



Structural Racism, Workforce Diversity, and Mental Health Disparities: A Critical Review

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Received: 11 May 2022 / Revised: 25 July 2022 / Accepted: 26 July 2022
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Abstract

Objective Racial workforce diversity has been suggested as a critical pathway to address persistent racial mental health disparities. However, structural racism has been noted to diminish such workforce diversity efforts. The purpose of this critical review is to identify the mechanisms through which structural racism operates in organizations, including mental health organizations, to undermine workforce diversity efforts and reinforce inequities.

Methods Using the theories of racialized organizations, the current review critically draws on literature underscoring the racial character of organizations as mezzo-level racialized structures that may systematically activate and uphold white privilege in the mental health workplace.

Results Findings suggest that in the context of institutionalized white dominance, workers of color within mental health organizations may experience race-based cultural exclusion, identity threat, and racialized workplace emotional expression, and be burdened by racialized tasks. The workers of color may also become the means for organizations to attract communities of color due to their diverse characteristics, yet workers' effects to address disparities in mental health are minimized due to potential racialized organizational forces, including the whiteness of organizational leadership and color-blindness.

Conclusions and Implications for Practice Structural racism may create resistance to the efforts and effects of a racially diverse workforce within mental health organizations. This review calls for a race-conscious framework that drastically shifts the traditional organizational structure to an inverted hierarchy (i.e., client-centered management) to maximize diversity efforts in the mental health organizational workforce to address racial disparities in mental health.

Keywords Workforce diversity · Structural racism · Mental health disparities · Mental health organizations · Leadership

Introduction

In the context of persistent racial inequities that contribute to disparities in mental health outcomes among persons of color, ensuring recruitment and retention of a mental health workforce with diverse racial backgrounds and identities has been suggested as a critical pathway to address the cause [1–4]. Indeed, the existing literature on healthcare organizations generally suggests that a diverse workforce may have favorable effects for reducing disparities in health outcomes. For example, a diverse healthcare workforce positively improved team functioning and service recipients' outcomes [5]. A diverse mental health workforce may fill in

the gaps in the cultural and linguistic capital that can foster trust and understanding between providers and diverse service recipients [71]. It thus may be a potential pathway to reduce barrier and mistrust to mental health service access and utilization by communities of color, although other scholars from the perspective of organizational demography have suggested that a racially diverse workforce may increase interpersonal conflict and dissatisfaction among workers [76].

The literature has noted that inequities in healthcare systems have historical and contemporary roots in structural racism—cultural, societal, and organizational ideas and practices that are rooted in white supremacy [6–8, 74]. Accordingly, the pervasive nature of structural racism in society, within which healthcare organizations are nested, severely undermines healthcare organizations' ability to actualize favorable gains through a diverse workforce when filling the gaps in their diversity and inclusion efforts [5, 9,

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10]. Therefore, without an explicit focus on structural racism as a critical mechanism, our efforts to increase diversity and inclusion and eliminate health disparities have limited effects [11–13].

The purpose of this critical review is to explore and identify the mechanisms through which structural racism operates in organizations, including mental health organizations, to undermine workforce diversity efforts and reinforce inequities. Guided by the theories of racialized organizations, the current review critically draws on literature underscoring the racial character of organizations as mezzo-level racialized structures that may systematically activate and uphold white privilege [7, 14, 15]. From the review, we develop a conceptual model to shed insight into the potential mechanisms by which mental health organizations (nested within the healthcare subsystem of the larger racialized system of white superiority) remain institutionally resistant to the efforts and effects of a diverse workforce. We argue that without careful attention through a race-conscious analytic framework, mental health organizations, operating from corporate business models (characterized by race-neutral organizational structures and processes), can reinforce racialized occupational segregation. Consequently, white individual workers maintain the apex of the organizational hierarchy over workers of color. Such racialized organizations maintain unfair white advantage, affecting workforce diversity and burdening workers of color, which can eventually influence their turnover decision.

The current review is structured as follows: First, we provide the background to this review (i.e., COVID-19 and the racial reckoning of 2020). Second, we introduce the theoretical framework of racialized organizations. Third, we review empirical literature evaluating how organizations, including mental health organizations, are designed to sustain whiteness (i.e., overarching worldviews that normalize and sustain unfair material, social, and symbolic advantage of individuals who are socially classified and socialized to be white). Fourth, we introduce a conceptual model to visualize the contention that organizations are structurally designed to maintain white superiority. This review directs attention to the critical need for mental health organizations to use a race-conscious framework when recruiting and retaining a racially diverse workforce, addressing racial disparities in mental health in the context of structural racism.

