Taking Issue

The Need for Population-Based Approaches to Understanding Racial-Ethnic Disparities in Psychosis Outcomes

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Racial-ethnic disparities in health outcomes are widely documented. In this issue, Oluwoye and colleagues report on racial-ethnic disparities in outcomes following first-episode psychosis (FEP) in the Recovery After an Initial Schizophrenia Episode Early Treatment Program (RAISE-ETP). In a cluster-randomized controlled trial, 34 community mental health centers (CMHCs) across 21 states were randomized to standard community care or to multicomponent coordinated specialty care (CSC). The results show that in standard care, the non-Hispanic black group had greater psychopathology throughout follow-up compared with non-Hispanic whites, a disparity that was absent in the group receiving CSC. Non-Hispanic blacks in CSC were less likely than non-Hispanic whites to receive family psychoeducation, showing that most but not all racial-ethnic disparities were eliminated in the intervention arm. In another study in this issue, Lopez and colleagues questioned Latinos with a psychotic disorder and their family members about their knowledge of specific psychotic symptoms and found low psychosis literacy across the sample.

Commented [DJ1]: [Au: “community mental health treatment centers” has been abbreviated to CMHCs, as has “community health center.” Please revise if these are not interchangeable. This was running a bit longer than 750 words, so this was one of the edits to shorten.]

Low psychosis literacy in marginalized populations may delay help seeking and may mean longer duration of untreated psychosis and a more difficult route to appropriate care. Conceivably, young people lacking insight into their illness and living in communities with low levels of psychosis literacy risk more complex and compulsory trajectories into care and, as demonstrated in the RAISE study, more severe symptoms at baseline and—in standard care—at follow-up. Moreover, the article by Oluwoye et al. shows that some racial-ethnic minority groups are less likely to receive evidence-based interventions once in treatment. Although implementation of specialized services may reduce some disparities, these two studies demonstrate that reducing inequalities in mental health literacy and improving access to specialist care for psychosis remain substantial public mental health challenges.

More research is required to fully contextualize these findings, which remain bounded by the health care systems in which participants were recruited. For example, all CMHCs enrolled in the RAISE trial were required to have sufficient experience, commitment, and resourcing to offer an early treatment program for psychosis throughout the study period. Although such criteria provide a robust basis for experimental studies, a series of personal, social, economic, political, and methodological filters will ultimately determine selection into such a trial and therefore have important consequences for translating findings into an effective, coordinated, and coherent public mental health strategy when such programs are deployed “in the wild.” The original RAISE trial demonstrated beneficial outcomes for people enrolled in the CSC early treatment program over standard care. But, crucially, standard care was provided by CMHCs that had already demonstrated a minimum level of fidelity in providing specialist care for people with psychosis. Centers that could not ensure sufficient levels of experience, commitment, or resourcing would not have been eligible for the trial. Two worrisome unknowns are the proportion of the U.S. population lacking access to CMHCs that could implement RAISE-style treatment programs and the extent to which such access is equitably distributed. If some underserved communities are disadvantaged in ways that also increase their risk of developing psychosis—such as via increased exposure to deprivation, inequality, discrimination, or social isolation—then the level of unmet need for treatment in large segments of the population may be considerable.

Remarkably, in the United States, little is known about the burden and distribution of psychotic disorders in the population at large. Population-based studies are needed to address these gross deficits in knowledge if the United States is to achieve effective, widespread dissemination of RAISE-style early treatment programs, as originally envisioned by the study’s original investigators. In response, the National Institute of Mental Health has supported programs such as the Early Psychosis Intervention Network, which promises to build an informatics platform to better understand the characteristics of clinical high risk and FEP. Such investment needs to be coupled with efforts to accurately delineate the incidence of psychotic disorders in the U.S. population. Here, the U.S. mental health system can learn from approaches taken in northern Europe where evidence-based early treatment programs are underpinned by epidemiological data quantifying the incidence of psychotic disorders within and across populations. From this position, we will be able to deploy early treatment programs for psychosis that are not only efficacious but also effective in targeting care to communities in which need is greatest.