IN BALANCE OR IMBALANCE?

LOOKING AT TREATMENTS THROUGH EQUITY & OUTCOMES

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INTRODUCTION

STARTED IN THE FIELD IN 1988

CLINICAL PSYCHOLOGIST

15+ YEARS AS CLINICIAN & ADMINISTRATOR IN RESIDENTIAL TREATMENT

20+ YEARS IN PRIVATE PRACTICE

10+ YEARS AS ASSOCIATE PROFESSOR OF CLINICAL PSYCHOLOGY

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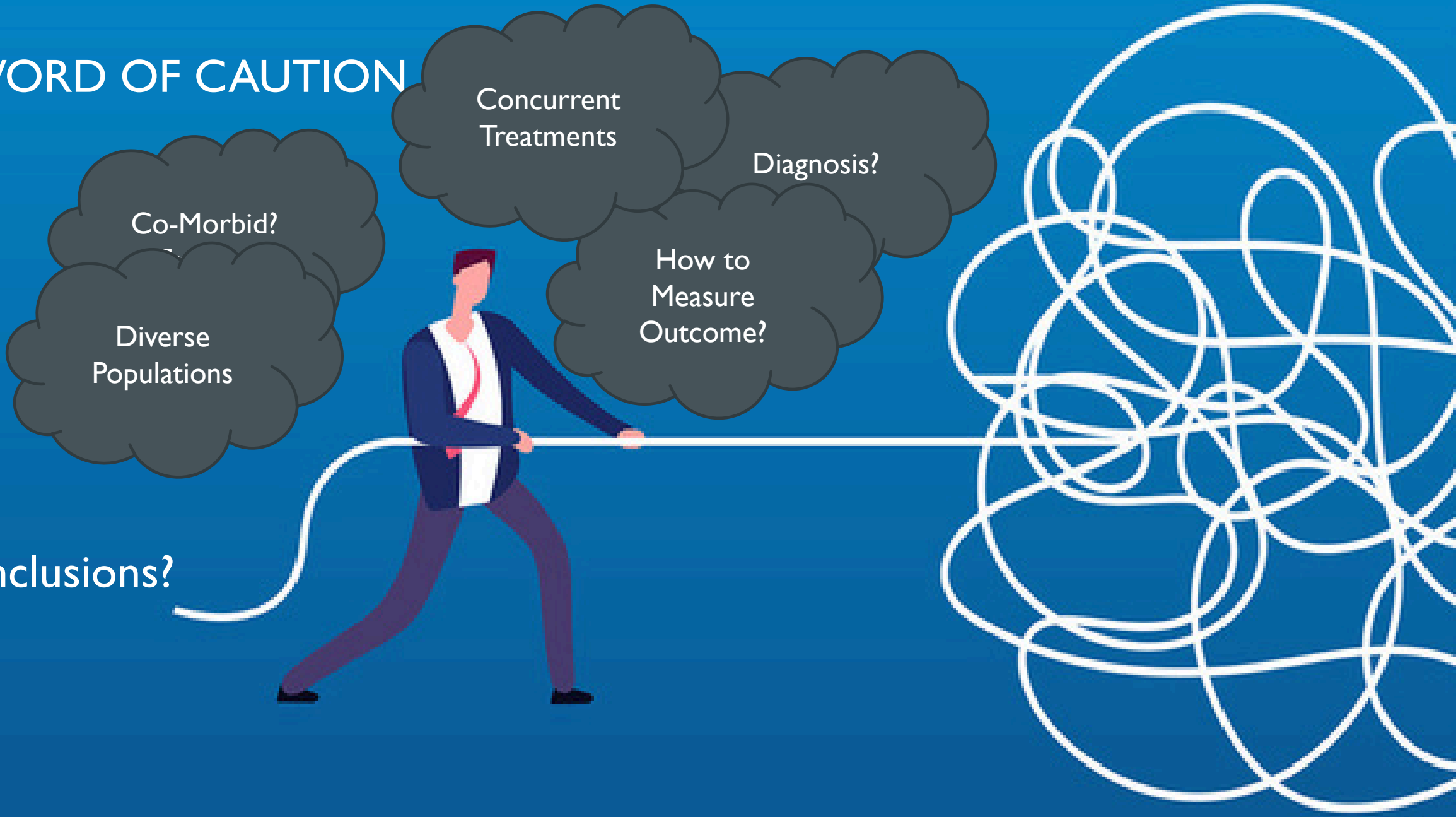
OVERVIEW

- Looking at Racial inequities in our system
- Foundations of Punishing Treatments in our History
- Foundations of Treatment Outcomes
  - *Methodology, Replication, Effect Size*
- Starting with identifying the problem…Diagnosing
- Evolution of our Diagnostic models
- Looking at treatments
- Next steps

A WORD OF CAUTION



- Conclusions?

MODEL FOR

ADDRESSING

DIVERSITY

- Age & generational influences
- Developmental
- Disability
- Religion & spiritual orientation
- Ethnic & Racial Identity
- SocioEconomic Status
- Sexual Orientation
- Indigenous heritage
- National origin
- Gender

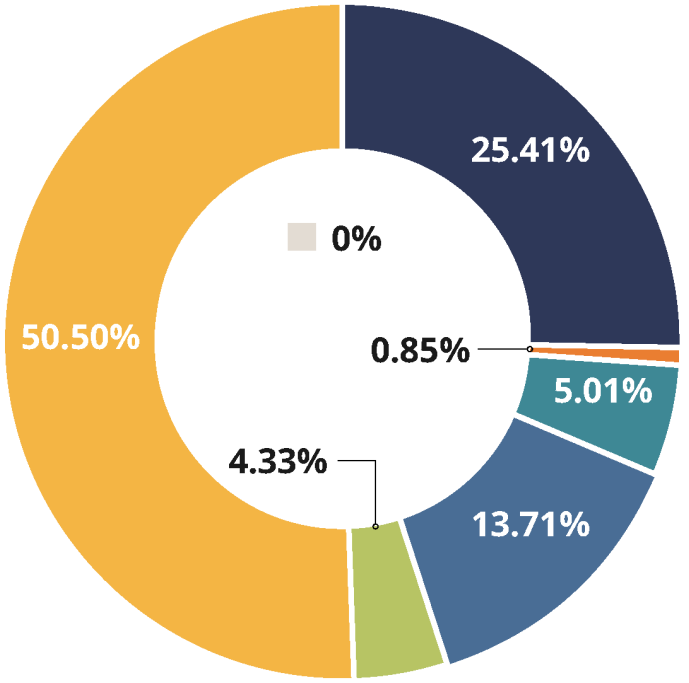
THE DILEMMA

- The goal was to review outcome data
- The first speedbump was to find data that explicitly compared treatment outcomes for Caucasian vs children of color
- The data that *was* available, was fairly small in sample size, making conclusions difficult
- So, I stepped back and looked at factors we should be considering when developing our intervention strategies for diverse youth & families

