The Psychiatric Rehabilitation of African Americans With Severe Mental Illness

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African Americans make up approximately 12% of the U.S. population, a total of around 36 million people. Evidence suggests that African Americans suffer from significant and persistent disparities within the mental health system. African Americans with severe mental illness are less likely than Euro-Americans to access mental health services, more likely to drop out of treatment, more likely to receive poor-quality care, and more likely to be dissatisfied with care. Dominant patterns of treatment for African Americans with psychiatric disabilities are often least suited to long-term rehabilitation. To be successful, interventions must simultaneously target three levels: macro, provider, and patient. Five domains are posited that cut across these levels. These are cross-cultural communication, discrimination, explanatory models, stigma, and family involvement. These need appropriate research and action to enhance the psychiatric rehabilitation of African Americans. Potential solutions to overcome barriers raised within these domains are suggested. (*Psychiatric Services* 61:508–511, 2010)

According to U.S Census Bureau figures released in 2005, African Americans make up approximately 12% of the U.S. population, a total of around 36 million people. Evidence is overwhelming that African Americans suffer from significant and persistent socioeconomic and health disparities. They are significantly more likely than persons from other racial groups to be of a lower socioeconomic status. Over half of African Americans are poor or near poor, compared with 26% of Caucasians and 33% of Asians and Pacific Islanders (1). This has been attributed to limited opportunities in previous generations, as well as ongoing marginalization (2). An accumulating body of literature on the social determinants of health suggests that living in these socioeconomic conditions are predictive of manifold suffering, distress, and illness (3,4). Indeed, specific research has consistently related low socioeconomic status among African Americans with disproportionately negative health outcomes. African Americans are significantly more likely to rate their own health as poor or fair, compared with Euro-Americans, Latinos, and Asian Americans. Also, African Americans experience significantly higher age-adjusted mortality than any other ethnoracial group in the United States (5–7).

Additionally, without question African Americans are one of the most underserved ethnoracial groups in terms of general health care. Twenty-one percent of nonelderly African Americans do not have health insurance, and 28% are reliant on Medicaid or Medicare (8). These rates are significantly higher than those of Euro-Americans and Asian Americans. Many surveys converge to suggest that quality of care for African Americans is significantly worse than that of other ethnoracial groups, even when analyses controlled for insurance, income, and other confounders (9).

African Americans and mental health

The above-mentioned disparities are mirrored within the mental health system. Numerous studies suggest that African Americans are significantly less likely than Euro-Americans to access mental health services. Compared with Euro-Americans, African Americans are more likely to drop out of treatment, many after the first appointment. They are also more likely to receive poor quality of care and be more dissatisfied with their service experience (10–13). A recent study suggested that disparities in mental health care between African Americans and Euro-Americans worsened between 2000–2001 and 2003–2004 (14).

All these processes can be illustrated by more detailed analysis of African Americans with severe mental illness in the public mental health system. Severe mental illness can be intensely painful for the afflicted and can seriously impair function, often leading to job loss, disruption of social networks, loss of housing, and victimization. Numerous studies have suggested that African Americans are more frequently diagnosed as having severe mental illness, compared with Euro-Americans (15–17). African Americans living with severe mental illness also have a comorbid substance use disorder (dual diagnosis) at a significantly higher rate than Euro-Americans or Latinos (18). Living with a dual diagnosis places further burdens on individuals with severe mental illness, leading to further involvement in crime, violence, and victimization. This demands collaborative intervention.

Fortunately, there is a sizeable movement in the field of mental

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health dedicated to the rehabilitation of people with psychiatric disabilities. Rehabilitation was a concept often exclusively used to refer to people with physical disabilities. However, a progressive alliance of researchers, consumers, journal editors, and statutory bodies (such as the National Institute for Disability and Rehabilitation Research) has ensured that this concept has entered into the discourse of psychiatry. This alliance is further committed to ensuring that those with psychiatric disabilities receive effective rehabilitative services. These services include supported employment, supportive housing, effective case management, and dual diagnosis treatment. All these services aim to rehabilitate the individual back into the community so that he or she can lead rewarding and non–service-dependent lives. The rehabilitation movement extensively overlaps with the recovery movement. The latter is a consumer-driven movement that refuses to accept the poor prognosis predicted for severe mental illness, believing that individuals can recover from mental illness to lead meaningful lives, if only the right supports and assistance are given.

Unfortunately, dominant patterns of treatment for African Americans with psychiatric disabilities are often least suited to long-term rehabilitation or recovery. This is a population perhaps least affected by the discourse and practice of the innovative field of psychiatric rehabilitation. African Americans are significantly less likely than Euro-Americans to use specialty rehabilitation services even when analyses control for potential confounders (19). They are less likely than Euro-Americans to receive evidence-based pharmacotherapy or treatments such as electroconvulsive therapy (11,20,21). They are also significantly less likely than Euro-Americans and Latinos to receive case management services (22). This mirrors trends in rehabilitative services in other areas of psychiatry—for example, African Americans are less likely to receive a referral for rehabilitative care after a traumatic brain injury (23). Mental health in this case is no different from physical health; African Americans are less likely than Euro-Americans to receive a referral for cardiac rehabilitation services and indeed many other rehabilitative services in physical health (9,24). On the other side of the coin, African Americans with severe mental illness are far more likely than Euro-Americans to be hospitalized, to use crisis services, or to be brought to the emergency room by law enforcement (10,25,26). Again this egregious finding stretches back decades and is a situation that does not appear to be improving over time (27,28).