Social Background

On the heels of the COVID-19 pandemic, which revealed the enduring violence of structural racism, along with simultaneous unabated killings of Black individuals and other persons of color, the year 2020 saw a large, global movement protesting structural racism in the USA [16, 17]. As a

result, several institutions, organizations, and professional associations (e.g., American Medical Association, American Psychiatric Association, National Association of Social Workers) are reckoning with the role of structural racism in persistent health disparities and their complicity in the perpetuation of structural racial inequities [13, 18, 19, 75]. For example, following the civil unrest precipitated by the police killings of Black individuals, especially the death of George Floyd, as well as the disproportionate impact of COVID-19 on persons of color, the APA president Geller resolved to address structural racism in the professions' diversity efforts. To this end, the presidential structural racism taskforce was formed [13]. Addressing structural racism, from a justice standpoint, requires a deep understanding of the structural workings of racism and race (the processes and practices that activate and apply racial meanings) to uphold white superiority in mental health organizations.

Mental health organizations may purport to be addressing racial inequities by diversifying their workforce; however, their efforts within persistent, unjust racialized structures and processes in the larger racialized social system maintain unfair white advantage [20, 21, 71]. This may severely undermine effective workforce diversity and inclusion, which may operate to entrench, not dismantle racial inequities. For example, Alegria and colleagues [22] reviewed research including observational and field studies related to efforts aimed at addressing mental and behavioral health disparities. They identified three common assumptions that may perpetuate health disparities if they are not addressed: (1) improvement in accessibility to healthcare services alone, without addressing structural-level factors such as racism, will not reduce or eliminate disparities; (2) ensuring minority preferences in current service planning and implementation, without altering structural processes that direct practice, may strengthen disparities; and (3) evidence-based interventions may be available but may not address healthcare disparities if they lack a structural racism focus in their conceptualization and design [22, 23]. Therefore, it is important to understand the larger racialized social systems within which mental health organizations are embedded.

Prevalence of Racial Disparities in Healthcare Workforce

Research has shown evidence of negative racialized experiences toward healthcare workers of color, which also has been linked to turnover decisions. For example, Hennein et al. [10] surveyed 997 healthcare workers within academic hospitals to investigate the predictors, perpetrators, and nature of racialized encounters of workers of color. In the findings, 85% of the healthcare workers of color reported racialized experiences ranging from structural racism to interpersonal racism with their co-workers, supervisors,

teachers, and patients. The same study suggests that the prevalence of racism that healthcare workers of color must contend with ranges from 22 to 71%. Majority of these workers are workers of color provide direct care and are often referred to as community health workers, peer support specialist, outreach workers, and family peer advocates [70]. They experienced racialized encounters, such as excessive monitoring by security and supervisors, increased exposure to risk and vulnerabilities during pandemics such as COVID-19, violence, micro invalidation from both organization staff as well as some clients, unfairness in pay and promotion policies, and vicarious trauma [71, 73, 75]. These experiences were linked to decreased opportunity for upward mobility and increased job turnover.

Similarly, Dill and Duffy [32]’s study showed how structural racism operates in the US healthcare system, including mental health organizations, to stratify Black individuals, especially Black women, into hazardous roles with the lowest wages and the most limited organizational support (e.g., direct workers, support staff). Their study found that Black women were overly represented (compared to any other racial and gendered groups) in the healthcare workforce. However, Black women were more likely to be affiliated with these lower-level positions, resembling the pattern during slavery where enslaved Black individuals worked under White individuals’ management. Interestingly, several of the service recipients that many of these mental health workers of colors, working at these lower-level positions serve are people of color with complex needs that require more time and resources [71, 75]. However, because of their lack of job autonomy, they can be limited in their ability to leverage organizational resources to provide the quality services.

USA as a Racialized Social System

Many scholars have argued that the USA is a racialized social system that operates to actualize a white racial worldview or whiteness through interconnected racialized organizations and cultural processes and practices [7, 8, 14, 15, 24–28]. These scholars contend that white framing is the dominant foundational feature of US society which orients the majority of whites as well as those who accept or conform to white’s worldview. According to Isabel Wilkerson [29], this racialized system (which she describes as caste) is historically and structurally rooted, and white racial framing directs individuals and groups to their historically assigned racial strata. In this regard, health organizations, including mental health organizations, mechanize ways of activating and achieving the goals of structural racialized systems that elevate whiteness [7, 30, 31]. Workers (regardless of their racial group memberships) within racialized organizational contexts are thus participating in racialized affairs to maintain whiteness. Achievement of mental health equity,

therefore, demands a conceptual framework that realistically confronts the root of the unjust racist ideas and practices that privilege whites and dehumanize non-whites [21, 30].

