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# COMBATING ANTI- BLACKNESS AND WHITE SUPREMACY IN ORGANIZATIONS

## RECOMMENDATIONS FOR ANTI-RACIST ACTIONS IN MENTAL HEALTHCARE

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The background is a collage of three images. The top right shows a raised fist symbol, a common symbol of protest and solidarity. The bottom right shows a cityscape with a prominent building. The bottom left shows a close-up of a person's head, possibly a woman, looking down.

# ABOUT THIS GUIDE

This guide is for everyone committed to [anti-racism work](#), particularly in the context of the mental health field.

Typical diversity, equity, and inclusion (DEI) work can only include and create “equity” for Black communities within the confines of white supremacy. This guide advances efforts to dismantle white supremacy and combat [anti-Blackness](#) in departments, organizations, and institutions.



Intentionally, this guide spotlights and uplifts the voices of Black women and gender expansive communities often ignored and silenced in their fields and by the [media](#).

This guide can be used by any person in an organization or department, including Black employees. However, it is important to note that combating anti-Blackness at a systems level is not the responsibility of Black employees; it is work for those who benefit from anti-Blackness.

We often see the white supremacist approach to managing racial guilt through assigning Black staff members “diversity programming” work (if it is not in their job description). This work can stir up racial trauma for Black employees. Please see the list of Black consultants in Part 3 of the guide. These professionals can do anti-racism work with your department, organization, or institution.

Black employees will feel the changes being made in a department or organization through [anti-racist actions](#), not through conversations. Black employees can be offered the [option](#) of being included in anti-racist action planning.

Black mental health professionals can use this guide to determine how they might also combat anti-Blackness and white supremacy in their clinical work with clients.

Being an anti-racist therapist is unlike being a culturally competent therapist or a therapist who practices cultural humility. The former is accountable to act against a system of oppression, instead of capitalizing on it.

BABE KAWAII-BOGUE

In this guide, I pose questions to consider when **combating anti-Blackness and white supremacy in departments, organizations, and institutions**. I also draw on my own work and context to provide additional considerations for how you might decide to implement these strategies in your workplace.

The guide is organized as follows:

Part 1 offers **general strategies** for combating anti-Blackness in **typical organizations**.

Part 2 offers **specific strategies** for addressing these issues in **mental healthcare**.

Part 3 offers **additional resources** to facilitate continued **anti-racism work**.

Before you read this guide, I want to be clear that these ideas and strategies are not my own. While the stories I tell and the questions I pose are based in my experiences, these resources have been developed over time with my collaborators, almost exclusively women of color. I cannot pinpoint the exact origin of any particular strategy, but I do know that these strategies were voiced and created by a community of mental health activists. I dedicate this guide to them for their devotion to systems change and to Black therapists across the country.

BABE KAWAII-BOGUE

JUNE 2020

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# FOUNDATIONS OF ANTI-BLACKNESS IN BEHAVIORAL HEALTHCARE

## TRIGGER WARNING: THE FOLLOWING DISCUSSES A HISTORY OF ANTI-BLACK VIOLENCE & OPPRESSION.

The intentional language of this guide uses the term **mental healthcare** instead of behavioral healthcare.

The term **behavioral healthcare** has origins in anti-Blackness.

Anti-Blackness today is hearing someone say, "Well, he shouldn't have run away from the police." Fleeing danger is a natural [physiological response](#), and those that fail to acknowledge this fact have clearly been misled. Though, present day anti-Blackness has [unsevered](#) origins. Anti-Black racism, such as rationalizing murder, is rooted in our field's practice of [scientific racism](#).

Scientific racism emerged in the 17th century just after the onset of chattel slavery, in order to legitimize the dehumanization and murder of Black people through [racial capitalism](#).

Scientific racism birthed the seeds of anti-Blackness, which were planted directly into the field of behavioral healthcare in the 19th century. Behavioral healthcare as a field was fully operational in the 19th century and it supported the systemic oppression of Black people through a single mental illness diagnosis.

In 1851, a physician named Samuel A. Cartwright coined the term [Drapetomania](#), a conjectured mental illness that caused African slaves to try to flee slavery. Drapetomania became a credible mental illness in the Southern Region of the United States, harming the physical and psychological consciousness of Black communities and potentially impacting their intergenerational migration post-reconstruction era.

**Attempts to control Black people's behaviors were prompted by the elite's interest in racial capitalism and the white supremacist fear of Black agency, freedom, and liberation.** If Black liberation exists, white communities can no longer benefit from white supremacy. This subconscious thought process is what creates fear in various racial groups who benefit from anti-Blackness.

Behavioral healthcare expanded through the 20th century. In 1911, a man named Edward Thorndike coined the term, "behavior modification" in the article, [Provisional Laws of Acquired Behavior or Learning](#). In 1912, Thorndike was elected as the [President](#) of the American Psychological Association. He was a proponent of eugenics and was provided with a Carnegie Foundation [endowment](#) (equivalent to \$5 million today) to develop intelligence testing.



The hidden chains by the feet of the Statue of Liberty, a gift to the U.S. [commemorating](#) emancipation. In the 1870 model, the statue is holding broken chains in its left hand, signifying Black freedom and liberation. The chains were later replaced with a tablet detailing the rule of law. -Statue of Liberty History Lecture by [Dr. Joy DeGruy](#)



# FOUNDATIONS OF ANTI-BLACKNESS IN BEHAVIORAL HEALTHCARE

In the 1920's, his intelligence research reinforced legislation to prevent the immigration of reportedly intellectually inferior groups to the U.S. Thorndike used behavioral science to justify the dehumanizing treatment of Black, Indigenous, and other people of color, women, Eastern and Southern Europeans, and people from lower socioeconomic statuses. Thorndike's white supremacist research became the [foundation](#) for behavioral research in psychology [today](#).

[Dr. Amber McZeal](#) points to the suspicious emergence of behavioral therapy during the civil rights movement in the U.S. The field also surfaced during the anti-apartheid movements in South Africa, the U.S., and the U.K. Synchronously, Joseph Wolpe (South Africa), B.F. Skinner (U.S.), and Rachman & Eysenck (U.K.) were the founders of behavior therapy. During this time, Black communities were organizing across the country and the world through [collective action](#) to combat racial injustice.

Behavior therapy sought to manipulate behaviors deemed as problematic by the field of psychiatry, a white dominant cultural field that created the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952. The field continued to expand through the 1950's & 1960's.

Behavioral healthcare has historically aligned itself with a medical model. Medical models have quantitative measurable outcomes, as behaviors are more feasibly measured than mental and spiritual processes. Researchers have only started questioning [epistemological racism](#). Indeed, measurement outcomes are based in white dominant cultural traditions, which [Dr. Joy DeGruy](#) discusses in her work examining Dr. Edwin Nichols' [Philosophical Aspects of Cultural Difference](#).

White dominant culture believes existence and value is based in measurement. Oftentimes, funding for mental healthcare is contingent upon measurable outcome data - thus part of the capitalist impetus to move towards a behavioral model of care.

For instance, [Dr. Darlene Hall](#) reveals the San Francisco Department of Public Health's Community Mental Health Services ([CMHS](#)) division in the 1990's transformed into Community Behavioral Health Services ([BHS](#)) today. Simultaneously, the percentage of Black residents in San Francisco drastically declined from the 1990's (12%) to the present day (%5).

Black children are still [4 times](#) as likely to live in poverty than white and Asian children, but in gentrified urban centers like San Francisco, Black children are [15 times](#) as likely to live in poverty than white children.