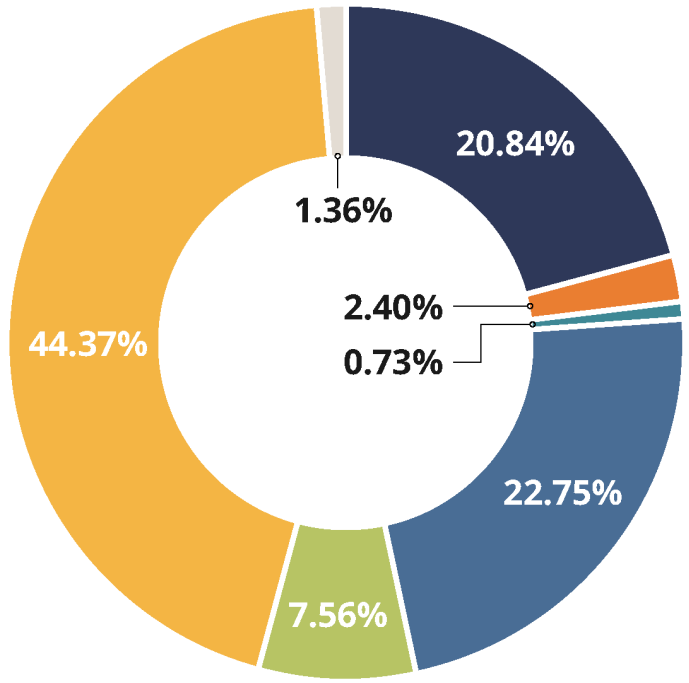
THE CHILD WELFARE LANDSCAPE

- 2018 data
- *National Conference of State Legislators*
- children of color are more likely to experience multiple placements,
- less likely to be reunited with their birth families,
- more likely to experience group care,
- less likely to establish a permanent placement and
- more likely to experience poor social, behavioral and educational outcomes

Child Population by Race



Children in Foster Care by Race



- Hispanic or Latino
- Non-Hispanic American Indian
- Non-Hispanic Asian, Non-Hispanic Native Hawaiian and other Pacific Islanders
- Non-Hispanic Black
- Non-Hispanic multiple race groups
- Non-Hispanic White
- Race unknown

Source: Annie E. Casey Foundation's Kids Count Data Center, 2018

JUVENILE JUSTICE

- Youth of color constitute less than half of the U.S. population, however, they make up 62% of the youth charged in the juvenile justice system.

YET…

- "Racial and ethnic minorities are at particular risk for mental health disorders in adulthood, although interestingly, rates of those disorders are lower in adolescence, relative to the non-Latino white population."

- American Psychological Association, 2019

BARRIERS

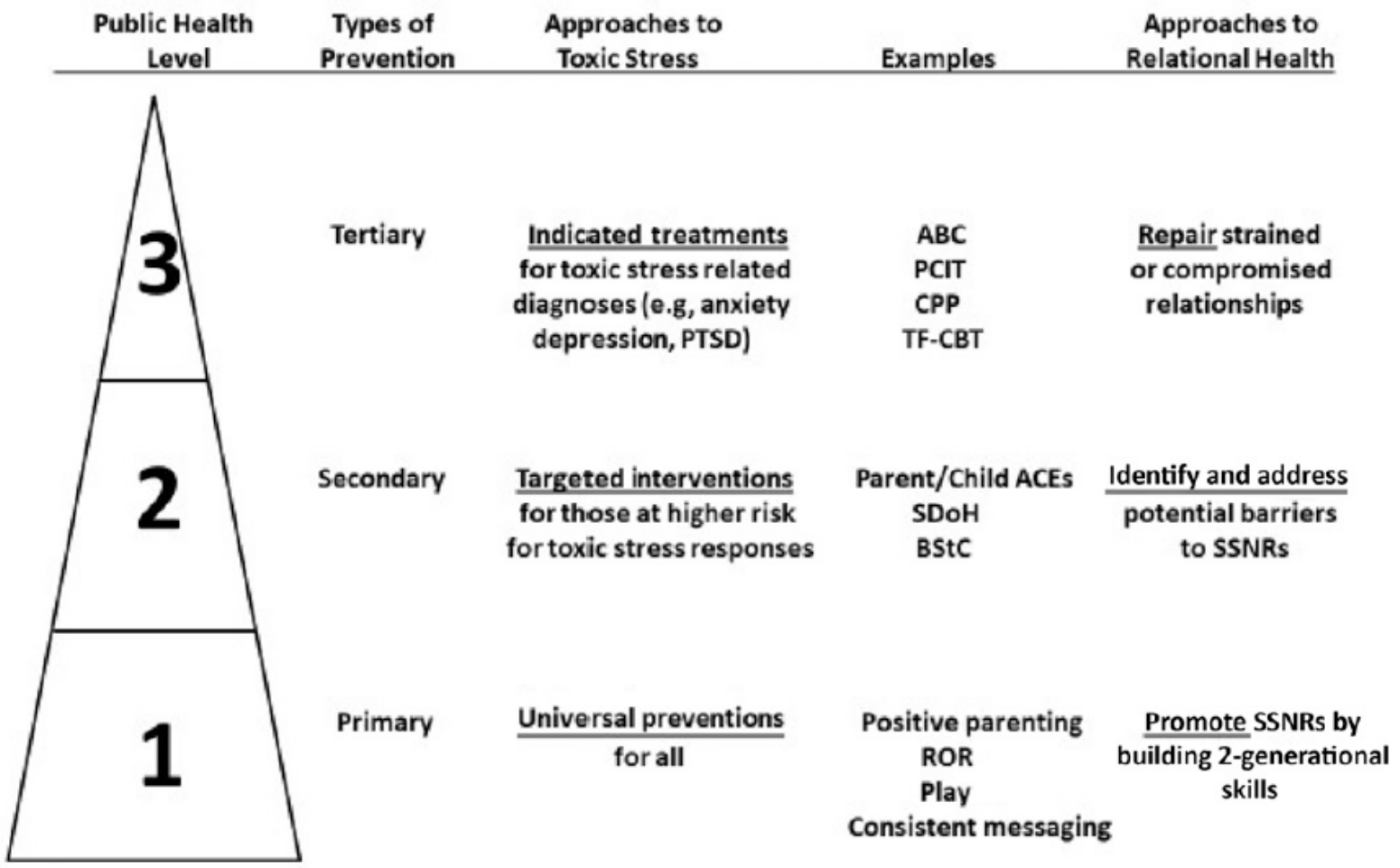
- Access to care (insurance, transportation, providers in the community)
- Diagnostic differences…externalized behaviors (in minorities) often result in legal engagement…Internalized conditions more often are not addressed (compared to white counterparts)
- School disciplinary differences – "black American students are far more likely to be suspended or expelled and,
- conditional on an office referral, more likely to receive stiffer punishments. These disparities are particularly concerning as they are associated with long-term outcomes, including employment and involvement in the criminal justice system."

