not ethnicity. Furthermore, the NSDUH relies on self-reported data, and individuals might under-report or deny substance use due to social desirability bias or fear of legal consequences. The stigmatization of substance use is shared among many racial and ethnic groups;[4] however, the weight and social consequences of being labeled as someone who uses drugs or has a mental health diagnosis are particularly damning in the Black community where people can be ostracized, excommunicated from social groups, and thought to be embarrassing the culture.[5,6] Moreover, Black Americans might be more reluctant to participate in the survey due to historical mistrust or concerns about data confidentiality, leading to potential self-selection biases.[7,8]

There is value in using a classification system to understand mental illness as pathology;[9] however, supposedly objective tools developed by majority populations might not fully capture the experience of being racialized as Black. We acknowledge the utility in using a common language for mental illness that many understand, and simultaneously recognize that these classifications offer shortcomings for Black people in general.[10] The criteria used to locate pathology should be accompanied by a complex analysis of the systems that produce mental illness and compromise mental health. The DSM classification system tends to locate problems in the bodies and behaviors of individuals, and this tendency coupled with a preoccupation with categorizing differences by race, instead of understanding the effects of racism, inevitably leads to a bioracist framing of

mental illness classification. The DSM classification system and papers in the scientific literature[11–13] rely on racial categories to explain patterns of health, essentialize race, and locate the problems of mental illness in the physical, social, and moral failures of individuals and groups—a frame most often applied in the context of evaluating the circumstances of mental health and Blackness. In this Series paper, we outline how racism is the foundational system influencing public health practices that negatively affect Black Americans.

We cannot discuss mental illness among Black people in the USA without first investigating the pervasiveness of racism. We begin with a comprehensive definition of racism, with a specific focus on anti-Black racism. We then delve into the understanding of racism as a fundamental cause of health inequities. We examine the racist roots embedded within drug policies, epidemiology practices, and the racial classification of mental disorders, critically analyzing their contributions to perpetuating systemic biases.

## Understanding racism

Racism is the rule of US society, not an unintentional mishap or malfunction. No person, system, industry, or organization is untouched by racism.[14,15] A comprehensive systems framing of racism identifies multiple dimensions of the ways racism functions to create inequity,[14] and by examining the various systems in which racism operates, this framing illuminates multiple pathways for addressing racial inequities in health.[16–18] Multidimensional models of racism vary, but consistently reference dimensions of racism that can be broadly categorized as individual (eg, interpersonal, discriminatory, or appropriated) and structural (eg, systemic or cultural).[14,15,19] These dimensions include interpersonal or personally mediated racism (by which thoughts, motives, intents, and actions of others are assumed because of how someone is racialized), internalized racism (negative messages by the oppressed racialized group about their inherent value), appropriated racial oppression (instances in which people who do not personally experience racial oppression attempt to claim or represent the experiences or struggles of oppressed racial groups), structural or systemic racism (by which societal institutions and systems systematically create and perpetuate racial inequalities and disparities that operate at a broader societal level), and cultural racism (cultural systems that "visibly and invisibly ground assumptions of white superiority and power across institutional, cultural, and social environments").[15] In each of these domains, racism contributes to racial inequities across systems of mental health; for example, by shaping collective ideologies about the nature of mental health and health inequities, and beliefs about race, Blackness, and Whiteness that inform health culture, the science of mental health, direct care practices, and health policy. Exposure to each domain of racism, ranging from maltreatment on the basis of race to a greater likelihood of being incarcerated for substance use, contributes to the production of chronic psychosocial stress, and threatens mental health.[20,21]

Cultural racism, for instance, reflects the processes used to attach social meaning to race and racialized bodies (ie, racialization) and determine the race-based values or basic stereotypes associated with those actors (ie, stigmatization).[15] Public framings of deservedness and humanity are associated with race and have long been used as tools to shape public narrative and policy,[15] including cultural dialogues related to race, mental health, and substance use.