Researchers have discovered that serial forced displacement [predicts](#) interpersonal and community violence. For this reason, low-income urban African Americans are at a [heightened risk](#) for exposure to traumatic events. Ensuing, they are disproportionately impacted by violence with a death by homicide rate [10 times](#) greater than white Americans. Consequently, African Americans are afflicted with the [highest rates of PTSD](#) of any ethnic group in the U.S.

White supremacy is benefiting from anti-Blackness while serving Black communities in a field that fails to acknowledge its white dominant cultural foundations. The pervasive denial of systemic anti-Blackness continues to influence mental illness stigma and distrust of behavioral healthcare services. Admitting that our field has an unaddressed foundational problem is the first step in the [stages of change](#).



# PART 1

## GENERAL STRATEGIES FOR COMBATING ANTI- BLACKNESS AND WHITE SUPREMACY

Part 1 of this guide addresses **general strategies** for combating anti-Blackness and white supremacy in typical organizations.

These strategies are listed below and detailed on the following pages.

1

CREATE TIME FOR ORGANIZED  
SYSTEMS CHANGE

2

CREATE AN ANTI-RACIST  
ACTION COMMITTEE

3

CREATE A CONSULTATION  
SPACE FOR BLACK EMPLOYEES

4

SUPPORT BLACK EMPLOYEES'  
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SUPPORT AND EMPOWER  
BLACK LEADERSHIP

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EXPAND RECRUITMENT OF  
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DECONSTRUCT WHITE  
DOMINANT CULTURE

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CENTER BLACK AND  
INDIGENOUS PEOPLE

10

CHALLENGE PRODUCTIVITY  
DRIVEN SYSTEMS

# STRATEGY #1

## CREATE TIME FOR ORGANIZED SYSTEMS CHANGE

### QUESTIONS TO CONSIDER

How much time is carved out during work hours every month to discuss and implement anti-racist actions to combat anti-Blackness in your department? How is this work compensated?

### ADDITIONAL CONSIDERATIONS

Many of the strategies I list here will involve **time** - time that should be offered during work hours by department and institutional leaders. Systemic change requires considerable time and collaboration. However, leaders often fail to provide sufficient resources - including time and support - to do the anti-racist action work that needs to be done.

I recommend watching Dr. Brittney Cooper's talk on [The Racial Politics of Time](#). In her talk, Dr. Cooper details how white people control time in our society. Black, Indigenous, and other marginalized people of color are stripped of their time through shortened life expectancies, environmental racism, incarceration, gentrification and employer control over what they can and cannot do with their time.

Creating **time and space on the clock for anti-racist action** is therefore one of the most important actions leaders can make to combat anti-Blackness and white supremacy in their departments, organizations, and institutions.

## STRATEGY #2

# CREATE AN ANTI-RACIST ACTION COMMITTEE

### QUESTIONS TO CONSIDER

Does your department have a committee dedicated to frequent anti-racist action planning? To what extent do your departmental policies and practices combat anti-Blackness?

### ADDITIONAL CONSIDERATIONS

To combat anti-Blackness and white supremacy, departments and institutions need **dedicated groups** (such as committees) that regularly meet during paid work hours. Structured groups can help build momentum as well as community among people in the organization committed to anti-racism work.

Outside of dedicated committees, **designate time to plan anti-racist actions** - ideally during staff meetings. Carving out consistent time for these preparations during scheduled meetings will help create and maintain an anti-racist community in the department and organization.

Dedicated opportunities to plan anti-racist action will ensure continuity and accountability even if you or other leaders are not present. Indeed, one goal of anti-racism work is to create and sustain lasting systemic change even after you and your colleagues leave the institution.

## STRATEGY #3

# CREATE A CONSULTATION AND HEALING SPACE FOR BLACK EMPLOYEES

### QUESTIONS TO CONSIDER

Is there space for people of color to support each other at work? Does this space meet the needs of Black employees?

### ADDITIONAL CONSIDERATIONS

I recommend developing a **consultation and healing space** in your department for Black staff to connect in a safer environment.

Sometimes it's helpful to create space for people of color in the organization to consult one another, as [dedicated spaces for Black and Indigenous community members](#) are an integral part of anti-racism work.

Leaders can provide the necessary resources to create these spaces. However, it is important that Black and Indigenous community members have autonomy over the space, such as co-creating group values, expectations, structures, and having the agency to opt-out of an additional work obligation.



## STRATEGY #4

# SUPPORT BLACK EMPLOYEES' PROFESSIONAL DEVELOPMENT

### QUESTIONS TO CONSIDER

Who is actively supporting, mentoring, and advocating for Black employees in your department? What can you do to improve professional development for Black staff? (without creating extra unpaid labor for Black employees)?

### ADDITIONAL CONSIDERATIONS

Ensure that there is at least one person dedicated to providing (and monitoring) **professional development** specifically for Black employees.

It's also important to **hold supervisors accountable** for their support and feedback, particularly given how [racism and sexism affect professional development experiences among women of color](#).

Supervision can make-or-break a Black clinician's entire career. **Hire external clinical supervisors** if you are unable to provide Black clinicians with BIPOC supervisors who are also racially conscious and committed to anti-racism.

Important note: Black does not equal anti-racist. Thus, hiring a Black supervisor with a white supremacist mentality is informally referred to as, *melanin swatching*. People of color do not benefit from white supremacy to the extent that white people do, but people of color are arguably more vulnerable to and dependent upon white supremacist ideologies for survival. It is important then to hire Black supervisors who maintain an anti-oppressive lens.

# ADDRESSING ANTI-BLACKNESS IN CLINICAL SUPERVISION



"I EXPERIENCED MICROAGGRESSIONS IN EVERY  
SINGLE MEETING WITH MY SUPERVISOR."

At one point in my career as a mental health professional, I was assigned the only clinical supervisor available. He was a white identified man from a wealthy community in the Bay Area.

I experienced microaggressions in every single meeting with my supervisor. He eventually refused to sign-off on most of the clinical hours I had accrued due to his inability to provide enough supervision for me (which he failed to mention before starting supervision).

I learned that my experience is not an uncommon practice when white men feel threatened by Black clinicians. I have heard countless stories from across the country about white men supervising Black clinicians who refused to sign off on hours because of a tiny typo in paperwork (like missing punctuation) or making it difficult for Black clinicians to obtain hours towards licensure - in an effort to assert power over them. Realizing that this was a common practice across the country, I ended supervision prematurely.

Eventually, I was able to receive culturally appropriate supervision from a new leader in an organization that was founded and operated by people of color. The leader was an Asian-American man who attended public schools in San Francisco, from the same district I was serving as a clinician.

This person had also worked in various communities and was well connected with other Black professionals in the field.

On top of his leadership responsibilities, he volunteered to supervise me and another PhD-level Black clinician for our psychology licensure hours.

He provided us with mentorship and introductions to other Black psychologists in his networks throughout the state. Most importantly, he supported my professional development. Specifically, recommending me for a Postdoctoral Fellowship with the American Psychological Association's [Minority Fellowship Program](#). He also encouraged my development in mental health policy and advocacy training at the local and state levels.

He was honestly the best supervisor I could have hoped for in my life at the time. I am eternally grateful to him for the mentorship and connections he provided me. I just imagine what would have happened if I had stayed with the other supervisor. Which goes back to my original comment: **supervisors can make-or-break a Black clinician's entire career.**

**It is essential to have adequate representation of supervisors of color who are actively anti-racist.**

## STRATEGY #5

# SUPPORT AND EMPOWER BLACK LEADERSHIP

### QUESTIONS TO CONSIDER

What is the history of leadership in your department and organization? How many Black people have been hired as directors and appointed as board members? What is the current leadership landscape?

