MEASURING AND UNDERSTANDING RACIAL/ETHNIC DISPARITIES IN SUBSTANCE USE TREATMENT

Brandeis Harvard NIDA Center

To Improve System Performance of Substance Use Disorder Treatment

March 27, 2020

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HEALTH EQUITY RESEARCH LAB

Identify and reduce health care disparities in underserved populations by developing and rigorously evaluating clinical and policy interventions, leveraging community assets, and mobilizing system transformation.

PROMOTE EQUITY IN HEALTHCARE THROUGH RESEARCH

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CHE

CENTER FOR HEALTH EQUITY

WHAT WE DO

HEALTHEQUITYRESEARCH.ORG (CAMBRIDGE)
PRIMECHE.COM (BRONX)

Use data analytics to prevent negative social, health and mental health outcomes among racial/ethnic minority populations

Intervene to reduce disparities in negative social, health, and mental health outcomes.

Mentor disparities researchers

Identify the mechanisms and factors of resiliency underlying pathways towards health in the face of social and economic adversity

Patient and Family Engagement: *research guided by community members and their accumulation of knowledge, confidence, and self-determination, for their own health and health care.*

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OUTLINE

- A framework: how disparities in behavioral health arise
- Substance use and substance use treatment by race/ethnicity
- Measuring and tracking disparities grounded in a conceptual framework (in our case a definition from the IOM) as opposed to what is "available to us" in statistical packages
- Moving from measurement and tracking to understanding underlying mechanisms (Tim)

What will not be covered:

- Review of disparities in substance use and SUD treatment and the role of the criminal justice system and SES
- CBPR methods to reduce behavioral health disparities

  (Delman, Creedon, Cook et al. Health Affairs, DOI: 10.1377/hlthaff.2018.05040)
- Discrimination outside the healthcare system and how it impacts behavioral health
- Moving towards a de-segregated, community-based behavioral health treatment system.

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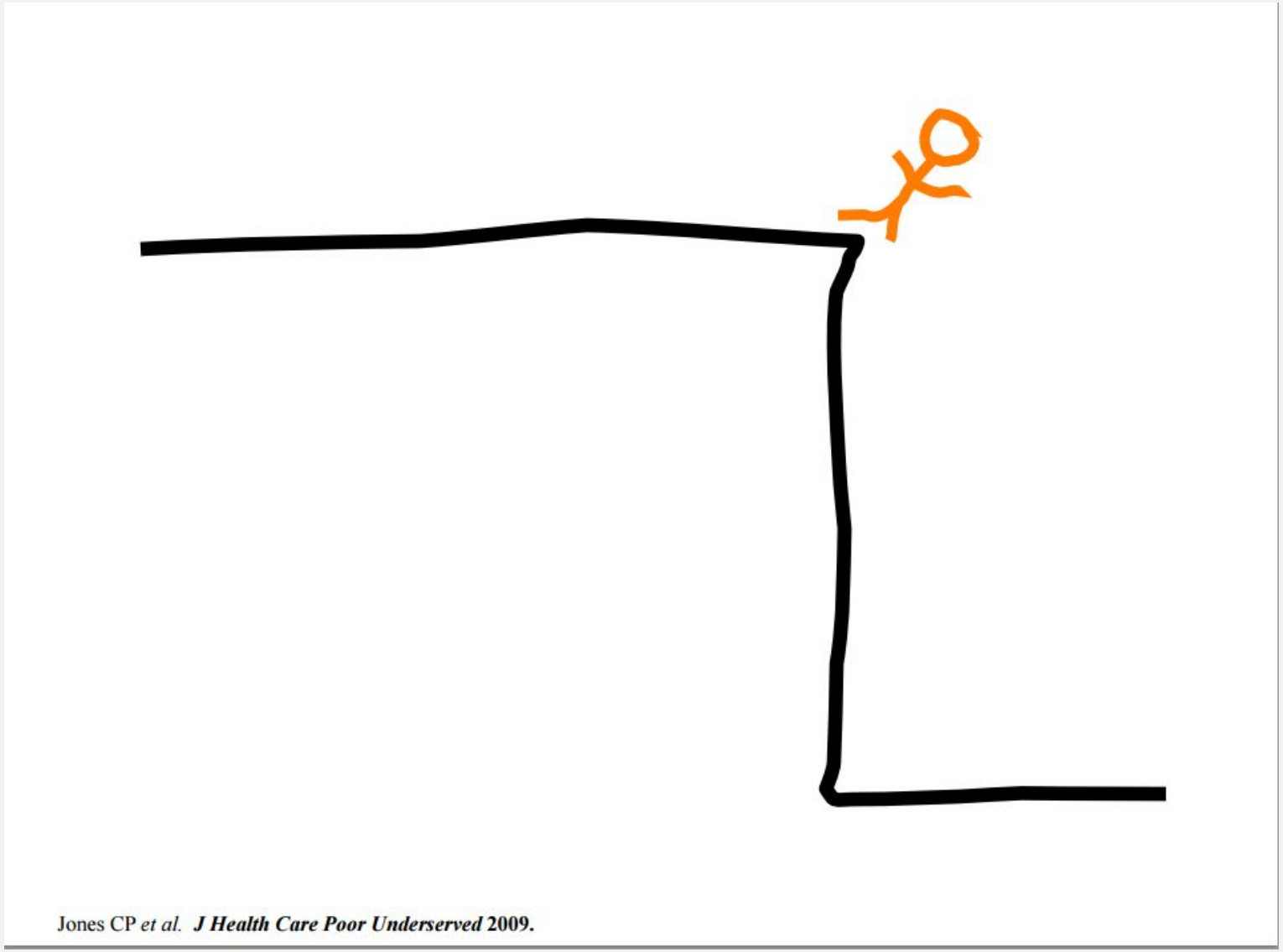

Jones CP *et al.* ***J Health Care Poor Underserved*** **2009.**

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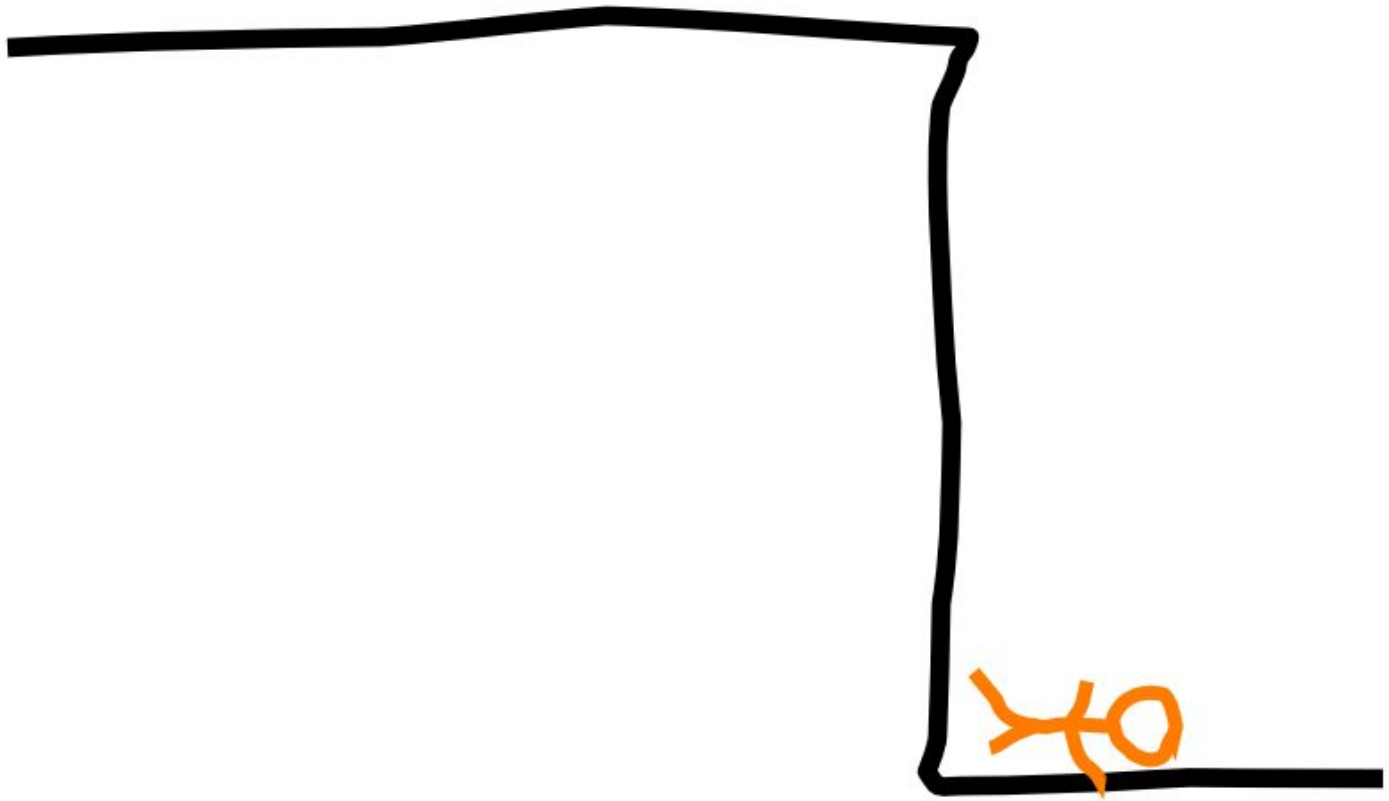

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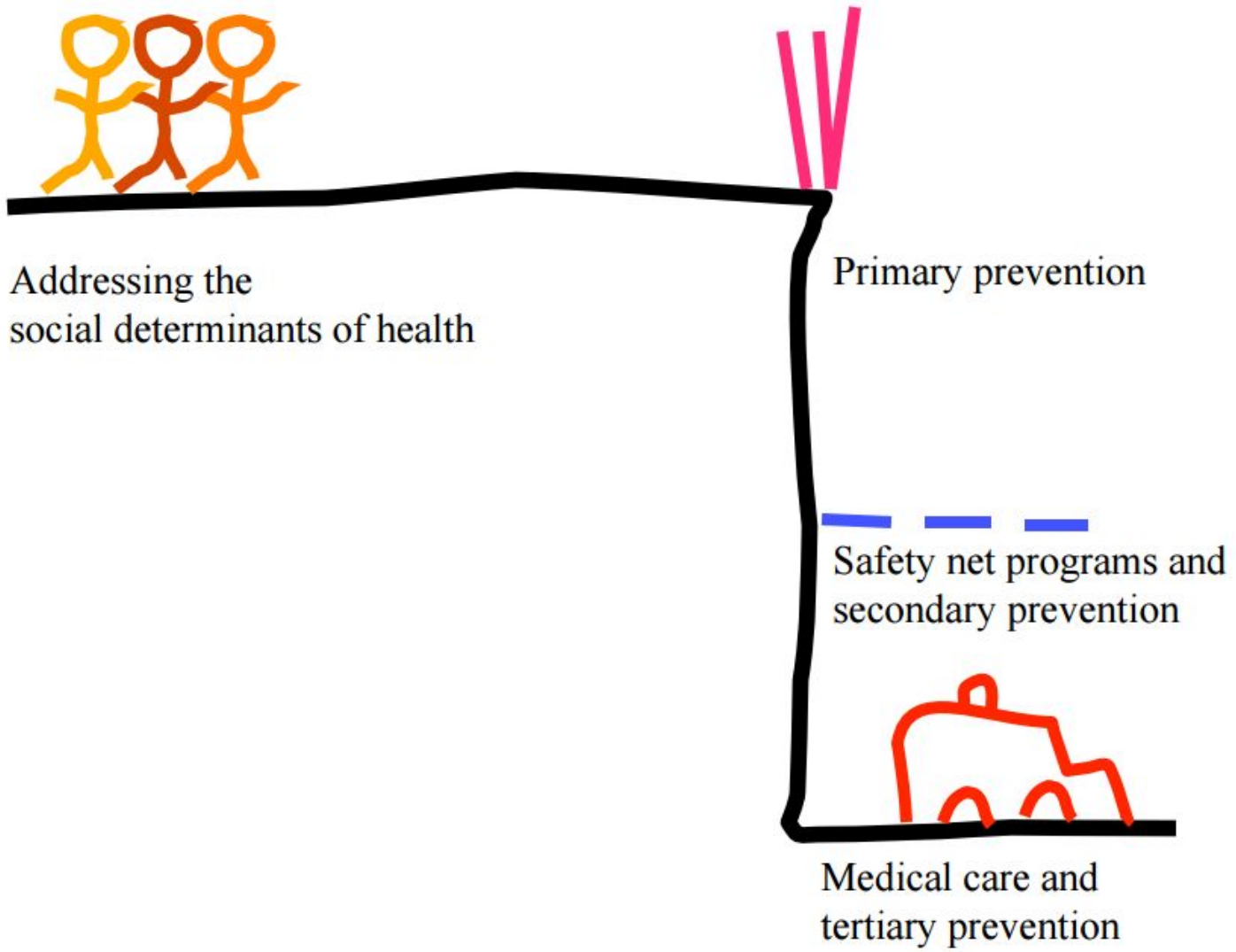

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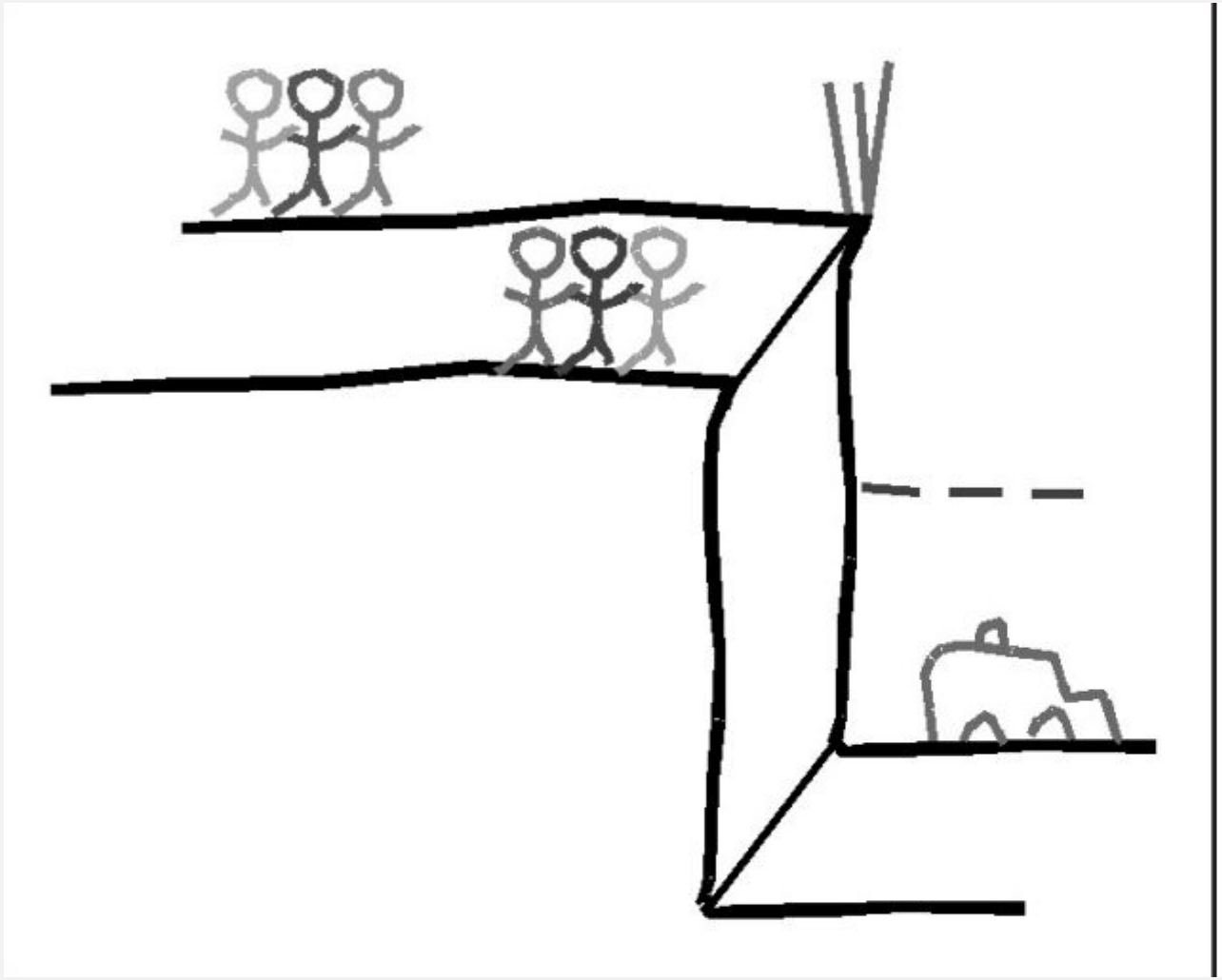
HOW INEQUITIES / DISPARITIES ARISE