Stigma and racism are two interconnected social phenomena that profoundly affect individuals and communities. In the context of racism, stigma plays a crucial role in perpetuating and reinforcing discriminatory practices. The intersectionality of stigma and racism creates a unique set of challenges for Black individuals who are subjected to multiple layers of discrimination. Racial stigma can compound the negative experiences of Black individuals, amplifying the barriers they face to culturally informed mental health care.[22]

## Racism is a fundamental cause of health inequity

Racism is a fundamental cause of health inequities, and influences every social determinant known to contribute to population health.[23] Empirical evidence shows that education, housing, income, access to and quality of health care, and environmental and psychosocial stressors are all inextricably linked to systems of racism.[15,19,24,25] Interpersonal racism creates chronic psychosocial stress, and affects diagnosis, treatment, and quality of health.[19] Through formal and informal policies, laws, and practices, structural racism undergirds financial, educational, judicial, health, environmental, and housing systems that historically root and sustain disadvantage throughout the social ecosystem.[26] Cultural racism shapes the ideological framings and narratives of the causes and treatment of mental disorders generally, and mental disorders in Black Americans specifically, in a manner that influences direct practice, policy, and research, and chronic psychosocial stress.[27,28] Vicarious racism functions as indirect exposure through an individual's network or racial group that also contributes to a toxic and stress-laden atmosphere that affects mental health.[19]

As a root cause, racism must be addressed directly to eradicate racial inequities in health. We must then evaluate the roots of mental disorders and mental health-care systems. The definitions and frames of mental health and mental illness, and our processes and prescriptions for diagnosing, treating, and maintaining wellness have all been grounded in Whiteness and myths of White supremacy.[22,29] Acknowledging this grounding in Whiteness is crucial for framing our understanding of

existing data, research, assessments, and treatments of mental illness in Black Americans. These concepts of White supremacy, the inherent belief of White values and culture to be superior to others, especially those racialized as Black, must be understood and acknowledged in order to envisage the effect of psychiatry on the lives of Black Americans and to reimagine paths forward. Understanding how community can serve as a powerful tool in accessing mental health for Black Americans in the face of oppression is discussed in the second paper in this Series.[30]

## What is anti-Black racism?

Anti-Black racism has grounded the social, psychological, and economic systems of racism, undergirding the rationale for White European imperialism and the societal structures of the USA.[31] Anti-Blackness has been situated as the fundamental counterpart to White supremacy.[31,32] Thus, as White supremacy culture often functions as an invisible guide for social norms and values, Blackness is both visibly and invisibly situated as the derivative or deviation from those norms.[32–34] This position of anti-Blackness as the counterpart to White supremacy does not tie racial systems exclusively to a Black–White dichotomy.[32] Constructs of Whiteness and Blackness anchor social constructions and meanings attached to race and racism in the USA, and thus represent crucial points of both analysis and intervention.[34]

### The racist roots of epidemiology: reimagining the use of race data, racial analysis, and the classification of mental illness

Epidemiology establishes estimates of the burden of mental illness and provides guidance on how to interpret prevalence estimates from population health data. Effective sampling and minimizing bias are essential, particularly when the estimates are being used to determine policy. Thus, the methods of collecting, using, and analyzing epidemiological data are crucial to the ways in which the intersection of race and mental illness in the USA is understood.

According to the NSDUH, an estimated 8% of US adults in 2019 met criteria for major depressive episode based on the DSM-5.[9,35] Race and ethnic differences are evident: the crude unadjusted prevalence of major depressive episode was 7% among White men, 10% among White women, 4% among Black men, and 8% among Black women. The sampling approach used for the NSDUH, however, does not include a statistically representative sample of Black adults living in the USA, and thus might not be adequate for estimating major depressive episode prevalence in the Black population. By comparison, the National Survey of American Life (NSAL) used a sampling strategy that captured a more nationally representative and ethnically diverse sample of Black people from cities that are representative of Black American life.[36] As such, the NSAL captured a higher proportion of Black people who are representative of the Black American population. Conducted between Feb 2, 2001, and June 30, 2003, lifetime major depressive disorder prevalence estimates in the NSAL were highest for White people (17·9%), followed by Caribbean Black people (12·9%), and African Americans (10·4%); however, 12-month major depressive disorder estimates across groups were similar. In the National Comorbidity Study,[37] the 2-month prevalence estimate of major depressive disorder among non-Hispanic Black individuals (n=1953) was 8·0% compared with 7·1% among non-Hispanic White individuals (n=5634). The NSDUH and the NSAL use the same DSM-IV diagnosis for major depressive disorder based on the Composite International Diagnostic Interview, but the NSAL data support estimates by ethnic group within the Black sample (eg, Black Caribbeans) and include community-level data that support a contextual analysis that moves beyond descriptions of racial difference to assessments of the nature of those differences. The NSDUH data do not include the properties of mental disorders (eg, severity and resistance to treatment) that might vary across racial groups, and do not include the social conditions contributing to racial variance in the prevalence and quality of mental disorders. The NSAL differs from the National Comorbidity Study[37] and the Epidemiologic Catchment Area Study,[38,39] as it has a larger sampling of Black Americans and Black Caribbeans and provides the ability for subanalysis that the latter do not provide.