### ADDITIONAL CONSIDERATIONS

To combat anti-Blackness in our departments and communities, we need to **empower Black people in leadership** roles. Focus on ensuring that Black candidates are adequately prepared for, promoted to, and are adequately supported in leadership roles in your institution.

African Americans - those whose ancestors experienced chattel slavery in the U.S. - are particularly underrepresented in leadership roles. Anti-Blackness is also failing to distinguish diversity among Black people, seeing the African Diaspora as homogeneous. This invisibility of Black diversity can contribute to a lack of representation of African Americans in leadership roles.

For instance, several prominent Black leaders today descend from families that have not endured the 400+ year legacy of white supremacy in the U.S. and its associated injustices, including: chattel slavery, Jim Crow, mass incarceration, poverty, housing insecurity, and racialized health disparities.

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# STRATEGY #5

## SUPPORT AND EMPOWER BLACK LEADERSHIP

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These injustices make it especially challenging for African Americans to advance professionally within the same white supremacist structures that subjugated multiple generations of our ancestors.

Author [Resmaa Menakem](#) examines the present and historical realities that have taught Black people to fear white supremacist retaliation, revealing, "when white people get upset, Black people die."

Therefore, it is rare to find prominent African American leaders who have survived the intergenerational erasure of tribal and national heritage, and the white supremacist execution of African American leadership identity. Black Americans who experience additional marginality due to sexual orientation, gender, socioeconomic status, and/or disability are even less represented in leadership roles.

Notably, Black liberation will be a collective one; it will not be homogeneous. Therefore, it is crucial to support and empower a diversity of Black leaders, including African American leaders with histories of chattel slavery in the U.S., as well as Black leaders with lineages from across the African Diaspora.

## STRATEGY #6

# EXPAND RECRUITMENT OF BLACK EMPLOYEES

### QUESTIONS TO CONSIDER

Do you have an intentional process for recruiting Black employees? If you are a non-Black leader in your department or organization, how are you ensuring that Black applicants are adequately represented in the hiring process?

### ADDITIONAL CONSIDERATIONS

Over the past four years, my department has only hired one Black employee. When I asked my previous boss why no Black applicants were selected for interviews over the years, she said there were no Black applicants. I then asked where she was recruiting applicants; she replied with the name of a predominantly white graduate institution in the Bay Area (which also happened to be her alma mater). I said, "That's the problem."

We must expand recruitment efforts for available positions. Sharing **job listings in Black professional communities** (e.g., Facebook groups for Black clinicians; see page 26) and listservs for Historically Black Colleges and Universities can ensure Black candidates are represented in the applicant pool.

Host **information sessions** dedicated to Black, Indigenous, and other people of color. This helps build a network for sharing future job openings and signals your organization's commitment to hiring and supporting Black employees.



## STRATEGY #7

# IMPROVE RETENTION OF BLACK EMPLOYEES

### QUESTIONS TO CONSIDER

Have you checked in with your Black employees to see what might help them personally, emotionally, and professionally? Have leaders in your department and organization asked Black staff what they need to continue working and remain engaged? What does racial equity look like for your department or organization? How do you account for invisible labor when determining work equity? How do you compensate Black employees for their emotional and racial labor?

### ADDITIONAL CONSIDERATIONS

Do everything you can to **meet any requests** that Black employees share when they communicate their needs to continue working at your organization.

Understand how **white supremacy and anti-Blackness** affect members of your organization. For instance, who lives closer to work because of gentrification, housing discrimination, renter's and homeownership privilege? Who might need to leave work promptly to avoid a long commute home for these same reasons? Who has easier access to transportation to work?

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## STRATEGY #7

# IMPROVE RETENTION OF BLACK EMPLOYEES

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Who is benefiting from white supremacy and anti-Blackness at your organization? If your organization is mostly or exclusively people of color, who is benefiting from racial or social [proximity to whiteness](#)?

All of these experiences and positionalities affect - and are affected by - racial equity issues, and should be taken into consideration to create racial equity for Black employees.

Ask Black employees how their working conditions could be more humane and accommodating. Do not attempt to uphold power for the sake of it. It will remain difficult to retain Black employees if they do not believe you care about equity or their wellbeing as staff members.

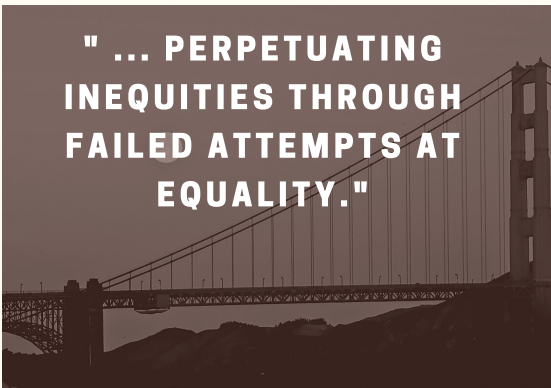
# IMPROVING RETENTION THROUGH ANTI-RACIST EQUITY MEASURES

The problem with equality is that racial groups are not treated equally and do not perform equal amounts of invisible labor. Therefore, efforts to create equality within the confines of white supremacist heteropatriarchy, will benefit employees with racial and gender privileges, and simultaneously contribute to oppressive structures that neglect the needs and unique contributions of marginalized racial and gender groups (Black and Brown women/gender expansive employees).

This reality is why many labor union models are outdated - because they are based on a 19th century version of labor equality for able-bodied, cisgender, heterosexual men. Union ideologies never had to take into account equity and invisible labor disparities rampant in present day organizations. Given this, it is important for employers to create equity-based policies and practices in organizations instead of perpetuating inequities through failed attempts at equality.

In mental healthcare, equity seems to appear in supporting select marginalized racial groups with the exception of Black employees. In my organization, multilingual and licensed clinicians receive an increase in their salaries. Why do clinicians who speak a second language receive increased pay? Simple: an entire population of clients would not receive mental health services unless a multilingual clinician is available, which is why multilingual clinicians are in high demand.

Let's take a moment to consider Black therapists and Black clients within this context of service need.



**" ... PERPETUATING  
INEQUITIES THROUGH  
FAILED ATTEMPTS AT  
EQUALITY."**

My position as a group therapist was held for seven years by a white man before me, who spoke Spanish. I have heard endless statements from staff across the school district tell me that students were not willing to come to groups when he held my position. My position serves predominantly Black and Brown youth, many of whom either do not have parents in their lives, or live in group homes, or are involved in the Juvenile Justice System.

I work on a team of high school-based clinicians throughout the city of San Francisco. Our team, mostly white and Asian, only include four Black therapists (only two site-based) who serve 15,000 students, 90% of whom are students of color. Only two of the Black clinicians, including myself, grew up in San Francisco and were once students in the district we serve.

When I see shame in the eyes of a Black or Brown youth as they tell me they were just strip searched at Juvenile Hall, I am a rare clinician on my team who can look back into their eyes and say, 'I know what that feels like.'

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# IMPROVING RETENTION THROUGH ANTI-RACIST EQUITY MEASURES

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I know what it feels like to be locked up behind bars as a Black youth for being poor and experiencing ongoing violence with no one to protect you from it. I know what it feels like to be discarded into group homes as a youth in a city that displaces and discards its Black communities. My father was also a Black youth in San Francisco who was discarded into the foster care systems in San Francisco and Oakland.