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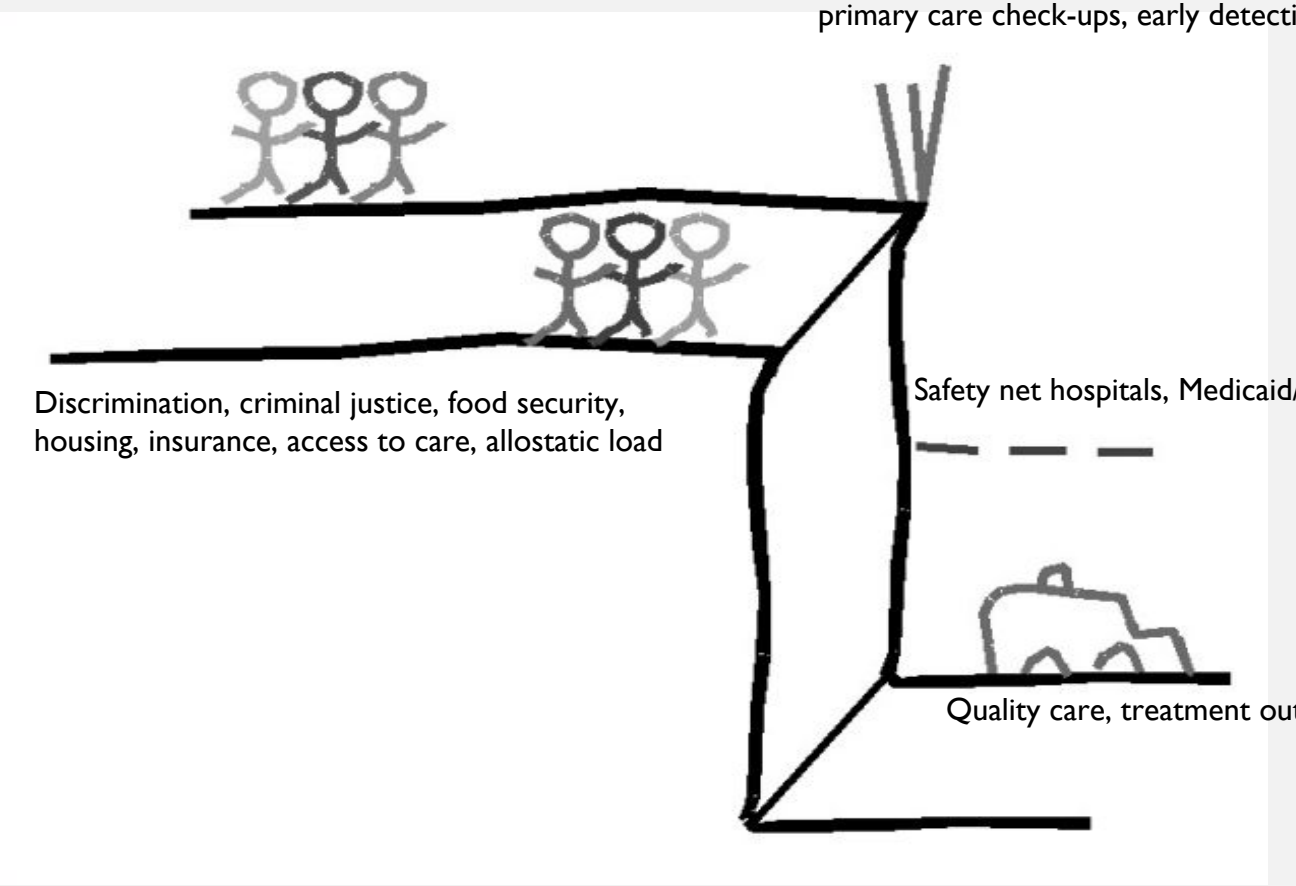
Jones CP et al. ***J Health Care Poor Underserved*** 2009

DISPARITIES WITHIN AND OUTSIDE OF THE HEALTHCARE SYSTEM



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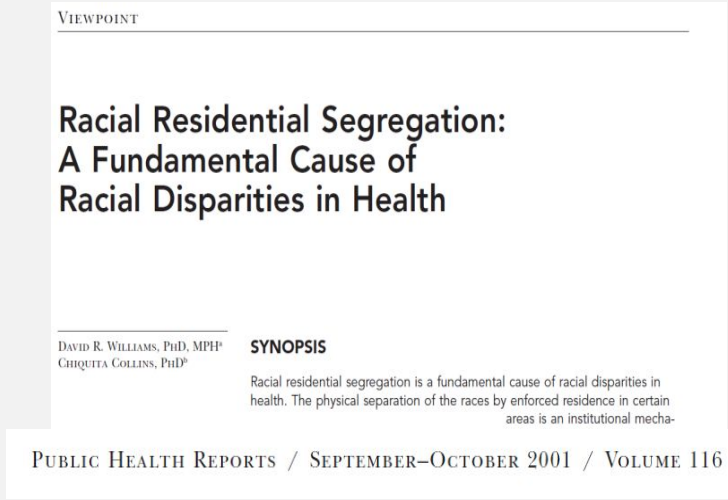
MECHANISMS UNDERLYING DISPARITIES (**WARM UP)

- Poorer social determinants of health (e.g., residential segregation combined with fewer neighborhood resources (Williams and Jackson 2005; Link and Phelan 1995))
  - Employment opportunities
  - Schooling
  - High-risk jobs
  - Neighborhood/housing quality
    - Lead exposure
  - Access to healthier foods
  - Crime, homicide


VIEWPOINT

Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health

DAVID R. WILLIAMS, PHD, MPH[a]
CHIQUITA COLLINS, PHD[b]

SYNOPSIS

Racial residential segregation is a fundamental cause of racial disparities in health. The physical separation of the races by enforced residence in certain areas is an institutional mecha-

PUBLIC HEALTH REPORTS / SEPTEMBER–OCTOBER 2001 / VOLUME 116

- Systematic Racism (negative beliefs about racial/ethnic minorities incorporated into societal policies and institutions) (Williams and Williams-Morris 2000).

- **Interpersonal patient-provider discrimination**

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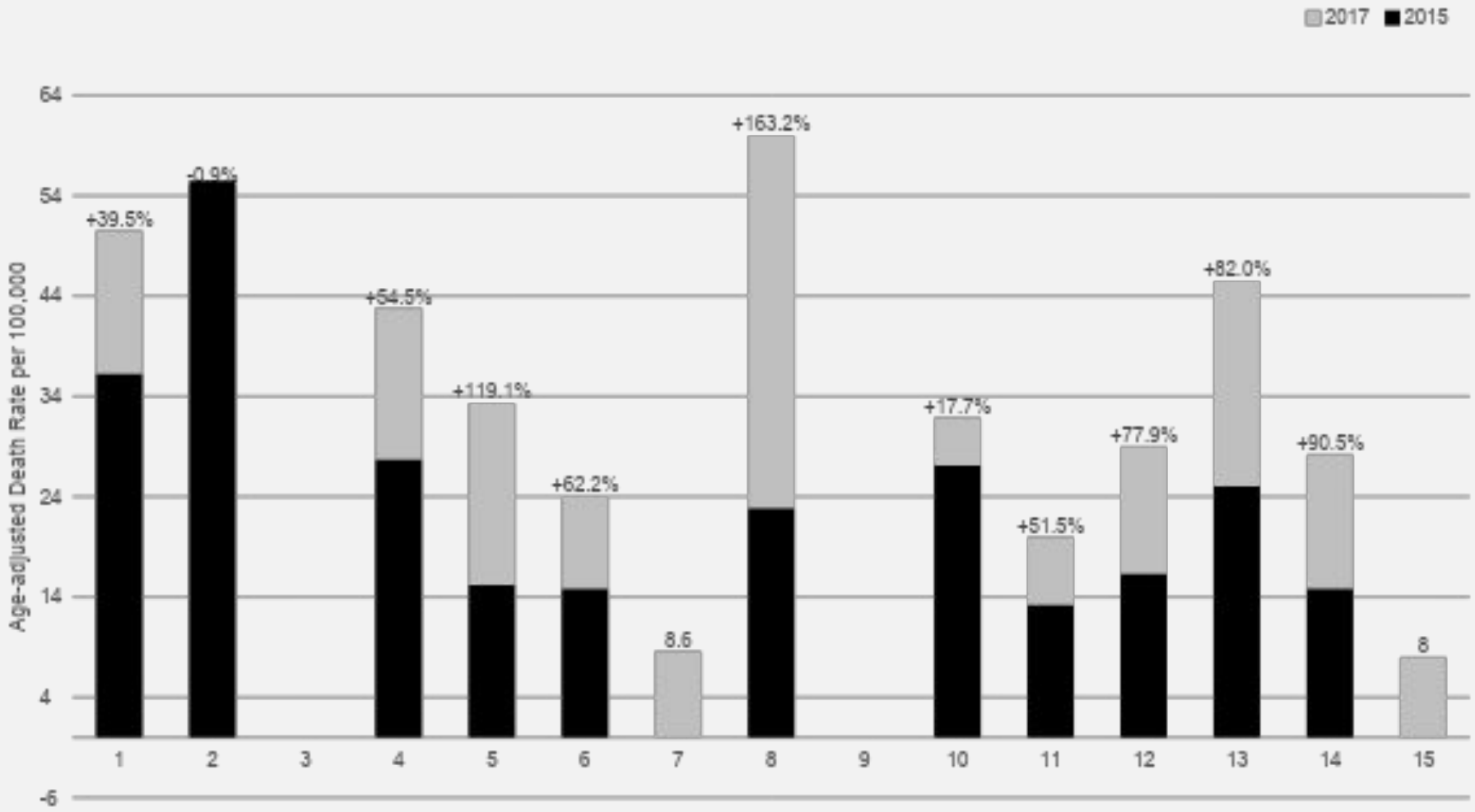
Opioid-related Death Rates
By Race/Ethnicity In Five States, 2015 And 2017



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Flores et al. in preparation

Access: <10% of those with SUD receive SUD treatment

	Non-Latino Whites	Latinos	African American
Substance Use Disorder			
12 months service use	5.3%	6.4%	6.8%
	n=8584	n=1836	n=1789
Lifetime service use	**15.3%**	**18.4%***	**18.6%****

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National Epidemiologic Survey on Alcohol and Related Conditions (NESARC); and Cook and Alegria 2012 Psychiatric Services

After Access, Disparities In SUD Treatment Completion

- Blacks and Hispanics less likely to complete treatment for all substances except prescription opioids
- Native Americans less likely to complete for alcohol, marijuana, heroine, and opiates
- Asian Americans more likely to complete treatment than whites

- Even those that do complete are extremely likely to relapse, be hospitalized and end up in treatment again.

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Saloner and Cook 2013 Health Affairs doi: 10.1377/hlthaff.2011.0983

BEYOND THE NUMBERS: UNDERSTANDING ACCESS TO AND RETENTION IN TREATMENT***

Results from "What Attracts, What Doesn't Attract, What Keeps?" Exercise with Blacks United in Recovery led by La Verne Saunders and Valeria Chambers (11-27-18)

What Attracts?	What Doesn't Attract?	What Keeps?
• **Authenticity** • **Empathy, acceptance, action, compassion** • **Honesty & trust** • **Appreciation** • **Relationships and connections** • **Useful information** • **Being heard & seen**	• Judgement • **Lack of cultural responsiveness** • De-validation • Lack of training • Evidence of institutional racism • Process-oriented vs people-oriented • Lack of diversity	• Familiar faces & consistent staff • Acceptance & commitment • Shared vision • Cultural humility • Able to contribute, share and help out • Shared experiences • **Being comfortable and safe**

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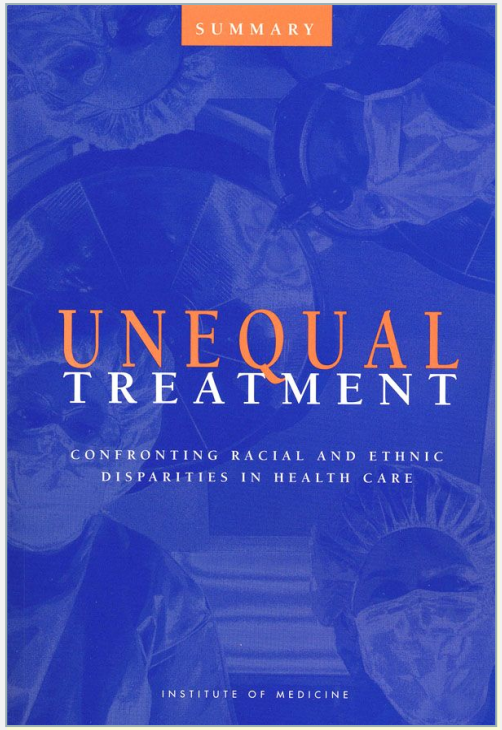
DEFINING RACIAL/ETHNIC HEALTHCARE DISPARITIES

- Defining and tracking a healthcare "disparity" to make it more relevant to practice / policy (IOM 2002)
- MA Title XVII, Ch. 118E, Section 13B
  - "Hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care."
- Value-based payment contracts are intended to improve overall well-being. We know less about impact on disparities.
  - Song et al. 2017 Health Affairs, Lower- Versus Higher-Income Populations in the AQC: Improved Quality and Similar Spending. Health Affairs.
  - Lewis et al. 2012. The Promise And Peril Of Accountable Care For Vulnerable Populations: A Framework For Overcoming Obstacles. Health Affairs.
  - NIMH R01 (PI Cook and Horvitz-Lennon looking at VBP in NY and OR Medicaid)



Institute of Medicine, 2003

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SUBSTANCE USE TREATMENT DIFFERENCES ARE DUE TO MANY FACTORS:

- African-Americans and Latinos
  - have lower average rates of education and income in the U.S. which are associated with lower access
  - are more likely to be uninsured – also associated with lower access
- Asians have lower rates of substance use disorder than whites
- Providers have biases that may lead to discrimination which deters those with substance use treatment from accessing care.
- Differential harm from research, detention, involuntary commitment
- Hospitals/community health centers have had a legacy of segregation policies
  - *Simkins v Moses H. Cone Hospital* (1963), challenged the federal government's use of public funds to expand and maintain segregated hospital care; segregation still correlated with hospital closings and treatment availability
- Limited evidence (Jimenez et al. 2012) that African-Americans prefer to seek spiritual advice over clinical treatment for behavioral health problems.

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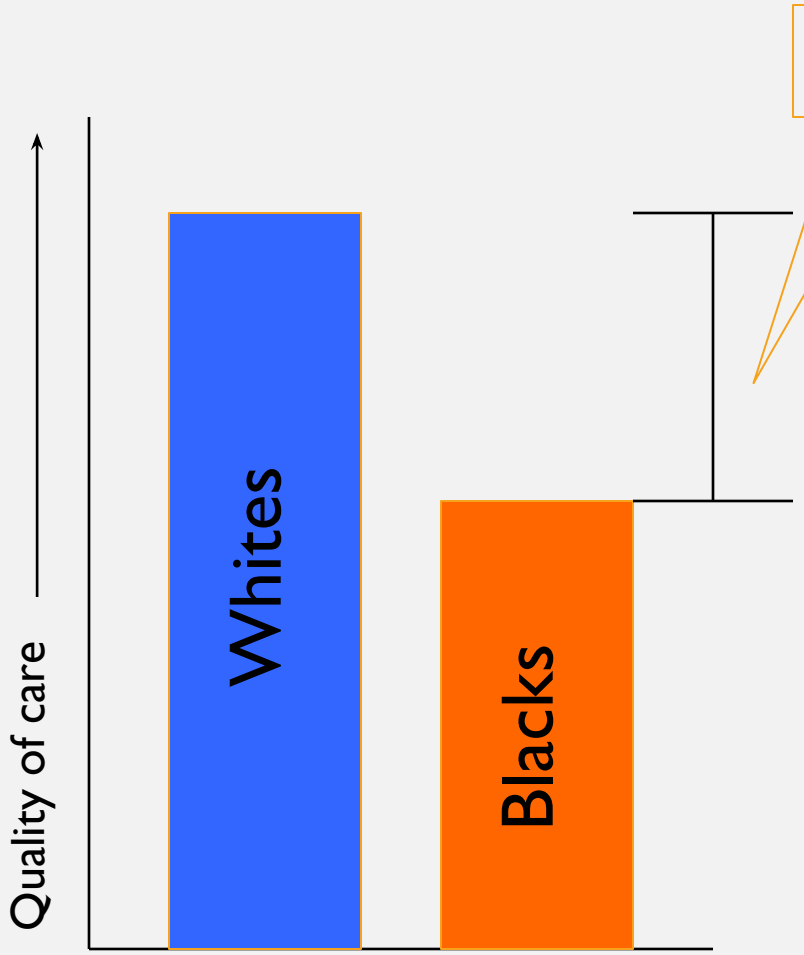
DEFINING HEALTHCARE DISPARITY: DIFFERENCES, DISCRIMINATION, AND DISPARITY



The difference is due to:

Clinical Need & Appropriateness & Patient Preferences
Healthcare Systems & Legal / Regulatory Systems
Discrimination: Bias, Stereotyping, and Uncertainty

Disparity

IOM *Unequal Treatment* 2002

DEFINITION OF RACIAL DISPARITIES: IOM

- **"Disparities are all healthcare differences not due to clinical appropriateness and need and patient preferences."**

  - Disparities *do include* differences due to discrimination
  - Disparities *do include* differences due to "the differential impact of healthcare systems and the legal/regulatory climate" on racial/ethnic minorities
  - (i.e., differences due to being lower SES and uninsured)

  - Disparities *do not include* differences related to health status (clinical appropriateness and need), and patient preferences

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COMMONLY USED DISPARITIES METHODS (OUT OF THE BOX STATISTICAL METHODS)

- Typical method of measuring disparities using a regression framework from previous studies

$$1)\ y=\beta_0+\beta_R RACE_i+\beta_A Age_i+\beta_G Gender_i+\varepsilon$$

$$2)\ y=\beta_0+\beta_R RACE_i+\beta_A Age_i+\beta_G Gender_i+\beta_H Health_i+\varepsilon$$

$$3)\ y=\beta_0+\beta_R RACE_i+\beta_A Age_i+\beta_G Gender_i+\beta_H Health_i+\beta_I Income_i+\varepsilon$$

- β_R represents a "residual direct effect"