- Attitudes toward diagnoses and Mental Health Treatments?

ANOTHER INFLUENCE

- Families below the poverty line are three times more likely to be substantiated for child maltreatment (Drake & Jonson-Reid, 2014).
- Economic disparities and historical systemic disadvantages have fueled disproportionate child welfare system involvement among families of color; Black, Latino, and American Indian/Alaska Native (AI/AN) families are disproportionately more likely to be poor due to longstanding systemic conditions
- Evidence about the root causes of child maltreatment has been well documented, including poverty-related risk factors such as unemployment, single parenthood, housing instability, earlier child-bearing, and lack of child care
- The income status of families is a significant predictor of involvement with the child welfare system and county-level poverty rates are associated with foster care placement rates among children of all races

Chapin Hall Policy Brief, July 2021. System Transformation to Support Child & Family Well-Being: The Central Role of Economic & Concrete Supports



AAP, 2021 – Preventing Toxic Stress

LAYERED INTERVENTION

Residential Treatment can leverage the importance of Safe, Stable, Nurturing Relationships not only to provide Level 3 strategies, but to reach across community providers to intervene early…e.g. FFPSA

To see where we're going, we should know where we've been

- Knowing the history of "Treatment" helps inform our approach.
- It's important to recognize that "Experts" guided these treatments

"INSANITY PROVED CURABLE!"

- 1789 – cure of King George III
- These treatments became commonplace in the "cure" of madness.
- Water Therapy – temporarily drowning the patient
- Swinging Chair – most common mechanical device in the early 1800s. "The chair could, in one fell swoop, physically weaken the patient, inflict great pain, and invoke terror – all effects perceived as therapeutic for the mad…In the hands of a skilled operator, able to rapidly alter the directional motion of the swing, it could reliably produce nausea, vomiting, and violent convulsions. Patients would involuntarily urinate and defecate and plead for the machine to be stopped."

TREATMENT HISTORY

- 1684 – Thomas Willis: Insane were "animal-like"

  "Discipline, threats, fetters, and blows are needed as much as medical treatment …forcing them to respect and fear intimidation …maniacs will recover much sooner if they are treated with tortures and torments in a hovel instead of with medicaments."

- The primary treatments advocated by English physicians were those that physically weakened the mad – bleeding to the point of fainting and the regular use of powerful purges, emetics, and nausea-inducing agents.

- "While nausea lasts, hallucinations of long adherence will be suspended, and sometimes perfectly removed, or perhaps exchanged for others, and the most furious will become tranquil and obedient."

COMING TO AMERICA

- "Madness caused by morbid and irregular actions in the blood vessels in the brain." Treatment is copious bleeding…as much as four fifths of one's blood.

- In a short time after their implementation, the devices touted by Dr. Rush were seen as abusive & reflective of unenlightened thought.

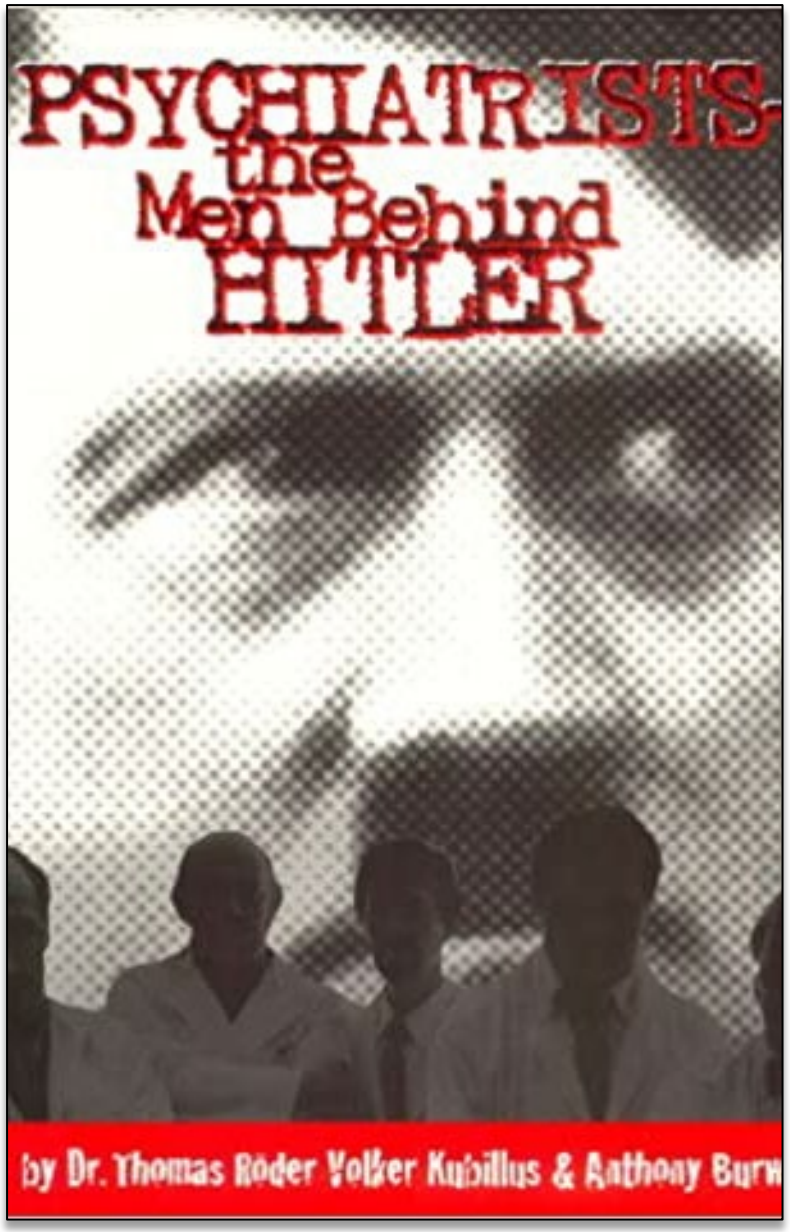
FATHER OF PSYCHIATRY

- Benjamin Rush is on the seal of the American Psychiatric Association.
- He also signed the Declaration of Independence.
- In 1797, Dr. Benjamin Rush, the "father" of American psychiatry, declared that the dark skin of Blacks was caused by a rare, congenital disease called *Negritude,* which derived from leprosy. The only cure was to turn the skin white.
- Rush also is "notorious for having bled George Washington to death." Breggin, 1991.