I know what it feels like to be born into a lineage of violence, displacement, premature deaths, segregation, poverty, and chattel slavery caused by centuries of white supremacy and anti-Blackness. I would not have had a chance in life if I was not offered a Black woman therapist for five of the most challenging years of my youth. I knew she understood me, so I stayed in therapy and was able to survive and eventually thrive in life.

After starting my position, my trauma, grief & loss, and mindfulness therapy groups began to reach capacity, to the point where I had to create two groups for certain schools that had higher percentages of Black and Brown youth. Clearly, [Black clients need Black therapists](#), so why are Black clinicians not offered salary incentives for serving a population that would not otherwise receive mental health services? A simple answer is anti-Blackness in policies that evolved out of centuries of exploiting Black lives and labor in the U.S., and an historical refusal to adequately compensate Black employees for their incredible value to organizations and departments.

Compensation policies/practices that do not consider Black clinicians' unique ability to serve Black and Brown clients has everything to do with white supremacist and anti-Black racist ideologies of value.

Resultantly, anti-Blackness in mental healthcare policies and practices have long served as [barriers](#) to mental health care access and treatment effectiveness for Black communities (see my article, [Mental Health Care Access and Treatment Utilization in African American Communities](#)).

Let's now examine the anti-Blackness represented in my organization's policy/practice to provide those who are licensed with increased salaries. The passing rate for the EPPP for psychology licensure is 86% for white clinicians, but only 61% for Black clinicians (see [EPPP Race Study](#)). According to this salary policy/practice in my organization, white clinicians receive increased salaries for already benefitting from white supremacy and anti-Blackness in standardized testing. This financial benefit from anti-Blackness does not include savings on the exorbitant EPPP testing fees (\$700) Black clinicians have to pay each time they attempt to take the exam - as well as the high cost of EPPP testing preparation materials they continue to pay until they pass the exam.

Anti-Blackness pervades almost every segment of our institutions and mental health system. Anti-Blackness is embedded in the policies and procedures that certain racial groups benefit from at the expense of other racial groups.

This is why creating equity for Black employees in your department, organization or institution is necessary to combat white supremacy and anti-Blackness in our field.

# RETENTION EFFORTS FOR BLACK EMPLOYEES



How can you determine what will help retain your Black employees? Simply ask the following question at least once a year to every Black employee:

**What do you need to feel valued enough to continue working here?**

To begin these conversations, I surveyed Black clinicians across the U.S. in various online forums, asking one question: **What are one or two things an employer can do to retain you as an employee?** I received roughly 100 responses in a 48-hour period. The responses the clinicians provided were aligned with the strategies provided in this guide. The top 10 responses are listed below, in order of most to least frequently reported.

In addition to considering these survey responses, organizational leaders need to gather, analyze, and act on their internal **retention data**.

When a Black employee leaves your department or organization, it is important to have a survey method in place to ask transitioning Black employees what the department or organization could have done to help retain them.

Failing to complete this qualitative data could lead to the loss of current or future Black employees.



### 1. Increase Pay for Black Clinicians

Approximately 90% of the respondents provided this answer. One would argue that most employees want a salary increase no matter how much they are paid, but this is not an ask from everyone. This is an ask from a group whose lives and labors have been exploited to create [racial capitalism](#) that continues to exploit their lives and labors today. This is an ask from a group who has the highest level of [student loan debt](#) in the country. It is an ask from those who are discriminated against for jobs, housing, and even for relationships - all of which are important survival needs that allow non-Black communities to build financial and social safety nets. Anti-Blackness and white supremacy has stripped financial safety nets from beneath the feet of Black communities.

If you do not have Black therapists on staff, you do not have Black clients who trust the services you run. The field of mental health has perpetuated violence against Black lives since chattel slavery, and has evolved into a mental health system today that continuously fails to meet the needs of Black communities. Thus, the mental health system has yet to prove itself as trustworthy for Black clients. [De'Shaun Thornton](#), a consultant and director of a school based mental health program for youth in Oklahoma City, highlights the need for increasing pay for Black therapists. Specifically, he notes that Black clinicians must be available as providers to serve Black clients' mental health needs, because we are situated in communities and spaces with unique access to culturally appropriate healing resources.

Increasing pay for Black clinicians includes paying Black trainees in graduate programs who normally receive no pay for their practicum or fieldwork hours. If there are barriers to employee minimum wage mandates that prevent the provision of stipends to trainees, become creative (e.g. offer a grant program for Black trainees). Engage in advocacy efforts to support legislation urging professional training and licensing bodies to subsidize the unpaid training requirements for underrepresented mental health professionals.

Failing to offer compensation for Black trainees is an equity issue that prevents many Black students from pursuing careers in mental healthcare.

Take action to advocate for increased pay for Black clinicians at all levels of training.

### 2. Stop Overworking Black Clinicians

- Reduce the amount of paperwork required for clinicians to create more time for them to effectively do their jobs.
- Reduce workload overall.
- Take into account the invisible labor Black clinicians are required to do. This point goes back to who controls Black people's time.

(see Part 1. Strategy 10: Challenge Productivity Driven Systems)

### 3. Provide Paid Training and Professional Development Support

- Provide training incentives.
- Reimburse professional development and continuing education.
- Offer training opportunities led by Black consultants that will enrich and advance Black clinicians' careers.

(see Part 1. Strategy 4: Support Black Employees' Professional Development)

### 4. Hire Black Leaders to Increase Black Representation and Support in Leadership & Management

Provide pathways for clinicians to move into upper management and, once there, provide support for Black leadership.

(see Part 1. Strategy 5: Support and Empower Black Leadership)

### 5. Increase Paid Time Off (PTO)

Respondents described needing a break, feeling overworked, wanting a drastic increase in PTO, and/or expanding standard PTO to include mental health days for Black clinicians.

(see Part 2. Strategy 5: Provide Paid Recovery Time for Black Clinicians)

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### 6. Offer Telecommuting

Allow clinicians to work or attend meetings from home whenever possible.

This ask is related to the distance Black employees live from work due to gentrification, housing discrimination, etc. It also has to do with being overworked and not wanting to potentially add a 2-4 hour round-trip commute to their already overburdened days. (Unfortunately, crossing two bridges and commuting 2-4 hours per day is not uncommon for Black employees in the San Francisco Bay Area.)

(see Part 1. Strategy 7: Improve Retention of Black Employees)

### 7. Offer Flexible Schedules

The need for a flexible schedule is a response to employers' failure to recognize or compensate invisible Black labor. Therefore, a flexible schedule is required to create time to provide and recover from that invisible labor.

(see Part 1. Strategy 10: Challenge Productivity Driven Systems)

### 8. Stop Micromanaging Employees

(see Part 1. Strategy 7: Improve Retention of Black Employees)

### 9. Create Organized Policies and Procedures

Create and share specific and clear policies and procedures to follow when serving clients. Unwritten policies and procedures can cause more burden and invisible labor for Black clinicians who then must create them.

(see Part 1. Strategy 7: Improve Retention of Black Employees)

### 10. Support Black Mentorship

Provide a Black mentor to Black clinicians, either from inside or outside the agency.

(see Part 1. Strategy 4: Support Black Employees' Professional Development)

## STRATEGY #8

# DECONSTRUCT WHITE DOMINANT CULTURE

### QUESTIONS TO CONSIDER

What are the origins of your departmental norms, practices, and policies? What are the origins of white dominant culture in your department or institution? To what extent is your organizational culture rooted in white dominant culture? What institutional models do you draw upon that are founded in white dominant culture? How does this culture affect Black employees and racial equity more broadly?