- Omitted variable bias - β_R difficult to interpret
- Difficult to track this coefficient (or change in coefficient) over time and across studies

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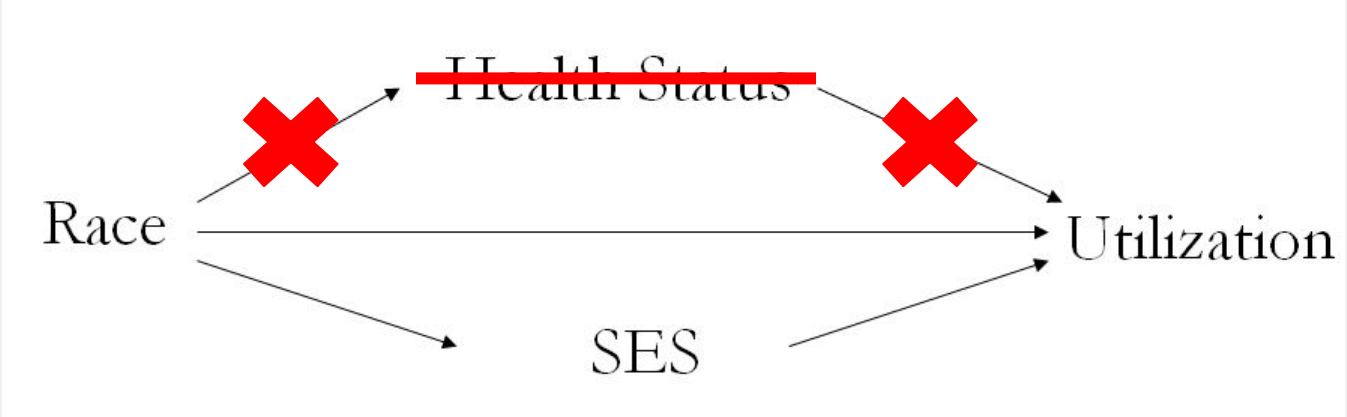
OPERATIONALIZING THE IOM DEFINITION



(1) Fit a model
(2) Transform *distribution* of health status (not SES)
(3) Calculate predictions for minorities with transformed health status
    - Average predictions by group and estimate disparities

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OPERATIONALIZING THE IOM DEFINITION

- Adjust for mental health status (clinical appropriateness/ need), but not SES variables (system level variables)
- In a regression framework:

$$y=\beta_0+\beta_R RACE_i+\beta_H Health_i+\beta_S SES_i+\varepsilon$$

White: $\hat{y}_W=\beta_0+\beta_R RACE_{White}+\beta_H Health_{White}+\beta_S SES_{White}+\varepsilon$

Black: $\hat{y}_B=\beta_0+\beta_R RACE_{Black}+\beta_H Health_{White}+\beta_S SES_{Black}+\varepsilon$

Disparity: $\hat{y}_W-\hat{y}_B$

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FIT A (NON-LINEAR) MODEL OF BH CARE EXPENDITURES

Two-part model

Access (Expenditure>0): Probit

$$\text{Prob}(y>0) = \Phi(x'\beta)$$

Expenditures: GLM with quasi-likelihoods

$$E(y|x) = \mu(x'\beta) \quad \text{and} \quad \text{Var}(y|x) = (\mu(x'\beta))^{\delta}$$

- with log link function
- and variance proportional to mean (δ=2)

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1. Fit a model
2. Transform HS distribution
3. Calculate predictions

TRANSFORMATION OF HEALTH STATUS

- In a linear model, we could adjust at the mean
- In a non-linear model, we must adjust the entire distribution.
- How do we adjust?
  - "Rank and replace" method
  - Propensity score weighting balances racial/ethnic groups on health status only
  - (Random replacement – not recommended)

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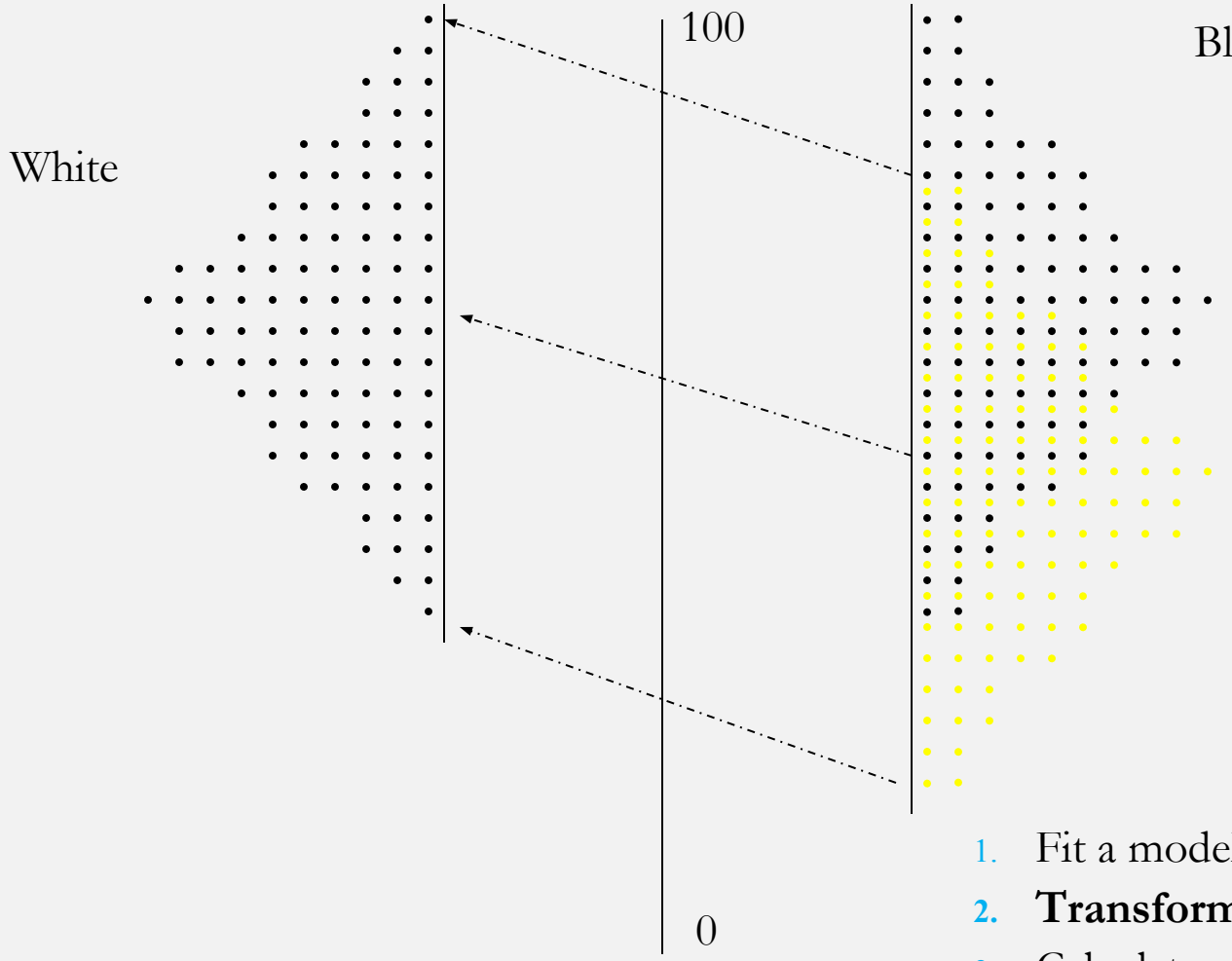
1. Fit a model
2. Transform HS *distribution*
3. Calculate predictions

ADJUST NEED (HS) "INDEX" (RANK AND REPLACE)



1. Fit a model
2. **Transform HS *distribution***
3. Calculate predictions

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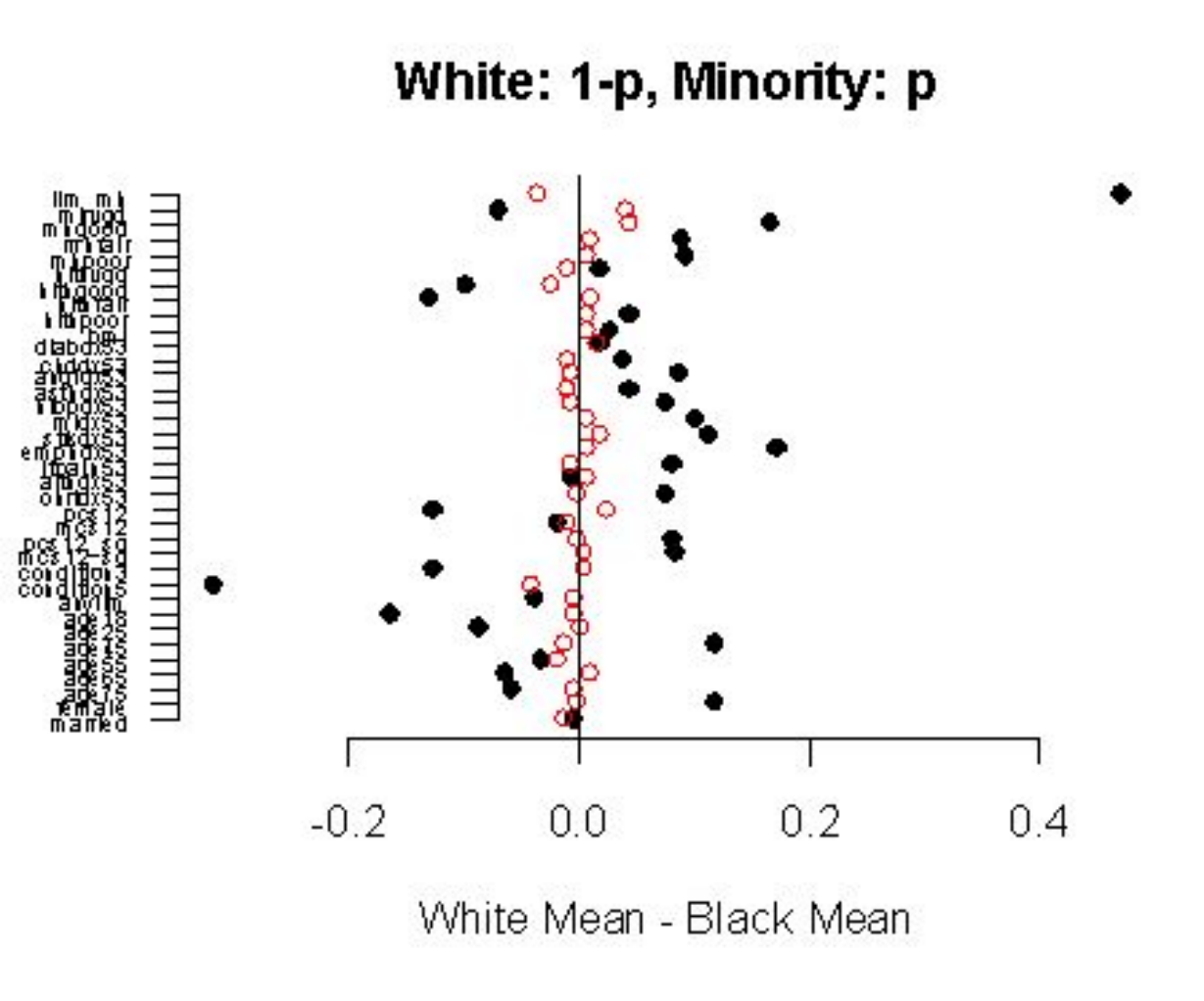
Propensity Score Weighting

$$P(White)=\beta_0+\beta_1(HS)=\hat{e}_i(z)$$



1. Fit a model
2. **Transform HS *distribution***
3. Calculate predictions

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STATA EXAMPLE

DOES THE METHOD MATTER?

HSR Health Services Research

© Health Research and Educational Trust
DOI: 10.1111/j.1475-6773.2010.01100.x
METHODS ARTICLE

Comparing Methods of Racial and Ethnic Disparities Measurement across Different Settings of Mental Health Care

Benjamin Lê Cook, Thomas G. McGuire, Kari Lock, and Alan M. Zaslavsky

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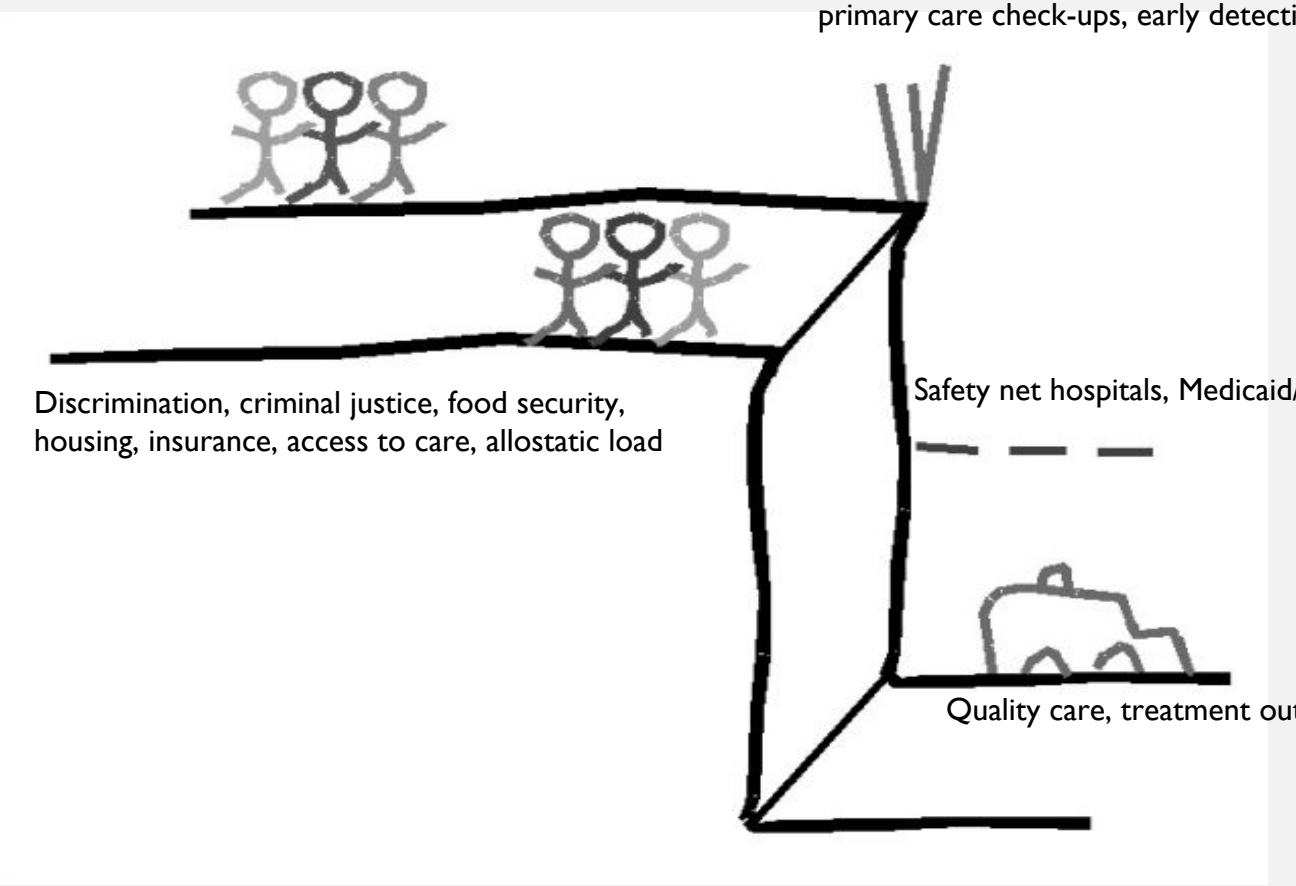
DISPARITIES WITHIN AND OUTSIDE OF THE HEALTHCARE SYSTEM



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Montefiore

EINSTEIN
Albert Einstein College of Medicine

RACIAL/ETHNIC DISPARITIES IN SUBSTANCE USE DISORDER TREATMENT: EFFECTS OF WHAT?

