

## Dangerous

*They want to wait for something to happen, not like proactive. Maybe something happens and then you have to bring him back to the hospital; then we can try whatever [the psychiatrist] said, some acute care or something.*

—MALA (JAMES'S MOTHER), PHONE INTERVIEW, WEEK 12

Michael and his family came to the United States from West Africa when he was young. His family felt welcome in the large African immigrant community in North Texas. In high school, Michael was a star basketball player. "Everyone loved everything I posted on Facebook," he recalled wistfully. After graduation, Michael enrolled in community college to save money on tuition and housing and began studying to be a medical professional. Life seemed good. However, behind closed doors, things started to unravel.

His older sister, Liza, noticed that Michael seemed a little off during his senior year of high school. For example, when she came home from college for Christmas, Michael had stopped shaving. It seemed a small thing, but for her it was a red flag. "He always shaved. He was always [well] dressed. So I was like—he wasn't dressed?"

While visiting home again the following summer, Liza noticed a change in his speech patterns and focus on school. He kept changing his mind about what he wanted to study, but, she explained, "I thought—well, I didn't know what I wanted to do. So he doesn't know what he wants to do! But then, I noticed more when he'd talk to me—it wasn't a structured talk. It was like, he'll talk, and he'll go from one subject to the next subject, and then he won't remember what the last subject was."

Around this time, Michael began spending more time alone in his room. He also started smoking a lot of cannabis. He had smoked recreationally before, but Liza thought this seemed different.

"It was like this whole bunch of things on his mind that he couldn't really get out. He won't talk to anybody, but there's so much stuff that it was . . . a lot to

understand. Conversation was hard to follow because it was so much . . . We didn't think it was . . . Nobody in our family we know has . . ."

Liza's voice kept trailing off. She could not even say it: no one in their family had mental illness.

Michael started community college but dropped out after his first semester. He began a job and then quit. Everyone was concerned, but his mom especially so. She valued educational achievement. She kept asking Michael what his reason was for not going back to college, but he did not have one.

"It made [Mom] really sad . . .," Liza said, "like, depressed, because she didn't know how to help him."

As one year in his room doing nothing turned into two and then three, Liza said the family witnessed a real deterioration in his condition. Liza felt that Michael had been isolated for too long. She explained:

I know the last year was the worst. The first two years were just, like, you know, but the last year was just the worst. You're isolated for so long, you have twenty-four hours a day to think about just, like, you're—it's not safe to be alone with your thoughts twenty-four hours a day. It's, it's just not safe or healthy [. . .] when you have that much time, you overthink something, and it's really, really unhealthy for you and your mind, and, like, I feel like, for your heart. I feel like your soul and everything, just, not physically, but spiritually, too . . . 'Cause he thought that we were, like, poisoning him."

Michael stayed in his room for the better part of three years. He stopped eating much. "Every day," Liza said, "without fail, [Mom] would go to his room, bring him food, and like make sure that he was eating and that . . . It was just really sad; you just didn't know what to do. Like you didn't even know what was wrong." She continued:

He got really skinny. He would self-diagnose himself and say he was allergic to this and that. My mom was like, "I've been feeding you like this since you were little. Like, the doctors would've . . . something would have happened to you, if you were allergic to this, when you were little. You're 20 years now, and how did you all of a sudden become allergic to milk?" She's like, "That's what I'm not understanding: why would your own mom poison you?" And Michael thought we were just, like, believing in the devil and stuff.

Michael later said: "I would think my family was trying to kill me, and they were like devil worshippers, and people could read my mind. I don't know. I was thinking I was Jesus. I don't know."

His family felt helpless.

"A lot of the things he did," Liza said, "like unpredictable behaviors, like, feeling . . . we're possessed with the devil, or we're poisoning him, all these really off-the-wall thoughts . . ."

Liza struggled to get the words out. No one offered a lot of detail about what came next, but his family eventually called the police when Michael hit a breaking point and tried to attack Liza's toddler. He thought she was a demon.

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Many families and young persons facing early psychosis do not seek mental health care except as a last resort. Researchers call this "delayed help seeking." Delayed help seeking occurs in many conditions, including cancer, pregnancy, and diabetes, and is caused by many different factors. But in terms of mental health help-seeking delays, one main factor is that the family does not know much about mental illness or that it terrifies them to consider it. Michael's sister, Liza, could not even say the words—psychosis, schizophrenia (his eventual diagnosis), mental illness—even though Michael and the family had been struggling with it for years. Studies suggest that for Black youths, the average period between the onset of psychotic symptoms and treatment is nearly a year and a half.<sup>1</sup> For Michael, it sounded like at least three years.

As part of our research project, my team also conducted interviews with thirteen mental health providers in North Texas who both identified as and worked with individuals from ethnoracially minoritized groups to ask them what helped or hindered people in seeking mental health care. The groups discussed were most commonly African American, Black African, and Hispanic-identifying persons, and one of the providers also talked about the Asian community. Nearly all thought persons from these minoritized groups lacked both knowledge specifically about mental health and mental illness and resources to support mental health.

"I think education is the first step. I don't think it's the only step," one provider said. "I think what's really difficult when it comes to mental health is trying to change the culture. One, you have to speak up about it. Two, you have to educate people about it. And, three, you have to be willing to stand up and have these really tough conversations."