Aggregate analysis of mental illness can mask racial or ethnic influence. Black people across various ethnic groups in the USA and in other majority White countries experience a higher burden of mental illness compared with White people.[2,15,40] The epidemiology of racial and ethnic differences in the prevalence of mental disorders and persistence (ie, how long problems last) of mental health problems is complex. For some outcomes such as major depression, the rates might be lower for White people compared with Black people; however, among people with a mental disorder, the severity and persistence are higher in Black people compared with White people.[40] Race is not an inherently meaningful determinant of health, and thus, failing to analyze why race predicts health outcomes results in what has been called a bioracist framing[19,42] that implies the cause of disease lies in immutable differences between racial groups. Despite a robust literature that establishes racism to be a primary contributor of mental illness among Black people,[43] epidemiological research rarely explicitly incorporates racism as a key mechanism, although some scholars are beginning to account for racism and this practice is changing.[19,43] Racism must be evaluated as a fundamental cause of racial differences in health to meaningfully understand and remediate disparities among racial groups.

To critique the epidemiology of mental health for Black people, we must explicate the empirical and theorized ways in which the dimensions of racism (eg, institutional, structural, and personally mediated or interpersonal) manifest and interact at each level of social ecology.[27] Ford and Airhihenbuwa developed a comprehensive framework using critical race theory as a methodology to center racism, rather than race, in analyses and interventions related to racial inequities in health.[44] Sound empirical characterization[27] is crucial to any meaningful anti-racist health policy research and practice. Sound characterization of structural racism must include an accurate accounting of the deep historical legacy of structural racism and ways that structural racism is sustained in different geographical contexts.[41] Addressing the function of structural racism in relation to racial inequities in health requires that we move beyond an individual lens and evaluate the ways systems intersect to reinforce racial inequities. Similarly to the ecological model suggested by Karter and Kamens to understand the multiple ways the DSM-5 has been critiqued, we apply an ecological systems model and attempt to synthesize the literature across multiple levels (eg, individual, micro, meso, and macro) for critiquing the DSM psychiatric model[45] to provide a conceptual tool to interrogate how race and racism influence mental health prevalence[46,47] estimates across race and ethnicity in the USA. Each of these frameworks requires that the conditions and systems that produce racial inequities in health are questioned:[46] are there accurate estimates of mental health burden among Black people in the USA? How should prevalence estimates from US national surveys be interpreted?[8] How do multiple dimensions of racism inform the interpretation of mental health among Black Americans and the actions and decisions made by people in power?

A comprehensive data integration and analysis approach could use publicly available datasets on political, economic, and environmental exposures to racism and individual-level data.[48] In the panel, we include ways to better capture mental health diagnoses among Black Americans.

Evaluating systems of structural and cultural racism can provide key insights into the social conditions associated with race that influence mental health systems.[15,29] Cultural racism includes the influence of collective narratives that shape how epidemiological patterns are interpreted. For example, Black men are killed by the police at a rate estimated to be twice the rate of White men.[49] From 2009–12, 22% of civilian deaths from police in 17 US states were estimated to involve mental illness or substance-induced disruptive behavior.[50] Among those who died who had a history of mental illness, 47% had a current mental health problem and 59% had alcohol use disorder or another substance use disorder.[50] Print and broadcast media coverage of shootings is more likely to portray White people as having a mental health condition whereas Black people in these same instances are more likely to be portrayed as violent and a threat to society.[24] Exposure to police violence is a source of acute and chronic psychosocial stress that has been associated with mental illness, including psychosis.[49,51] Even indirect or vicarious exposure to racial violence at the hands of police can be a vicious influence on mental health among Black Americans.[49,51]

The role of racism can also be examined in treatment outcomes. Treatment seeking and treatment completion rates for substance use and for mental disorders are lower

***Panel*: Practices to capture mental health data for Black people in the USA**

**Identify relevant datasets**
Identify publicly available datasets that contain information on political districting, economic factors, environmental exposures to racism, and individual-level data related to emotional wellbeing.