Brandeis Harvard NIDA Center

To Improve System Performance of Substance Use Disorder Treatment

March 27, 2020

Timothy B. Creedon, PhD'19

Research Scientist, Health Equity Research Lab (healthequityresearch.org)

Cambridge Health Alliance

OUTLINE

- ***Building on*** measurement and tracking, what's needed to isolate the causes of racial/ethnic disparities?
- Counterfactuals embedded in the IOM disparities framework
- Effects of [what]?
- Putting it all out there: structural causal models

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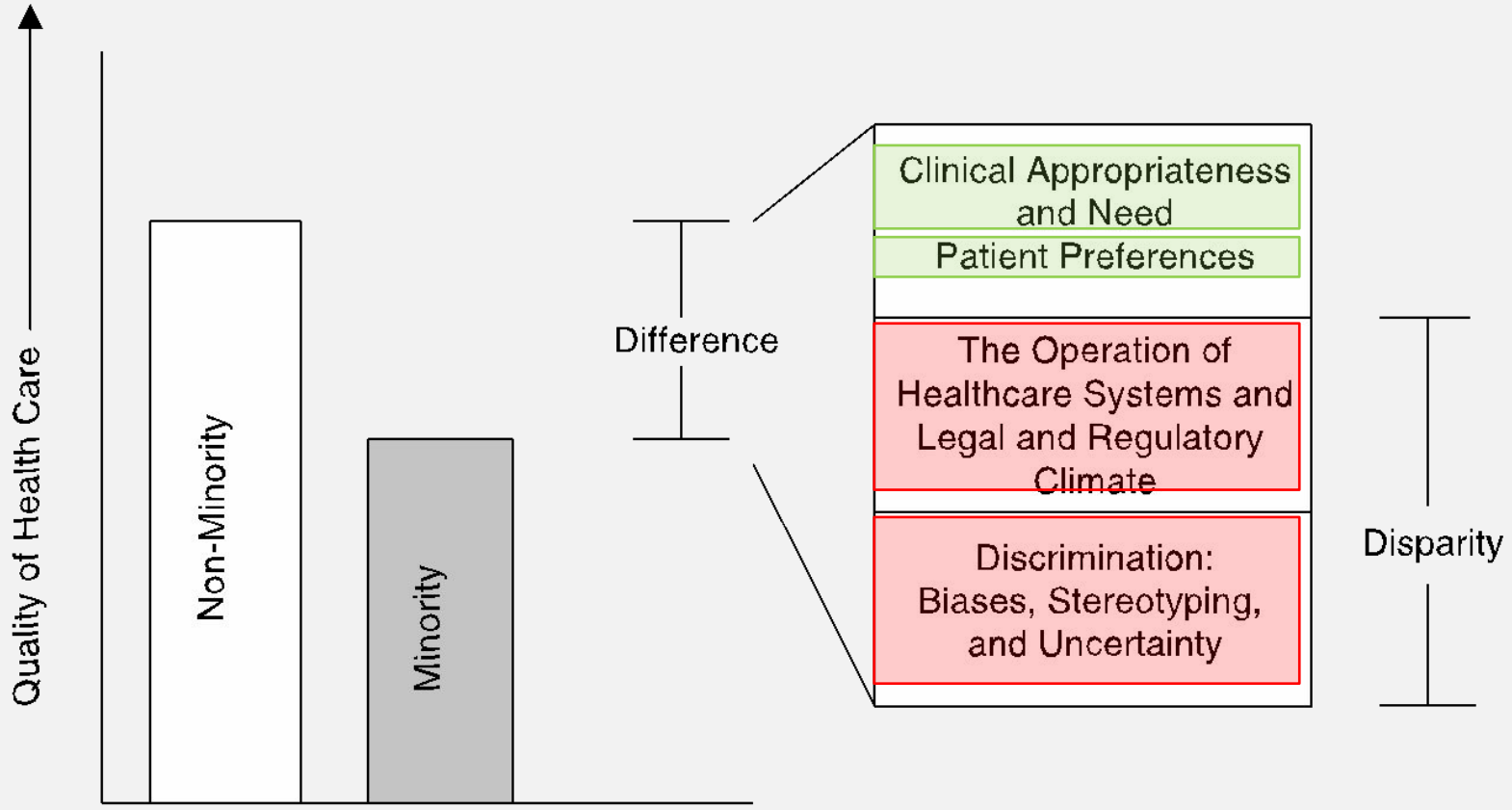
MORE TO DO ON MEASUREMENT
PATIENT PREFERENCES, DISCRIMINATION



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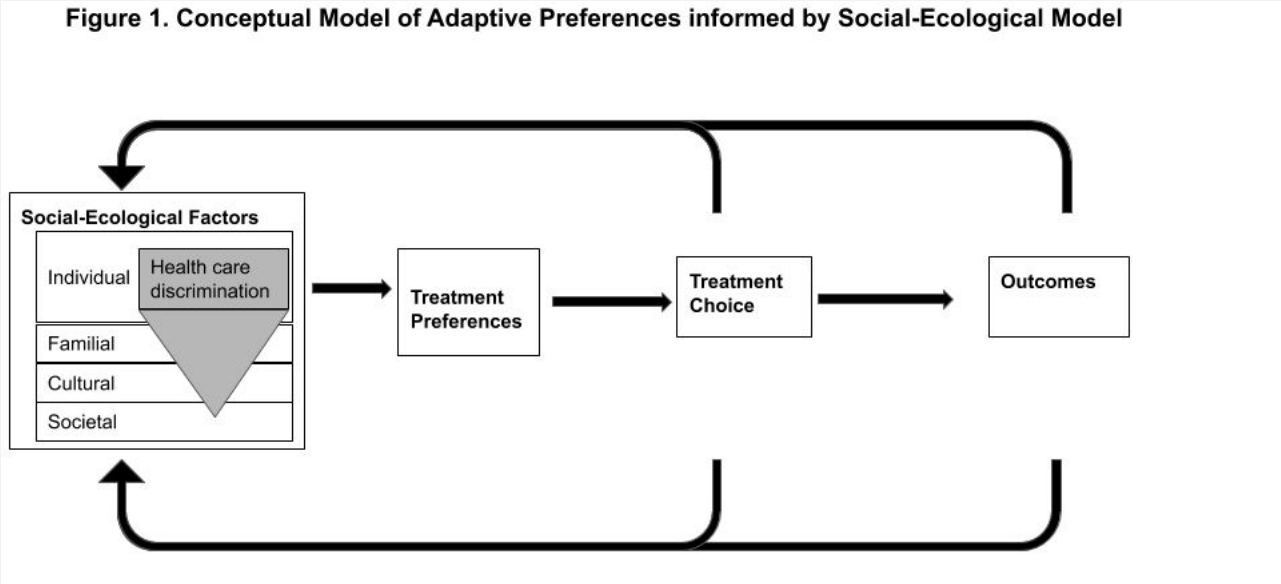
IOM racial/ethnic disparities framework

(Institute of Medicine, 2003; Cook & Alegría, 2011)

PCORI STUDY ON PREFERENCES

Title: Improving Methods of Incorporating Racial/Ethnic Minority Patients' Treatment Preferences into Clinical Care
PI: Cook



(Stokols, 1992; Nussbaum, 2001)

- **Aim 1.** Develop and administer a national survey to:
  - Better elicit and measures depression treatment preferences
  - Assess to what degree depression treatment preferences vary by:
  - Race/ethnicity
  - By experiences of prior healthcare discrimination
- **Aim 2.** Interview survey participants to understand how prior discrimination influences treatment preferences, preferences elicitation, and receipt of preferred treatment
- **Aim 3.** Interview clinical stakeholders to assess the feasibility of incorporating systematic preferences elicititation and healthcare discrimination data into treatment planning

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AIM 1 STUDY DESIGN

- **Web-based survey using GfK KnowledgePanel (KP)**
  - Sample frame of residential addresses covering 97% of U.S. households
  - Used in previous mental health-related surveys to include underrepresented groups and those without internet access
- **711 adults with depression**
  - 18+ year old non-Hispanic white (n=250), non-Hispanic black (n=209), and Hispanic individuals (n=252), allowing comparisons to past studies using these groups
  - Aimed for 250 from each racial/ethnic group
  - n=81 (11%) took the survey in Spanish
  - Depression diagnosis: scores of ≥10 on 9-item depression scale from the Patient Health Questionnaire (PHQ-9)
- **Survey instrument components**
  - Survey respondent characteristics (e.g., demographics)
  - **Depression treatment preferences (discrete choice experiment)**
  - **Past experiences with health care discrimination**
  - Recent health care utilization
- **IRB** approved all aspects of the study, including the survey's development and administration.

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SURVEY QUESTIONS ABOUT DISCRIMINATION

- Have you ever felt that you were treated unfairly while getting medical care by your medical provider because of your [race/color, ethnicity, language/accent, sexuality, gender]?
- Have you ever felt that you were treated unfairly while getting medical care by front desk staff because of your [race/color, ethnicity, language/accent, sexuality, gender]?
- Have you ever felt that someone close to you was treated unfairly while getting medical care because of their [race/color, ethnicity, language/accent, sexuality, gender]?

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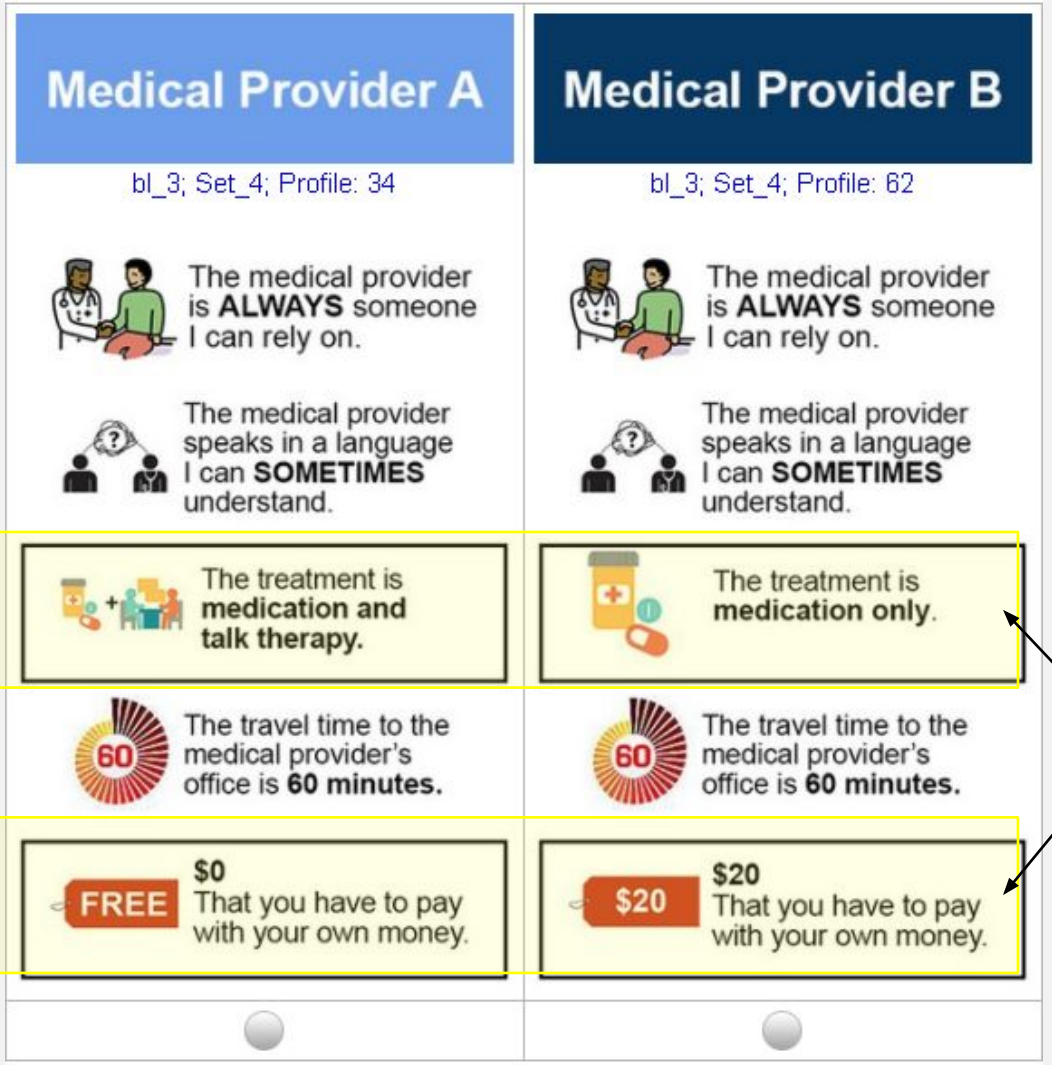
ELICITING PREFERENCES IN THE SURVEY

(DISCRETE CHOICE EXPERIMENT, EX. 1)

5 attributes

1. Provider reliability
2. Provider communication
3. Treatment type
4. Travel time
5. Out-of-pocket cost



18 random choices per respondent

2-4 attributes differ between A and B each time

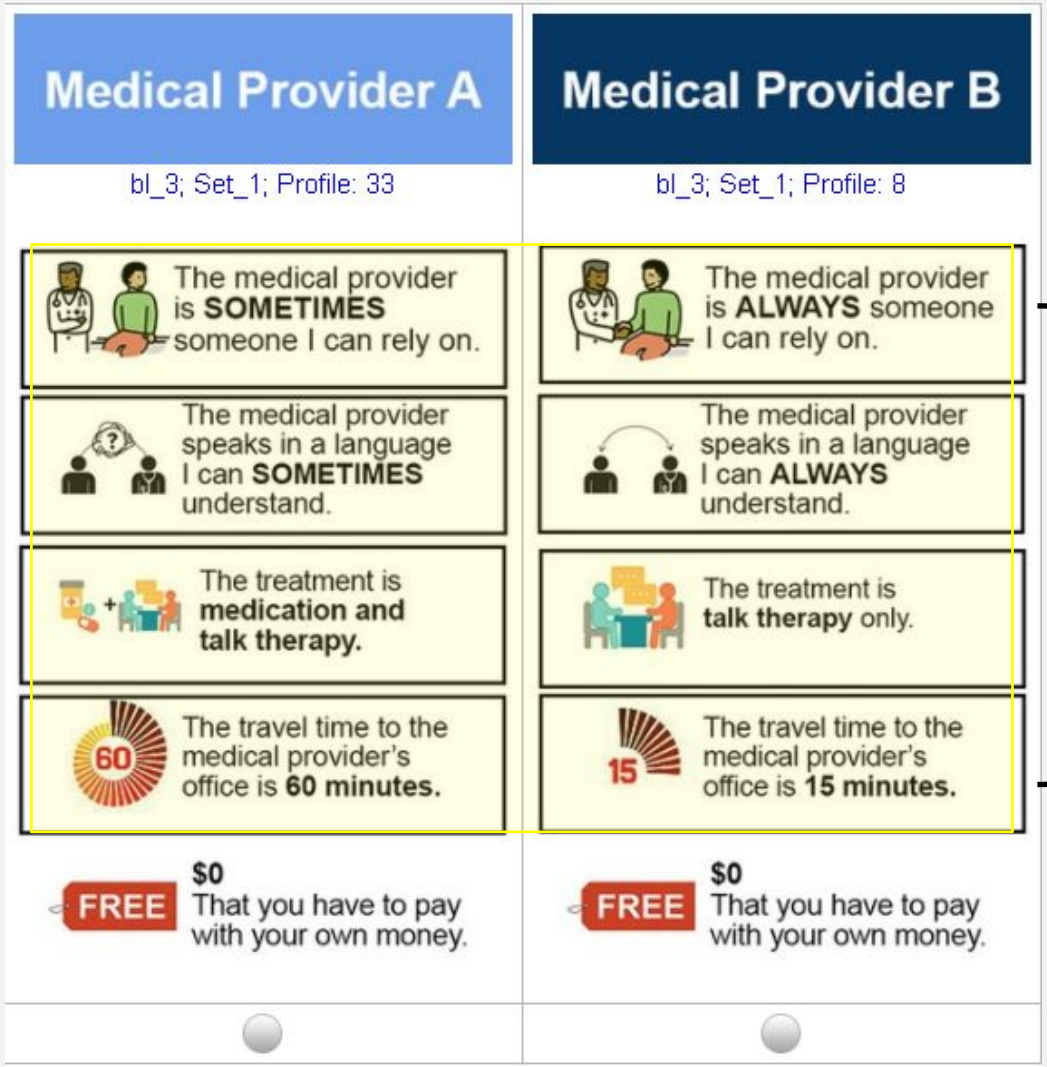
2 differences here

ELICITING PREFERENCES IN THE SURVEY

(DISCRETE CHOICE EXPERIMENT, EX. 2)