### ADDITIONAL CONSIDERATIONS

Organizational leaders and employees need to identify, challenge, and dismantle white dominant culture in their departments and institutions, irrespective of whether white people are working in an organization. White dominant culture can be practiced and upheld by any racial group, but white people are the greatest beneficiaries of these cultural practices on a systems level. Black, Indigenous, and other marginalized people of color are the most adversely impacted by white dominant cultural practices.

How will you agree to address white supremacy as a team?

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## STRATEGY #8

# DECONSTRUCT WHITE DOMINANT CULTURE

### ADDITIONAL CONSIDERATIONS

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Creating **accountability groups** is helpful for ensuring that people in your organization are combating anti-Blackness and white supremacy. These accountability groups can include white people and/or non-Black people of color who are committed to anti-racism work. This will help you create a **shared strategy or plan** for how to "[call in](#)" statements, decisions, and actions that are rooted in white supremacy.

Moreover, white and non-Black people of color in accountability groups or on diversity programming committees can use the strategies and resources in this guide to implement anti-racist action. Specifically, advocating to change policies, procedures, and structures that combat anti-Blackness and white supremacy in your department, organization, or institution. Accountability groups also need to be accountable for members' anti-racist actions. Discussions mean nothing if action is not taken to create systems change.

[This worksheet](#) is a helpful tool to identify, challenge, and transform white dominant culture in your department. Examining this document in accountability groups and all-staff meetings signals that you are serious about committing to a safer and more equitable working environment for everyone.



# STRATEGY #9

## CENTER BLACK AND INDIGENOUS PEOPLE

### QUESTIONS TO CONSIDER

How do Black and Indigenous people experience work in your organization? What are some situational and environmental microaggressions that non-Black people perpetuate? What can you do to address these harms?

### ADDITIONAL CONSIDERATIONS

**Seek input from Black and Indigenous staff and clients** about what changes they would like to see in the workplace, then take steps to address any harm they are experiencing.

Whenever possible, **prevent Black staff and clients from experiencing anti-Blackness**. For instance, some Black clinicians who work in white dominant cultural spaces request the option to schedule appointments with Black clients directly to minimize their clients' engagement with white supremacist practices, structures, and institutions. Meet clients' needs if they express a preference for a clinician's racial identity.

Ensure that **Black culture** is embedded within the organization. For instance, leaders can support [local Black-owned restaurants](#) when ordering food for staff events. All staff can intentionally support Black owned businesses outside of work.

## STRATEGY #10

# CHALLENGE PRODUCTIVITY DRIVEN SYSTEMS

### QUESTIONS TO CONSIDER

How do you value and allocate time in your organization? How is the pace of work a racial equity issue?

### ADDITIONAL CONSIDERATIONS

Black lives have long been exploited to build colonial capital on U.S. soil and globally. Black employees occupy some of the lowest paid positions with the poorest working conditions. **Black liberation cannot exist unless there is a conscious effort to dismantle capitalism.** While we all work within a capitalist system, we can **challenge productivity goals and expectations.** This is one of the most powerful ways to combat anti-Blackness in the workplace.

Challenge productivity driven systems by offering **space and time for Black employees to breathe**, Resist the urge to needlessly intensify the pace of work - instead, incorporate 30-minute blocks of time during the workday for breathing and attending to human needs.

Governmental standards do not dictate a maximum amount of designated break time. You can thus alter your organizational structure to create as much space and time as possible. This anti-racist action can help to address ableism, creating infrastructures for a diversity of abilities and accessibility needs.

## PART 2

### SPECIFIC STRATEGIES FOR COMBATING ANTI-BLACKNESS IN MENTAL HEALTHCARE

Part 2 of this guide addresses specific strategies for combating anti-Blackness and white supremacy in mental healthcare.

These strategies are listed below and detailed on the following pages.

1

DIVEST FROM LAW  
ENFORCEMENT

2

COMBAT ANTI-BLACKNESS  
WITH CLIENTS

3

SUPPORT BLACK CLINICIANS  
EXPERIENCING ANTI-BLACKNESS

4

EMPOWER BLACK CLIENTS  
THROUGH FEEDBACK LOOPS

5

PROVIDE PAID RECOVERY TIME  
FOR BLACK CLINICIANS

6

REDEFINE RISK AND SAFETY FOR  
BLACK CLIENTS & CLINICIANS

7

REASSESS BOUNDARIES AND  
TIME FRAMES FOR TREATMENT

8

DECENTER CLINICIANS AS PRIMARY  
HOLDERS OF KNOWLEDGE

9

RECONCEPTUALIZE  
PATHOLOGIES

10

ENCOURAGE AND SUPPORT  
ADVOCACY & ORGANIZING EFFORTS

# STRATEGY #1

## DIVEST FROM LAW ENFORCEMENT

As I continue to note, police officers have [no place](#) in mental healthcare. There are many ways to divest from law enforcement in your communities and organizations.

**Contact Crisis Support Teams:** The Bay Area for instance, provides Mobile Crisis Response Teams, Comprehensive Child Crisis Services, Community Crisis Response Teams, and Access Programs (Acute Crisis Care and Evaluation for System-Wide Service). Make it clear you do not want police involved in the care of your client.

**Optimize Mental Health First Aid** (Peer Training): Connect to or develop a system of mental health first aid and peer training efforts to avoid involving law enforcement in mental healthcare.

**Utilize and Contract with Ambulance Companies:** In the San Francisco Bay Area, I have had good experiences with Royal Ambulance. You can request the race or gender of the EMT when contacting an ambulance company. When I used this ambulance company, a team of EMT women asked my client what color blanket they wanted, then offered them a purple blanket before getting into the ambulance.

It was like watching a best case scenario in a system that is otherwise so violent towards Black people.

It really does give me hope to see the results of divesting from police officers and law enforcement more generally.

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# STRATEGY #1

## DIVEST FROM LAW ENFORCEMENT

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Legally, if a client refuses to go to hospital, 9-1-1 & police are the default to be contacted. I have had strong enough relationships with my clients that I have only had to involve police officers once in the past 15 years. In these situations, I tell my clients that legally the default will be to call 9-1-1 or the police, but I do not want to involve them in your care. As a last resort, I will give clients the option of calling an ambulance or calling the police. I have not had to do this more than once or twice in my career. **The trust and relationships developed with clients are safer ways of protecting them from police involvement.**

If police involvement is required as a last resort, you can make a request for the police dispatcher or 9-1-1 to send a non-white officer and/or a woman officer to the scene. For clients who have experienced racial or gender trauma from police officers, this is an important demand from police to **ensure that you are protecting the client from further trauma or potential violence.** You can state that the client has a history of racial trauma and needs to have a non-white or non-male officer at the scene. You can also request race and gender preferences when calling EMT's. I have worked heavily in Black communities, especially with women and girls and I have advocated against a white male police officer or EMT to escort one of my Black women clients to the hospital. If police are present with your clients for any reason, **you can be an advocate** by staying in the room with police and your client. Do not leave them alone with police. Advocate for your clients' safety and educate police about what clients might need for safety based on their current condition.

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## STRATEGY #2

### COMBAT ANTI-BLACKNESS WITH CLIENTS

Clinicians need to address white supremacy and anti-Blackness with clients. This is work that needs to be done by, with, and for white folks. Therefore, it is important to train and hire white therapists who are committed to anti-racism. For instance, white therapists can role play with other white therapists on how they will "call in" clients regarding their perspectives on white supremacy. It is vital that you practice challenging white supremacy so that you are prepared to respond to clients' views.

