Treatment Advocacy Center

OFFICE OF RESEARCH AND PUBLIC AFFAIRS

Research Summary

July 2024

The Overrepresentation of Black Americans in Assisted Outpatient Treatment: Taking a Closer Look

Coercive treatments for severe mental illness (SMI) can be necessary and lifesaving; at the same time, they can also cause distress and trauma to people who experience them. Coercive treatments should only be used when necessary to protect the wellbeing of a person with SMI and/or other members of society.

In the United States, Black people with SMI have been found to be more likely to receive coercive mental health treatments including involuntary hospitalizations,[1] the use of physical restraints,[2] the use of chemical restraints (i.e., drugs intended to sedate and calm patients),[3] and assisted outpatient treatment (AOT)[4] than people from other racial groups. To understand these disparities, it is first necessary to understand systemic factors, such as bias and lack of access to treatment options, that lead people to involuntary treatment, and why these factors are disproportionately likely to impact Black Americans.[a]

The system's failure to provide timely and effective treatment

One reason why people with SMI sometimes require coercive treatment is a lack of timely, effective, and affordable treatment options. When someone with SMI first begins to experience symptoms, they and their loved ones may seek voluntary hospitalization or community services. However, upon seeking help, they may find their community doesn't have a mental health clinic able to provide timely evaluation or outpatient services at the onset of symptoms; a shortage of psychiatric beds, resulting in hospitals turning them away[5]; and/or an inability to afford medication or treatment from nearby psychiatrists.[6,7]

The situation is even worse for Black Americans, who are 1.7 times more likely to be uninsured than white Americans.[8] Black Americans are also 1.2 times more likely to have public insurance.[9] Public insurance, also called Medicaid, is not accepted by many mental health specialists and most psychiatrists.[10] Lower income Black Americans are also less likely to have access to insurance coverage than lower income white Americans.[11] Without health insurance that covers treatment for mental illness, people who are experiencing a mental health emergency may be unable to afford and access timely treatment for their mental illness.

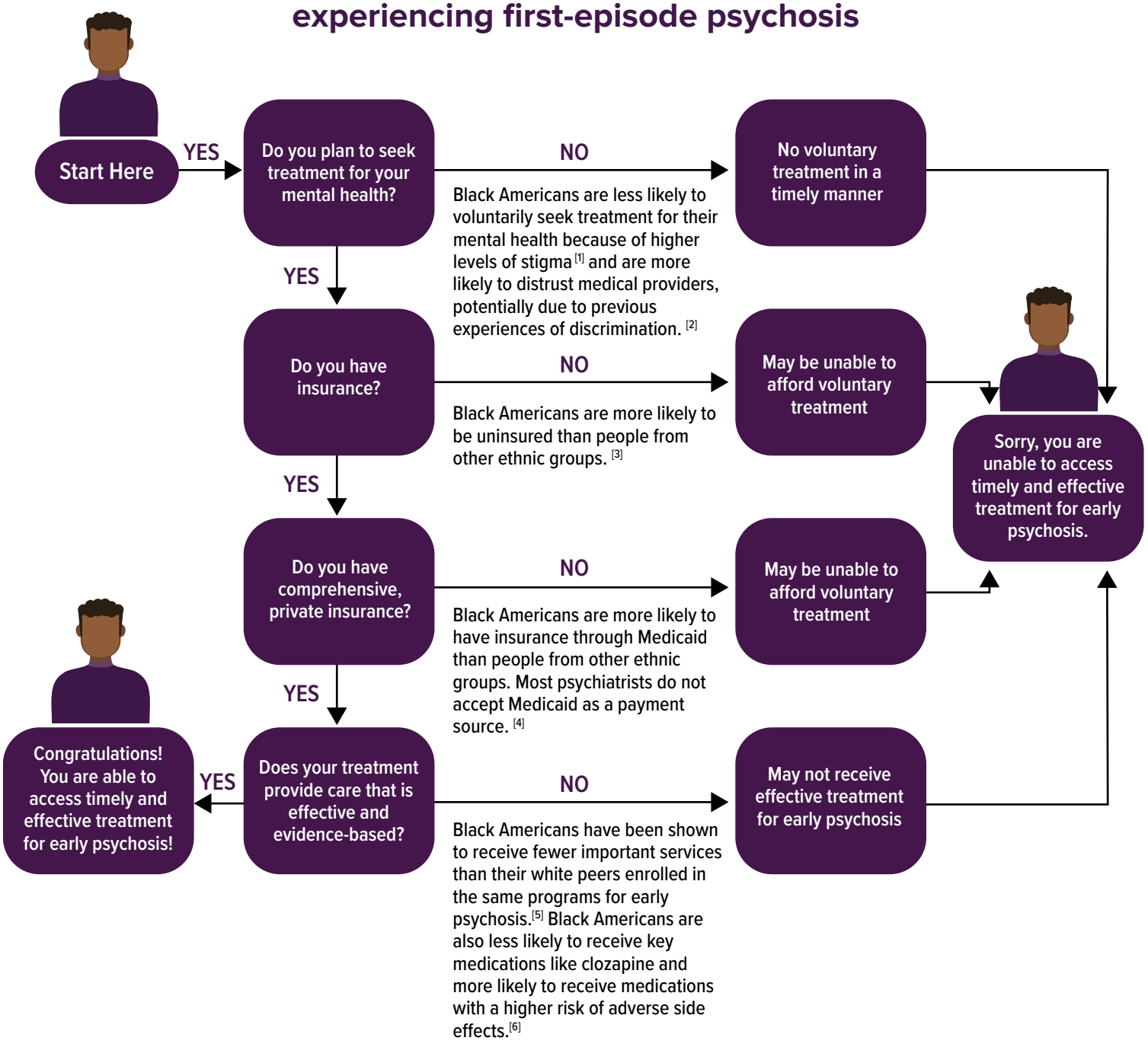
When Black patients enter treatment, they may still be less likely to receive the most effective medications. When in treatment, Black patients have been shown to be 1.3