THE SUPPORT FOR EUGENICS

- 1921 – A meeting financed by the Carnegie & Rockefeller Foundations:

- Over the few days of the conference, speakers from Johns Hopkins, Princeton, Harvard, Columbia, Cornell, MIT, and NYU presented papers on the expense of defectives on society. They gave talks of 'The Jewish Problem' and 'Negro-White Intermixture'. Many of the scientists' charts and exhibits were put on display in the U.S. Capitol, remaining there for three months.



IMPLEMENTING EUGENICS

- Segregating the insane was the first goal.
- By 1929, **272,527** people were in mental hospitals (vs. 32,000 before eugenics took hold).
- From 1907 to 1927, only 8000 sterilizations were completed.
- In 1927, the US Supreme Court ruled that castration was constitutional… **"experience has shown that heredity plays an important part in the transmission of insanity, imbecility, etc."**
- Bad Science Had Become the Foundation for Bad Law.
- At that moment, America stood alone as the first Eugenic country.

ADDITIONAL "TREATMENT"

- Lobotomy

  New York Times, 1937, this procedure could relieve "tension, apprehension, anxiety, depression, insomnia, suicidal ideas, delusions, hallucinations, crying spells, melancholia, obsessions, panic states, disorientation, psychalgesia (pain of psychic origin), nervous indigestion, and hysterical paralysis."

DIAGNOSTIC CHALLENGES

- Understanding the Evolution
- Reliability
- Validity
- Embedded Power
- Alternatives

"The results of the DSM-5 field trials are a disgrace to the field. For context, in previous DSMs a diagnosis had to have a kappa reliability of about 0.6 or above to be considered acceptable. A reliability of 0.2 to 0.4 has always been considered completely unacceptable, not much above chance agreement."

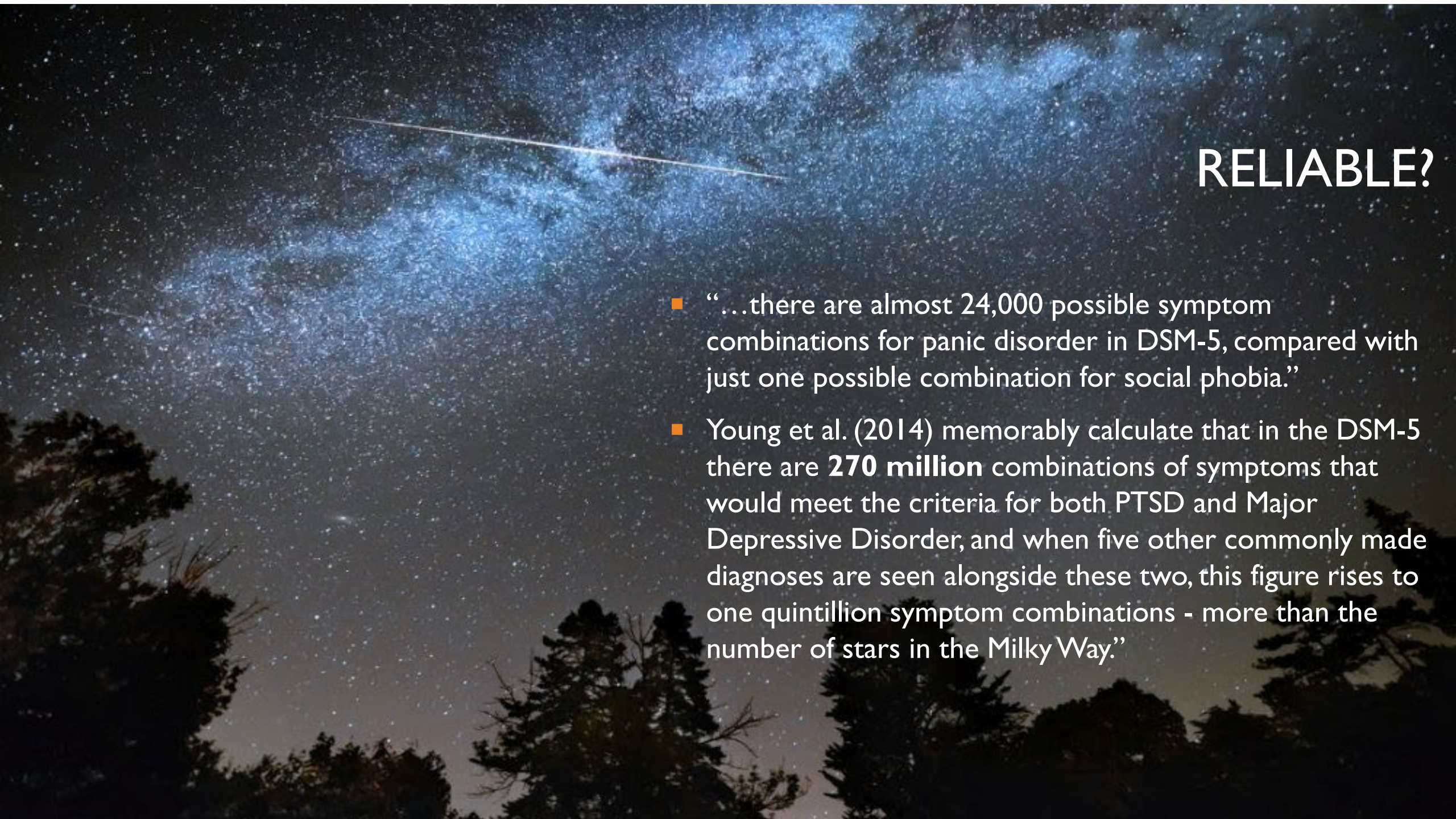
Frances, 2012

	DSM-5	DSM-IV	ICD-10	DSM-III
Generalized anxiety disorder (GAD)	0.20	0.65	0.30	0.72
Post-traumatic stress disorder (PTSD)	0.67	0.59	0.76	0.55
Schizophrenia	0.46	0.76	0.79	0.81
Bipolar disorder type I	0.54		0.69	
Major depressive disorder (MDD)	0.32	0.59	0.53	0.80
Major neurocognitive disorder	0.78		0.60	0.91
Mild neurocognitive disorder	0.50			
Alcohol use disorder	0.40		0.71	0.80
Hoarding	0.59			
Binge-eating disorder (BED)	0.56			
Bipolar disorder type II	0.40			
Mixed anxiety-depressive disorder	0.06			
Attenuated psychosis syndrome	0.46			
Obsessive-compulsive personality disorder (OCD)	0.31			
Antisocial personality disorder	0.22			
Autism spectrum disoder	0.69	0.85	0.77	0.01
Attention-deficit hyperactivity disorder (ADHD)	0.61	0.59	0.85	0.50
Disruptive mood dysregulation disorder (DMDD)	0.50			
Oppositional defiant disorder (ODD)	0.41	0.55		0.66
Conduct disorder	0.48	0.57	0.78	0.61

INTER-RATER AGREEMENT… KAPPA COEFFICIENT

- Here is a guide to understanding Kappa scores:

Kappa	Agreement
< 0	Less than chance agreement
0.01 – 0.20	Slight agreement
0.21 – 0.40	Fair agreement
0.41 – 0.60	Moderate agreement
0.61 – 0.80	Substantial agreement
0.81 – 0.99	Almost perfect agreement



RELIABLE?