**Data collection and processing**
Retrieve the identified datasets and ensure they are in a compatible format for analysis. This analysis might involve cleaning, standardizing, and merging datasets to create a unified dataset that incorporates multiple dimensions of information.

**Data analysis**
Utilize statistical and analytical techniques to analyze the integrated dataset. For political districting, examine demographic information and political boundaries to assess the potential effect on emotional wellbeing. Analyze economic data to understand socioeconomic disparities and their relationship to emotional wellbeing. Explore environmental exposure data, such as incidents of police shootings, and examine their influence on emotional wellbeing.

**Risk index development**
Based on the individual-level data and exposure factors, develop a risk index that quantifies different exposures to racism and their potential effect on emotional wellbeing.

**Interpretation and communication of findings**
Interpret the results of the analysis, identifying patterns, correlations, and potential causal relationships between different factors and emotional wellbeing. Present the findings in a clear and accessible manner to communicate the insights gained from the analysis. By following this approach, researchers and analysts can leverage existing datasets to gather comprehensive data on political, economic, and environmental exposures to racism, as well as individual-level data that inform a risk index for different exposures. This integrated analysis can contribute to a better understanding of the complex interplay between these factors and emotional wellbeing, and inform policies, interventions, and further research in this field.

in Black Americans than in White Americans,[36,52] and are linked to structural, institutional, and interpersonal racism. NSDUH 2020 data indicated that among people aged 18 years or older with serious mental illness, 58% of Black adults received treatment, far lower than the national average of 64·5%. For any mental illness, only 37% of Black adults received treatment compared with the national average of 46·2%. Disparities also exist for receipt of prescription medication, which was 27% among Black people, 44% among White people, and an average of 39% nationally.[35,53] Racial and ethnic disparities in health care reflect access to treatment and other issues that arise from socioeconomic conditions.[29] Until the political and economic factors that influence the underfunding of mental health treatment within Black communities are addressed, racial inequities will persist.

Mass incarceration is another structural system that undergirds systemic racial inequities in mental health.[54] The USA mass incarceration industrial complex is estimated to earn US$182 billion each year.[55] Several intersecting economic systems direct resources away from communities of color and perpetuate generational cycles of poverty and crime.[54,56] In 2014, an estimated 70–75% of New York state's prison population came from seven neighborhoods in New York City, which had high rates of concentrated poverty and disinvestment and underinvestment in social and economic resources.[42,57]

Considering the importance of the role that community-level factors play in shaping the mental health of Black Americans,[58] national surveys, such as the NSDUH and the National Epidemiologic Survey on Alcohol and Related Conditions, should be designed to provide estimates of incidence and prevalence of mental disorders and substance use disorders at the neighborhood level, and include data that support evaluation of the social conditions that contribute to any observed racial differences in those estimates. The funding of these surveys should be revised to shift epidemiology-driven conversations about mental disorders in Black Americans away from narratives that blame individuals and toward community-driven solutions.[57,58]

## Racism in the USA health system: the racist roots of drug policy

Drug policy in the US health system is an example of how racism affects Black American mental health and our understanding of it.[59] In this Series paper, we choose to focus on the war on drugs, a US Government initiative to stop illegal drug use through heavy criminalization that is notable for its prominent contribution to two of the most important anti-Black social inequities in the last 50 years: the USA's near absence of adequate mental health care for those who cannot afford it (a category into which a disproportionate number of Black people fall) and the cumulative individual-level and community-level effects of drug war hyperpolicing, criminal justice involvement, and mass incarceration.[60] Funding for the war on drugs has led to an inability to support adequate, culturally informed mental health care that is geared at addressing the unique stressors of Black Americans.[61,62] The heavy focus on financing these ineffective policies has only contributed to the criminalization of substance use, especially for Black Americans who use substances,[62] instead of investments in a mental health treatment system with robust primary, secondary, and tertiary prevention efforts, known to have a positive effect on overall mental health outcomes.[30,58]