Another provider described a cultural context in which people clearly understood that if they had a "physical thing," then you "see a doctor that can touch you and see what's going on and you can get an X-ray . . . When it comes to mental health, you're just like, 'Oh, just change your thinking and everyone will be okay.' Or, 'Pray more and it's going to be okay.'"

Most of the families I worked with offered some plausible explanation for the young person's behavior that had little to do with psychosis. Amy's family thought she was abusing her ADHD medications. David's father and Michael's sister thought it might be substance use. James's mom thought he had a broken heart. Mental illness is not something people think of first, in part because of the societal stigma against it in the United States, a stigma that affects both family members and the young person in need of help.<sup>2</sup>

In general, widespread stigma discourages people from seeking care and presents mental illness in a negative light.<sup>3</sup> This may be especially true for persons from

ethnoracially minoritized groups. Nearly all the providers my team interviewed mentioned their concerns about stigma in the groups they served. Research supports this pattern. Persons who identify as Black, Asian, or Latino are more likely than whites to express higher levels of stigma against persons with mental illnesses.<sup>4</sup> This makes sense: a person with an already-diminished sense of moral agency as a member of a minoritized group begins with less capacity and fewer resources to manage the threat to moral agency that mental illness presents for the young person and their family. Black, Asian, and Latino persons with mental illness may conceal their symptoms to protect their family's resources or reputations or because they fear being perceived as a burden.<sup>5</sup>

Providers held the position that there were also cultural reasons that discouraged families and individuals from seeking mental health support. One of our providers who worked with Asian refugees mentioned that in some Asian communities whose religious beliefs included reincarnation, seeking mental health care meant that you were “not accepting your fate. You're not accepting the fact that something has happened to you because of something you did in your past life that predetermined that you are going to suffer.” Seeking mental health help was “anathema” to the culture, the provider said. In some Asian cultures in which reincarnation is a possibility, people saw suffering in this life as a gift—an opportunity to atone for the mistakes of a past life and earn merit for the next one.<sup>6</sup>

Another provider who worked primarily with individuals who identified as Black said that “mental health is . . . considered taboo or something. People who have mental health problems, they are ostracized . . . They are considered evil, or witches and wizards, and it's not very good . . . They're not embraced. People who have mental health problems, they are just left to wander around and deteriorate mostly.”

Research suggests that for Black Americans, who for hundreds of years have as a group embodied resilience despite the historical atrocities of slavery and current ongoing racism and discrimination, mental illness may be seen as a weakness, and so people avoid disclosing that illness to avoid judgment.<sup>7</sup> Anthropologist Tanya Luhrmann documented similar perspectives on being labeled as “crazy” among homeless African American women living on the streets of Chicago, for whom it signaled a vulnerability that could invite victimization, such as theft or sexual assault.<sup>8</sup>

Referencing the Hispanic population, a provider from a Spanish-speaking clinic in Dallas explained: “They know the family member needs help, but they . . . are not inclined to look for help because they think—‘*no loco*, they're not crazy, and if not, then why would you be going to that place for crazy people?’”

One of my consultants on the project, Maggie Caballero, a bilingual self-identified Latina who had lived experience of serious mental illness and led her own peer treatment program, told me that there was no gray area—either you were crazy (*loco*) or you were not (*no loco*) in Spanish-speaking cultures—and you wanted to do everything you could to avoid being perceived as *loco*. *Loco* was

reserved for people who could not be helped such as addicts and people who could not be cured. Maggie and several other Latinas in the study also told me that they feared *chismes*, or people gossiping about their lives and mental health status. If they were *loco* and became the subject of shameful *chismes*, they worried that the people they cared about might give up on them.

Anthropologists such as Kristin Yarris have suggested that gender affects social norms, roles, and expectations in the Latino community broadly, and also explored how individuals and their families perceive, explain, and handle a psychotic disorder as family caregiving arrangements shift in response to symptoms.<sup>9</sup> In addition, our consultant and providers told me that for Latino men, the Hispanic cultural tradition of machismo required them to maintain an image of strength. Having a mental illness could compromise that image. As one provider explained, “Hispanic men have the machismo thing, and they would be very stigmatized and perceived to be weak within that context.”<sup>10</sup>

This is not to say that the stigma of mental illness does not apply to persons from groups that are not minoritized. Many people in American society writ large consider any individual with mental illness, especially psychosis, to be defective, unpredictable, and dangerous.<sup>11</sup> No one wants to be *that* person or have their child labeled as such. Protecting themselves or their children from culturally fueled stigmatizing ideas about mental illness is only one reason to delay seeking help, though.

As mentioned earlier, many of the mental health providers we interviewed claimed that young persons and families delayed help seeking because they had limited knowledge about mental illness. Researchers write about this phenomenon as “low mental health literacy.”<sup>12</sup> Health literacy research assesses whether individuals can read health information and understand numerical claims. Mental health literacy researchers argue that this construct, often measured quantitatively via knowledge assessment tests, demonstrates how well individuals understand what mental illness is, how to recognize the warning signs, and how to successfully seek out treatment. They then compare individual scores between different cultural groups. In general, researchers have found that persons from minoritized groups in the United States have lower mental health literacy than their white counterparts. This has, in turn, been associated with the persistent underuse of mental health services and higher caregiver burden.<sup>13</sup>

Surprisingly, I could find little critique of the construct or its measurement to question what—and whose—ideas, knowledges, priorities, and practices were being used to determine what constituted “high” or “low” health literacy. However, I did find literature suggesting that discriminatory practices in health care perpetuate poor health literacy by denying better information and education about health care to groups with lower general literacy levels, which only reinforces power imbalances between professionals and patients and further justifies unequal treatment.<sup>14</sup> Thus, mental health literacy is often promoted to prevent and fight medical discrimination, which seems reasonable.