- "…there are almost 24,000 possible symptom combinations for panic disorder in DSM-5, compared with just one possible combination for social phobia."
- Young et al. (2014) memorably calculate that in the DSM-5 there are **270 million** combinations of symptoms that would meet the criteria for both PTSD and Major Depressive Disorder, and when five other commonly made diagnoses are seen alongside these two, this figure rises to one quintillion symptom combinations - more than the number of stars in the Milky Way."

IS THERE RACISM IN DIAGNOSING?

"General Scientific Summary

- This meta-analysis shows that Black individuals are 2.4 times more likely to receive a diagnosis of schizophrenia than White individuals and shows that more rigorous diagnostic procedures fail to eliminate this racial disparity. This racial disparity has persisted over time and appears to vary with study demographics, setting, and perhaps geographic region."

Journal of Abnormal Psychology
2018, Vol. 127, No. 1, 104–115

Meta-Analysis of Black vs. White Racial Disparity in Schizophrenia Diagnosis in the United States: Do Structured Assessments Attenuate Racial Disparities?

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Fordham University

Arundati Nagendra and Benjamin Buck
University of North Carolina at Chapel Hill

0021-843X/18/$12.00 http://dx.doi.org/10.1037/abn0000311

Researchers have repeatedly observed that clinicians diagnose Black individuals with schizophrenia at greater rates than White individuals. We conducted a meta-analytic review to quantify the extent of racial diagnostic disparities in schizophrenia, examine whether structured-interview assessments attenuate these disparities, and assess for moderating factors. Studies were included that presented original probability-sample data and reported data sufficient to derive odds ratios and 95% confidence intervals (CIs) for schizophrenia diagnosis by race. In total, 14 studies using structured-interview diagnostic assessments and 41 studies using unstructured assessments met our inclusion criteria. Substantial heterogeneity was observed, but there was little evidence of publication bias. Inverse heterogeneity models showed that Black individuals were diagnosed with schizophrenia at greater rates than White individuals across all studies ($OR = 2.42$, 95% CI [1.59, 3.66]) as well as in studies using unstructured ($OR = 2.43$, 95% CI [1.59, 3.72]) and structured-instrument ($OR = 1.77$, 95% CI [1.31, 2.38]) diagnostic assessments. Studies using structured-instrument diagnostic assessments did not show statistically attenuated odds ratios compared with studies using unstructured assessments. Metaregression analyses indicated higher disparities in studies with higher proportions of White patients or lower average patient age; evidence was equivocal as to the effect of study setting (e.g., hospital vs. community clinic) and geographic region on racial disparities. Overall, racial diagnostic disparity in schizophrenia represents a robust albeit heterogeneous clinical phenomenon that has been stable over the past 3 decades; structured-instrument assessments do not fully mitigate these disparities, but power analysis suggests they may have a small effect.

General Scientific Summary
This meta-analysis shows that Black individuals are 2.4 times more likely to receive a diagnosis of schizophrenia than White individuals and shows that more rigorous diagnostic procedures fail to eliminate this racial disparity. This racial disparity has persisted over time and appears to vary with study demographics, setting, and perhaps geographic region.

Keywords: schizophrenia, racial disparities, diagnosis, meta

Mental health researchers have repeat
cians diagnose Black[1] individ
rates than White individ
Fischer, 1969

DR. SAMUEL CARTWRIGHT

- Surgeon and Psychologist in Louisiana. In 1851, identified a mental illness.
- "It is commonly taken for granted, that the color of the skin constitutes the main and essential difference between the black and the white race; but there are other differences more deep, durable, and indelible, in their anatomy and physiology, than that of mere color. In the albino the skin is white, yet the organization is that of the negro. Besides, it is not only in the skin, that a difference of color exists between the negro and the white man, but in the membranes of the muscles, the tendons, and in all the fluids and secretions. Even the negro's brain and nerves, the chyle and all the humors, are tinted with a shade of the pervading darkness."
- But Cartwright identified this disease as a deviation from what was considered normal…slavery.
- Medical schools were only for the elite at this time in U.S. history

