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Racial and ethnic disparities in research and treatment of people with schizophrenia

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As we look back and reflect on the year 2020, there were two major themes that stand out and that cannot be ignored by us in this introduction. The first is the Corona virus (COVID-19) pandemic, of course. However, the keywords 'COVID' and 'psychiatric' provide 3533 hits on PUBMED as of December 20, 2020. The other large 2020 issue was the 'Black Lives Matter' movement, that went viral much like the Corona virus. We saw demonstrations and marches all around the world demanding attention for the large disparities in risks and opportunities between White and non-White peoples of all nationalities.

A patient currently being treated by one of us (LED), a young African American man with a diagnosis of schizophrenia, recently commented that he felt marginalized by doctors and the pharmaceutical industry because although they are now advertizing antidepressants and even antipsychotic medications for schizophrenia, bipolar disorder, and depression on the national TV, he had never seen a person that looks like him with his hair braided, with arm tattoos and dark skin color in the advertisements. He wondered why we think the medications advertised could then truly be appropriate for him.

Clinicians and researchers, who develop new treatments and research this disease no doubt have racial and ethnic implicit biases that they are completely unaware of and thus without realizing it, may diagnose and apply medications to patients based on how they 'look'. For example, studies show that patients who are of African origin tend to be diagnosed more with schizophrenia than with an affective disorder [1,2]. Yet a Caucasian individual with the same symptoms may obtain the diagnosis of bipolar disorder or depression with psychosis.

Although we clinicians may think of ourselves as being free of racial prejudice, implicit association tests, like the one provided by Harvard University, indicate that implicit associations, do exist for the vast majority of people. If you want to check for yourself, take a minute to do the test: <https://implicit.harvard.edu/implicit/takeatest.html> Of course, the presence of such implicit associations can be

corrected willingly on the basis of rational thinking, but this takes a mental effort, which is not always made in the rush of the day.

The implicit biases of clinicians need to be addressed in all aspects of healthcare. Because of an implicit bias in how racial minorities are perceived, it may be that Black patients will receive higher doses of antipsychotics, end up in restraints significantly more than Whites [3], and could be more likely to be involuntarily admitted to hospital than Whites [4,5]. In the Netherlands, compulsory admission was significantly more frequent for Moroccans, Surinamese, and Dutch Antillean immigrants, compared to Dutch natives [6]. The bias of White police officers toward Black men, erroneously perceiving them as more physically threatening than Whites [7], could be generalized to medicine as well. Minorities may be erroneously seen as more threatening and thus held in seclusion longer than Whites.

Recently, recognition that racial and ethnic disparities in mental healthcare outcomes occur and the need to address them has initiated intense discussions [8,9]. The disadvantages of inquiring and noting individual race/ethnic background are obvious, but on the other hand, ignoring these factors may hide large disparities in mental health. In many ways this is an emerging psychiatric crisis, with dramatic differences between various groups. For example, Between 1991 and 2017, suicide attempts among Black adolescents in the USA increased by 73%, whereas attempts among White youth decreased, according to an analysis of more than 198,000 high school students nationwide [10]. A well-known example is the 3–10-fold increased risk for psychosis among non-European immigrants

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living in Europe [11]. Unfortunately, second generation immigrants, born in European countries have even higher risk ratios, implying that the immigration process itself may not be the causal factor, but rather the fact that they belong to ethnic minorities [12]. Similar risk ratios for individuals belonging to ethnic minorities, especially of non-White descent, have been shown for substance abuse [13].

We are now in the era of precision medicine, whereby treatment for individuals can be guided by their genetic as well as social determinants of health. Medication response, side effects and optimal doses of medications may vary among racial and ethnic groups. For example, one study comparing White and Black subjects in an olanzapine treatment trial, found that Black patients were significantly more likely to experience weight gain than White patients [14]. Thus, this may not be the medication of choice as a first treatment for Black patients. Unfortunately, many treatment trials do not include a large enough number and wide enough variation in ethnic origin of participants to be able to recommend individualized care distinctions. Post hoc analyses of efficacy and side-effects in larger (registration) trials would be greatly encouraged.