On the other hand, labeling minoritized persons as having “low mental health literacy” seems to place the onus of reform on the individual—they need to know better by educating themselves; if we educate them, that will fix the problem—while potentially distracting us from the upstream structural barriers that also need to be addressed. For example, the reluctance to seek help may also be fueled by a learned lack of trust in medical settings and practitioners that leads individuals to feel as though they have few options for help in the first place.<sup>15</sup> Medical mistrust is considerably more elevated in Hispanic and Black adults than in white adults, particularly when the former perceive they have been discriminated against by health care professionals, and even more so when they believe that discrimination was due to income or insurance status.<sup>16</sup> Such mistrust can be a survival strategy.

Other structural and social determinants of mental health, such as the segregation of neighborhoods through structural racism, can lead to the unequal distribution of mental health resources for individuals from minoritized groups and also affects families trying to navigate institutional pathways to care.<sup>17</sup> In 2016, the providers we interviewed claimed that there were no 24-hour mental health facilities available south of the Trinity River (and Interstate 30) where the vast majority of Black and Hispanic families lived. More than one-third of these families lived below the poverty line, a fact that can be attributed largely to redlining and other documented racist practices of residential and financial segregation in Dallas—practices that have also affected persons from minoritized groups elsewhere in the United States.<sup>18</sup> Other structural factors like health insurance and treatment costs pose additional barriers to mental health service utilization.<sup>19</sup> Lack of mental health insurance, lack of affordable mental health services, inflexible appointment times, insufficient scheduling procedures, and the long process to initiate treatment have been found to prolong help seeking for Black individuals and their family members.<sup>20</sup>

For immigrants, the stakes are also high. “There’s a lot of barriers,” one provider explained. “First, these people, they are scared, especially—some of them don’t have papers. The fear of coming out, that, ‘Oh, I don’t have health insurance. What am I doing? Nobody is going to care for me, and I don’t know anyone.’” Anthropologists have described both the fear of seeking care for undocumented persons and the mental health distress caused by living as an undocumented person in the United States—two structural situations that feed into each other to delay health help seeking.<sup>21</sup>

Several providers also thought that financial concerns were at the root of the problem. One explained:

Socioeconomically, I think their chances of being at a higher income level and to be able to afford the necessities of life, the chances of that decreases. And due to that, they are not given the proper education. They are not given the proper care that they need at home because mom or whoever is taking care of them is working two to three jobs to be able to support [her children]. So given all those reasons and

putting that together, they don't get the appropriate care at the appropriate time, which leads to a delay in diagnosing them or taking a violent episode that may end up putting them in a jail initially because they have not ever been diagnosed with a mental health issue. Then from there, you start the cycle of: How do you get them to an evaluation process? How do you get them to a mental health facility like ours? So they go through some traumatic episodes before they get to this point—to some care. There was never somebody looking at them and just saying, "I think there's something going on with this kid," which delays their care.

All these barriers can prevent help seeking despite a strong potential need stemming from high levels of adverse life experiences for minoritized youths, which can heighten one's risk of developing psychosis. Nearly half of the providers mentioned the role of traumatic experiences as affecting the lives of the young persons with whom they worked. For Black youths in particular, research suggests that traumatic experiences include higher levels of childhood adversities such as residential instability and parental unemployment, incarceration, substance use, and exposure to violence than for white children.<sup>22</sup> Hispanic youths are also exposed to more violence than their white counterparts.<sup>23</sup>

One provider explained what they meant by *trauma*: "When I say the word *trauma*, a lot of people go to like, 'Oh, you hit your head,' or some major disaster, that trauma. But trauma can be that you saw your mom get hit by your dad. Or trauma can be that your sister abused drugs and you saw her do it. And so there's a lot of stuff that can come from trauma and how it can affect the brain and affect a teenager in general."

Trauma can also stem from living in foster homes or a single-parent household. As one provider said, "Anything that's in our past that has to do with adverse childhood experiences—there's a lot that has been contributing and it's not talked about." Unaddressed childhood trauma, such as physical and sexual abuse, is also linked to increased substance use as a coping mechanism,<sup>24</sup> which, as we know, can trigger or exacerbate psychotic symptoms. In fact, up to 70 percent of persons experiencing early psychosis also meet criteria for a substance use disorder, defined as problematic substance use that is disrupting one's everyday life.<sup>25</sup>

While the reasons for delayed help-seeking are myriad, all lead to a longer period during which a person receives no mental health support for their symptoms. When those symptoms include psychosis, this period is known in the literature as the duration of untreated psychosis (DUP).<sup>26</sup> Experiencing a longer DUP can have consequences. Research suggests that persons experiencing longer DUPs in the United States and United Kingdom typically have more severe symptoms, are more likely to attempt self-harm, and have lower chances of getting back to "normal" performance in work, school, and self-care.<sup>27</sup> This risk seems to increase the longer a person goes without support. So, for example, a person with a DUP of four weeks has 20 percent or greater severity of symptoms at follow-up relative to a person who had only been experiencing psychosis without treatment for one

week. In addition, longer DUPs for young people often place a greater strain on their family.<sup>28</sup>