DRAPETOMANIA

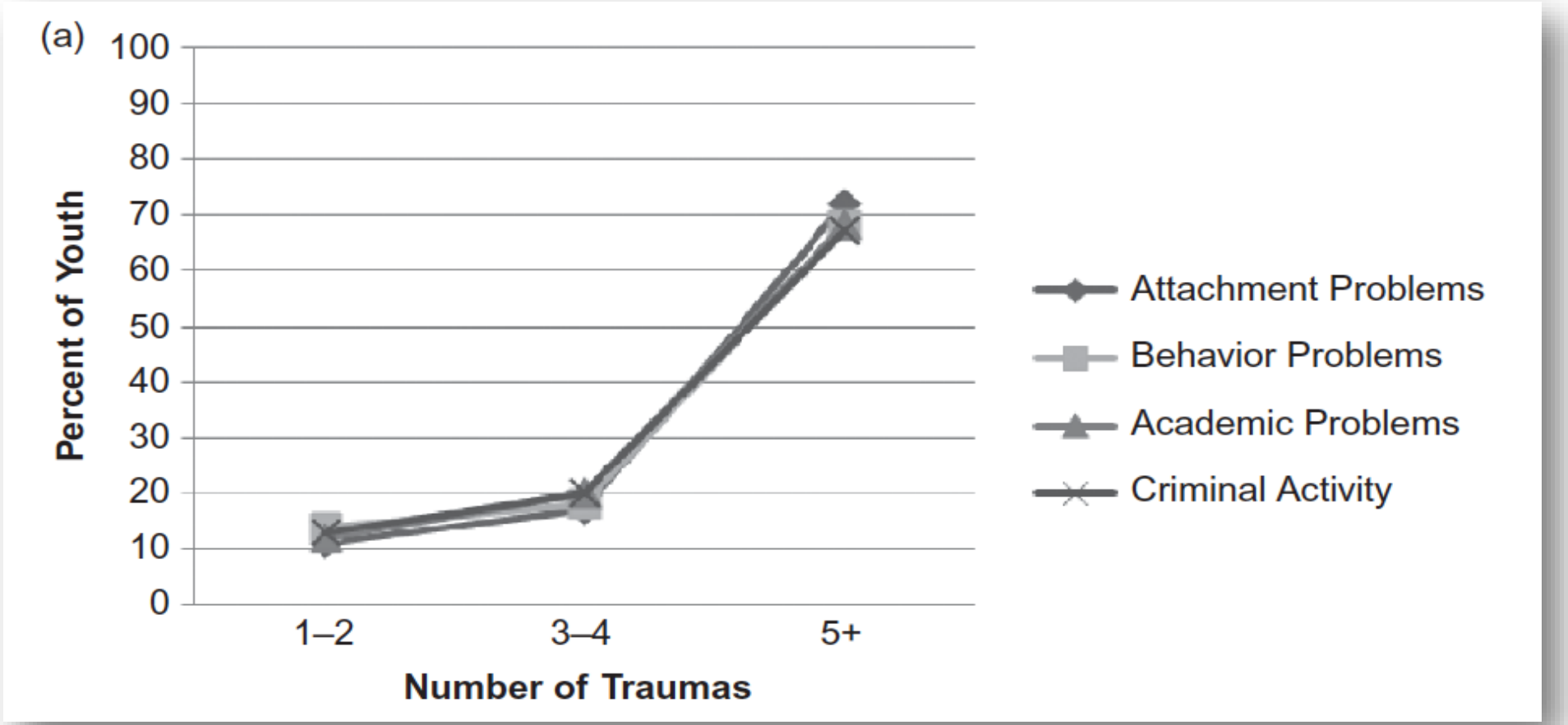
- "A runaway slave is mania mad or crazy. It is unknown to our medical authorities, although its diagnostic symptoms be absconding from service, is well known to our planters and overseers. In noticing a disease that, therefore, is hitherto classed among the long list of maladies that man is subject to, it was necessary to have a new term to express it. The cause in most cases that induces the Negro to run away from service is as much a disease of the mind as any other species of mental alienation, and much more curable as a general rule. With the advantages of proper medical advice strictly followed, this troublesome practice that many Negroes have of running away can be almost entirely prevented, although the slaves are located on the borders of a free state within a stone's throw of abolitionists."
- The Treatment for Drapetomania as Cartwright later described, "beating the devil out of them." And amputation of the toes was also suggested.
- Cartwright also described another mental disorder, *Dysaethesia Aethiopica,* to explain the apparent lack of work ethic exhibited by many slaves. The diagnosable symptoms included disobedience, insolence, and refusing to work -- and physical lesions. What treatment did Cartwright suggest? "Put the patient to some hard kind of work in the open air and sunshine," under the watchful eye of a White man.

- Interestingly, data available 20 years ago revealed that the membership of the American Psychiatric Association was 38,200 members, only 865, or 2.3 percent, are African-American and 1,720, or 4.5 percent, are Hispanic. Some 12,000, or 31 percent, are women.
- Homosexuality was only removed as a psychiatric disorder as of 1994

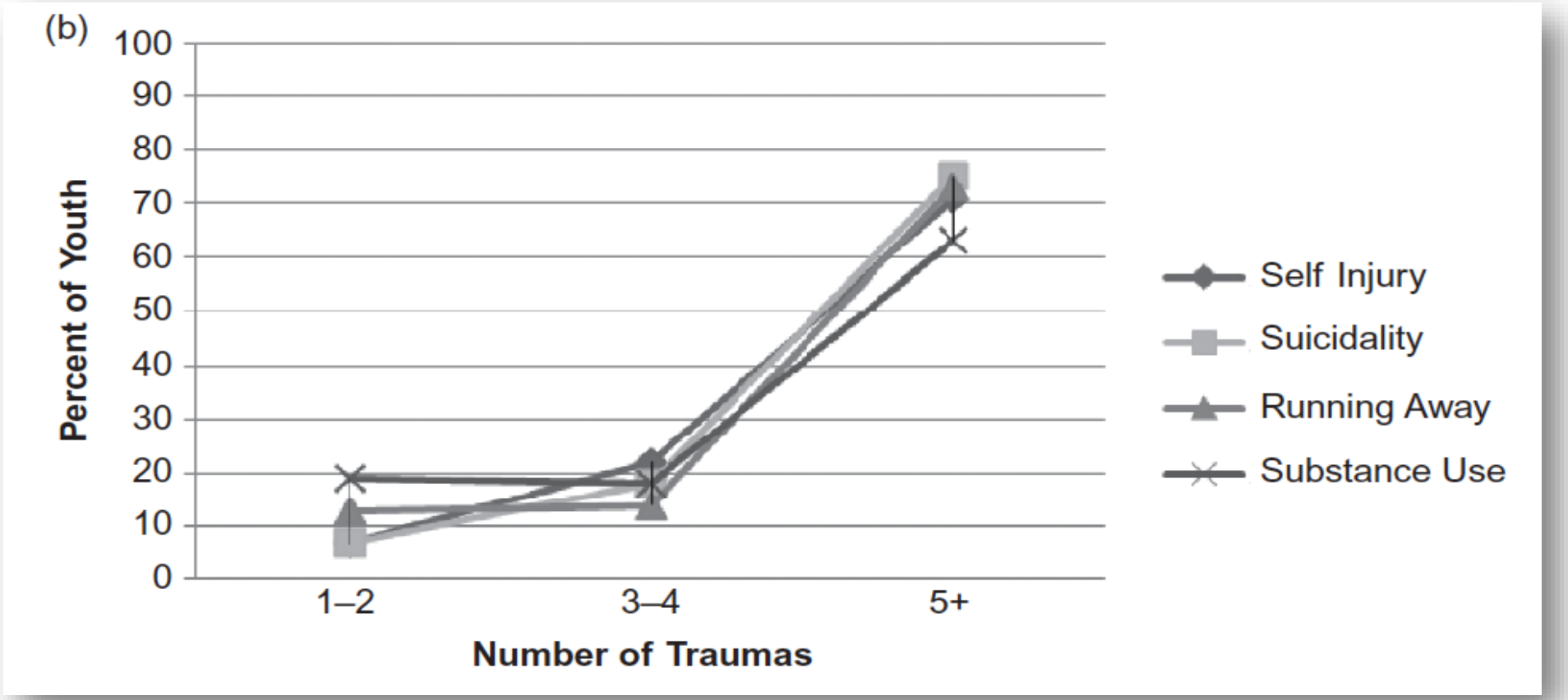
- Assessment Leads to Diagnosis
- Diagnosis Leads to Treatment
- Treatment Leads to Outcomes

- *and we know adversity drives most disorders*

NCTSN


(a)
100
90
80
70
60
50
40
30
20
10
0
Percent of Youth
1–2
3–4
5+
Number of Traumas
Attachment Problems
Behavior Problems
Academic Problems
Criminal Activity

NCTSN


(b)
100
90
80
70
60
50
40
30
20
10
0
Percent of Youth
1–2
3–4
5+
Number of Traumas
Self Injury
Suicidality
Running Away
Substance Use

PTSD – CLINICAL FEATURES
LOOK FAMILIAR?