times more likely than white patients to be prescribed first-generation antipsychotics, rather than second-generation antipsychotics.[12] [13] [14] First-generation antipsychotic medications are more likely to have adverse side effects. These adverse side-effects have also been shown to be more severe for non-white patients.[15] Black patients are also up to two times less likely to be prescribed clozapine, which is the only evidence-based antipsychotic for treatment-resistant schizophrenia.[16] More research is needed to determine the extent of racial disparities in SMI treatment, including disparities in antipsychotic prescription patterns.[17] Understanding the reasons underlying these disparities is especially important given that when people are unable to access timely and effective treatment for psychosis, they are likely to experience more severe symptoms and poorer functioning.[18] [19]

Involuntary and coercive treatments for mental illness are typically applied to people who are acutely symptomatic and unable to engage in voluntary treatment because of their illness. This could include people who are too symptomatic to seek voluntary services or people who are unable to take care of themselves because of their symptoms.[20] Accordingly, this disparity in access to timely and effective care may result in Black patients being more likely to experience intense and persistent symptoms that then require coercive treatments to begin the journey toward recovery.

> "Black people are more likely to be prescribed first-generation antipsychotics at higher doses, which leads to increased adverse side effect burden, more mistrust in the mental health system, and treatment non-adherence. This chain of events leads to disparities in access to our most powerful antipsychotic tool, clozapine, which leads to poorer treatment outcomes and higher symptom burden in this population."
>
> Menand, E., & Moster, R. (2021). Racial Disparities in the Treatment of Schizophrenia Spectrum Disorders:How Far Have We Come?. Current Behavioral Neuroscience Reports, 1-8

Systemic barriers to voluntary treatment after experiencing first-episode psychosis