Method

This paper critically reviews the existing literature, discussing ways structural racism may negatively affect a marginalized workforce, through a race-conscious lens to inform the development of a conceptual framework to direct future research and practice in a mental health workforce.

According to the Search, Appraisal, Synthesis, and Analysis (SALSA) framework [69], a critical review is an extensive review and evaluation of the quality of the literature on the subject under investigation. It extends description of the identified literature by entertaining a degree of analysis and conceptual innovation that intends to generate new hypotheses or models. The models developed from critical review may reflect a synthesis of existing work from diverse literature sources or “schools of thought or it may be a completely new interpretation of the existing data” (p. 93). Contribution to the issue under investigation is the basis for evaluation, and the literature synthesis is typically in the narrative, conceptual, or chronological form [69]. Critical review may lack the systematicity or standard quality assessment procedures of other more structured approaches to literature synthesis (e.g., systematic review, and meta-analysis). However, the potential of a critical review to assemble and evaluate what is of value from previous and related body of work or providing a new phase of conceptual development is appealing for this paper, in particular, when literature on structural racism and workforce diversity in mental health organizations is very limited. To guide our critical review, we employed the theory of racialized organizations.

Theory of Racialized Organizations

Ray [15, 26] conceptualizes and explicates the theory of racialized organizations to show that in a racialized society like the USA, organizations (such as health, education, housing, and criminal justice) are subsystems of the racial social structure and are interconnected to maintain white superiority [6, 8]. The theory of racialized organizations contends that organizations enforce the social contract that entitles whites to organizational resources (e.g., roles, authority, social prestige, and material rewards) over non-whites [15, 25, 33, 34]. In this regard, organizations are key to addressing how the racialized structure accumulates, manages, monopolizes, and distributes resources to perpetuate itself. Organizational rules, processes, and routines are suggested to link whiteness to material and social resources that produce and reproduce racial hierarchy like the antebellum plantation era where the preservation of white privilege

was prioritized over the well-being and mental health of racialized and vulnerable groups [25, 33, 77]. Thus, in a post-Civil Rights era, “segregation via exclusion was replaced by segregation through unequal incorporation,” and organizational settings are important contexts to assess racial dynamics [15, p. 34, 35].

Based on the theory of racialized organizations, organizations are designed to credential whiteness as the legitimate avenue for retention and success to the exclusion of the diverse cultural, social, and linguistic capital of workers of color. Yet, organizations decouple race from the conversation around inequality and maintain that their structures and operational procedures are neutral [15, 24]. By ignoring the white racial norms that characterize organizations, the opportunity to make structural changes is missed, and White workers or those who accept white cultural worldviews have an enhanced ability to access and deploy organizational resources while simultaneously diminishing the ability of workers of color [12, 15]. Accordingly, the dominance of the white racialized worldview in the larger USA racial landscape (through interconnected racialized organizations and culturally reinforcing racialized practices) may structure mental health organizations to persist inequities that contribute to persistent mental health disparities [6, 12, 36, 37].

The theory of racialized organizations suggests that substantive workforce diversity must extend beyond mere demographic compositions and understand the organizational structures and processes that maintain social and cultural worldviews that recognize the humanity of individuals described as White [7, 38, 39] while misrecognizing and dehumanizing those who are considered non-White [20, 77, 78]. Within such a racialized system, whiteness defines an ideal leader, embodying and expressing a cultural, linguistic, and social presentation that aligns with and sustains the overall white racial worldviews [25, 33, 38, 40]. White leadership with white credential defines organizational culture to guide routine organizational processes and practices that are often framed in ostensibly neutral ways [24, 38].

Critical Review

This critical review shows that through the assumption of neutrality within a white racialized context, organizational processes and practices normalize and strengthen whiteness through color-blindness (i.e., the false notion that individuals and institutions’ silence on race can prevent prejudice and discrimination) [14, 41]. By claiming race neutrality, organizations may appear attractive to workers of color [42]. However, upon entering the workplace environment, many workers of color encounter situations where the diversity climate is not neutral but designed to maintain white dominance to the social and cultural exclusion of workers of color (see A, B, & C in Fig. 1)

[12, 35, 38, 43, 43]. Accordingly, workers of color may perceive a threat to their identities and a violation of the perceived psychological sense of safety that they felt under the assumption of *neutrality* conveyed by the organization [24, 42]. These processes can be emotionally distressing and disappointing to workers of color as they experience organizational contexts that are institutionally resistant to their [workers of color] cultural and communal assets. Such neutrality processes also disregard their cultural and social identities while simultaneously expecting them to adopt a white racial worldview [12, 20, 42, 43] (see D, E, & F in Fig. 1).