- From the DSM 5
- "Individuals with PTSD may be quick tempered and may even engage in aggressive verbal and / or physical behavior with little or no provocation…
- They may engage in reckless or self-destructive behaviors such as dangerous driving, excessive substance use, or self-injurious behavior…
- Heightened sensitivity to potential threats…
- May be very reactive to unexpected stimuli, or jumpiness to loud noise, unexpected movements…
- Concentration difficulties, including difficulty remembering daily events or attending to focused tasks are commonly reported…
- Problems with sleep…
- Auditory pseudo-hallucinations, paranoid ideation…individuals may experience difficulties regulating emotions or maintaining stable interpersonal relationships…"

AAP, 2020

- "As there is at present no evidence to support the use of medications without first providing evidence-based psychotherapies in the treatment of pediatric PTSD."

SERTRALINE VS. PLACEBO

OUTCOME IS RATING OF PTSD SYMPTOMS

Sertraline	Placebo	1,[37] 129	Low for no benefit; placebo with greater decrease in parent-rated PTSD symptoms over sertraline (LS mean difference 95% CI of -9.1, -0.6 with CSDC); placebo with greater decrease in clinician-rated PTSD severity via CGI-S (LS mean difference 95% CI of -0.8, 0)	Mixed

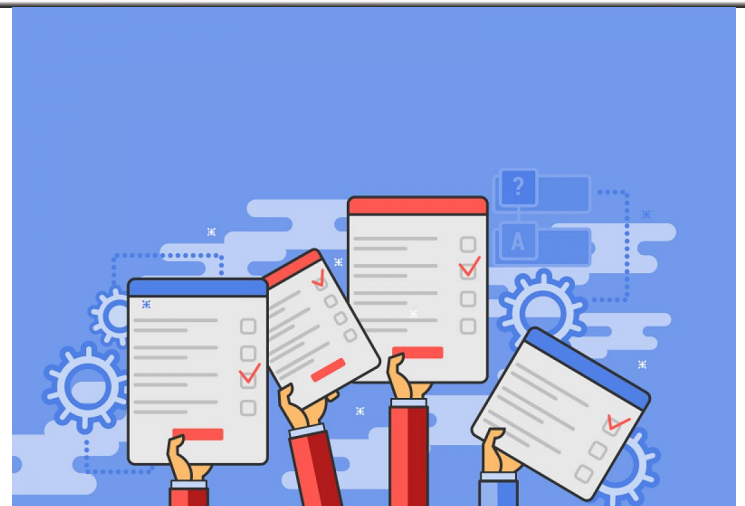
** Further research must be conducted and interventions may need to be adjusted for African-American children based on recent analyses indicating that AA children show no improvements with TF-CBT+SSRI; however DO seem to respond to TF-CBT alone. (NCTSN)

THE BASICS OF TREATMENT OUTCOMES

- Effect Size
  - Cohen's d compares the Mean score of the treatment group to the Mean score of the control group

Relative size	Effect size	% of control group below the mean of experimental group
	0.0	50%
Small	0.2	58%
Medium	0.5	69%
Large	0.8	79%
	1.4	92%

- Ways to Measure Outcome
  - Multiple tools to measure the same symptoms (e.g. Hopelessness) may not reveal consistent scores/outcomes



Evidence-Based Treatments

- Standardized
- Designed to focus on a primary diagnosis / problem
- Based on research with large samples

Culturally Competent Interventions

- Requires Individualized tailoring of intervention based on diversity
- Moves away from standardized care
- May impact expected outcomes based on research

META-ANALYSES OF PSYCHOTHERAPY WITH MINORITIES

- Note that none of the meta-analyses reveal results that even reach a Moderate Effect Size.
- There is debate around the use of standardized treatments, or the necessity to integrate culturally informed modifications to these treatments
- Studies with modifications are few and very small samples

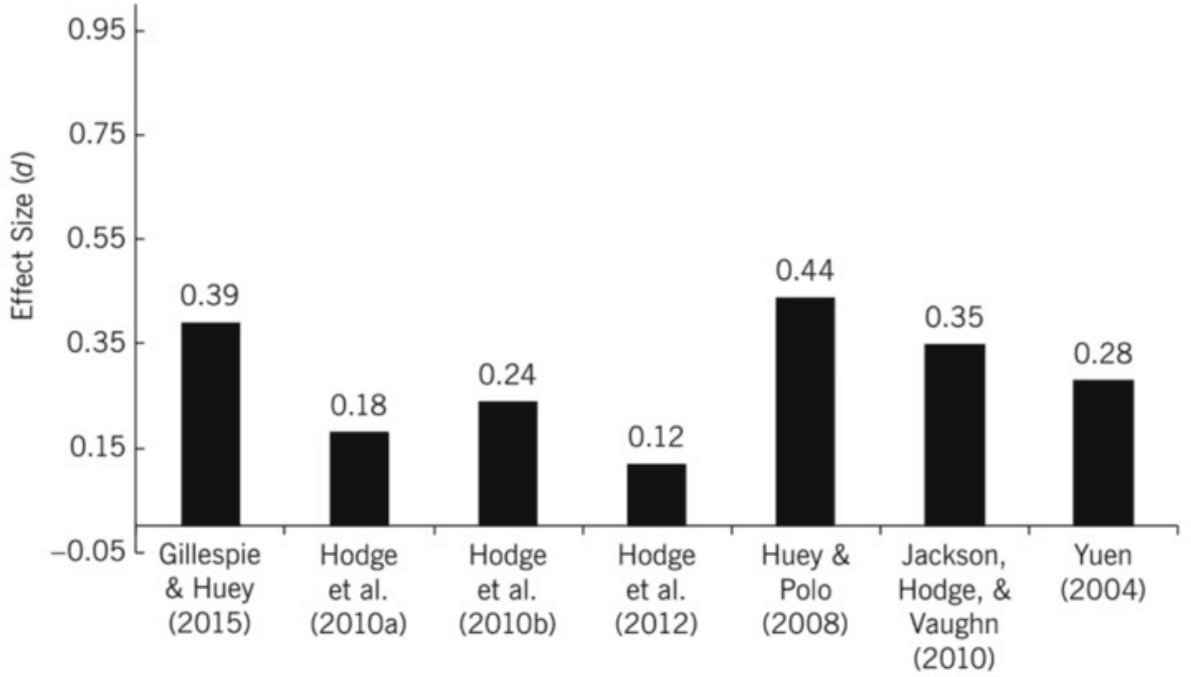


FIGURE 21.1. Meta-analyses evaluating effects of interventions for ethnic-minority youth.