Explaining and solving inequalities

In studying these multifarious inequalities, researchers have divided influences on mental health into three levels of action: macro-level factors, provider-level factors, and patient-level factors. The most rigorous studies collect data from all three sources, so that findings can be triangulated. These studies have helped to conceptualize the problems experienced by African Americans in utilizing available rehabilitative and mental health services. These studies have commonly attempted to shed light on two related questions: First, why do African Americans utilize mental health rehabilitative services less than other groups? Second, as indicated by dropout rates and other negative outcomes, why are they less satisfied when utilizing such rehabilitative services?

Although the epidemiological and health services data point toward these gross racial inequalities, clear answers to these questions have not been forthcoming. There is an urgent need to further examine through rigorous empirical study the service experience of African Americans in psychiatric rehabilitation. Such examination can benefit from the application of preexisting theory and consideration of extant research related to the experience of racial and ethnic minority groups in the mental health system. Five topics, listed below, have emerged from the existing corpus of work. Examination of their intensity and impact could assist in the refinement and development of psychiatric rehabilitation services for African Americans.

Cross-cultural communication

It has often been posited that when the culture of the clinic is at odds with the culture of the community, miscommunication and misunderstanding between patient and provider prevail (8,11,12). It has been stated that the African-American community often does not perceive the mental health clinic as a service provider but rather as a place to be fearfully avoided (29). This is a problem mainly at the provider level. Interventions that enhance a provider's cultural competence could be an effective remedy. Only then should persuasive outreach work be conducted to encourage service engagement in the community.

Discrimination

It has been argued that African-American patients often perceive that mental health services are discriminatory and worry that services provided mainly by Euro-Americans for African Americans may have nefarious purposes. This may be a legacy of the Tuskegee syphilis trial or of wider experience of governmental services (30,31). This situation is compounded by the greater likelihood of involuntary commitment among African Americans and by the excessive prescription and higher dosing of medication in this population (32). This problem straddles the macro, provider, and patient level. Antidiscrimination initiatives at the societal and provider level may help tackle discrimination—for example, affirmative action in the hiring of mental health agency staff. Also, providers who work collaboratively with local black organizations may be considered more Afrocentric by African Americans. This may lead to less suspicious attitudes toward mental health services among African Americans.

Explanatory models

African-American patients may believe that their experience of distress and suffering is a moral or religious problem rather than a medical or psychiatric one (33,34). This may lead them to avoid mental health services or to drop out if services do not recognize or validate their explanatory models of distress and illness. They

may be more likely to seek help from other entities, such as the black church (17). This challenge exists at both the provider and the patient levels. Innovative solutions to this problem include alliances between providers and black churches to work together to improve rehabilitation and recovery among African Americans. This requires providers to be open to alternative worldviews to better serve this population.

Stigma

Stigma regarding mental illness and use of mental health services exists across the general population. However, it may be particularly acute among minority populations. Stigma is both a macro-level and a patient-level problem. Stigma existing in the wider community, in the localized black community, or in the family may act as a barrier to the utilization of rehabilitative services. This stigma might be internalized by African Americans in psychiatric rehabilitation, further compounding its pernicious effect. Stigma may also lead African Americans to frequent primary care clinics for mental health problems, which are notorious for undertreating mental disorders (35,36). Antistigma initiatives at national, local, and provider levels might be effective in diminishing stigma in the African-American community. Effective strategies might involve using African-American leaders to promote antistigma messages, as well as collaborative work with well-respected black secular and religious bodies.

Family involvement

Related to stigma, family involvement may be a key factor in psychiatric rehabilitation. Close-knit families may make decisions collectively, rather than individually. On the one hand, families sometimes discourage persons with mental illness from seeking treatment. On the other hand, families often encourage service engagement and remain a helpful source of support. However, family involvement is discouraged in U.S. delivery systems, which remain firmly individualistic in orientation (37–41). Increased attempts should be made to make rehabilitative services welcoming to family involvement. This could build on existing practices, such as assertive community treatment or family psychoeducation, which explicitly attempt to harness family support as a therapeutic strategy.

Conclusions

African Americans with psychiatric disabilities are overburdened, underserved, and in need of improved and effective services. In this Open Forum, we have outlined the problem and suggested some solutions. It should be noted that rehabilitative programs for persons with psychiatric disabilities in the general population have had powerfully beneficial effects. Supported employment, integrated dual diagnosis treatment, and the provision of supportive housing all enhance recovery and rehabilitation (42–44). However, as previously stated, data suggest that minority groups often access these effective services less frequently and at later stages (45). Indeed, in a recent article, Bae and colleagues (46) stated that "research on community-based psychosocial rehabilitation of persons with severe mental illness has rarely examined ethno-cultural factors." Research and action is needed posthaste. Finally, it should be noted that rehabilitation is essentially a tertiary prevention approach. Broader mental health disparities can be tackled only through primary and secondary prevention that targets underlying socioeconomic inequalities that influence the onset and course of mental illness in the first place.

Acknowledgments and disclosures

The authors thank the National Institute for Disability and Rehabilitation Research for funding their ongoing research "Building Knowledge and Capacity in the Rehabilitation and Recovery of African-Americans Suffering From Severe Mental Illness: The Dartmouth-Howard Collaboration" (project number H133A080063), which led to the formulation of the ideas expressed in this Open Forum.

Dr. Lawson is a consultant for Reckitt Benckiser Pharmaceuticals and AstraZeneca and has received grant support from Pfizer and AstraZeneca. Dr. Whitley reports no competing interests.

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