5 attributes

1. Provider reliability
2. Provider communication
3. Treatment type
4. Travel time
5. Out-of-pocket cost



18 random choices per respondent

2-4 attributes differ between A and B each time

4 differences here

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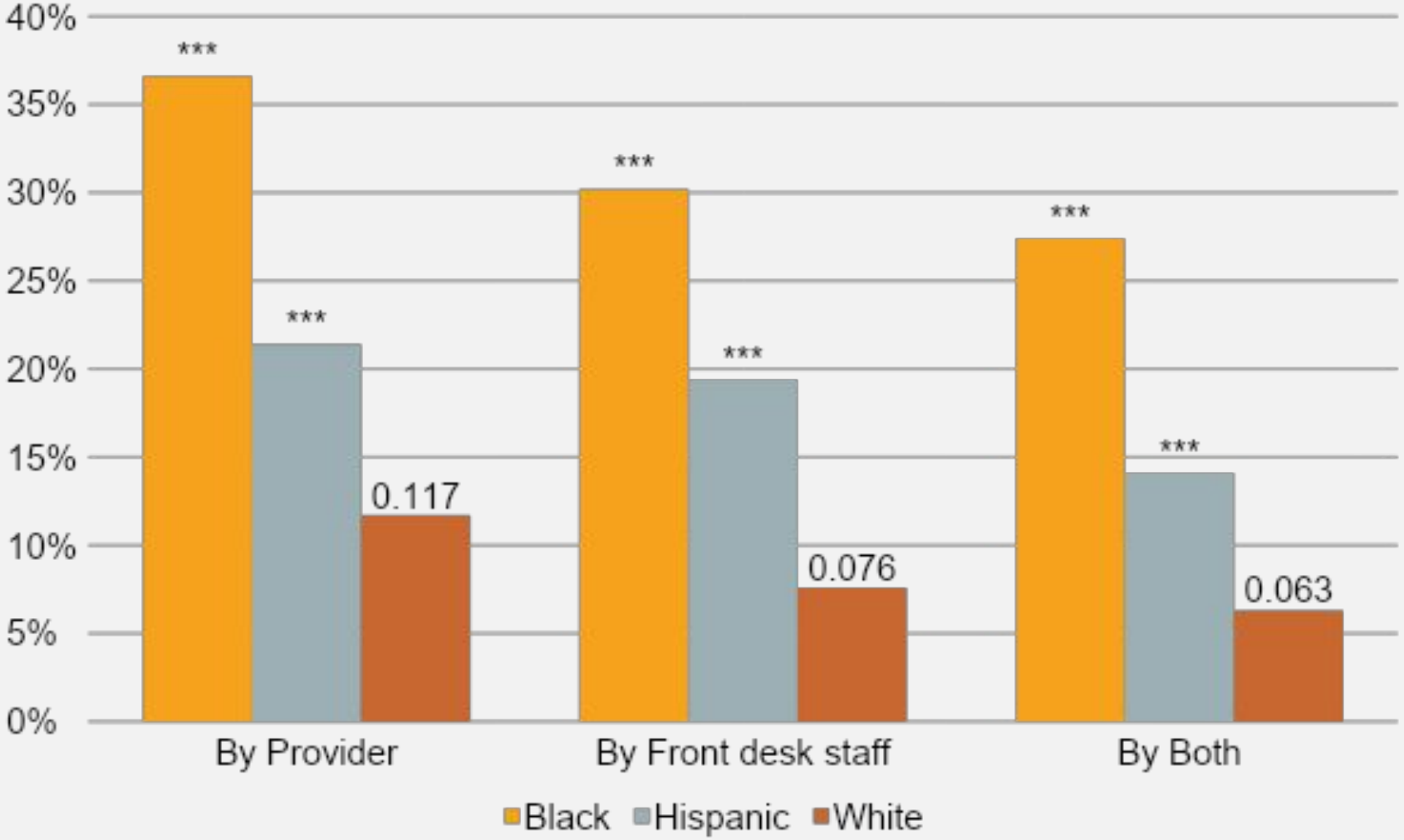
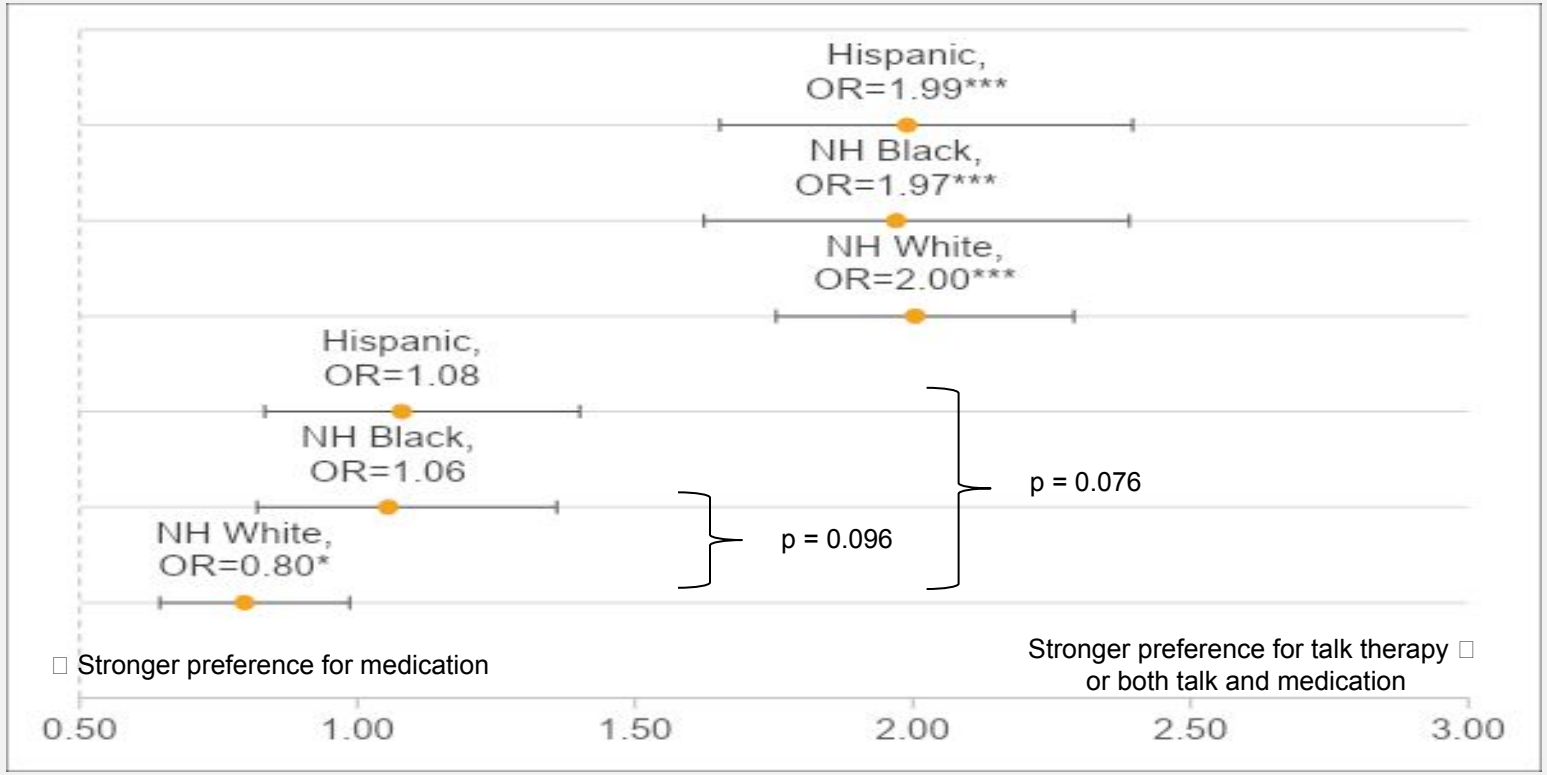
RESULTS: PAST HEALTH CARE DISCRIMINATION



N=711; Differences from reference group (white) stat. sig. at ***p<0.001.

RESULTS: PREFERENCES FOR MEDICATION VS. TALK THERAPY

Talk only vs. medication only



Both vs. medication only

Preference for providers offering medication only versus talk therapy only or both as treatment for depression, by racial/ethnic group.

Values less than 1 indicate a preference for medications, and values greater than 1 indicate a preference for talk therapy.

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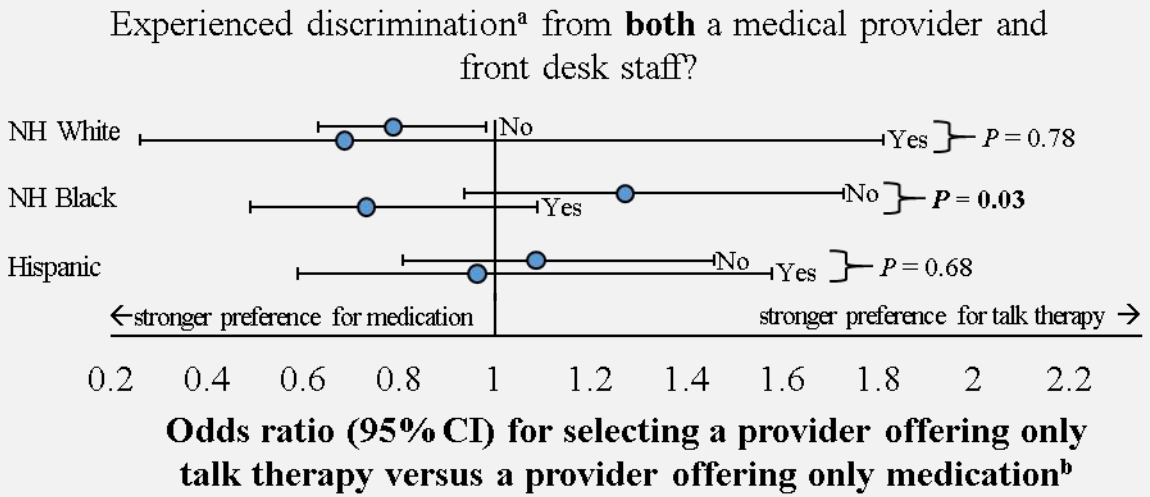
RESULTS: ASSOCIATION OF CURRENT PREFERENCES WITH PAST DISCRIMINATION



Preference for providers offering medication versus talk therapy as treatment for depression, by racial/ethnic group and whether or not one experienced past discrimination in healthcare settings.

[a] Discrimination defined as having ever felt that one was treated unfairly by one's medical provider while getting medical care based on one or more of the following personal characteristics: race/color, ethnicity, language/accent, sexual orientation, and gender.

[b] Values less than 1 indicate a preference for medications, and values greater than 1 indicate a preference for talk therapy.

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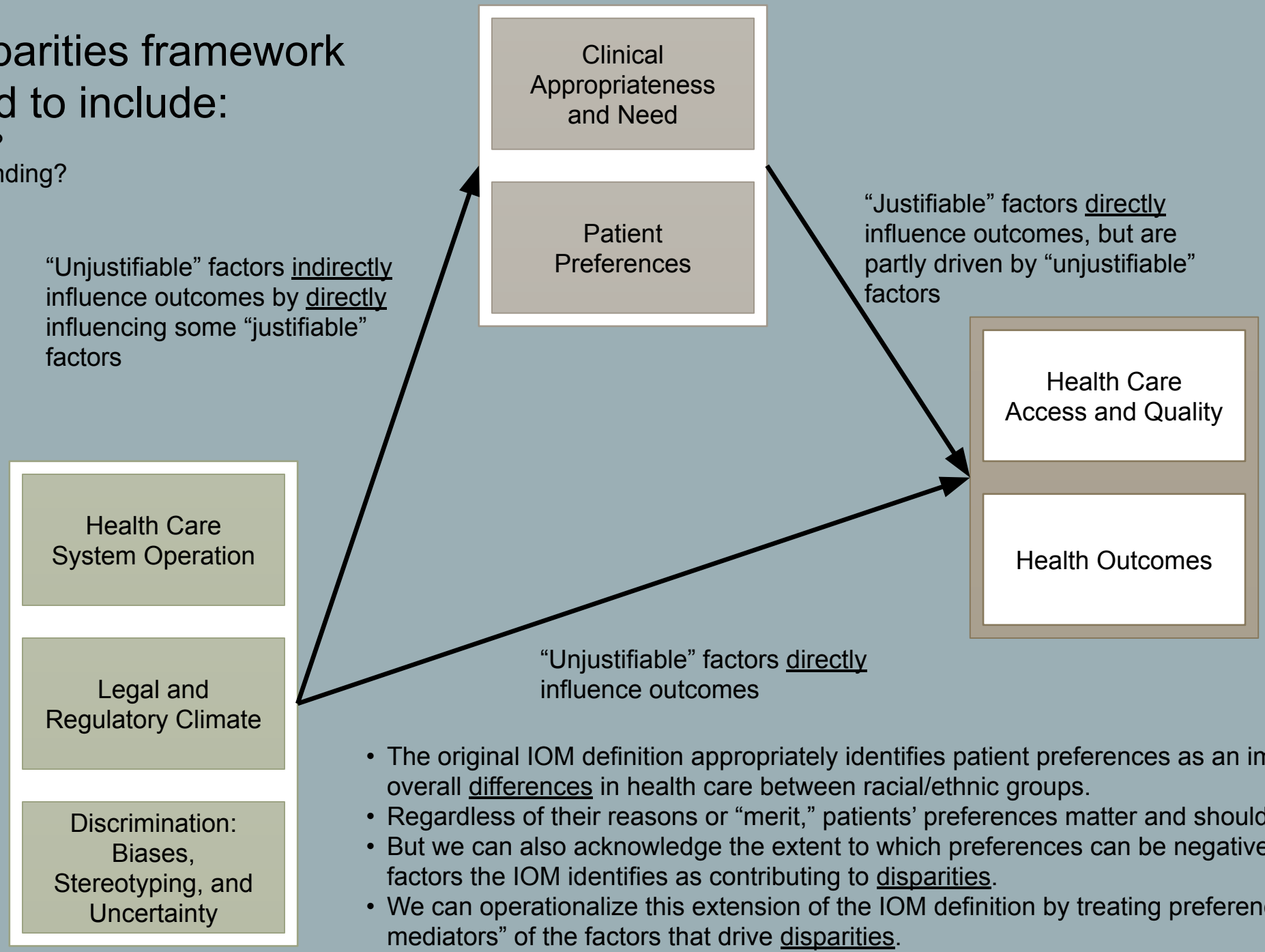
IOM disparities framework extended to include:

- Mediation?
- Or confounding?



- The original IOM definition appropriately identifies patient preferences as an important piece of overall differences in health care between racial/ethnic groups.
- Regardless of their reasons or "merit," patients' preferences matter and should be respected.
- But we can also acknowledge the extent to which preferences can be negatively influenced by the factors the IOM identifies as contributing to disparities.
- We can operationalize this extension of the IOM definition by treating preferences as "partial mediators" of the factors that drive disparities.

THE LADDER OF CAUSATION

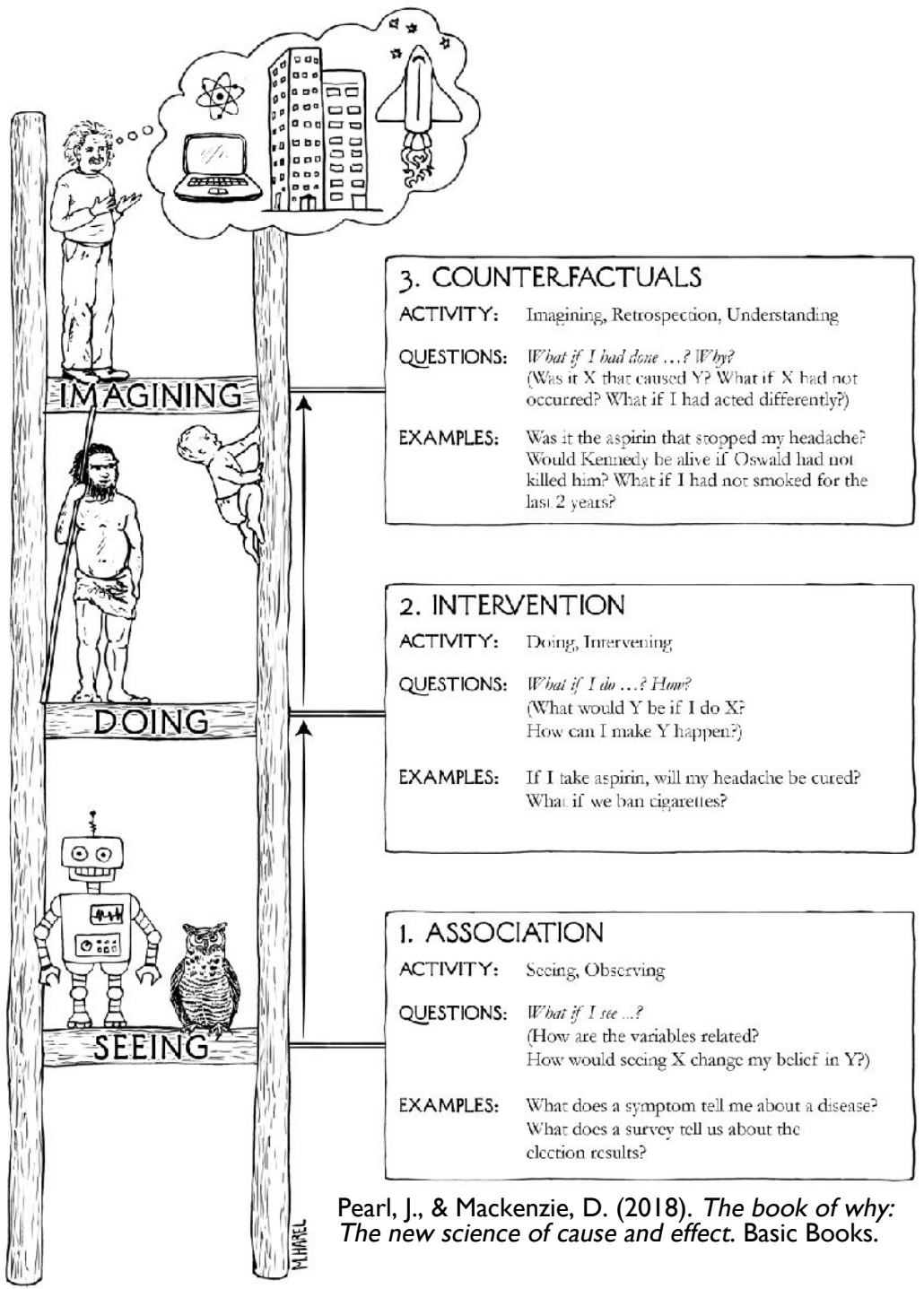
To get to Rung 2:

- What do we do/intervene on?

To get to Run 3:

- What do we imagine being different?

- What are the causal mechanisms?



Pearl, J., & Mackenzie, D. (2018). *The book of why: The new science of cause and effect.* Basic Books.

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CAN "EFFECTS OF RACE" BE CALLED "CAUSAL"?

- Race is nonmodifiable(?)
- "Controlled presentation" studies
  - Manipulate perception of race
  - Housing or employment discrimination
  - Trials
- Who is the subject?

(Zaslavsky, Sonik, & Cook)

"EFFECTS OF RACE"?

- Patient-level outcome, described two ways:
  - "The patient didn't get pain meds because he was Black"
  - "Doctor Jones refused Rx for pain meds because ~~the patient was~~ Black"
  - "Doctor Jones refused Rx for pain meds because the doctor discriminated against the patient who was black"
- Who is the subject? What is the treatment?
  - What is the experiment (or observational study)?
  - Can all other variables be held constant? Should they be?

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(Zaslavsky, Sonik, & Cook)

MULTILEVEL CAUSAL PERSPECTIVE

- Data: Black patients get less pain meds:
  - "The doctor prescribed less pain meds to Black patients because he thought they were more likely to abuse the meds."
- Why:
  - What system, community, culture, society-level factors influenced?
  - Within-person effect, influenced by higher-level factors

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(Zaslavsky, Sonik, & Cook)

MULTILEVEL CAUSAL PERSPECTIVE

- Data: Clinic serving Black patients prescribed less pain meds.
- Why:
  - "The doctors at Clinic A prescribed inadequate pain medication because they had no pain management expert."
  - "Black patients went to Clinic A because transportation to other clinics was unavailable"
  - Between-unit effect
- Moving agency up a level also shifts locus of responsibility.