## STRATEGY #3

### SUPPORT BLACK CLINICIANS EXPERIENCING ANTI-BLACKNESS

While all clinicians of color will have to deal with racism from white clients, Black clinicians will have to deal with anti-Blackness from clients of all races. It is important as a department to create support and pathways that encourage and de-pathologize Black therapists' decisions to terminate or transfer clients who hold harmful or unexamined white supremacist values.

# STRATEGY #4

## EMPOWER BLACK CLIENTS THROUGH FEEDBACK LOOPS

Creating **client feedback loops to empower Black clients in treatment** is necessary to combat anti-Blackness and white supremacy.

Black clients ought to inform how services are provided. Offer clients access to an easy method of filing grievances about experiences of oppression in the therapy room or within the mental healthcare system.

We want to empower Black clients to be able to help shape their own wellness experiences. This goes beyond traditional surveys that are not sufficiently anonymous. This is where a department can become creative in thinking about ways to implement client feedback based on available resources and structures.

It is also important to notify clients their voices have been heard and that action is being taken, particularly as it pertains to departmental efforts to better meet the needs of their Black clients. It's ok to communicate directly with a client if they do not wish to remain anonymous.

Empowerment develops through conversation and interactions, not through a short survey that goes unanswered. Clients will feel more empowered and engaged in services if they believe they are actively helping to shape them.



## STRATEGY #5

# PROVIDE PAID RECOVERY TIME FOR BLACK CLINICIANS

**Black clinicians face unique challenges** in the mental healthcare system. In sessions, we are often holding the pain of entire families, communities, and generations. We are more likely to work with clients who are disproportionately impacted by trauma and violence. We are also likely working through our own extensive trauma, lack of safety in sessions, and difficulty accessing culturally appropriate supervision and affordable mental healthcare. It is not difficult to find a white clinician who takes insurance. However, racial inequities can make it challenging to find a Black clinician who accepts insurance. Racial inequities that affect financial access to Black therapists include:

- 1) Disproportionate levels of **student loan debt** that pressure or force Black therapists to only accept private pay clients.
- 2) **Gentrification** that simultaneously increases costs of private pay therapy and decreases Black consumers' financial reserves to pay for private care.
- 3) **Racial biases** in the licensure process and on licensing exams that delay or altogether prevent Black therapists from becoming licensed.

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## STRATEGY #5

# PROVIDE PAID RECOVERY TIME FOR BLACK CLINICIANS

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For these reasons, it is important to offer adequate support and resources for Black clinicians' mental health, including sufficient **spaciousness in their schedules** and ample **paid recovery time**. This will help Black clinicians sustainably continue to provide mental healthcare (while also navigating anti-Blackness and white supremacy).

Leaders also should remain aware of their Black employees' experiences in the wake of collective racial trauma, such as widely publicized instances of police brutality. Witnessing and mourning this violence and potentially retraumatizing Black clinicians and their patients can make it incredibly difficult to focus and function, especially in white dominant cultural spaces.

Having access to sufficient paid time off and comprehensive mental healthcare can facilitate "[calling in Black](#)" by giving Black clinicians the time, space, and resources they need to process and heal.

## STRATEGY #6

# REDEFINE RISK AND SAFETY FOR BLACK CLIENTS & CLINICIANS

How are your actions (or lack thereof) as a clinician putting Black clients at risk of harm?

How have we been taught about risk within our white supremacist training institutions? Let's challenge ourselves to **think about risk in a more holistic and politicized way.**

For instance, a Black person is at elevated risk for being targeted by state violence and harm. **Consider how you can reduce Black people's risk of harm** by reconceptualizing their positionalities.

Specifically, become more mindful of what is written in a progress note and how much detail is provided, taking into consideration the [mental health-to-prison pipeline](#). Practice writing notes with the least amount of personal and detailed information to reduce risk for Black clients. Keep in mind to include in notes only what is absolutely necessary for liability and continuity of care; anything beyond that could elevate risk for clients' confidentiality rights, especially those on MediCal and those involved with the court system.

For a powerful account of the mental health-to-prison pipeline, I recommend reading [When They Call You a Terrorist: A Black Lives Matter Memoir](#) (see resources in Part 3).

## STRATEGY #7

# REASSESS BOUNDARIES AND TIME FRAMES FOR TREATMENT

What practices do you use with clients that are based in white supremacy? For instance, as a therapist, what commodified therapeutic approaches are you using that exist as traditional healing methods by people of color across the globe? Are you aware of the origins of your practices with clients? Are these practices that can be replaced or dismantled to address commercialized white supremacy within the therapeutic approach? If so, how?

Reassess the frequency and duration of sessions with clients. Who says that one 45-50 minute session every week or two is adequate or appropriate for Black clients' treatment? Who gets to define and decide the terms and conditions for treatment? How can you best advocate for your Black clients to challenge the terms that are not ethical or clinically effective?

**Discuss treatment plans, time frames, and expectations** with Black clients, so they know upfront whether the treatment you are offering can best meet their mental health needs. If they determine you are unable to meet their clinical needs, then provide them with the option of another therapist (a Black, Indigenous, or other person of color). Provide them with ample culturally appropriate and accessible mental health referrals and resources.

Utilize **self-disclosure as a tool rather than a problem** in treatment. Some Black clients respond better to transparency and a more open relationship with their clinician.

Also consider the location, setting, and environment of mental healthcare. Consider visiting or using other spaces as invited or appropriate, such as walks, picnics, basketball games, community events, etc.

## STRATEGY #8

# DECENTER CLINICIANS AS PRIMARY HOLDERS OF KNOWLEDGE

Peer groups and group wellness spaces can be central to healing. Does your department offer a **Black healing circle** or other dedicated spaces for Black clients to heal together?

Decentering clinicians as primary holders of knowledge includes **decentering coloniality** in treatment. Many colonialist psychotherapy models capitalize on Indigenous holistic healing practices (including African Indigenous spirituality and approaches to healing).

When thinking about healing practices, it is important to recognize that Black clients also heal in holistic ways.

For instance, [trauma is healed through physical](#), spiritual, and interpersonal regulation, including prayer, movement, breathing, meditation, as well as creating safe and soothing connections with the living world.

Recalibrating one's fight-or-flight response is not a cognitive undertaking. It is important then for therapists to educate themselves on their clients healing practices and consult when unfamiliar with a client's traditional modality of healing.

## STRATEGY #9

# RECONCEPTUALIZE PATHOLOGIES

When possible, **eliminate diagnoses**, **avoid pathologizing clients**, and **renounce** [deficit thinking](#).

Redefine and reconceptualize symptoms and diagnoses as clients' **self-protection and strength**.

For instance, disassociation is the body's way of keeping it safe from harmful systems and circumstances. Flashbacks are a way to help one revisit that which the body is hoping to work through.

## STRATEGY #10

# ENCOURAGE AND SUPPORT POLICY, ADVOCACY AND ORGANIZING EFFORTS

Engage in policy, advocacy, and organizing efforts. Encourage and support Black staff and clients to engage in these efforts if they desire. Understand how advocacy has a place in shifting mental healthcare protocols, procedures, access, and treatment effectiveness.

Engaging in advocacy opportunities is one of the most powerful ways to impact your Black clients' wellbeing because Black clients are underrepresented in vital decision-making circles.