The larger context is the general historical stigmatization of Blackness, of the working class or poor, of the use of certain substances (although not of others), of women, of queerness, and of mental and physical disability, or any combination which will intersectionally amplify the force of social disapprobation.[63] It is this force with which the war on drugs and, more broadly, the mechanisms of hyperpolicing and mass incarceration over the past four or more decades have violently pushed hundreds of thousands—perhaps millions—of individuals using substances into the carceral system[61,64–67] when a more just society (one with a more robust mental health-care system, for example) might have attended to these individuals' needs. Along with these individuals have been an uncounted but undoubtedly large number of people with other untreated behavioral health challenges that also have brought them into the criminal justice system through disruptive or antisocial behavior. The architects of mass incarceration and the war on drugs have been members of the executive and legislative branches of the US Government (eg, presidents, governors, mayors, and their administrations; US Congress; various state houses; and local city councils).[67,68] In their generally permissive attitude toward carceral expansion, the courts (ie, the judicial branch of the US Government) have provided the foundation of the legal and administrative structure of the war on drugs. The US Supreme Court, the Courts of Appeals, or the district courts at any point in the history of the war on drugs could have invalidated many of the most draconian and violent elements of the war on drugs. The media has participated in the mass incarceration aesthetic on constitutional grounds. Whether in print, digital, or broadcast journalism, so-called reality television shows such as *Cops* (1989–present), or in innumerable fictional television and film depictions, the media for decades has steadily provided anti-Black, anti-Latinx, and drug use-stigmatizing narratives that have depicted people using drugs (specifically cocaine) as debased criminals more in need of carceral disposal than behavioral health care, and have depicted the majority of those people as non-White.[62,69,70] The mass consumption of these narratives has profoundly shaped public discourse and policy formation, making the public all the more willing to support what the US Constitution arguably would not have and what the courts should not have supported.[62]

The power of stigma and cultural representation cannot be overstated—after all, stigma has preceded and informed the war on drugs, hyperpolicing, and mass incarceration, and not the other way around.[67] Racist drug-related moral panics since the late 19th century have included the figurative tropes of the crazed and violent so-called Negro cocaine fiend, and (in both the USA and the UK) the Chinese opium dealer who enslaved middle class White women and men through addiction.[23] In both cases, these 19th and early 20th century narratives were more politically useful fiction than anything resembling actuality, not dissimilar to the untrue propositions that drug use in Black communities justified the post-1980 phenomenon of hyperpolicing and mass incarceration, or that Mexican and Central American immigration should be curtailed because these migrants themselves are fentanyl traffickers.[23,62,71–79] We might contrast this with the current moment. In 2015, print and broadcast media turned their attention to the escalating rate of opioid-related fatalities, typically framing this as the lamentable result of a combination of economic stagnation and social ennui experienced by the White semirural poor, the innocent naivete of middle class White suburban youth, or the inadvertent iatrogenic addiction of hard-working White patients with pain ultimately victimized by Big Pharma.[80] Absent from the narrative were the tropes of moral degeneracy and failed citizenship that historically accompanied descriptions of Black drug use. Also absent was any discussion of the simultaneous and substantial rise in opioid-related deaths among Black individuals, which had nearly doubled since 2000.[62,72] The policy response to this latest iteration of the opioid crisis has emphasized public health solutions focused on social services and mental health treatment, with substantial resources dedicated to addressing multiple dimensions of the crisis. The National Institutes of Health, for instance, have awarded more than US$890 million to the Helping to End Addiction Long-term Initiative, which includes substantial investments in reducing opioid overdose deaths by 40% in targeted communities within 3 years;[81] however, even within this new sociopolitical climate emphasizing public health interventions over the criminalization of opioid use, White Americans are more than twice as likely as Black Americans to receive treatment for substance use disorders or general mental health-care services, and Black people remain more likely to be arrested or otherwise criminally sanctioned as a result of opioid use.[62,72] This treatment of opioid misuse as a public health concern, rather than criminal behavior, might be the result of lessons learned by the scientific community, but seems more likely to be due to a persistent reliance on different narratives and policy solutions for substance use depending on the racialized identity of the person using substances.

The historical context for the formation of Blackness in the western hemisphere can be traced back to Europe's demand for pleasure-giving psychoactive substances. Of the main New World slave plantation industries[82]—ie, sugar, tobacco, coffee, rice, and, later, cotton—for which some ten million or more people were forcefully migrated from Africa to the western hemisphere to cultivate,[82] tobacco, coffee, and sugar were essentially luxury goods to be enjoyed by the European elites, but soon spread widely throughout the continent and to the middle and working classes in European colonies and geopolitical peripheries.[83] Thus, Europe and its current and former colonies underwent profound economic, demographic, political, and cultural transformations largely through the expansion of pleasure-enhancing commodities unavailable in previous eras, the consumption of which was tied intimately to the crucible of race itself.[83]