(Zaslavsky, Sonik, & Cook)

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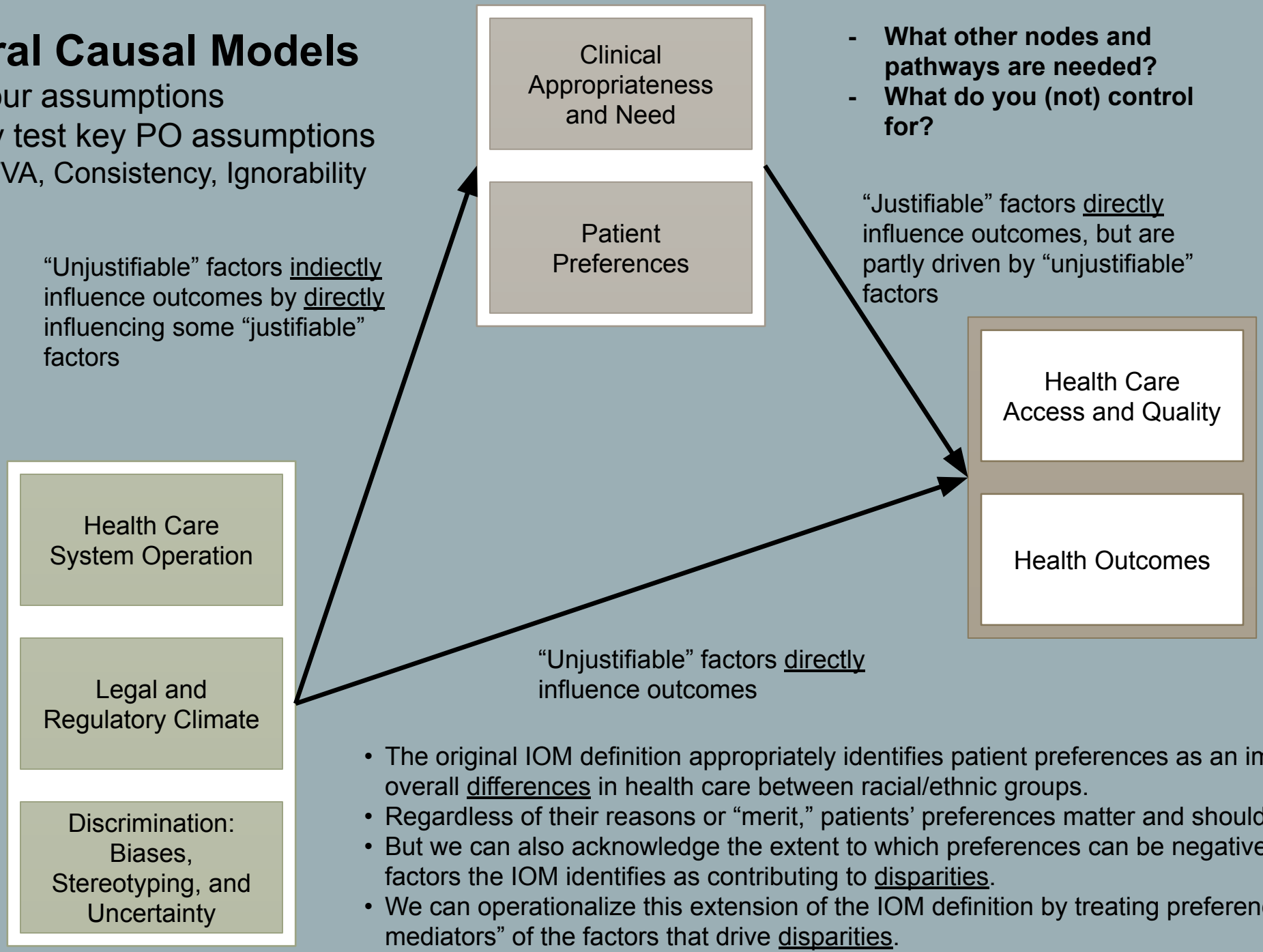
Structural Causal Models

- Show your assumptions
- Explicitly test key PO assumptions
  - SUTVA, Consistency, Ignorability



- **What other nodes and pathways are needed?**
- **What do you (not) control for?**

With sufficient data and design
- Estimate using SEM

- The original IOM definition appropriately identifies patient preferences as an important piece of overall differences in health care between racial/ethnic groups.
- Regardless of their reasons or "merit," patients' preferences matter and should be respected.
- But we can also acknowledge the extent to which preferences can be negatively influenced by the factors the IOM identifies as contributing to disparities.
- We can operationalize this extension of the IOM definition by treating preferences as "partial mediators" of the factors that drive disparities.

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ADDITIONAL SLIDES CONTENTS

- Review of disparities in substance use and SUD treatment and the role of the criminal justice system and SES
- Discrimination in the behavioral health care setting
- Discrimination and behavioral health
- Moving towards a de-segregated, community-based behavioral health treatment system.

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Disproportionate Incarceration And Involuntary Commitment of Minorities With Mental Health and Substance Use Disorders

- Black people with mental health conditions, particularly schizophrenia, bipolar disorders, other psychoses, and co-occurring substance use disorders are more likely to be incarcerated than people of other races (Hawthorne et al. 2012)
- Black people are disproportionately more likely than Whites and Latinos to be forced into psychiatric treatment and medication (Swanson et al. 2009);
- Black people are more likely to be taken to ER by police and then involuntarily committed than other races (Snowden et al. 2009)

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" Double Jeopardy" Living With SUD And Mental Illness - Youth

- Racial/ethnic minority youth
  - 32% of the population, but more than 60% of individuals in the juvenile justice system (Snyder & Sickmund, 2006).
  - 8x more likely to be in a juvenile detention center (Wordes & Jones, 1998).
  - More likely to have negative perceptions of policing, influenced by personal/friends'/family's experiences, media coverage, and neighborhood conditions (Weitzer & Tuch, 2004).
- **65% of youth** in juvenile justice are diagnosed with a psychiatric or substance use disorder (Desai et al., 2006).
- Youth with emerging mental illness difficulty regulating behavior and affect small conflicts escalate into violent altercations criminal justice involvement.

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Disparities In Incarceration Closely Linked to Substance Use

- Policing of drugs shifted in 1986 (Anti-Drug Abuse Act and subsequent laws - more officers, longer prison sentences)
- The distortion of crack use and its long-run effects on perceptions of race and drug use:
  - "What had really changed in my world was not the creation of an unprecedented wave of drug-induced violence and a codeless new group of predatory youth. It was how our problems were being described and explained… politicians seeking reelection – of both parties – had spread the word that drugs were the cause of inner-city problems." – Hart 2013, *High Price*
- Some early signs of shifting from sentencing to treatment
  - Expansion of drug courts and diversion programs
  - Fair Sentencing Act of 2010 – reduced crack and powder cocaine sentencing disparity
  - First Step Act 2018 - eases three strikes, modifies minimum mandatory sentences for nonviolent drug offenders

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The backdrop: <10% of those with SUD receive SUD treatment

	Non-Latino Whites	Latinos	African American
Substance Use Disorder			
12 months service use	5.3%	6.4%	6.8%
	n=8584	n=1836	n=1789
Lifetime service use	**15.3%**	**18.4%***	**18.6%****

Mood disorder			
12 months service use	**54.7%**	**45.2%*****	**37.0%*****
	n=7538	n=2008	n=1973
Lifetime service use	**55.5%**	**46.4%*****	**38.9%*****

National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

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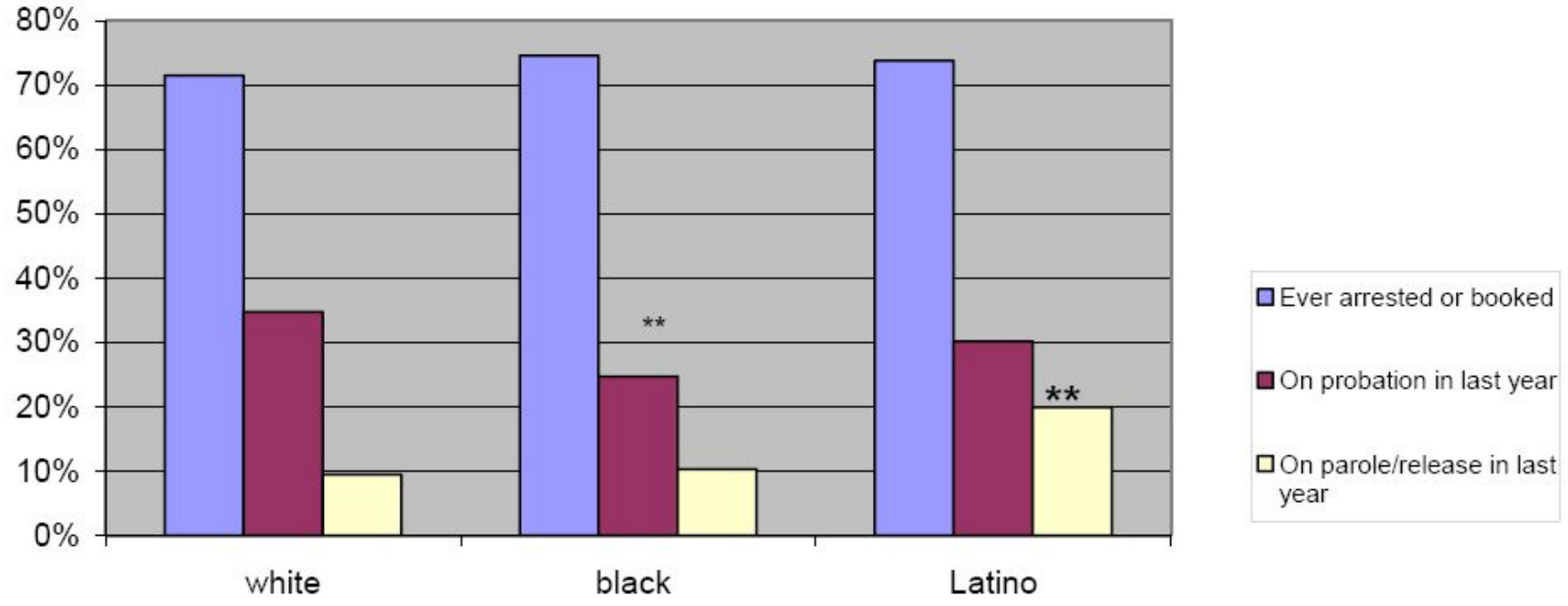
Nearly All Individuals With Substance Use Treatment Had Criminal History

Percent with Criminal History of Those that Had Any SA Tx Services in Last Year (n=3,195)

Approximately 70% of population using substance abuse treatment services were arrested or convicted in their lifetime.



Sources: 2005-2007 National Survey of Drug Use and Health
** Significantly different from non-Latino Whites at α<.05 level

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3 Models: Any Substance Abuse Treatment Among Adults W/ SUD

Race	Need Model Odds Ratio	Need Model and Criminal History Odds Ratio	Need Model, Criminal History & SES Odds Ratio
Non-Latino white	1.00	1.00	1.00
Black	.82	.75	.64*
Latinos	.81	.80	.67*

Adjusted for 1) severity of SUD, MH status, health status, age, gender; 2) criminal history; 3) insurance, income, marital status, education, urbanicity

Cook and Alegria, 2012, Psychiatric Services

Summary: Criminal Justice System And Access To SA Treatment

- A majority receiving SA treatment are in mandated treatment programs for parole or probation requirements (IOM 1990; SAMHSA 2002)
  - Individuals in the throes of substance abuse and dependence are unlikely to voluntarily enter treatment (Hora 2002)
  - Naltrexone/Vivitrol introduced in 2010 expands SA treatment options especially in rural areas (MacGillis 2017)
- Blacks' greater interaction with the criminal justice system (Pescosolido et al. 1998) is an underlying reason for their having rates of substance abuse treatment equal to whites
  - Treatment in these settings more likely perceived as coercive and dehumanizing (Newton-Howes and Mullen 2011)

- <u>Need for providers to engage in advocacy to reform the SA Treatment and Criminal Justice Systems</u>

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For those with access, there are disparities in Treatment Completion In Publicly Funded Treatment Centers

- One-third of the approximately two million people entering publicly funded substance abuse treatment in the U.S. do not complete treatment.

- Racial and ethnic minorities with addiction disorders constitute approximately 40 percent of the admissions in publicly funded substance abuse treatment programs and may be particularly at risk for poor outcomes.

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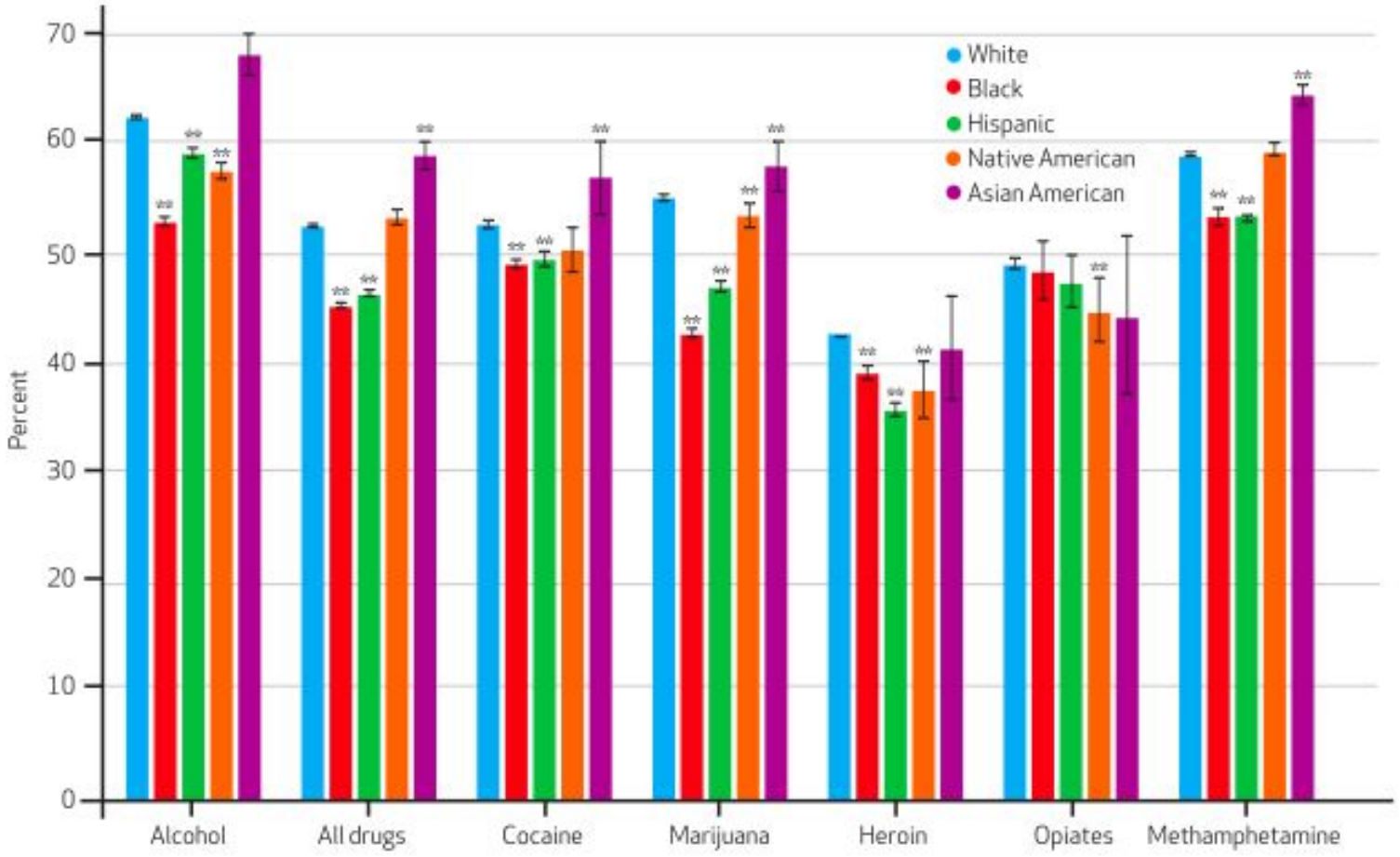
Saloner and Cook 2013 *Health Affairs*

Results: Tx Completion By Substance

EXHIBIT 2

Treatment Completion Rates For Alcohol And Major Drug Categories, By Race Or Ethnicity



SOURCE Authors' analysis of the Substance Abuse and Mental Health Services Administration's 2007 Treatment Episode Data (Note 17 in text). **NOTE** Error bars indicate 95% confidence intervals. **Significant difference from whites ($p < 0.05$).

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After Access, Disparities In SUD Treatment Completion

- Blacks and Hispanics less likely to complete treatment for all substances except prescription opioids
- Native Americans less likely to complete for alcohol, marijuana, heroine, and opiates
- Asian Americans more likely to complete treatment than whites

- Even those that do complete are extremely likely to relapse, be hospitalized and end up in treatment again.