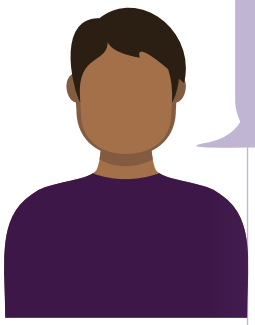
[1] Clement, S., et al. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine*;
[2] Bazargan, M., et al. (2021). Discrimination and medical mistrust in a racially and ethnically diverse sample of California adults. *The Annals of Family Medicine*.
[3] National Institute of Minority Health and Health Disparities. https://www.nimhd.nih.gov/docs/byomm_factsheet02.pd
[4] Olfson, M., et al. (2023). Racial-ethnic disparities in outpatient mental health care in the United States. *Psychiatric services.*
[5] Oluwoye, O., et al. (2018). Racial-Ethnic Disparities in First-Episode Psychosis Treatment Outcomes From the RAISE-ETP Study. *Psychiatric services.*
[6] Menand, E., & Moster, R. (2021). Racial Disparities in the Treatment of Schizophrenia Spectrum Disorders: How Far Have We Come?. *Current Behavioral Neuroscience Reports, 1-8*

Bias in assessments of dangerousness

A person can typically only be treated for mental illness involuntarily if a clinician or judge determines there is a substantiated risk that they will cause harm to themselves or someone else if left.[21]

of danger may contribute to why Black patients are more likely to experience involuntary admissions to hospitals, even when they have the same diagnosis, referral source, age, gender, housing status, and insurance status as white patients.[24]

> "Social psychologists have established that faces of Black males trigger thoughts of violence, crime, and dangerousness, and thoughts of crime trigger thoughts and images of Black males."
>
> Bennett, M. W., & Plaut, V. C. (2017). Looking criminal and the presumption of dangerousness: Afrocentric facial features, skin tone, and criminal justice. UCDL Rev., 51, 745.



Biased perceptions of dangerousness against Black Americans can lead health care providers to determine that Black Americans are more likely than white Americans to cause harm to themselves or someone else, even when this is not the case. In fact, there have been numerous studies showing that images of Black faces cause a larger fear response in the brain than white faces.[22] This elevated fear of Blackness found in the brains of American adults is not found in children or young teenagers,[23] suggesting that the association between Blackness and danger is socially constructed and not based on biology. These elevated perceptions

The specific association between schizophrenia, violence, and Blackness began in the civil rights era. In 1968, while the nation's attention was fixed on widespread racial justice protests and unrest, the second version of the Diagnostic and Statistical Manual (DSM-II) was published. In this version of the DSM, people with paranoid schizophrenia were described as angry and male, with the DSM telling psychiatrists that "the patient [with paranoid schizophrenia]'s attitude is frequently hostile and aggressive…and his behavior tends to be consistent with his delusions."[25]

During the 1960s and 1970s, mainstream newspapers repeatedly warned the public of "crazed black schizophrenic killers," while advertisements for antipsychotic medications drove home the association between Blackness, violence, and schizophrenia by featuring angry Black men holding Black Power fists.[26] This bias was so prevalent that the FBI went so far as to "diagnose" important leaders of the civil rights movement such as Malcolm X and Robert Williams with schizophrenia[27] in order to make them appear dangerous and to discredit their beliefs. While the field

A 1974 advertisement for the antipsychotic Haldol. The image features a Black man raising a black power fist with the caption "Assaultive and belligerent? Cooperation often begins with Haldol." [30]

of psychiatry no longer endorses these blatantly racist stereotypes and beliefs, their influence remains. Black men continue to be over-diagnosed with schizophrenia and under-diagnosed with mood disorders like depression and bipolar disorder.[28] [29]

People with schizophrenia who receive effective treatment are no more likely to commit violent crimes than the general population,[31] [32] and while all people with schizophrenia suffer from biased perceptions of dangerousness,[33] this prejudice may be worse for those who live with compounded perceptions of dangerousness from both their diagnosis of schizophrenia and the color of their skin. These biases may lead medical providers, law enforcement officers, and other decision-makers, especially within the criminal legal system, to determine that a Black patient is more of a danger to themselves or others than a white patient, despite them not actually posing an elevated risk. Because being a danger to oneself or others is typically a prerequisite for involuntary hospitalization, this may increase the likelihood that a Black patient with SMI will receive coercive and involuntary treatments for their mental health.