In slave economies in the western hemisphere, the appropriateness of forced (and racialized) labor went largely unquestioned. The relationship of Black Americans to such substances as consumers played a significant role in larger discussions related to Black freedom. Two historical examples from the 19th and early 20th centuries—the racialization of alcohol consumption and cocaine use—prefigure modern (after World War 2) American drug policy and the war on drugs.[23,84–88]

Long before the modern post-American Civil War and Progressive Era temperance movement, many of the South's governing bodies had legislatively forbidden or strongly regulated the distribution of liquor to Native Peoples and enslaved or free Black Americans.[75] The South created this legislation to secure the moral order and White public safety to protect against the narrative of violent excesses of so-called uncivilized peoples. Slaveholders themselves often attributed Black uprisings to alcohol, and state prohibitions were passed after the spectacular slave revolts staged by Denmark Vesey in 1822 and Nat Turner in 1831.[75] Furthermore, Willis has noted, "the specter of freedmen gathering in public to consume alcohol ignited white fears",[75] a sentiment that played a direct role in the emerging Southern prohibitionist movement. By the early 20th century, Southern alcohol prohibition was so closely linked with anti-Blackness that the majority of Black Southerners would not support it.[77,89–91] During the post-Reconstruction period in the USA, the enforcement of prohibition laws disproportionately targeted establishments owned by Black individuals and Black neighborhoods, leading to high rates of arrests, convictions, and incarceration among Black individuals.[78,79] The rise of illicit alcohol production and consumption of dangerous homemade alcoholic concoctions posed health risks and contributed to mental disorders in these communities. Additionally, the economic effects of Prohibition resulted in job losses and economic instability within Black communities.[89] These historical factors, along with systemic inequalities and scarce access to mental health resources, have had long-lasting effects on mental health outcomes in Black American communities.

### Search strategy and selection criteria

The PubMed and Google Scholar databases were searched for articles published between Jan 1, 1969, and Nov 12, 2023, using the terms "racism", "racial inequalities", "mental health", "Black people", "minority", and "public policy". Articles resulting from these searches and relevant references cited in those articles were reviewed. Only articles published in English were included in our references. All authors used the search strategy. AJ selected the final list of references to be included in the Series paper, with consultation from content experts as needed. Disagreements were resolved via consensus after discussion with first author CDC and senior author AJ.

The politics of cocaine at the turn of the 20th century also featured narratives of Black inebriety that were part of a larger ideological collection of mythologies of laziness, perfidy, criminality, and failed citizenship among Black Americans.[89–91] Between the late 1890s and the 1920s, American newspapers, especially in the South, regularly featured graphic details of supposed outrages by Black people against White people. The phrases "cocaine fiend", "run amuck", and "crazed by cocaine" appeared frequently, often in the same story,[77] and were readily used to justify official restrictions, mob violence, and policing of Black Americans. Similar to the politics of alcohol, the perception of cocaine-fueled violence by Black Americans derived from general post-Reconstruction fears of Black economic and political power.[77] Common tropes of previously trusted servants turning on their kind employers, of Black men given cocaine-fueled superhuman strength and the audacity to attack townsfolk and police officers, or of murderous Black female romantic or transactional sexual partners preying upon unsuspecting White men, for example, revealed a larger imperative to criminalize and police Black individuals.[77] So powerful were negative ideas of Blackness that popular media and political leadership alike cast substances associated with Blackness in a particularly threatening light. As Carstairs argues, "cocaine acquired its reputation as 'the most dangerous drug' because of its associations with Black men. It shows how racialization can infuse our images of drugs and their psychotropic effects…"[77] Thus, racialized beliefs are frequently attached to perceived effects of a substance[23,25,58] and not its actual physiological effects.

## Conclusion

A reckoning with this history must be a part of our general discussion to reform the meanings and values that we assign to race and the ways race is weaponized in the formation of health policy and practice. For the mental health of Black Americans, we need to have Black sociologists, anthropologists, scientists, researchers, clinicians, and citizen experts setting the priorities and providing perspectives at all levels. With Black people setting the agenda, there is an increased likelihood that the crucial questions that are salient for Black communities will be raised and addressed. Black representation can also help ensure diverse representation in all facets of society and consideration of factors relevant to Black communities.

**Contributors**

All authors contributed equally to writing and editing each section of the Series paper. All authors read and approved the final manuscript.

**Declaration of interests**

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