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# ENCOURAGE AND SUPPORT POLICY, ADVOCACY, AND ORGANIZING EFFORTS

As the only known trauma, grief, and loss counselor for an entire school district, [I helped create and advocate for policies to benefit my clients at the state level](#). I do not see how mental healthcare can be a separate effort from policy and advocacy work. Policy makers are not therapists who understand details of our work, which is vital in creating effective mental health policies. Policies that impact your colleagues and clients - including those indirectly related to mental health - are policies that you can help shape on a local, state, or federal level.

Every single employee and institution can advocate for policy efforts to eliminate or reduce student loan debt. Black communities, and Black women in particular, carry the [highest level of student loan debt](#) in the country. This is due to a history of racial capitalism and present day heteropatriarchy impacting Black women's ability to reduce their student loan debt.

Student loan debt impacts Black clinicians' work decisions. I have worked with Black professionals in their 20's and 30's who have almost half a million dollars in student loan debt, earning only \$45-\$65,000 a year in San Francisco. They need their institutions actively advocating to support bills at the state and federal levels for student loan debt relief. Organizations can write [support letters](#) and receive signatures from their employees to support bills with the click of a mouse.

Supervisors can research deadlines for local, state, and [federal loan repayment, forgiveness, and cancellation programs](#). Carve out time, offer structured workshops, and support for Black employees to successfully receive student loan debt relief from these programs, so they can continue to serve the clients from their communities.

I learned through an online source (not from anyone in person) that my own organization was eligible for a [state loan repayment program](#). I wasn't sure if I even qualified for it, but I interacted with a white male employee applying for it the day it was due. When I found out I did qualify, I rushed to complete my application and was awarded the loan repayment grant a few months later.

White folks, especially men, have increased access to social capital and proximity to knowledge about financial opportunities. After paying down most of my student loan debt and recognizing the barriers to debt relief for Black women, I decided to write a book on student loan debt for women of color. (Look out for it early next year.) Now, I advocate for student loan cancellation at various levels of government because it is one of the most insidious anti-Black schemes of our modern era.

If you supervise Black employees, support your employees with opportunities to couple their work with policy and advocacy training. There are hundreds of policy and advocacy training opportunities with organizations like, [Black to the Future](#), [Public Policy Institute](#), [Women's Policy Institute](#), [She Should Run](#), and [Emerge America](#).

As mental health professionals, we can start small with policy and advocacy training and attend organized lobby days with our professional organizations, such as the California Psychological Association ([CPA](#)), the Social Work Coalition for Anti-Racist Educators ([SWCAREs](#)) and the California Association of Marriage and Family Therapists ([CAMFT](#)).



## PART 3

# RESOURCES

## CONSULTANTS

THERE ARE THOUSANDS OF CONSULTANTS IN THE FIELD OF MENTAL HEALTHCARE AND DIVERSITY PROGRAMMING.

THIS IS A SHORT LIST OF CONSULTANTS I TRUST TO SUPPORT YOUR COMMITMENT TO EFFECTIVELY SERVE BLACK STAFF AND CLIENTS IN ORGANIZATIONS AND MENTAL HEALTHCARE. CONSULTATION IS VITAL TO COUPLE WITH THE STRATEGIES IN PARTS 1 & 2.

WE MUST REMAIN CONNECTED AND INVOLVED WITH BLACK MENTAL HEALTH PROFESSIONALS TO EFFECTIVELY SERVE BLACK COMMUNITIES. THIS MEANS REMAINING EMBEDDED IN THE COMMUNITY.

# CONSULTANTS

## DARLENE A. HALL, PHD



*Creator:* Intersections Consulting

*Specialties:* Power/privilege and diversity; Mental health; Trauma; Organizational development; Program evaluation; Youth development

*Location:* San Francisco, Bay Area

*Contact:* <http://intersectionsconsulting.com/>

*Availability:* Inquire Within

*Media:* [Brief overview](#) of the menu of consulting, training, technical assistance, coaching, and facilitation services provided

## AMBER MCZEAL, PHD



*Creator:* [Evolution Muse Healing Arts Production's Decolonizing the Psyche: Innovations in Community Based Learning](#)

*Specialties:* Somatic, community liberation, Indigenous, ecological psychologist; Facilitator; Healing arts practitioner

*Location:* San Francisco, Bay Area

*Contact:* [ambermczeal@gmail.com](mailto:ambermczeal@gmail.com); [amber@decolonizingthepsyche.com](mailto:amber@decolonizingthepsyche.com)

*Availability:* Online & In-Person

*Media:* [Rooted](#)

## RELANDO THOMPkins- JONES, MSW



*Creator:* Notes from an Aspiring Humanitarian

*Specialties:* Social justice education on college campuses and in secondary schools; Diversity and inclusion consultant and workshop facilitator in organizations and community groups

*Location:* Allendale, MI

*Contact:* <https://www.relandothompkinsjones.com/>

*Availability:* Inquire Within

*Media:* [Notes from an Aspiring Humanitarian](#)

# CONSULTANTS

**SHAWNA  
MURRAY-  
BROWNE, LCSW**



*Creator:* Decolonizing Therapy for Black Folks Online Course

*Specialties:* Liberation-focused integrated psychotherapy; Mind-body medicine; QiGong; Race-based trauma education

*Location:* Baltimore, MD

*Contact:* <https://www.shawnamurraybrowne.com/>

*Availability:* Online & In-Person

*Media:* [A Collective Virtual Journey: Decolonizing Therapy for Black Folks](#)

**DE'SHAUN L.  
THORNTON,  
LPC**



*Creator:* Brothas In Therapy

*Specialties:* Batterers intervention program facilitator; Family and divorce mediation consultant; School-based mental health program director; LPC supervisor

*Location:* Oklahoma City, OK

*Contact:* [dl.thornton@live.com](mailto:dl.thornton@live.com)

*Availability:* Online & In-Person

**ANIM AWEH,  
LCSW**



*Creator:* Therapy Over Silence Podcast

*Specialties:* Black women and health; Understanding the relationship between physical and mental health; Postpartum and perinatal wellbeing; Mindfulness; CBT

*Location:* Atlanta, GA

*Contact:* [animaweh@gmail.com](mailto:animaweh@gmail.com)

*Availability:* Online & In-Person

*Media:* [Therapy Over Silence](#) (Apple Podcasts)

# CONSULTANTS

**SHAWNA  
MURRAY-  
BROWNE, LCSW**



*Creator:* Decolonizing Therapy for Black Folks Online Course

*Specialties:* Liberation-focused integrated psychotherapy; Mind-body medicine; QiGong; Race-based trauma education

*Location:* Baltimore, MD

*Contact:* <https://www.shawnamurraybrowne.com/>

*Availability:* Online & In-Person

*Media:* [A Collective Virtual Journey: Decolonizing Therapy for Black Folks](#)

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*Specialties:* Black women and health; Understanding the relationship between physical and mental health; Postpartum and perinatal wellbeing; Mindfulness; CBT

*Location:* Atlanta, GA

*Contact:* [animaweh@gmail.com](mailto:animaweh@gmail.com)

*Availability:* Online & In-Person

*Media:* [Therapy Over Silence](#) (Apple Podcasts)

# CONSULTANTS

## ALEXANDRA LOUIS, RMHCI



*Creator:* ReEnvision Harmony

*Specialties:* Anti-racism and anti-oppression work; Cultural diversity and awareness in counseling

*Location:* Miami, FL

*Contact:* <https://reenvisionharmony.com/contact-us/>

*Availability:* Inquire Within

*Media:* [ReEnvision Harmony Blog](#)

## NORISSA WILLIAMS, PHD



*Creator:* [Liberation Consulting Group](#)