AOT and racial disparities

Because of longstanding biases and socioeconomic disparities, Black Americans with SMI are more likely than white Americans with SMI to experience poverty[34] and lack comprehensive insurance coverage.[35] When people are unable to access timely, effective treatment in the early stages of their illness, they may get sicker.[36] If they deteriorate to the point of being unable to care for themselves, are putting their own lives at risk, are at risk of harming others, or become engaged with the criminal legal system, the state may intervene to place the person in involuntary care.

AOT, and other involuntary outpatient treatment programs, have been proposed as less-restrictive options for people with SMI who have a history of psychiatric hospitalizations, incarcerations, and who require supervised treatments to help them stabilize and live safely in the community.

What is Assisted Outpatient Treatment (AOT)?
While not appropriate for everyone, AOT allows people with severe mental illness to live in the community while being required to adhere to a personalized treatment regimen. An AOT order may also include regular check-ins with the local court to monitor a person's progress.

High levels of stigma toward mental illness in Black communities can prevent people from seeking early treatment.[37] These high levels of stigma combined with a systemic lack of access to early treatment and higher likelihood of being deemed "dangerous" may contribute to Black Americans with SMI being more likely than white Americans with SMI to experience psychiatric hospitalization and be arrested.[38] [39] Because an extensive history of hospitalization or involvement with the criminal legal system is typically necessary for an AOT court order, Black Americans may accordingly be more likely than white Americans to be eligible for AOT.

Why understanding disparity matters

It is often suggested that racial disparities in treatment should be addressed by eliminating programs in which they are identified, rather than by doing the more

complex work of understanding what drives these disparities and what services may be necessary to ensure access to care for all communities.

Just as the closure of state hospitals due to quality-of-care concerns created significant gaps in the continuum of care for individuals with SMI, eliminating the practice of AOT would also remove a less restrictive alternative to inpatient hospitalization or involvement with the criminal justice system for those with the most severe mental illnesses. This is especially true as AOT is a treatment option that targets those who have been failed by the public mental health system in the past and have, as a result, been at greater risk of crisis-based hospitalization or arrest. AOT accordingly presents an opportunity to both ensure that those who are in the greatest need of services are prioritized by the mental health system and ensure that the system is held accountable for providing them with quality care.

AOT is also designed to be an alternative to hospitalization or incarceration and there is ample evidence that it works. Numerous studies have found that AOT can reduce hospitalizations,[40] arrests,[41] and violence against oneself or others,[42] as well as increase a patient's ability to care for themselves.[43] All people with SMI deserve to be treated in the least restrictive environment possible, especially those who are more likely to have been failed by our mental health system in the past. Accordingly, if we decide to limit or reduce AOT programs because of the overrepresentation of Black Americans in them, we may be eliminating an effective pathway to care and reinforcing the systemic overrepresentation of Black Americans in more restrictive environments like hospitals, jails, and prisons.

REFERENCES

[1] Shea, T., Dotson, S., Tyree, G., Ogbu-Nwobodo, L., Beck, S., & Shtasel, D. (2022). Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment. *Psychiatric Services*, *73*(12), 1322-1329.
[2] Smith, C. M., et al. (2022). Association of Black race with physical and chemical restraint use among patients undergoing emergency psychiatric evaluation. Psychiatric Services.
[3] Smith, C. M., et al. (2022). Association of Black race with physical and chemical restraint use among patients undergoing emergency psychiatric evaluation. Psychiatric Services.
[4] Swartz, M., Swanson, J., Steadman, H., Robbins, P., & Monahan, J. (2009). New York State assisted outpatient treatment program evaluation. Durham, NC: Duke University School of Medicine.
[5] Fuller, D.A., Sinclair, E., Geller, J., Quanbeck, C., Snook, J., (2016). Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds. *Treatment Advocacy Center.* https://www.treatmentadvocacycenter.org/going-going-gone.
[6] Stearns, J., (2020). The Cost of Medications. *American Association of Psychiatric Pharmacists.* https://stage.nami.org/NAMI/media/NAMI-Media/Research/The-Cost-of-Medications_2023.pdf
[7] Leonhardt, M., (2021). Health and Wellness. What you need to know about the cost and accessibility of mental health care in America. *CNBC.* https://www.cnbc.com/2021/05/10/cost-and-accessibility-of-mental-health-care-in-america.html
[8] Keisler-Starkey, K., Bunch, L.N., (2022). Health Insurance Coverage in the United States: 2021. *The United States Census Bureau.* https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf
[9] Keisler-Starkey, K., Bunch, L.N., (2022). Health Insurance Coverage in the United States: 2021. *The United States Census Bureau.* https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf
[10] Olfson, M., et al. (2023). Racial-ethnic disparities in outpatient mental health care in the United States. *Psychiatric services.*
[11] The Commonwealth Fund. (2023). Inequities in Health Insurance Coverage and Access for Black and Hispanic Adults. https://www.commonwealthfund.org/publications/issue-briefs/2023/mar/inequities-coverage-access-black-hispanic-adults
[12] Robinson, D. G., et al. (2015). Prescription practices in the treatment of first-episode schizophrenia spectrum disorders: data from the national RAISE-ETP study. *The American Journal of Psychiatry, 172*.