Workers of color are also expected to suppress their distress and frustrations associated with the racial exclusion and their perceived identity threat to make the workplace environment emotionally safe for white colleagues and leadership [12, 35, 38]. Workers of color are burdened with racialized tasks of managing their own racial stress and creating a safe space for whites to thrive [35, 44]. At the same time, workers of color, especially those who are mid-level and lower-level workers (see E & F in Fig. 1), are expected to present the organization to communities of color as liberal and just [12, 35]. In the end, the structure of white racialized health organizations (while failing to make structural changes for workers of color to belong and thrive through their diverse traits) engage in racial outsourcing—using diversity efforts to convey the organization’s attractiveness to communities of color while sustaining a white worldview, designed to actualize the profit interest of a racialized society that upholds white privilege through corporate business model, in service [31, 75]. Through racial outsourcing, workers of color, by their proximity to minoritized groups, are mechanized means to access and creatively extract the resources within communities of color instead of addressing disparities in health-care. As whiteness remains resistant to change, workers of color may be overburdened by racialized tasks and eventually decide to leave. From this understanding, structural racism through institutionalized whiteness of organizations can persist the production of mental health disparities in the context of diversity directly by structurally maintaining a white racial worldview and indirectly by overburdening workers of color with racialized tasks (see Fig. 1). In the sections that follow, we address how these processes unfold within organizations. Although our focus is on mental health organizations, the literature structural racism in the mental health organizational contexts is limited. Given that mental health organizations operate under the larger healthcare organization systems, we included broader healthcare organization literature, addressing structural racisms in workforce, to facilitate our review.