Of course, all this research highlights how serious it was that Michael had been struggling for three years without care. Researchers argue that, in part because of delays in seeking or accessing care, Black youths with early psychosis typically present with more severe psychotic symptoms and often access care through a “catalytic event” (e.g., accident, arrest) involving emergency services and police involvement.<sup>29</sup> More intense positive symptoms often contribute to unusual or dangerous behaviors that then prompt families to seek and initiate treatment.<sup>30</sup> This was true for Michael, who tried to harm his niece before help was called—and that help was the police. Research on this topic in the United States is limited, but one Canadian study found that “emergency services were most often the contact that helped individuals obtain appropriate treatment for psychosis.”<sup>31</sup>

Shortening the duration of untreated psychosis has thus been the focus of many early intervention for psychosis programs around the world, which try to prevent negative consequences such as catalytic events and police involvement by helping young people access care as soon as possible after symptoms begin. However, early recognition of psychosis symptoms requires people in the community—family members, teachers, coaches, pastors—to recognize that a young person is developing a serious mental health issue that requires support as early as possible, and to connect people to those supports quickly before a crisis occurs. Unfortunately, for most of the youths in our study like Michael—and so many others not in my study—a quick connection to mental health support was not part of their story.

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Sofia ultimately got help through emergency services after some long delays—and her early interactions did not initially inspire her to trust or desire more mental health care. Sofia had studied abroad in Latin America during college to improve her medical Spanish but left the program early and returned to the United States after a traumatizing assault at gunpoint. Back at school, she told her roommates what happened to her, and they were not supportive. According to Sofia, they gossiped about her (the dreaded *chismes*) and told others that she was crazy. Sofia thought they were racist. Her mother, Maria, who was born in Mexico, agreed.

Sofia’s conflicts with her roommates eventually became so significant that she had to move into a new apartment. “But she is not aggressive,” her mother added hurriedly. “She has never hurt anyone.” Maria said that everybody at school loved Sofia and repeatedly gave examples of how her daughter was so nice, so passive, and never bothered anyone. Maria thought Sofia had just chosen the wrong friends.

Sofia shared her thoughts: “I think it started gradually because there were little things that were happening in my life that I couldn’t control. And I couldn’t go to sleep. I was thinking that I was . . . I had the problems with my roommates. And then I couldn’t go to sleep.” When Maria visited Sofia at college to cook for her, she

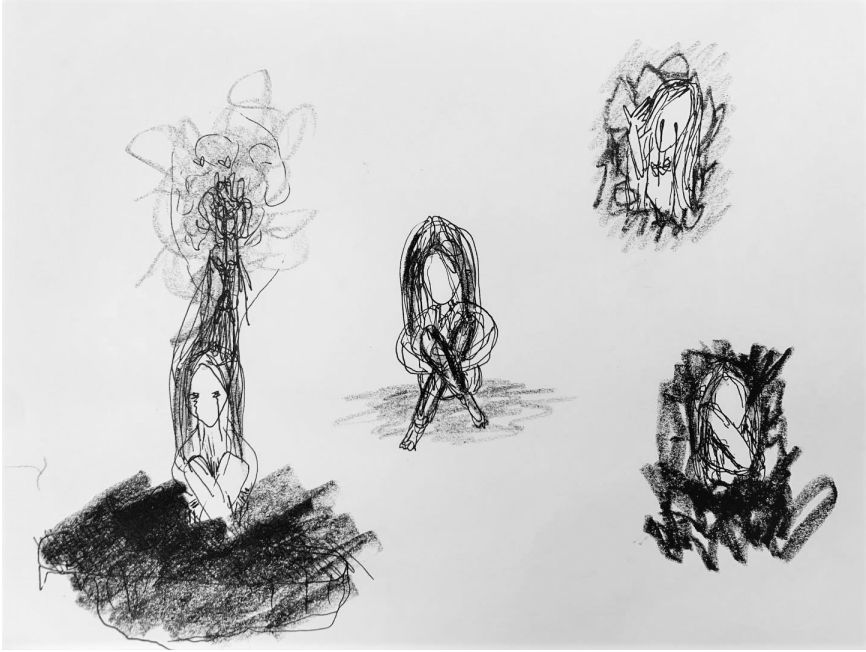


FIGURE 3. "Spiraling" by Lauren Ann Villarreal. The artist wrote the author in an email: "It's about the dark thoughts that flood my brain, seemingly from somewhere else, and I can't stop them. I drown in them, and they consume me. The dark thoughts made me feel small, trapped, I couldn't escape. I couldn't control the thoughts that would come to me. They became me." *Reproduced with permission of the artist.*

found some teas in her room to help her sleep. Maria took her for a walk in the park and tried to help her, "Okay, you look very tired," she told her.

That school term, Sofia failed several of her exams. She had always been an excellent student, and Maria started to really worry, "because she's not sleeping . . . She's very tired, and then she's studying. And it's just a lot of work in the school . . . I think it's too much for her."