In order to understand disparities in outcomes, the first stage, recruiting ethnic and racial minorities into research studies, is extremely important. Although this may be challenging [15], given for example mistrust of White doctors conducting the studies, not wanting to be thought of as being experimented on and not being properly educated about the importance of research trials for the group to which they belong [16], it needs to be made a priority. Minority physicians, unfortunately, are far too rare in academic research, but when they exist may instill the much needed trust. Nevertheless, when surveyed, there was very little difference among racial and White potential study participants in their willingness to be part of research studies and it may be that there needs to be more outreach within their local community settings to recruit minorities for studies [17].

The quality of innovative and integrated intensive healthcare for schizophrenia may also differ when comparing what is received by minorities compared to that given to nonminorities. Minorities with schizophrenia spectrum disorders have less access to treatments than nonminorities [18,19], and when they are scheduled for follow-up care, they are more likely to have 'no-shows' [20] and thus lack of compliance to long term treatments. However, it is also clear that the quality of mental healthcare delivery to minority groups varies geographically, with some areas of the USA found to

have significant disparities, whereas others do not [21]. These differences could not simply be explained by geographic access to care in general, with minority populations living in areas with sparse access, but has likely to do with referral and prescribing differences by healthcare providers.

Early on in the illness course, it is possible, even likely, that race and ethnicity can produce barriers to the best treatments and follow-up care after a first hospitalization for schizophrenia. In a longitudinal analysis of a Pittsburgh first-episode treatment program, Li *et al.* reported that Black patients were significantly less likely to adhere to treatment and thus Black patients improved less over time than Whites [22]. Similarly in an analysis from The Medical Expenditure Panel Survey of 2004–2010 of patients with an inpatient hospital stay, Blacks were less likely than Whites to receive any follow-up treatment after discharge [23] and less likely to be receiving medications for their symptoms [24]. Similarly, the US RAISE-ETP study found that in those subjects randomized to regular community care and not receiving the intensive care, Blacks had more symptoms and were less likely to receive services, such as crucial family psychoeducation than White non-Hispanics [25]. Prescription practices in the community also appeared to frequently include higher than recommended doses of medication and polypharmacy with racial and ethnic differences in these patterns [26]. In addition, the duration of untreated illness prior to that hospitalization may be greater for these minorities than Whites, particularly if they lack insurance coverage or are less educated about signs of mental illness and feel embarrassed and hide symptoms [27]. Stigma among minority families may be greater and this would lead to hiding illness and not seeking or following-up with treatment [28–30]. It could also lead to a delay in receiving treatment for a first episode of psychosis [31]. Stigma may be propelled by perceived or real discrimination, focused on race combined with mental illness. The outcome of a schizophrenia illness over the lifespan of individuals thus depends on our abilities as leaders in the mental health profession to discuss how to break down these barriers and be able to provide equitable mental healthcare. Barriers to care, whether due to economic, cultural or religious beliefs, need to be recognized and reduced.

We thus propose:

- (1) An international congress or a satellite to one of the established psychiatry congresses to focus on continuing this important discussion on 'Equity and Inclusion in the care of people with schizophrenia.'

- (2) Provide mandatory leadership training in implicit biases for psychiatrists when licenses to practice medicine are renewed or obtained, and when individuals are recruited to leadership positions in academic and clinical departments.
- (3) Editors of journals should request information on sample diversity when publishing treatment trials or relevant studies. All published human studies should include diversity information in their methods section.
- (4) Funding agencies should prioritize those proposals that examine racial and ethnic minority populations.
- (5) Widespread education of community practitioners about standards of equitable evidence-based care for schizophrenia, particularly after a first episode should be prioritized.
- (6) Models of mental healthcare specifically focused on minorities that are flexible and are sensitive to their cultural beliefs should be developed. These may include training of peer navigators in the community and meeting on a frequent basis with stakeholder community leaders so that an integrated care approach can be developed within the community and not just centered in big medical centers [32,33].

In summary, Black lives matter, black mental health matters, and equitable care for all racial and ethnic groups matter. Step one is awareness of the differences in risk ratios and treatments that people belonging to minorities encounter. We hope this commentary helps in that first step and we look forward to taking the next.

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