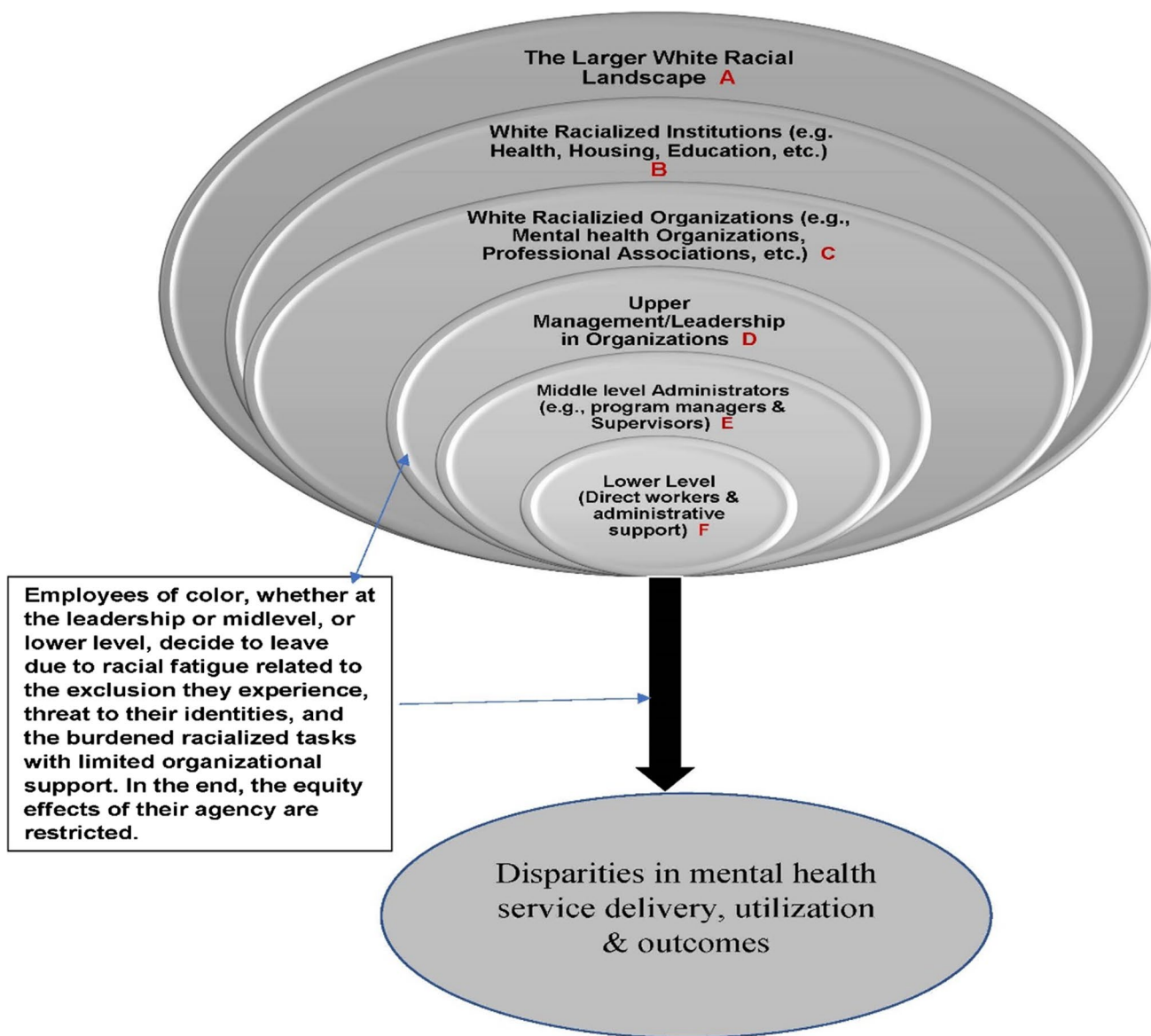


Fig. 1 Conceptual model displaying mechanism by which white dominance sustains occupational segregation through diversity to persist disparities

Whiteness as the Prototype of Leadership

The whiteness of organizational leadership is a critical mechanism through which structural racism operates to sustain a white racial worldview among mental health organizations despite a racially diverse workforce [45–47, 75]. Given the relative position of privileged individuals or groups (classified and socialized to be white) within a social system that is designed to maintain whiteness [25, 33, 48], white workers tend to be more appealing as organizational leaders [49–51] in ways that seem accepted by even non-whites. For example, Gündemir and colleagues [45] demonstrated that both whites and ethnic minorities associated leadership

traits (such as manager, decisiveness, assertiveness, and critical thinking) to white names compared to ethnic minority names. Their findings show that an implicit pro-white bias in leadership is a mechanized path underlying the underrepresentation of racial/ethnic minorities in leadership positions.

Similarly, Rosette and colleagues [47] indicated that Whites were more likely to be evaluated as effective and having more leadership potential than people of color, especially when a white leader had recently been associated with organizational success. The more people consistently evaluate leaders to be white, the more they were likely to internalize and unconsciously associate leadership with white traits. Another example includes Knight and colleagues [46]

study, indicating that Black leaders and White subordinates were rated negatively because such relationships do not align with the internalized notion of pro-white leadership. Conversely, White leaders and Black subordinates were rated positively, affirming and reinforcing these workers in their stereotypical societal positions. Workers who stay within their proscribed, racially stereotypical roles that sustain white dominance tend to be rated more positively than those who violate such roles, thereby perpetuating racial occupational segregation [15, 52] where White individuals are situated at the apex of the organizational hierarchy. This has been noted not only in business-oriented organizations, but in mental health organizations as well [71]. White leadership may situate workers of color to the lower-level position where they work directly with communities of color but have limited room for creativity, autonomy, and humane-centered practice because their performance evaluation metric tends to be driven by the racist capital interest of management that sustains white privilege [75].

Scholars have also noted that structural racism, through white-prototype leadership, can drive and perpetuate racial health disparities through the adoption, usage, and implementation of evidence-based practices and policies that are produced by research without attention to structural racism in its conceptualization and methodology [23]. This can limit workers of colors' ability to adopt and implement racially responsive practices that can enhance their effectiveness and could also affect workers' morale, thus influencing turnover decisions.

Color-Blindness

Color-blindness is another pathway through which structural racism can undermine workforce diversity in organizations [53, 54]. Diversity initiatives can be embedded within color-blind rhetoric to decontextualize race and racial inequities from the structures that create and reproduce the inequities [43]. In the face of mounting oppression, white framing orients organizational leadership to engage in reforms that respond to some of the concerns among persons of color and establish the appearance of progressive racial change (53). However, Byron and Roscigno [24] found that color-blindness overlooks the racialized organizational processes and practices that operate through organizational valuation and pursuit of the ideal worker, making workers submissive to white racial culture. Their study observed that color-blindness allowed organizations to police workers of color's performance, harass them to enforce boundary status, and retaliate against racial minorities who reported racialized incidents while preserving and protecting perpetrators. Thus, within a racialized society that is historically and structurally arranged to perpetuate a white worldview that creates inequities, color-blindness may function to convey the outward

expression of diversity while sustaining the inner workings of structural racism in upholding white privilege, through organizational mechanisms. These experiences can create anxiety among workers of color and convey the perception that organizations lack commitment to workers of color, which may inform turnover decisions [42].