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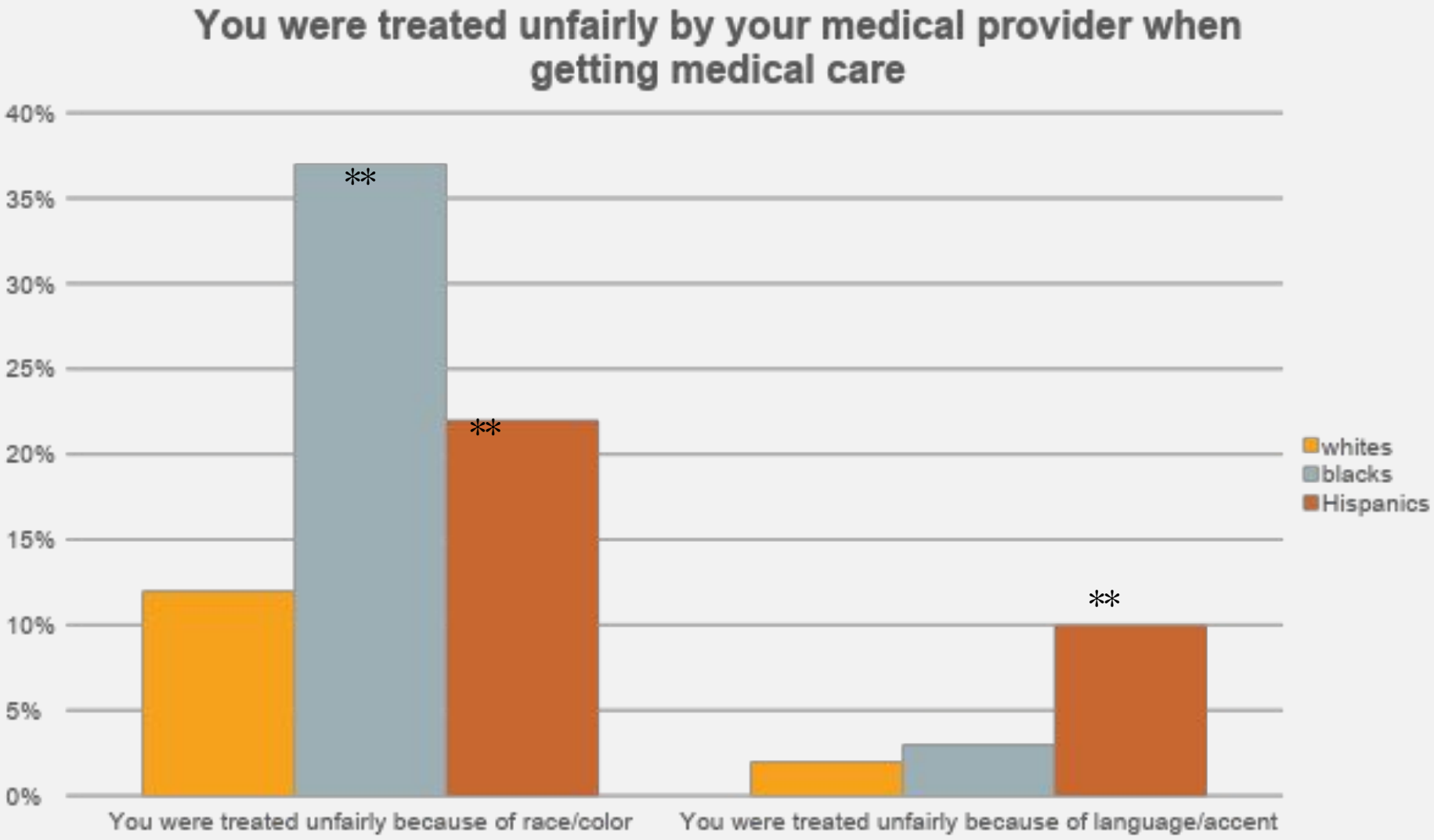
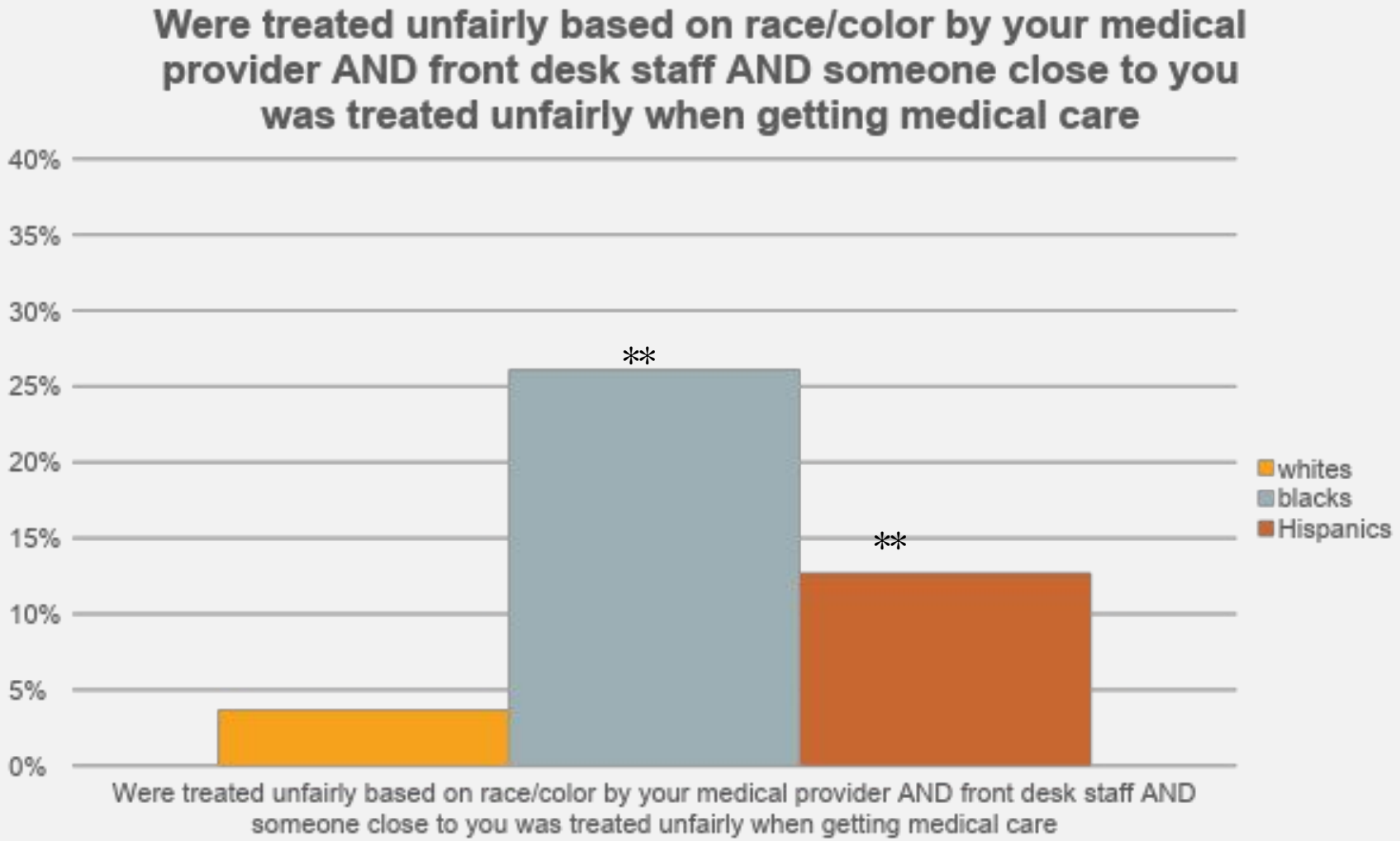
DISCRIMINATION IN THE MENTAL HEALTH CARE SETTING



** - significant at p<.05 level

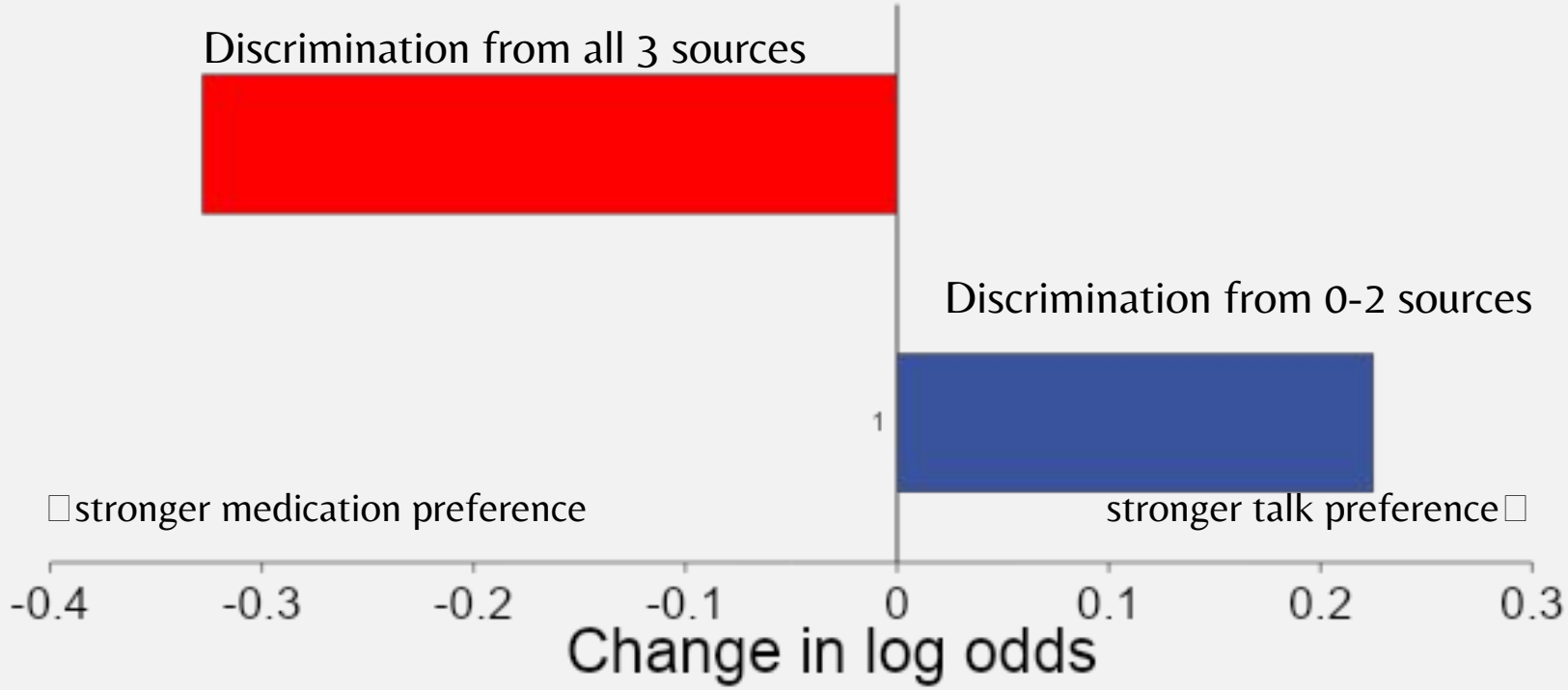
DISCRIMINATION IN THE MENTAL HEALTH CARE SETTING



** - significant at p<.05 level

DISCRIMINATION AND PATIENT PREFERENCES

- For the 25% of Blacks experiencing multiple forms of discrimination while getting health care, preferences shifted to favoring medications over talk therapy ($p < 0.05$).



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DISCRIMINATION BASED ON MENTAL HEALTH DIAGNOSIS

- *"Sometimes, I feel like I am being made out to be stupid ….[**One time] my therapist asked if I could boil water**, and I felt like…storm[ing] out of the office, but no, because I can't just do that because they'll just up my medication."*
- *"**I am afraid to go to emergency rooms**…I have had discrimination based on having a mental health disorder…Like I am traumatized from being discriminated and I get nightmares and I get thoughts throughout the day. I have got real memories coming into my head during the day that won't go away."*

OTHER EXAMPLES OF DISCRIMINATION

- **Based on insurance, income, or "class" / social status:**
  - *"But like if it's a white nurse up there doing your registration…they look at you really funny especially when you pull out your [insurance] card…"*
  - *"You're going to get a hard time because you have [Medicaid] or Medicare.* ***You walk in with two strikes against you."***
  - *"Because it's always the poor person, the one out, that all the pressure and the blame is put on…"*
- **Based on dress/appearance [also a Hispanic participant]:**
  - "***They would perceive you as you're a thug, you're going to rob them****…they're going to talk to you or treat you a certain way."*
- **Language:**
  - "Ok. Raza en cuestión de cuando ellos ven a una persona hispana como que dicen "oh, ellos no han aceptado su problema." Pero yo sí senti una diferencia entre el trato a un hispano hablante y a un Americano."
- **Based on gender:**
  - *"Dress, religion, sexual, I mean they just assume certain things just because you're a woman."*

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IMPACTS OF DISCRIMINATION

- **How did interviewees *feel?***
  - *"**I had such a bad, bad taste in my mouth**….You can't think about it much because it will get you angry."*
  - *"Don't get me wrong I'm not—there are many times that I would get upset or something in [talk therapy or group therapy], but **I try my best not to get upset at certain things because…you waste so much energy."***
- **What did they *do*?**
  - Many times, did not report it
  - "You know, it's a lot easier to just let it go."

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HAVING TO WORRY ABOUT THE *PROVIDER'S* COMFORT…

- *"I'm African American, this therapist I'm talking about is white…I've had some things happen to me that were racially, when I was a kid—racial violence. And so if the therapist is white and* ***they're going to be uncomfortable about me talking about something****, then that's not a good fit…*

BECAUSE THE PROVIDER CAN BE AN AGENT OF SAFETY/PROTECTION

- …[but] I want to keep my doctor in my world:
  - *"I've been hospitalized when I had no need for it. That's why I want to keep my doctor in my world because it's like I can say I'm normal or I'm healthy all I want.* ***No one is going to listen because I'm mentally ill, but if my doctor says "she is fine, she can do this," they will all back away.*** *They have no choice. So it's kind of like a necessity of life…*
  - ***"They took my kids away when they were born –right away. When they were born****…And they got away with it…Everyone said I could raise my kids but I couldn't get them back…"*

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DISCRIMINATION AND BEHAVIORAL HEALTH

- 42% of blacks and 38% of Native Americans experienced violence or threats because they are black;
- 51% of blacks, 37% of Latinos, 35% of Native Americans and 32% of Asians have personally experienced people using racial slurs or negative comments
- ~33% of Latinos and ~25% of Asians say they have been discriminated against when applying for jobs, when trying to rent a room or apartment or buy a house,
- 27% of Latinos and 32% of Native Americans say they've been unfairly stopped by the police (HSPH/NPR Poll 2017)

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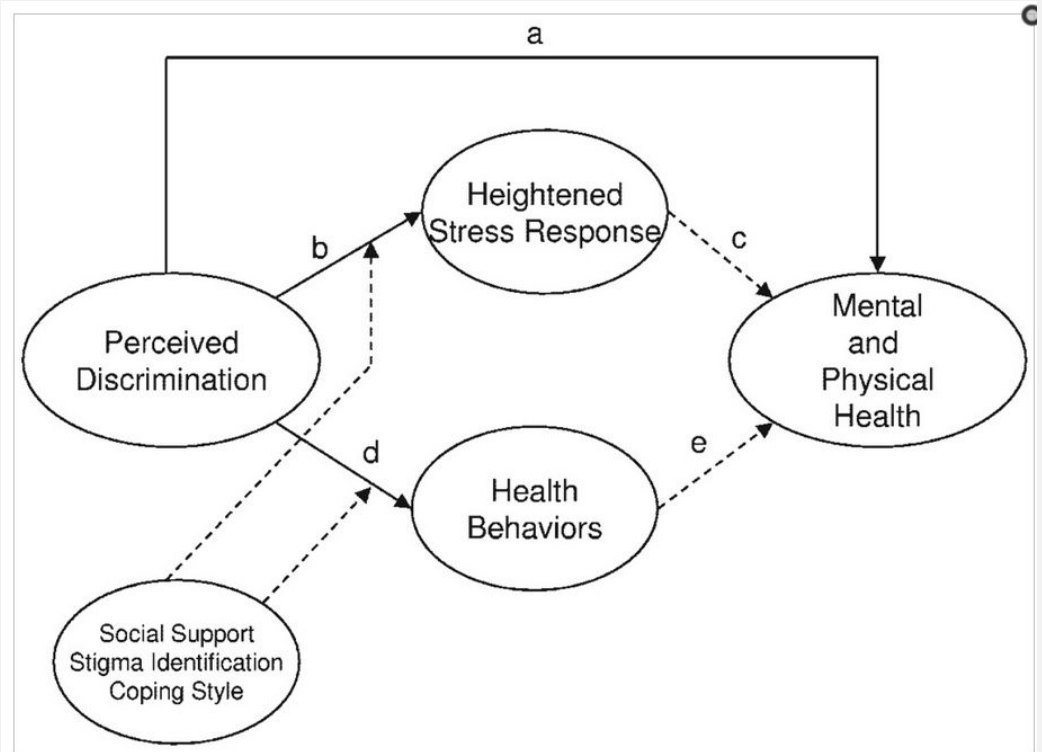
DISCRIMINATION AND HOW IT GETS UNDER THE SKIN

- Perceived Discrimination – pathway underlying disparities



Pathways by which perceived discrimination influences health outcomes. Solid lines indicate analyzed pathways; dashed lines represent pathways hypothesized by past research.