"THE EFFICACY WAS ESTABLISHED…"

- From the Physician's Desk Reference
- **Concerta** **3 & 4 week studies**
- **Adderall XR** **3 weeks**
- **Focalin** **4 weeks**
- **Strattera** **6, 8, 9 weeks**
- **Abilify** **4 and 6 weeks (with Sz)**
- **Geodon** **4, 6 and 52 weeks (with Sz)**
- **Zyprexa** **6 weeks (with Sz)**
- **Seroquel** **6 weeks (with Sz)**
- **Zoloft** **6 and 8 weeks**

CULTURALLY HUMBLE VERSUS COMPETENT

Cultural Humility

- "Cultural humility involves reflecting on what one knows about a particular group and what one does not know about the unique values, experiences, meanings, and goals of the individual in the therapy room, regardless of their group membership."

Practitioners who practice cultural humility in the clinical encounter are better able to connect with and serve their racial and ethnic minority clients

MINORITIES *UNDERREPRESENTED* IN RESEARCH

- "Participation rates are well below their (minority) representation in the population at large making the generalizability of the research findings limited."
- Thus, because of the small sample sizes, studies could not properly analyze treatment efficacy within specific minority groups.
- Nonetheless, results of clinical trials based on findings applicable mostly to male white subjects have been applied indiscriminately to minority populations.

CONSIDERING

ADHD

- The latest Practice Guidelines for ADHD are offered by the

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

- The words "African American" and "Hispanic" only occur once: "There is some evidence that African American and Latino children are less likely to have ADHD diagnosed and are less likely to be treated for ADHD"

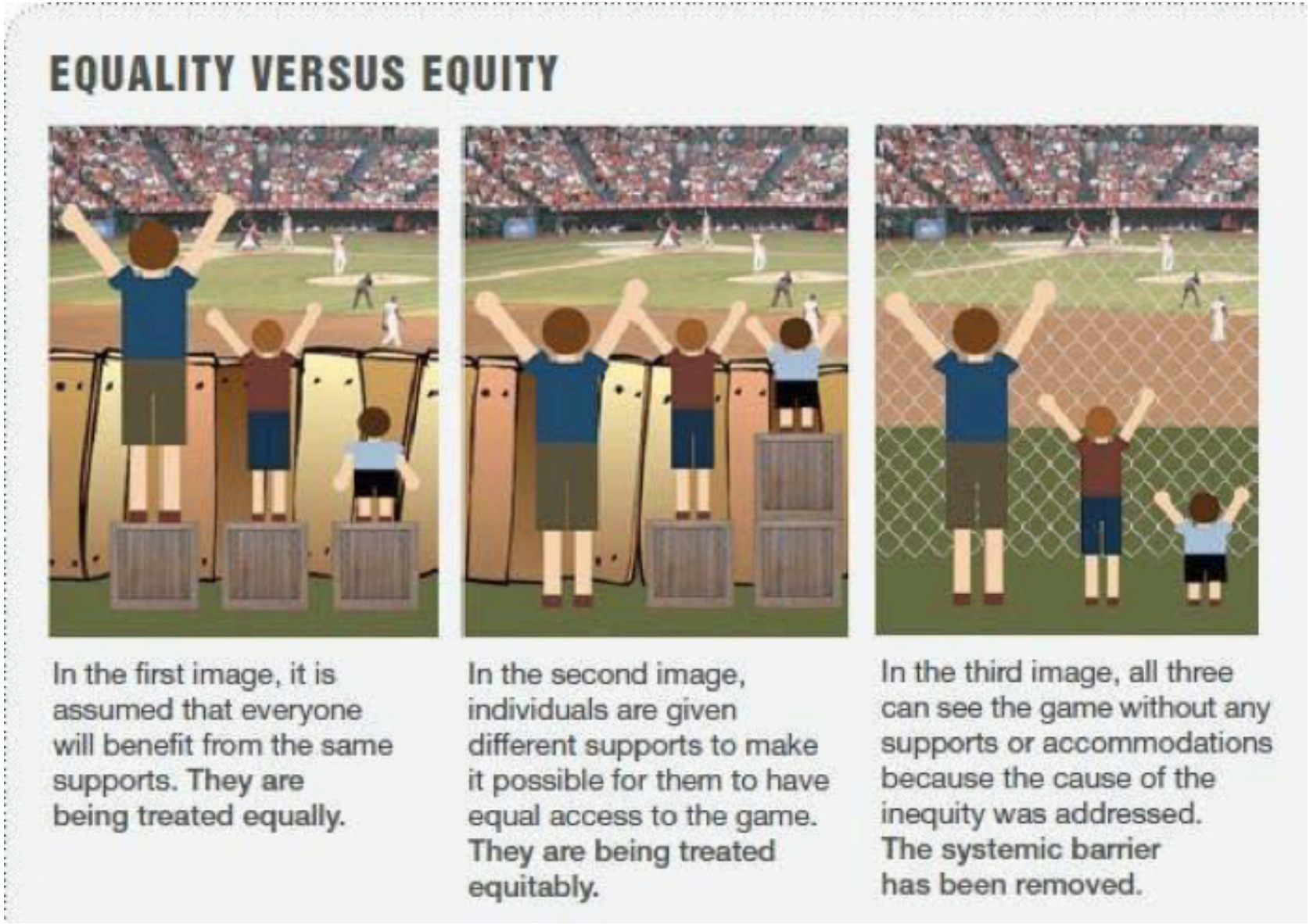
- How do we understand the differences?

SOME PERSPECTIVE

CHALLENGES IN ADHD CARE FOR ETHNIC MINORITY CHILDREN: A REVIEW OF THE CURRENT LITERATURE (2020). ORTAL SLOBODIN & RAFIK MASALHA

- Problem Identification:
  - "Parents from different cultures often have varying thresholds for differentiating normal from abnormal child behavior
  - African American parents are less likely to involve the school in the problem-identification process & express fewer concerns about ADHD-related difficulties
  - African American parents were more likely to call the behavior "bad" whereas Caucasian parents refer to it as a medical syndrome
  - Teachers are more likely to identify African American children higher on ADHD and conduct-related symptoms, while Mental Health professionals tend to associate these behaviors in African American adolescents with criminal orientations, whereas negative behavior among Caucasian adolescents was attributed to mental health problems.
- some African American parents believed that a diagnosis of ADHD is associated with a lifetime label, others viewed its medicalization as a form of social control with historical roots"

- An important image to promote continued review of our systems of care



http://www.businessdisabilityinternational.org/when-is-equality-not-equality/