*Specialties:* Training & workshop facilitator; Implicit bias; Anti-Black racism, Decolonizing research methods; Liberatory clinical practices; Socially just organizations, Structural competence; Needs assessment and strategic planning

*Location:* New York, NY

*Contact:* Dr.NorissaWilliams@gmail.com

*Availability:* Online & In-Person

*Media:* [Hiding Mental Illness](#)

## BABE KAWAII- BOGUE, PHD, LCSW



*Creator:* Combating Anti-Blackness and White Supremacy in Organizations: Recommendations for Anti-Racist Actions in Mental Healthcare *[this guide]*

*Specialties:* Anti-racist practices and policy/advocacy trainings in mental healthcare organizations; Black liberatory practices; Black feminist psychology; Attachment trauma; Trauma, grief, loss, and mindfulness groups for youth

*Location:* San Francisco, Bay Area

*Contact:* AntiRacistActionGuide@gmail.com

*Availability:* Online & In-Person

*Media:* [Culture Clash: Black Experiences in Mental Healthcare](#)

# COMMUNITY RESOURCES FOR BLACK STAFF AND CLIENTS

## FACEBOOK GROUPS FOR THERAPISTS OF COLOR

[Bay Area Black Female /  
Femme Therapists](#)

[Black Therapists ROCK™](#)

[Clinicians of Color in  
Private Practice](#)

[Decolonizing the Psyche](#)

[The Hub: Resources &  
Support for Therapists of  
Color](#)

[National Queer & Trans  
Therapists of Color  
Network](#)

[Therapists of Color - Bay  
Area](#)

## SAN FRANCISCO BAY AREA WELLNESS ORGANIZATIONS FOR BLACK COMMUNITIES

[Association of Black Psychologists](#) (Bay Area Chapter)

[Black Healing and Liberation Collective](#) (Oakland)

[Black Women Birthing Justice](#) (Oakland)

[Conscious Voices](#) (Oakland)

[East Bay Meditation Center](#) - meditation, movement, and  
retreats centered on Black, Indigenous, and people of color  
(Oakland)

[Namaste Ready](#) - donation-based yoga for Black men and  
other Black, Indigenous, and people of color (Oakland)

[Outdoor Afro](#) (Northern California)

[Rafiki Coalition](#) (San Francisco)

[LGBTQ Psychotherapists of Color](#) (SF/Bay Area)

[Sankofa Holistic Counseling Services](#) (Oakland)

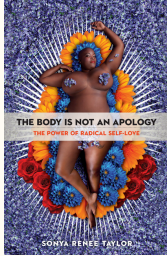
[Satya Bodyworks](#) - donation-based yoga & retreats for  
Black, Indigenous, and people of color (Oakland)

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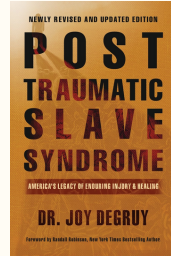
[44 MENTAL HEALTH RESOURCES FOR BLACK  
PEOPLE TRYING TO SURVIVE IN THIS COUNTRY](#)

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# RECOMMENDED READING FOR ANTI-RACISM & MENTAL HEALTH



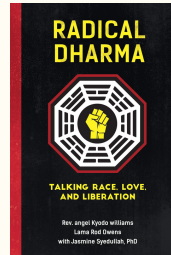
The Body is Not an  
Apology: The  
Power of Radical  
Self-Love



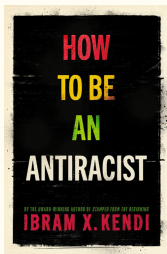
Post-Traumatic  
Slave Syndrome:  
America's Legacy  
of Enduring Injury  
& Healing



Emergent Strategy:  
Shaping Change,  
Changing Worlds



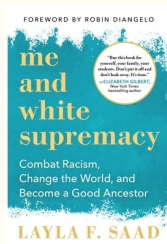
Radical Dharma:  
Talking Race, Love,  
and Liberation



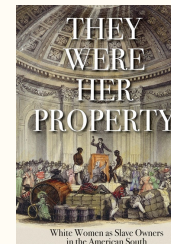
How To Be an  
Antiracist



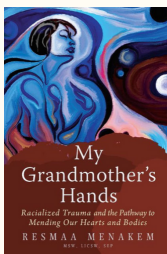
Separated: Family  
and Community in  
the Aftermath of an  
Immigration Raid



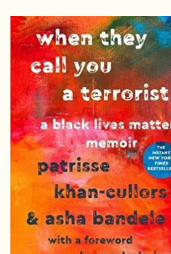
Me and White  
Supremacy: Combat  
Racism, Change the  
World, and Become a  
Good Ancestor



They Were Her  
Property: White  
Women as Slave  
Owners in the  
American South



My Grandmother's  
Hands: Racialized  
Trauma and the  
Pathway to Mending  
Our Hearts and Bodies



When They Call You a  
Terrorist: A Black  
Lives Matter Memoir



# ADDITIONAL ANTI-RACISM RESOURCES

[Black Lives Matter:](#)

[Anti-Racism Resources for Social  
Workers and Therapists](#)

Free Anti-Racist Webinars, Resources for People of Color - Healing Racial Wounding, Therapy/Funds Dedicated to People of Color, Resources for Self-Education About Racism in The US, How to Talk to Our Kids About Racism, Anti-Racism Resources / Guides / Toolkits, Anti-Racist Videos/Movies/TV Shows/Podcasts, Anti-Racism Organizations to Support, Self-Care.

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[Stanford Psychologist Identifies  
Seven Factors that Contribute to  
American Racism](#)

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[White Dominant Culture &  
Something Different: A Worksheet](#)

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[White Therapists: Here's What Your  
Black Colleagues Want You to Know](#)

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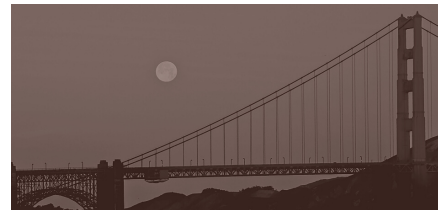
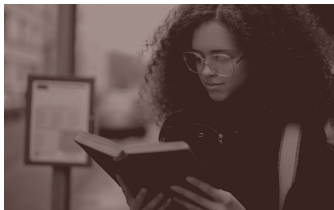


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# CONTRIBUTORS

This guide was created and curated by Babe Kawaii-Bogue, a therapist who embodies African, African American, Native Hawaiian, and Canadian/European ancestry. Babe was born and raised in San Francisco, CA and currently holds a unique position as the only trauma, grief, and loss counselor, serving youth of color in 15 high schools in the San Francisco Unified School District. She could not have created this guide without the voices and labor of the following Black women and queer/gender expansive allies:



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# COMBATING ANTI-BLACKNESS AND WHITE SUPREMACY IN ORGANIZATIONS: RECOMMENDATIONS FOR ANTI-RACIST ACTIONS IN MENTAL HEALTHCARE

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## ANY FEEDBACK OR QUESTIONS?

CONTACT **BABE KAWAII-BOGUE**

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If you feel this guide is valuable to your anti-racism work or can support racial justice in your workplace, you can offer a guide donation if you feel called to make that gesture of gratitude - even a few dollars is a generous gift. Non-monetary gestures of gratitude are also welcomed and appreciated.

Donations will be used to support the unpaid labors of the African American, Indigenous, and Latinx women who created this guide.

Please send guide donations to:

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Thank you for your commitment to racial justice and systems change. In solidarity and love.