[13] Menand, E., & Moster, R. (2021). Racial Disparities in the Treatment of Schizophrenia Spectrum Disorders: How Far Have We Come?. *Current Behavioral Neuroscience Reports, 1-8.*
[14] Lawson, W., et al. (2015). Racial differences in antipsychotic use: claims database analysis of Medicaid-insured patients with schizophrenia. *Ann Clin Psychiatry*, *27*(4).
[15] Tenback, D. E., Bakker, P. R., & van Harten, P. N. (2015). Risk factors for tardive movement disorders in schizophrenia. *Tijdschrift Voor Psychiatrie, 57*(2).
[16] Williams, J. C., Harowitz, J., Glover, J., Tek, C., & Srihari, V. (2020). Systematic review of racial disparities in clozapine prescribing. *Schizophrenia Research, 224.*
[17] Menand, E., & Moster, R. (2021). Racial Disparities in the Treatment of Schizophrenia Spectrum Disorders: How Far Have We Come?. *Current Behavioral Neuroscience Reports, 1-8.*
[18] Addington, J., et al. (2015). Duration of Untreated Psychosis in Community Treatment Settings in the United States. *Psychiatric Services, 66.*
[19] Penttilä, M., Jääskeläinen, E., Hirvonen, N., Isohanni, M., & Miettunen, J. (2014). Duration of untreated psychosis as predictor of long-term outcome in schizophrenia: systematic review and meta-analysis. *The British Journal of Psychiatry, 205.*
[20] Giacco, D., Conneely, M., Masoud, T., Burn, E., & Priebe, S. (2018). Interventions for involuntary psychiatric inpatients: a systematic review. *European Psychiatry, 54.*
[21] Treatment Advocacy Center. (2020). State Standards for Civil Commitment. https://www.treatmentadvocacycenter.org/storage/documents/state-standards/state-standards-for-civil-commitment.pdf
[22] Bennett, M. W., & Plaut, V. C. (2017). Looking criminal and the presumption of dangerousness: Afrocentric facial features, skin tone, and criminal justice. *UCDL Rev., 51*, 745.
[23] Telzer, E. H., Humphreys, K. L., Shapiro, M., & Tottenham, N. (2013). Amygdala sensitivity to race is not present in childhood but emerges over adolescence. *Journal of cognitive neuroscience, 25*(2).
[24] Shea, T., et al. (2022). Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment. *Psychiatric Services, 73.*
[25] Metzl, J. M. (2009). *The Protest Psychosis: How Schizophrenia Became A Black Disease.* Beacon Press.
[26] Metzl, J. M. (2009). *The Protest Psychosis: How Schizophrenia Became A Black Disease.* Beacon Press.
[27] Metzl, J. M. (2009). *The Protest Psychosis: How Schizophrenia Became A Black Disease.* Beacon Press.
[28] Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry, 4*(4), 133.
[29] Minsky, S., Vega, W., Miskimen, T., Gara, M., & Escobar, J. (2003). Diagnostic patterns in Latino, African American, and European American psychiatric patients. *Archives of general psychiatry, 60*(6), 637-644.
[30] Metzl, J. M. (2009). *The Protest Psychosis: How Schizophrenia Became A Black Disease.* Beacon Press.
[31] Compton, M. T., Zern, A., Pope, L. G., Gesser, N., Stagoff-Belfort, A., Tan de Bibiana, J., ... & Smith, T. E. (2023). Misdemeanor charges among individuals with severe mental illnesses: A statewide analysis of more than two million arrests. *Psychiatric Services, 74.*
[32] DeAngelis, T., (2022). Mental illness and violence: Debunking myths, addressing realities. *American Psychological Association.* https://www.apa.org/monitor/2021/04/ce-mental-illness