Then one night someone at the college called Maria and told her that Sofia was refusing to sleep inside. It was not clear why she would want to stay outside at night. Concerned, Maria picked Sofia up from college to take her to the hospital to get some help for her "nerves." "Nerves" or "nervous breakdown" or "*ataque de nervios*" is a common term for mental distress among Spanish speakers that often signals depression, anxiety, or panic rather than psychosis.<sup>32</sup> Anthropologist Janis H. Jenkins has argued that *nervios* is used strategically by Mexican American families when describing a family member with a psychotic disorder as an explanation that invites less stigma and encourages more family support for the person who is struggling.<sup>33</sup>

Maria initially took Sofia to the emergency room because she did not have any insurance, so that was the only option. At the county hospital, Sofia was given medication for her “nerves” and released. Sofia did not like the experience, and she did not like the way the medication made her feel so fuzzy-headed.

“She came home and she’s okay,” Maria recalled later. “But then she was reading the Bible. And she—later, she had a lot of nerves.”

Things became worse. “I wasn’t feeling good, and I just wanted to be outside,” Sofia explained. She refused to take more medication or stay inside.

Maria was very distressed. “If she takes the medicine, she’s okay. Because when the doctor gave her the medicine at the hospital, she’s okay. She comes home, she’s okay. But she don’t want to take the medicine the next day.”

Sofia would not come inside that night. Maria stayed with her, afraid to leave her outside alone. She was terrified Sofia would be assaulted again. She begged her to please go to the hospital with her to talk to “a friend.” Sofia refused.

Maria cleaned houses during the day—a form of employment that is difficult to take a day off from for family emergencies. So she worked through the day and watched Maria at night, but it was not a sustainable solution. Not knowing what else to do, she called the police. Maria cried as she explained, “She don’t want to go. And then police—he helped me take her because she don’t want to go. Because I don’t want to leave her outside. I’m very tired. Because I don’t sleep two days because [at night] I’m staying at the hospital and then outside with her. And then I’m very tired. I was very scared. I want to take care of my daughter, but this is not a good condition.”

The officers took Sofia into custody to transport her to Shady Elms. Sofia admitted herself voluntarily, though later she had no recollection of doing so. Possibly because she was on public insurance, within 24 hours of her arrival at Shady Elms she was transferred to a state hospital for a minimum of twenty-eight days.

In retrospect, there were signs that Sofia was in serious trouble: self-isolation, deteriorating relationships, difficulties with sleeping, a precipitous drop in her performance at school. Yet all these symptoms could be explained away by her traumatic assault, her roommates’ lack of kindness, and having to move out. As we have seen, families delay care for a whole host of reasons. But when people delay seeking help, at some point things become unmanageable—a breaking point. The young person becomes incomprehensible in their words and actions even to their own parents—a sign that they are having both a mental and a moral breakdown. Even the most advantaged people can end up in a dangerous situation when they are in crisis. Add in a whole host of social disadvantages, and it can be disastrous.

Without any intervention, people with psychosis can and often do become dangerous to themselves or others. Dangerous, it is important to note, does not necessarily mean violent, though the behavior can involve aggressiveness.<sup>34</sup> It was dangerous for Sofia to stay outside at night in a high-crime urban area. Sofia did not harm anyone, but she did physically resist the police when they tried to take

her to the hospital. One Canadian study found that around half of young people were physically or verbally aggressive leading up to their admission to an early-psychosis program.<sup>35</sup>

In these studies, factors related to more severe kinds of aggression included young age, lack of education, prior offending, and substance use—all well-known risk factors for violent behavior in general—as well as a longer DUP. Violence was also more likely in the period after initial treatment if a person was treated involuntarily, indicating that powerlessness in the treatment encounter may contribute to later aggression. Of course, these studies have their limitations, and more research is needed. Notably, however, a recent review of data from fifteen countries found that among persons with schizophrenia spectrum disorders, the odds that a person would engage in violence toward another person was less than 1 in 20 for women and less than 1 in 4 for men over a thirty-five-year period of their lives.<sup>36</sup> Obviously, the associations are complicated, and violence is hard to predict. Clearly, poverty, substance use, education level, and the experience of unchecked psychosis play a role. However, we must use this information to support people rather than stigmatize them.

Caution is all the more important since persons with serious mental illness are also at high risk of becoming victims of violence, especially if they are experiencing homelessness, substance use or abuse, or severe symptoms of psychosis or are engaging in criminal activity.<sup>37</sup> Sofia might have been seriously harmed if her mother had not guarded her during her nighttime wanderings. In addition, young people in the United States with early psychosis are at a heightened risk of mortality: they are 24 times more likely than their age-matched peers to die within twelve months of their diagnosis.<sup>38</sup>

And so, even though people with psychosis are more likely to be *victims* of violence or to die early, the media often highlight stories that vilify those who have engaged in extreme violence. The young people in our study were aware of these stories, too, and it frightened them. For example, while I was engaged in this research, Thomas Johnson, a 21-year-old Black Dallas native and former Texas A&M football wide receiver randomly attacked a local runner, 53-year-old Dave Stevens, with a machete early in the morning on a public trail. Johnson then stopped the next cyclist approaching, asked for a phone, and called 911 to let them know he had just killed someone. Later, at Johnson's trial in 2019, his aunt said, "He kept telling people that he was hearing voices and he needed help. And all they saw was his athletic abilities and no one would listen to him."<sup>39</sup>

Amy heard this story, too. She mentioned "the machete killer" about six weeks after her first admission. It had been on her mind:

There shouldn't be such a stigma around it, and it should be easier for people to obtain mental health care. Hearing stories like that guy who took a machete to that guy, that runner. Did you hear about that? I guess this young guy, maybe 20 years

old, who had mental problems, and his mom [her voice trembles] knew that he had all sorts of mental problems. I guess he went up to a runner at random and macheted him to death. Then the wife [of the runner] just committed suicide because she was disenfranchised by it. Things like that I feel like shouldn't happen. There should be more of a responsibility of people around and people in mental health care.

