Commentary: Racial Bias in Diagnosis and Medication of Mentally Ill Minorities in Prisons and Communities

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Dr. Hicks[1] adds welcomed momentum to the rising tide of awareness of disparities in access, diagnosis, and treatment of ethnic and racial minorities who suffer from mental disorders. Disparities in caring for these populations are plain to see in communities throughout the country and, as the recent Human Rights Watch Report, "Ill-Equipped: U.S. Prisons and Offenders with Mental Illness"[2] indicates, are especially glaring in forensic settings. The U.S. Department of Justice[3] reported in 1999 that 16 percent of all inmates in state and federal jails had severe mental illness. Two hundred eighty-three thousand people with serious mental illnesses were in jail or prison—more than four times the number in state mental hospitals. The average daily number of patients in state and county psychiatric hospitals has steadily decreased from 592,853 in 1950 to 71,619 in 1994. Recent surveys have indicated that 40 percent of families of persons with mental illness report that index family members have been arrested at some point in their lives. Moreover, a recent Department of Justice report showed that more than three quarters of inmates with mental illness have at least one prior prison, jail, or probation term. Some individuals are incarcerated scores of times. Probation systems are also affected, as 16 percent of probationers were persons with mental illness. When incarcerated, mentally ill offenders present problems, particularly when they arrive in a disoriented or psychotic state. Once in jail, they remain longer than others with similar convictions. Often their condition deteriorates and they become a behavior problem. Further, there is little planning when an inmate with a mental illness is released. People leave jail without supplies of needed medications, public benefits to pay their living costs, or Medicaid for community-based mental health services. As a result, many simply recycle through the criminal justice system.

These alarming trends are directly related to the inadequacies of community mental health systems and services. The widespread adoption of systems with proven effectiveness in addressing the needs of people with the most severe mental illnesses, such as assertive community treatment programs, would sharply decrease the number of people with severe mental illnesses involved in criminal justice systems. However, since these programs are available only sporadically throughout the country, strategies for reducing criminalization focus both on improving community mental health services, such as supported housing and crisis intervention teams, and on making available mental health courts as a means of addressing the treatment and support needs of people with severe mental illnesses while in the community and when in the criminal justice systems.

Without adequate mental health services, ethnic and racial minority patients are frequently mislabeled as criminals rather than as individuals suffering from a mental disorder. When a mental disorder is obvious to all, it is likely to be misdiagnosed, and if treatment follows, it may be rejected or be inappropriate because of the clinician's lack of awareness of the cultural issues involved.

In response to the U.S. Surgeon General's Report entitled "Mental Health: Culture, Race and Ethnic-

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ity,"[4] APA President, Richard Harding appointed a Steering Committee to Reduce Disparities in Access to Psychiatric Care. More recently, The New Freedom Commission on Mental Health[5] was established by President Bush to recommend new approaches on the national, state, and local levels to improve access and mental health services to those who need them.

Dr. Hicks' article points out further directions required to begin repairing this "shambles" of a "system"—that is, awareness of racial and cultural factors that shape manifestations of mental disorders and their treatments. All psychiatrists, especially forensic psychiatrists, should become familiar with the Cultural Formulation appended to DSM-IV-TR (Ref. 6, Appendix I), which recommends that the clinician assess the patient's self-perception of his or her own ethnic identity. Hicks correctly points out the scientific inaccuracies, inconsistencies, and bias-perpetuating racial classification in standard use today.

Other cultural issues of clinical importance to the treatment of mental disorders in minority patients include gender roles, immigration experiences (trauma, torture, etc.), language barriers, cultural explanations of their illness, which often also involve their religious beliefs, and various customary dietary practices including resorting to medicinal herbs for the treatment of "nerves."

Diet can have dramatic effects on the pharmacology of both psychotropic and nonpsychotropic medications by changing their absorption, metabolism, distribution, and elimination. These pharmacological influences depend on individual and familial genetic inheritance as well as on interaction with specific factors in the environment. For example, advances in the understanding of drug metabolism have revealed that genetically controlled liver enzyme systems (particularly the cytochrome-P450 system) can show substantial racial/ethnic variation in both the amount and in the activity of enzymes that metabolize many common medications, including psychotropic drugs. If a cytochrome enzyme responsible for the metabolism of a particular psychotropic has diminished activity (or is missing), toxic levels of the drug may develop. For example, African Americans and Southeast Asians have been found in some studies to require lower doses of tricyclic antidepressants than do whites to attain therapeutic responses and to avoid toxicity.

The guidelines provided in the Cultural Formulation of the DSM-IV are fundamental to diagnosing and treating mental illness in patients in a multicultural society, and the cultural issues encountered in psychotherapy are especially dependent on these fundamentals. Forensic psychiatrists should be able to recognize that not all unfamiliar traits, behavior, thoughts, or emotions in patients are necessarily the result of psychopathology. Similarly, they should consider that the unfamiliar dimensions of a patient may not be simply cultural in origin. It is also important that the psychiatrist be able to recognize and deal with differences in cultural values and their effects, negative and positive, on countertransference.

The Group for the Advancement of Psychiatry, Committee on Cultural Psychiatry has recently published a book[7] that can further guide the forensic psychiatrist through the intricacies of the Cultural Formulation in DSM-IV.[8] This useful guide will also serve as a textbook for courses and seminars in cultural competencies now required in all forensic psychiatry fellowship programs.

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