Closely related to color-blindness, white innocence has also been noted to undermine organizations' ability to establish and maintain a racially diverse workforce. It assumes that whites today do not have responsibility for the actions of the whites in history and that those whites who are responsible are those who express racist actions [14, 53]. Both color-blindness and white innocence do not encourage critical exploration to address structural racism and how it operates through organizations to sustain the concentration of workers of color at the bottom of the organizational hierarchy. These mechanisms reduce the effects of diverse workforce efforts by maintaining the persistent racial status quo. For example, Jones and colleagues [12] showed that psychoanalytically oriented training programs did not prepare white and non-white psychiatrists to effectively address the mental health needs of Black communities. A critical factor they raised was that psychiatry attends to a white middle-class orientation both in training and practice. They described it as *white institutionalized racism—covert in its design and insidious in its practice*, and Black individuals who choose to access the system (whether as staff, patients, trainees, or provider) must adopt the racist values that underpin the institution in some form. White racial worldview orients mental health practitioners to persist mental health disparities that affect individuals and communities of color through lack of attention to the racialized context and subsequently misdiagnosis and mistreatment [9, 20, 37, 78].

Race-Based Exclusionary Cultural Practices

The white institutionalized structure that embeds mental health organizations is resistant to other cultural worldviews. As a result, the assets that workers of color may bring to the organization (e.g., cultural and linguistic capital) that may foster trust and reduce barriers to accessing mental health services by communities of color [71] may be underutilized. Speaking with an English accent is one way cultural exclusion can manifest to undermine the recruitment and retention of a diverse workforce. Hosoda et al. [55] revealed that a Mexican accent was viewed as less likely to be hired or promoted to a managerial position compared to someone with a standard American-English accent. Similarly, Osseo-Asare and colleagues [56] found that graduate medical students of color perceived their workplace cultural climate fostered less inclusive practices (e.g., daily bombardments of microaggressions, viewed as ambassadors of their race/ethnicity, and challenges negotiating personal and professional identities while seen as other).

The racial and cultural othering that workers of color face (due to institutionalized whiteness) can make them feel psychologically unsafe and subsequently consider leaving the organization. For example, Nunez-Smith et al. [57] investigated the link between physicians' race/ethnicity, workplace discrimination, and job turnover. Their findings showed that racial/ethnic minorities were significantly more likely to have left at least one job due to workplace discrimination. In particular, 40% of those reporting experiences with workplace discrimination (compared to 10% of those who did not experience discrimination) were contemplating changing careers.

Race-Based Identity Threat

Research on identity verification and non-verification processes has shown that a lack of contextual/setting cues affirming individuals' identities may generate distressing emotions and reduce contextual engagement [58–60]. When organizations are embedded in whiteness, workers of mental health organizations from non-white ethno-racial groups are likely to perceive a threat to their identities because the culture of whiteness may not affirm them [15, 35, 42]. This may be experienced through stigmatization—cultural narratives or stereotypical views constructed about various ethnic group members that are activated and applied during social relationships to shape the nature and direction of social interactions in the workplace [61, 62]. Stone-Romero and colleagues [62] investigated work-relevant stereotypes about different ethnic groups. Study participants evaluated personal attributes (e.g., reliability, emotional adjustment, status, skill, and cognitive ability) about their own ethnic group as well as others. Overall, findings showed significant ethnic differences on these attributes, more negatively toward minorities. When one's own evaluations are not verified or affirmed by the context (workplace in this case), it threatens one's sense of safety [58, 59] and may foster disengagement (e.g., decision to leave).

Negative stereotypes about workers of color in organizations can generate identity relevant experiences that can produce cognitive and emotional reactions toward workers of color due to the discrepancy between their actual (the way one is perceived or capable of being perceived) and virtual (what is expected of the individual in relation to attitudes, personality, appearance, and values) attributes based on social identities [61, 62]. Activation and application of stereotypical narratives can have a negative influence on organizations by: “(a) lessening support for equal employment opportunities and multiculturalism, (b) supporting beliefs and ideologies that justify unfair discrimination against minority group members, (c) legitimizing existing social and power relations within social systems, and (d) serving as ‘political weapons’ that are used to subjugate and dominate ethnic minorities” [62, p. 62].

While the racial-ethnic identity of mental health workers of color can be an important asset when relating to communities of color, whiteness of mental health organizations can limit their effects. The structural disregard of the ethno-racial identities of mental health workers of color can increase their risk to vulnerabilities (e.g., reduced job satisfaction, increased burnout), which may negatively impact the quality of care they provide to clients. This in turn can affect their well-being and ultimately, decision to turnover.