Such stories perpetuate the vicious cycle of stigma that makes it harder for people to seek help and thus more likely that they will engage in dangerous behavior when they become confused. My own research unearthed many distressing stories. Some of the people I engaged with tried to harm themselves or behaved in ways that could result in bodily harm. Corrina locked herself in an extremely hot car. James parked his car in front of a train. Amy nearly jumped off a bridge onto a busy interstate. David tried to jump out of his father's moving car. Sofia insisted on sleeping outside. The list goes on.

At other times young people were at risk of harming—or did harm—others. James assaulted his girlfriend. Michael tried to harm his sister's child. Miranda punched her father. The following chapters contain many more examples. A dangerous crisis was often what prompted the young person to connect with a mental health care provider, most often via the police. It was difficult to connect a young person with care in the absence of medical insurance or easy access to mental health support.

The availability of mental health services and the laws that govern admittance to these services differ from state to state. However, each state system has similarities to the Texas system, and all present significant challenges to those who need help. One of the few avenues available for people in crisis, especially after hours, was to call the police. If someone was not deemed dangerous by the police, they could be treated in an emergency room and were often released quickly, as when Sofia visited the county hospital.

A medical facility might also place an “emergency hold” or “psychiatric detention” on someone for observation prior to release if they have been admitted to the facility for psychiatric reasons. Rules vary about the duration of emergency holds, who can initiate an emergency hold, the extent of judicial oversight, and the rights of patients during the hold.<sup>40</sup> In most states—and in multiple other countries, including Australia and South Korea—a person can be held involuntarily for up to 72 hours for observation. In Texas, to extend an involuntary commitment beyond 72 hours, a court overseen by a magistrate or justice of the peace can rule that person to pose so substantial a risk of harm to self or others that they cannot remain at liberty.<sup>41</sup> This was typically determined by review of a medical certificate issued by a physician and testimony from the patient and their family members. If a judge ruled that a person remained potentially dangerous, and if that person refused to be admitted to the hospital voluntarily, they were involuntarily committed.

A person could also voluntarily admit themselves to Shady Elms if they had symptoms of mental illness that could “benefit” from inpatient services, if a

payment plan was agreed upon, and if they had been informed of their rights as a voluntary patient. A person 16 years or older could request voluntary admission from hospital administrators; their parent or guardian could also make such a request if the person being admitted was under 18 years of age even without their consent.<sup>42</sup> Moreover, as soon as a person was admitted voluntarily, they could easily be shifted to involuntary commitment status if they refused treatment or asked to be discharged. They could then be held for a longer period. Sofia was brought to Shady Elms by police, admitted herself voluntarily, and then was shifted to involuntary status when she asked to be discharged. Notably, whether voluntarily or involuntarily, most of the people in my study landed at Shady Elms through police involvement.

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People make initial contact with mental health care via what are called pathways to care. The pathway to care begins the moment a young person starts having symptoms and run to their first point of contact with someone who offers mental health support. This care can be as simple as a visit to a general or family practitioner who offers them counseling or psychiatric medication, or as traumatic as a 911 call that results in armed police forcibly taking someone into custody for an involuntary psychiatric hospital visit.

There were three common pathways to care at Shady Elms. These routes emerged when members of my research team analyzed the stories of the thirty-eight young people who offered in-depth answers to our question, "Tell me how you came to be in the hospital." James, David, Miranda, Corrina, and Michael all came into the mental health care system because they seemed dangerous to themselves or others, and someone in proximity called the police, who brought them to the hospital. Nearly half of the young people entered care this way.

At that time, most people in the seven-county radius surrounding Dallas who had a psychiatric crisis and needed to be held for observation, or who were uninsured and so needed to enroll in the regional public mental health care plan, were sent to Shady Elms. In 2014, during an orientation to the facility, I learned that Shady Elms had served 26,000 patients representing about 80 percent of the annual psychiatric "patient population" in the region. Seventy percent of those had arrived in handcuffs.

For persons who are Black, their pathway to care is more likely to involve contact with law enforcement than for other racial or ethnic groups.<sup>43</sup> Black individuals are also less likely to seek mental health care from a primary physician than are individuals from other ethnic groups.<sup>44</sup> One study reported that pathways to care for African Americans were "often less desirable . . . with higher rates of involuntary civil commitment and police involvement."<sup>45</sup>

For most of the young people in my study, the police were involved in their introduction to mental health care. In most states, police are mental health crisis

first responders and, thus, frontline providers of “care.” Thirty-eight states allow police to take a person into custody without a warrant for an emergency psychiatric admission, and police officers are often explicitly in charge of initiating the short-term emergency commitment process.<sup>46</sup> Thus, to get help when someone will not do so voluntarily, the police must be involved.