[33] Imhoff, R. (2016). Zeroing in on the effect of the schizophrenia label on stigmatizing attitudes: A large-scale study. *Schizophrenia bulletin, 42.*
[34] Snowden, L. R., Cordell, K., & Bui, J. (2022). Racial and Ethnic Disparities in Health Status and Community Functioning Among Persons with Untreated Mental Illness. *Journal of Racial and Ethnic Health Disparities.*
[35] Keisler-Starkey, K., Bunch, L.N., (2022). Health Insurance Coverage in the United States: 2021. *The United States Census Bureau.* https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf
[36] Taylor, M., Hancq, E.S., Duration of Untreated Psychosis: Impact on Brain Health and Psychosis Symptoms. Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/reports_publications/duration-of-untreated-psychosis/
[37] Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine, 45*(1), 11-27.
[38] Shea, T., Dotson, S., Tyree, G., Ogbu-Nwobodo, L., Beck, S., & Shtasel, D. (2022). Racial and ethnic inequities in inpatient psychiatric civil commitment. *Psychiatric Services, 73.*
[39] Snowden, L. R., Cordell, K., & Bui, J. (2022). Racial and Ethnic Disparities in Health Status and Community Functioning Among Persons with Untreated Mental Illness. *Journal of Racial and Ethnic Health Disparities.*
[40] Pataki, G. E., & Carpinello, S. E. (2005). Kendra's Law: Final report on the status of assisted outpatient treatment. New York State Office of Mental Health; Esposito, R., Westhead, V., & Berko, J. (2008). Florida's outpatient commitment law: Effective but underused. Psychiatric Services, 59(3), 328; Munetz, M. R., Grande, T., Kleist, J., & Peterson, G. A. (1996). The effectiveness of outpatient civil commitment. Psychiatric Services, 47(11), 1251—1252; Zanni, G. R., & Stavis, P. F. (2007). The effectiveness and ethical justification of psychiatric outpatient commitment. American Journal of Bioethics, 7(11), 31—41; Quanbeck, C., Tsai, G., & Szabo, K. (2012). Cost-effectiveness analysis of Assisted Outpatient Treatment implementation in California's civil sector. Unpublished manuscript; Swartz et al. New York State Assisted Outpatient Treatment Program evaluation; Azar et al. 2018 report to Congress.
[41] Swanson, J. W., Borum, R., Swartz, M. S., Hiday, V. A., Wagner, H. R., & Burns, B. J. (2001). Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? Criminal Justice and Behavior, 28(2), 156—189; Gilbert, A. R., Moser, L. L., Van Dorn, R. A., Swanson, J. W., Wilder, C. M., Robbins, P. C., Keator, K. J., Steadman, H. J., & Swartz, M. S. (2010). Reductions in arrest under assisted outpatient treatment in New York. Psychiatric Services, 61(10), 996—999; Pataki & Carpinello. Kendra's Law; Azar et al. 2018 report to Congress
[42] Phelan, J. C., Sinkewicz, M., Castille, D. M., Huz, S., & Link, B. G. (2010). Effectiveness and outcomes of assisted outpatient treatment in New York State. Psychiatric Services, 61(2), 137—143; Swartz et al. New York State Assisted Outpatient Treatment Program evaluation; Azar et al. 2018 report to Congress; Swanson, J. W., Swartz, M. S., Wagner, H. R., Burns, B. J., Borum, R., & Hiday, V. A. (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. British Journal of Psychiatry, 176(4), 324—331
[43] Pataki & Carpinello. Kendra's Law; Swartz et al. New York State Assisted Outpatient Treatment Program evaluation