Racialized Workplace Emotional Expression

Related to identity threat, workers of color may experience tension around the expression and management of emotions within racialized organizations [35, 38]. As a constitutive feature of organizations, white framing sanctions organizationally legitimate ways of expressing emotions [7, 35] in seemingly race-neutral ways to normalize the emotional expression of white workers only. For example, in Wingfield's [35] study of healthcare workers of color, participants expressed that organizational feeling rules provided room for White workers to express anger that is not available to Black workers. Meanwhile, organizations expect workers of color to suppress feelings of anger, frustration, and disappointment and display calmness, congeniality, and pleasantness within the work environment. For Black workers, the persistence of racism in the form of stereotypes, racialized comments, and structural racial impediments make it challenging to present a pleasant demeanor [35, 44]. Expecting workers of color to suppress emotions and put on the outward trappings of diversity (where everyone is regarded within a working environment rift with inner workings of white supremacy) situates workers of color in a conflicting environment. The tensions associated with managing such conflicts can undermine workers' effectiveness, through emotional and mental challenges, and influence turnover decisions [35].

Racialized Task Burdens

Racialized minorities within racialized organizations are burdened with racialized tasks or labor [4, 7, 12, 43]. Ray, Herd, and Moynihan [27] developed the concept of racialized burdens to describe how organizational structures and practices that are typically adopted by organizations can foster internal segregation and hierarchical interactions [38, 63]. The hierarchy, initiated and sustained through socially ascribed status and positioning, demands that workers of color implement organizational policy and practice goals within the seemingly race-neutral processes and procedures that actually uphold the white racial ideology upheld by management [38, 63]. Through this process, mental health organizations may recruit a racially diverse

workforce and assign them to lower-level positions in the organizational hierarchy that are often vulnerable with the limited support (e.g., lack of job autonomy), but at a higher proximity to communities of color. In this way, workers of color, through diversity efforts, are engaged in tasks that are racialized. At the same time, these workers of color must carry on the arduous tasks of managing the conflict and tensions associated with such racialized tasks [35, 44]. Wingfield and Alston [38] contend that these racial tasks manifest in myriad ways at three levels: *ideological*, *interactional*, and *physical*. Ideologically, racial tasks are indicative of organizational cultures that are normative to white and middle-class frames of thinking and expression. Key actors include those who occupy the top of the organizational hierarchy such as CEOs and upper-level administrators. At the interactional levels, racial tasks represent the routinized self-presentation and emotional expressions that uphold the white racial framing standardized at the ideological level at the workplace. Middle-level managers and lower-level administrators are the mechanized ways by which racial tasks at the interactional levels are implemented (see Fig. 1D, E, F).

The racialized stratification that maintains racialized tasks within healthcare exposes workers of color to a disproportionate level of risks and vulnerabilities and limits organizational support, which can undermine workers' effectiveness, compromise their health, and ultimately influence turnover decisions [5, 64, 65]. For example, Nguyen et al. [65]'s report, from data generated through a COVID-19 symptoms app from the UK and USA, shows that in general, frontline healthcare workers were disproportionately impacted by risks and COVID-19 infections compared to the general population. Notably, within frontline workers, racial and ethnic minorities were impacted at higher rates than whites because of their job roles and limited organizational support (e.g., inadequate personal protective equipment). Although it was conducted outside of the USA, another example includes King et al. [64]'s study which examined the impact of diversity training on ethnic discrimination in the UK. Survey findings from 395 healthcare organizations, including hospital and community-based healthcare providers, linked ethnic discrimination to declining motivation and subsequently, turnover decisions among ethnic minority workers. More specifically, the more ethnic minorities were in the organization, the greater the negative effects of discrimination on ethnic minorities' job satisfaction. Their findings, which have been corroborated by Chrobot-Mason and Aramovich [66], suggested that diversity and inclusion efforts that can address the effect of discrimination on ethnic minority workers, and in turn contribute to retention, must simultaneously address the organizational-level discrimination.

Racial Outsourcing

Wingfield [31] conceptualizes racial outsourcing to further highlight the racialized character of healthcare organizations. Her study shows how racism may operate to undermine true workforce diversity and its promise of addressing health disparities. She contends that within healthcare organizations, diversity initiatives and programs' models, which adhere to business models, are inclined to prioritize profit over the direct benefits of recipients. Accordingly, in the context of changing racial demographic patterns and healthcare organizations' failure to transform organizational culture, norms, and workforce to reach communities of color, workers of color become the means by which to reach them through workforce diversity.

Healthcare organizations employ workforce diversity to achieve racist corporate interests instead of advancing equity and justice in healthcare delivery, accessibility, and outcomes. Linking racial outsourcing to racialized tasks, the contention is that workers of color within racialized organizations are engaged in equity labor in various ways to make healthcare organizations more accessible to communities of color to achieve racialized interest instead of healthcare equity and justice outcomes [31, 35, 38, 63]. In this way, diversity discourse naturalizes and conceals whiteness through language and practices that treat institutions as inherently white and exoticizes, criticizes, and compartmentalizes the cultural object of people of color as contributions to the presumable neutral "us" [53, p. 604]. Workforce diversity can thus operate to directly persist racial disparities in mental health because of the racialized profit intent and to indirectly burden workers of color to undermine their effectiveness, which can in turn influence turnover decisions (see Fig. 1).