But police interactions can be toxic. In my study, where most of the participants were Black and Latino, about two-thirds claimed to have been arrested before, and one-fifth had been arrested four or more times.<sup>47</sup> Some argue that criminal injustice falls along a racial gradient, with Black youths being treated worse than Latino youths, who are treated worse than white youths.<sup>48</sup> This may be due to the structural racism baked into policing practices around Black youths.<sup>49</sup> For example, by the age of 24, Black youths have nine times more interactions with police than their white counterparts, are more likely to experience force in those encounters, and are five times more likely to be injured.<sup>50</sup>

Police exposure is also associated with adverse mental health and substance use for Black youths.<sup>51</sup> Black Americans who have had a police interaction are twice as likely to report experiencing poor mental health as those with no police interaction.<sup>52</sup> While it is possible that individuals with poor mental health report more negative police interactions, some of these cited studies found a positive association between police stops and police victimization on one hand and psychological distress, psychotic experiences, depression, suicidal attempts, and suicidal ideation on the other, even when controlling for a prior history of mental health diagnosis.

Interactions between those with mental health problems and armed law enforcement are also common, can be dangerous, and can deter future help seeking. The risk of being approached or stopped by law enforcement is sixteen times higher for individuals with untreated mental illness than for other civilians. Data collected in 2020 and 2021 show that one-fifth of fatal police shootings involved persons with mental illness.<sup>53</sup> Being African American (instead of non-Hispanic white) and having a mental illness were strongly associated with those fatalities.<sup>54</sup> Fatal police shootings of persons with mental illness are more likely to take place in small and mid-sized areas, but there are plenty of examples from communities of all sizes across the United States.<sup>55</sup> Fatal police encounters for persons experiencing mental illness are also more common among those who are armed with a knife and at home.

James was at home when his parents called the police for help. Since he had come home from Shady Elms, things had taken a turn for the worse after he stopped taking his medications and intensified his substance use to more frequently include LSD and a homemade kind of methamphetamine made in the tailpipe of a car. He had been out of school, unemployed, and refusing to see any kind of mental health provider, his mother told us later when she called us for a phone interview. She hoped his story might help prevent the same thing from happening to someone else.

His father told the police that he was hiding in their house with his knife. They never imagined how badly things could go. In retrospect, his mother said, she was not even sure he had a knife. She thought he had something in his hand, and anyway, a person had to be dangerous to themselves or others to get the police to come to the house and help.

James did not go to the police voluntarily. He tweeted threats and racial slurs to the police. As a result, James was taken to jail instead of Shady Elms; it took weeks in jail for him to access mental health treatment. He had two surgeries for injuries he sustained. His mother's home was ruined. However, given that he allegedly had a knife, was at home, and had taunted the police, he was lucky to be alive.

The second most common pathway to care for people in my study involved members of a person's family or church—or both—bringing them in for emergency care. If the young person went to the local emergency room, they were often then escorted by police from that hospital to Shady Elms for the 72-hour hold. The police seemed to be the main form of transportation between facilities rather than an ambulance, likely for safety reasons. Staff and patients at Shady Elms noted that police arrivals came in the “back door.” Sofia was one such arrival when she was transferred from the county hospital after her second crisis.

A few did arrive at Shady Elms with their family (and no police) through the “front door”—a sliding glass door that opened into a small reception area with a TV, a couple of couches, and a welcome desk. From there, they were escorted through the first locked door into an intake room with a cot, a computer station, and a chair. Here, young people could be processed for a voluntary admission.

Gideon was a voluntary admission. When I first met him in the hospital, I was struck by his charm. He was a long, lean, first-generation African immigrant. He had moved to the United States about five years prior. He looked completely put together, and I wondered what he was doing at Shady Elms. He shared that he was attending community college and living with his family.

He accentuated that he was a strong Christian and he thought people would understand him better if he could go back to the place of his birth, because he felt Africans were more spiritual than Americans and more likely to believe in the demons that Gideon could see everywhere. Months later, I asked Gideon's brother, Jacob, if he agreed that Gideon was just a more spiritually sensitive person living in the wrong culture. He responded, “I'd say no. It's mental.” He emphasized that no one agreed with those beliefs here in the United States and that people in their home country, as well, would think he had both a spiritual and psychological problem.

Because of his faith, Gideon had never used drugs or alcohol. He also said he did not have a lot of friends because he spent most of his time praying. He told me, “I pray a little bit and pretty much speak in angelic tongues. I pray for the salvation of the United States. I might walk up and just, say, ‘In the name of Jesus Christ, we

know the rapture is coming.' I used to think that at my age, I'll probably just write a book about things that will happen at that time."

Gideon tried talking to others about his faith, "telling people about the Gospel, preaching and stuff," but in later interviews he acknowledged that his dad did not like it. The other church members did not like it. They convinced him to go to Shady Elms voluntarily. They told him he was just going to the hospital to get a test, so he agreed to go. "I was supposed to get the prophet testing," he told me. He thought "the test" would prove he was a prophet.

However, after his dad and his pastor left him at Shady Elms, he was forcibly strapped to a bed and injected with medications that made him feel horrible for days. Gideon thought that approach had to be against his rights as an American.