Pascoe and Richman 2009

The Health of Young African American Men, *JAMA*, 2015

DISCRIMINATION AND HOW IT GETS UNDER THE SKIN

- Personal experiences of discrimination lead to:
  - increases in psychological distress
  - depression symptoms
  - blood pressure
  - Increase in cortisol and other stress hormones that accelerate disease processes

(Pascoe and Richman 2009)

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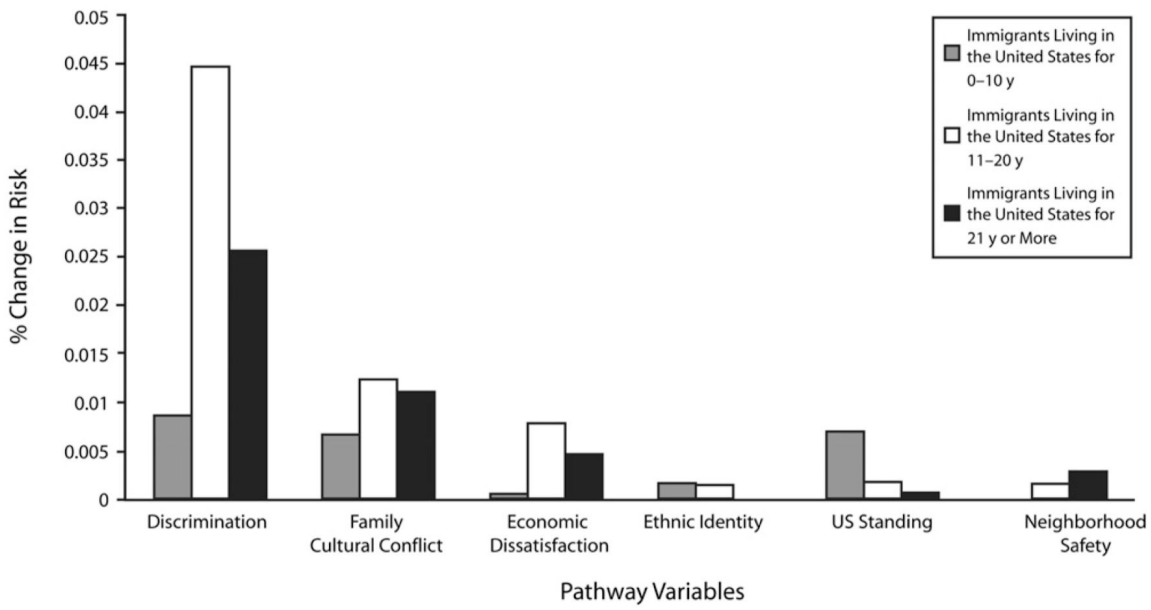
DISCRIMINATION (AND FAMILY CULTURAL CONFLICT) HELP TO EXPLAIN THE IMMIGRANT MENTAL HEALTH PARADOX**



Note. For the immigrants living in the United States 11–20 years and immigrants living in the United States 21 years or more, changes due to adjustment of the pathway variables "discrimination" and "family cultural conflict" are significant at $\alpha = .05$.

FIGURE 1—Predicted change in past-year risk of any psychiatric disorder attributable to pathway variables: Latinos in the National Latino and Asian American Study (NLAAS), May 2002–November 2003.

Discrimination: Acculturation is an "alterable cognitive shift" in one's desire to belong; immigrants are excluded from mainstream culture, despite having the social profile (e.g., education, occupation) necessary for acceptance (Cook AJPH 2009)

Family cultural conflict: *An trong noi, ngoi trong huong – when you eat, check the pot; when you sit, check*

DISCRIMINATION AND CRIMINAL JUSTICE

From prejudice to systemic racism in the criminal justice system:

- Anticipation of prejudice leads to a stress response (Sawyer et al. 2012)
- Repeated interactions with law enforcement can lead to stress and hyper-vigilance:
  - Aggressive policing "hopelessness" and being "dehumanized" (Brunson & Weitzer, 2009)
  - More police contact anxiety and PTSD symptoms (Geller, Fagan, Tyler, & Link 2014).
  - "Transmitting racial socialization to successive generations to promote racial awareness and to prepare an individual to survive in racist environments… Protective socialization is even more critical when it becomes the difference between life and death at the hands of law enforcement (Sewell et al. 2016, "Vile vigilance: An integrated theoretical framework for understanding the state of Black surveillance")

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DISCRIMINATION AND SYSTEMATIC RACISM:
"DOUBLE JEOPARDY" FOR YOUTH OF COLOR LIVING WITH MENTAL ILLNESS

- Youth with emerging mental illness difficulty regulating behavior and affect small conflicts escalate into violent altercations criminal justice involvement.
- Racial/ethnic minority youth
  - 32% of the population, but more than 60% of individuals in the juvenile justice system (Snyder & Sickmund, 2006).
  - More likely to have negative perceptions of policing, influenced by personal/friends'/family's experiences, media coverage, and neighborhood conditions (Weitzer & Tuch, 2004).
- 65% of youth in juvenile justice are diagnosed with a psychiatric or substance use disorder (Desai et al., 2006).

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Cook B, Barrett J, Hou S, Samson F. 2018. The Intersection of the Criminal Justice, Education, and Mental Health Care Systems and Its Influence on Boys and Young Men of Color. Prepared for RISE for Boys and Men of Color

SCHOOL TO PRISON PIPELINE

- Youth of color experience punitive expulsion as early as elementary school (Christle, 2005; Gregory, 2010).
  - Leads to racial gaps in academic achievement, unequal and inadequate education opportunities (Gregory, 2010).
- Strong associations between academic failure, exclusionary discipline practices, dropouts and delinquency (Christle, 2005).
- Lifetime risk of being incarcerated is 59% among African American males w/out a high school diploma (Massoglia, 2008).

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I SEE MYSELF IN THESE YOUNG PEOPLE… I GREW UP WITHOUT A FATHER. THERE WERE TIMES WHEN I MADE POOR CHOICES, TIMES WHERE I WAS ADRIFT. THE ONLY DIFFERENCE BETWEEN ME AND A LOT OF OTHER YOUNG MEN IS THAT I GREW UP IN A FORGIVING ENVIRONMENT.

BARACK OBAMA

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DIVERSION INTERVENTIONS AT THE INTERSECTION OF MH, CRIMINAL JUSTICE, AND EDUCATION

- **Individual level**
  - skills training, "character education", cognitive behavioral therapy, case management
- **Family level**
  - family commitment, investment, parenting and family communication skills training
- **Community**
  - partnership with police, temporary youth shelters, referrals to MH treatment sites, working with courts, schools
- **Societal**
  - changing existing services to better serve youth, reducing mass incarceration through diversion, improving attitudes and reducing discrimination in the police force

Need data at all levels

- ***Multi-Systems Therapy and Functional Family Therapy have strong evidence***

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EXAMPLE:
CAMBRIDGE SAFETY NET DIVERSION PROGRAM

- Youth Resource Officer (Police officer) works with social worker, school counselors and psychologist
- Officer trained to:
  - Recognize trauma and its symptoms
  - Act as case manager to link to supports
  - Present in schools, after schools, community.
- Baseline & specialized training for YROs with a mental health focus:
  - Hallmarks of Child/Adolescent Mental Health
  - Typical Child and Adolescent Development
  - Policing the Teen Brain in Schools
  - Person-Centered Case Management
  - **Bias and cultural awareness (CIT)**
- Implementation of a validated risk/needs assessment tool to assess and monitor youth.

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SAFETY NET DIVERSION PROGRAM: INCREASED MH TREATMENT

Table 3
Comparing Service Use Outcomes Before and After Intervention/Police Contact (N = 207)

MH Service	SN (n = 61)		A/S (n = 119)			
	Before (%)	After (%)	Before (%)	After (%)	p[a]	d[b]
Any psychiatric inpatient use	2.1	6.3	5.1	2.9	.16	.098
Any psychiatric outpatient use	14.2	32.5	25.6	19.7	.001*	.23
Any ED use	26.4	36.3	31.8	28.1	.095	.12

Note. MH = mental health; SN = safety net treatment group; A/S = arrested/summonsed control group; DID = difference in difference comparison; ED = emergency department (use of ED includes both physical and mental health diagnoses).
[a] p value from the DID comparison analyses. [b] Cohen's d effect size.
* $p < .05$.

- **Safety Net youth:** significant increase in outpatient MH services following contact with program
- **Arrested/Summonsed youth**: no significant differences in service use pre-post police contact

Janopaul-Naylor et al. 2019

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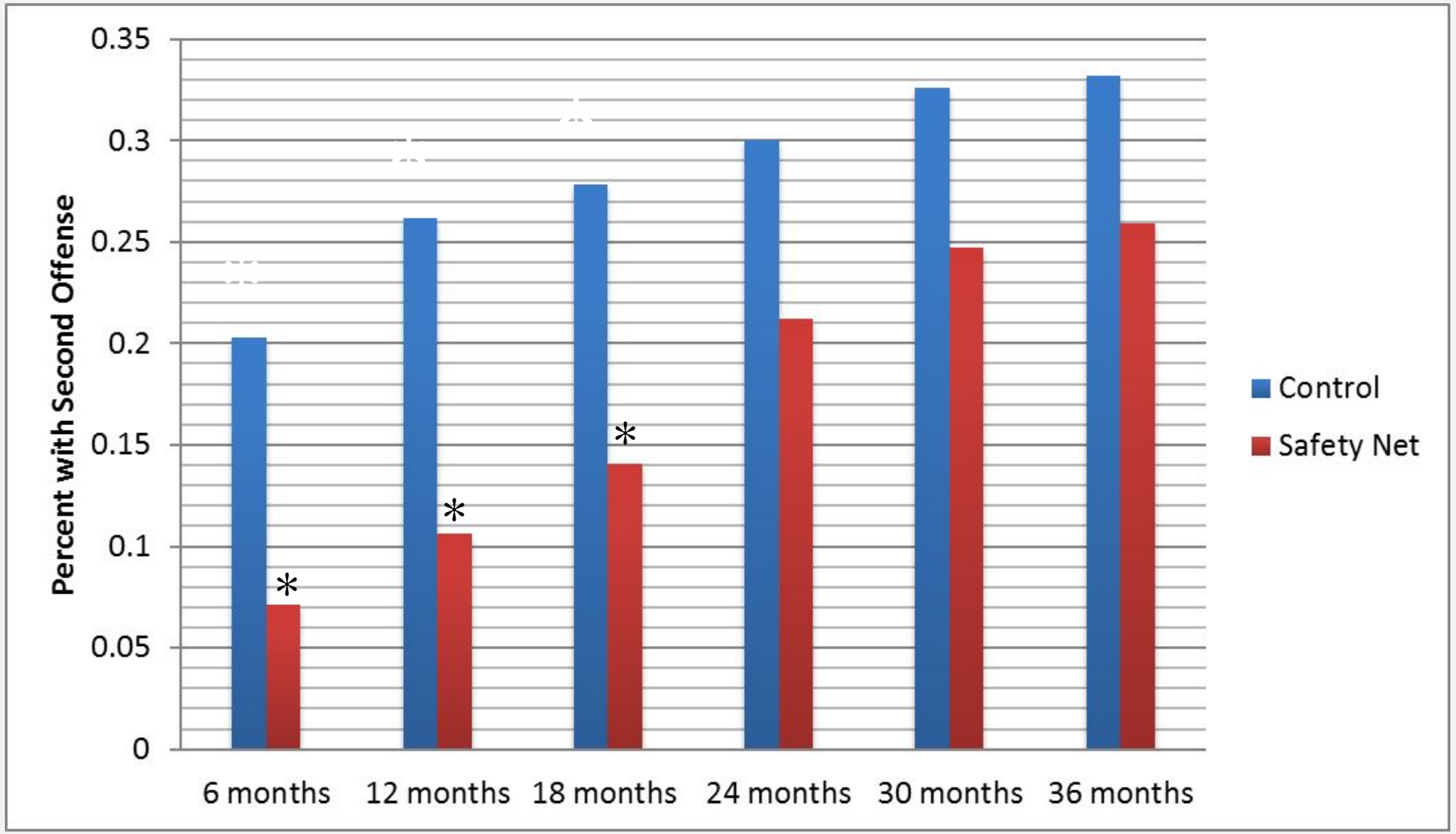
SAFETY NET DIVERSION PROGRAM: IMPROVED RECIDIVISM



Barrett et al. 2019

SUMMARY

- The disproportionate arrest and detainment of people of color and the school to prison pipeline are examples of how **negative beliefs about racial/ethnic minorities become incorporated into societal policies and institutions** (Williams and Williams-Morris 2000)
- Multisystem interventions with multisystem data can work.
- Safety Net and other multisystem interventions hold promise, but require resources, buy-in, and strong relationships.

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HOW COMMUNITY MEMBERS HAVE BEGUN TO FILL THE VOID IN SERVICES

- **Blacks United in Recovery**
  - P2P forum – e.g., skit used to discuss the multiple levels of family, peer, and personal stigma, obstacles to treatment, and culturally insensitive/racist treatment
  - Organizing to share stories, find peer support, dismantle stigma, and identify strategies on how to navigate the healthcare system;
  - Poised to push policies that increase access, reduce discrimination in treatment, and bring providers to these gatherings and into safe community spaces.

- **Corey Johnson Program at Roxbury Presbyterian Church**
  - Originally focused on neighborhood shootings and soon became a venue for community members to heal from trauma
  - Sessions: Men's groups, creative writing, Afro-flow yoga, Open mike poetry slam
  - Opportunity for one-on-one connections to peers with lived experience
  - Have difficulty keeping up with the numbers of Black and Latino men seeking help.

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OLMSTEAD ACT AND TITLE VI OF THE CRA

- The Olmstead Act (ADA) prohibits the unnecessary segregation of persons with disabilities.
- The Title VI Civil Rights Act prohibits discrimination on the basis of race, color, and national origin :
  - Black people disproportionately more likely than Whites and Latinos to be forced into psychiatric treatment and medication (Swanson et al. 2009);
  - Blacks are more likely to be taken to ER by police and then involuntarily committed than other races (Snowden et al. 2009)
  - Black people with MH conditions, particularly schizophrenia, Bipolar disorders and other psychoses are more likely to be incarcerated than people of other races (Hawthorne et al. 2012)
  - MH and medication-assisted treatment are common for inmates in correctional facilities (what would the 2:1 MH treatment access disparities look like if you included treatment in the CJ system?)

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WHAT WOULD A **COURT MANDATED SYSTEM** THAT DE-SEGREGATES MENTAL HEALTH TREATMENT LOOK LIKE?

- The case for litigation: Are state and local actors administering a service system that segregates individuals with mental health and discriminates on the basis of race, color and national origin?

- What would court-mandated services look like if this litigation should succeed (think Rosie D)?
  - Criminal justice reform and diversion
  - Changing the setting of treatment (BUR, Corey Johnson)
  - Provider navigator/trained police resource officers/social worker/provider teams (Safety Net)
  - Provider competency/orientation (Owen multicultural orientation framework)
  - Access to cultural liaison teams (Kirmayer's cultural consultation model)

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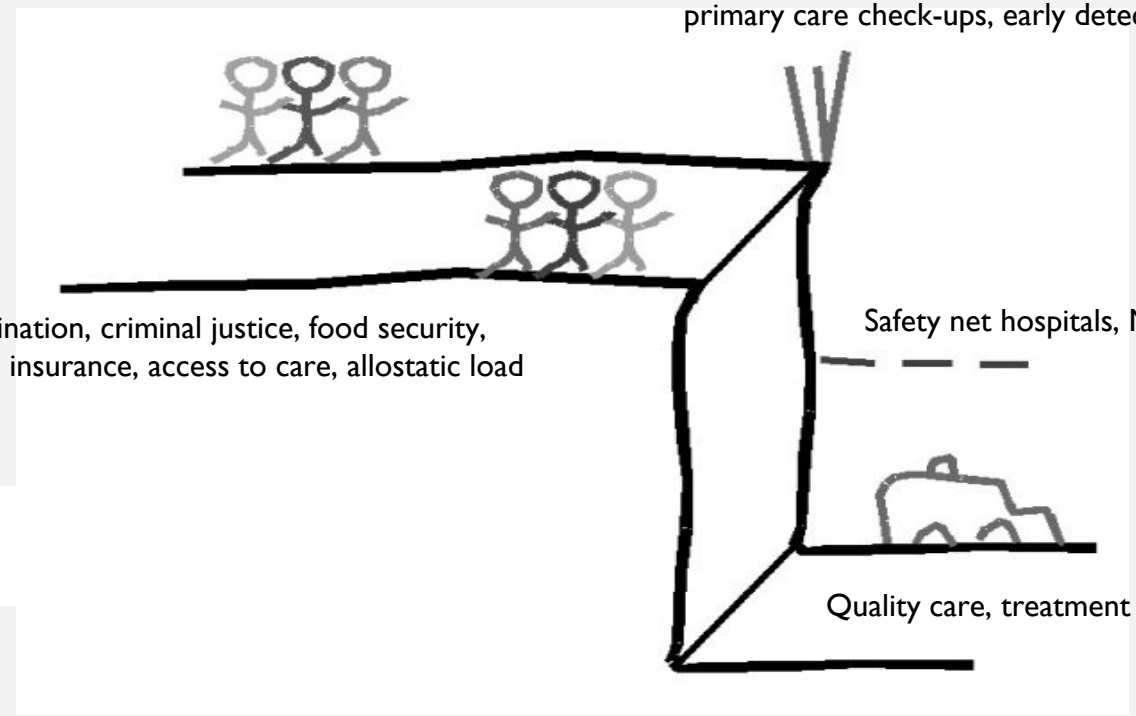
Take home

- Learn / re-learn data on disparities, how they arise, and provider discrimination
- Learn / re-learn the ways in which systematic racism impacts mental health
- Identify and get involved in strategies at legal (Olmstead) , policy (healthcare reform) and institutional levels (police depts.)



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Jones CP et al. ***J Health Care Poor Underserved*** *2009*