Summary

The critical review suggests an urgent need for mental health organizations to tackle organizational-level racism to address racial disparities. The common assumption about people of color throughout the nation's history has been grounded within a white racial worldview. This worldview does not attend to the impact of structural racism through the history of racialized slavery and contemporary racialization processes (e.g., mass incarceration, occupational and residential segregation, police brutalities and terrorisms, discrimination in housing and education) [16, 71, 72, 78]. Most interventions addressing racial/ethnic health disparities tend to focus on individual-level training and education of mental health workers, such as cultural competency training, education sessions, and in-service training to increase knowledge of different

racial-ethnic groups with limited focus on structural racism. The results of these efforts have shown that culturally driven interventions at the individual level, without a link to structural relations, have limited effects on racial health disparities [20]. Although recruitment and retention of mental health workers of color is an important pathway to address racial disparities in mental health, this critical review (as captured in the conceptual model) suggests that attention to institutional racism, taking a system or structural approach, is required to address the persistent health disparities through maximizing the efforts of a diverse workforce [67].

Recommendation for the Diverse Mental Health Workforce

To maximize the effects of workforce diversity and address racial disparities in mental health, we call for a race-conscious framework to direct inclusion and diversity efforts in the mental health workforce. Given that mental health organizations operate by the corporate or business model and are nested within a larger racialized system, it is in our best interest to address the persistent structural racism in our larger society. Unfortunately, history has shown the need for significant time for actual effects to be seen. While continuing our efforts at the large system levels, it is critical for mental health organizations to realize the underlying influences of racism in their organizational practice and to develop and implement strategies to disrupt and eliminate white racialized forces that limit the maximization of the efforts of racially diverse mental health workforce.

Mental health organizations are expected to provide human services by prioritizing people and their recovery goals to live meaningful lives [80]. If mental health organizations are going to be able to live up to this expectation, it is critical to identify and disrupt the organizational mechanisms by which white racial worldviews shape the inner workings of mental health organizations through racialized organizational processes, practices, and goals. The critical review showed that these mechanisms are often crafted in seemingly race-neutral actions.

Our recommendation is to bring our priority to achieving the organizational mission for serving diverse clients through the strengths of a diverse workforce. One way is to intervene within the organizational structure where the executives and leadership sit atop the organizational hierarchy, managing their workforce to meet racialized social demands. Consistent with client-centered practice and organization in mental health practice, we advocate for the inverted hierarchy [68] which situates clients at the top of the hierarchy and direct providers, supervisors, mid-management, and leadership follow in the subsequent

hierarchies. In the inverted hierarchy, the diverse direct workforce is not seen as a means of racial outsourcing, rather they are seen as the frontline advocates for diverse client communities. Supervisors and managers will be seen as the facilitators of the diverse workforce's efforts. Executives and leadership serve to protect the assets brought in by diverse individuals advocating for the diverse members of the organization. Accordingly, leadership should be constructed by diverse leaders of color to ideologically, interactionally, and physically mitigate racialized task burdens, equalize workplace emotional expression, and activate inclusive cultural practices at the workplace. In this way, strong race-conscious and responsive leadership can mobilize mental health organizations, as the mezzo-level agent of the larger racialized system, to interrogate and disrupt the continuing influence of the racialized system that sustains white dominance.

Actions to implement this recommendation should be informed by a race-conscious framework. Mental health organizations should be regarded as mechanisms to strengthen workforce for addressing disparities. Providing individual-level workforce training and education to improve cultural competency as well as recruiting diverse workforce is important. However, without understanding and addressing the influence of structural racism, the effects are limited. Race-conscious framework should direct mental health organizations (including their supporting organizations, such as the American Psychiatric Association) when addressing the underlying mechanisms of racial disparity.

Additionally, a race-conscious framework can help mental health researchers and organizations to develop race-conscious approaches in data collection, analysis, and interpretation. For instance, integrating a race-conscious framework in organizations' Human Resources (HR) analyses may be critical, including exit interviews and stayer interviews (i.e., exploring reasons why people stay at the organization) to examine any potential racial disparities. Mental health organizations collect historical HR data that may be helpful to analyze the potential patterns of HR practices through a race-conscious framework (e.g., racial disparities in turnover rates, positions, salary, promotion, job tenure). The current critical review may provide new perspectives in our national mental health workforce development efforts.

Declarations

Disclaimer The study was supported by National Institute of Mental Health R34 and Diversity Supplement Training (R34MH119411). The content is solely the responsibility of the authors and does not represent the official views of NIH.

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