Gideon expressed his frustration: "Some people are supernatural beings, you know? I guess those who don't understand, they think, 'Oh you're really nuts or something to see into the supernatural.' You can hear the talking of God and demons and stuff yourself . . . You can do everything, but just relax, you know? Relax and try to block them out. You don't want to be called nuts or anything; that's exactly what has come to pass."

Veronica, too, said that the first time she went to the hospital was somewhat voluntary. Veronica, a young woman who self-identified as African American, went in with her sister. "I was actually good," she explained, "until they put me all by myself. When I went there, I was like, 'Okay, my family's here; we're good. I'm just going to calm down or try to figure out what the heck is going on and then everything will be back to normal.' My sister was in and out of the door. She was on the phone. I think she was telling them, 'She's crazy, low-key crazy, but don't let her go out.'"

Since she was younger, Veronica felt that her older sister had more credibility. "If they follow you and are like, 'Hey, she has schizophrenia—don't let her leave. She's going to try to leave.' Then why wouldn't they try to keep you there, to make sure that you're fine and that you're okay to leave? I understand that aspect of it. They're doing their job! They were. Yeah. Now I hate hospitals."

This pathway to care was hard on young people. It often involved some type of manipulation from families or other trusted community members, and a betrayal of trust. Knowing their family has left them in the facility because they think they have a serious mental problem, having their stories dismissed or discredited, being locked into a hospital that they cannot leave without permission—all is difficult to process on one's own.

The third way a young person found themselves in contact with mental health support was to ask the police for help. This was unusual—only one in six of the young people in my study reported this—but it did happen. These young people just walked up to the police on the street or called 911. In my study, the people who directly contacted the police included one white woman, two white men,

one Hispanic woman, and two Hispanic men. All had a history of arrest, and one had been arrested more than four times. Even so, they seemed to trust the police.

Amy was one of these people. As mentioned, she stepped away from the ledge of the bridge and asked for help. Another young Hispanic woman, Elba, was struggling with postpartum psychosis and called the police to keep her safe from intruders. When they arrived, they thought she seemed paranoid and took her to the hospital. Similarly, Josue, a young Hispanic man, asked the police for help when he was drunk. He was hoping for a ride home or a booking into the jail so he could sleep off his buzz. Instead, they took him to Shady Elms.

Tyler, a tall, blond white man with sharp grey eyes, had a history of treatment for methamphetamine use. One day, Tyler explained, he walked to a local donut shop where he convinced the workers to let him use the phone. He then called the police and told the dispatcher they had better come get him because “I am 110% crazy.” Then he called them again. “They weren’t coming fast enough,” he continued,

and then I kept going and going and going. And then I threatened to break a window. And then, then the Hispanic workers walked out, and the police came with their big guns. You know, ready to shoot to kill. And I surrendered. Peacefully. And then I went to the cop car. And then down the road we go, and down the road we go, and down the road we go. And I ended up here. In my cage.

Tyler made it all seem so simple, like any other day. In all these instances, police were contacted for a variety of reasons and ended up assessing that the young person needed help with their mental health.

None of the young people who told me that they called the police for help were Black. While Black family members did call police when there was an emergency, the Black youths we interviewed did not. Yet, even though these young people did not call them directly, studies suggest that Black people with psychotic disorders interact with the police more often than white people and are more likely to be admitted involuntarily.<sup>56</sup> And, based on the research cited earlier, they are also more likely to have a fatal encounter with police.

And while we can—and should—critically parse the differences among persons from minoritized groups in their pathways to care, the fact remains that no pathway is ideal. Most involve police intervention and, too often, a crisis. The system—if there ever was one—is broken. There are better ways of caring for our young people.

. . .

Families from ethnoracially minoritized groups delay seeking help even when a young person is showing multiple signs of potential extreme mental distress. The young person—regardless of background—may be doing poorly at work, school, and relationships. They may increase substance use, hole up in their room,

sleep less, and express paranoid thoughts. However, it often takes a catalytic event or crisis for people to seek out care.

In this chapter I discuss some of the reasons revealed in the research literature as to why this may be so, including overall mistrust of medical providers, cultural stigma against having a mental illness, aversion to being labeled a person who is mentally ill, and low mental health literacy. I also describe structural barriers, such as the accessibility of mental health services, their availability for people who do not have mental health insurance, police involvement that seems to criminalize people in distress as “bad,” and the threat of police violence.

The pathway to care that emerges from this situation—waiting to seek help until a catalytic event has occurred and a person has become a danger to themselves or others—requires police intervention. This typical scenario fails everyone: the young person needing care, their key supporters, and society at large. Entering the world of mental health care through an arrest and forced admission to treatment can be dangerous physically and mentally and has profound impact on a person’s moral agency. Even those who are brought by families or trusted community members directly to an emergency room have often had interactions with the police before they received care. The police were sometimes seen as allies—and they can be—but police involvement in the pathway to care through emergency services can be distressing and even dangerous.

What would mental health care look like if we did not wait until people become dangerous before we got them help? We need to change the rules of engagement, and chapter 7 offers additional ideas for how to achieve this change. In chapter 4, we turn to what does happen to people when they finally arrive at the psychiatric emergency hospital—in this case, Shady Elms. Everything that has happened so far has led them to this point, but what kind of care will they receive?