Management of Psychotic Disorders in the Black Community

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SAMHSA
Substance Abuse and Mental Health Services Administration

MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

Our collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals.
Our services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

SAMHSA

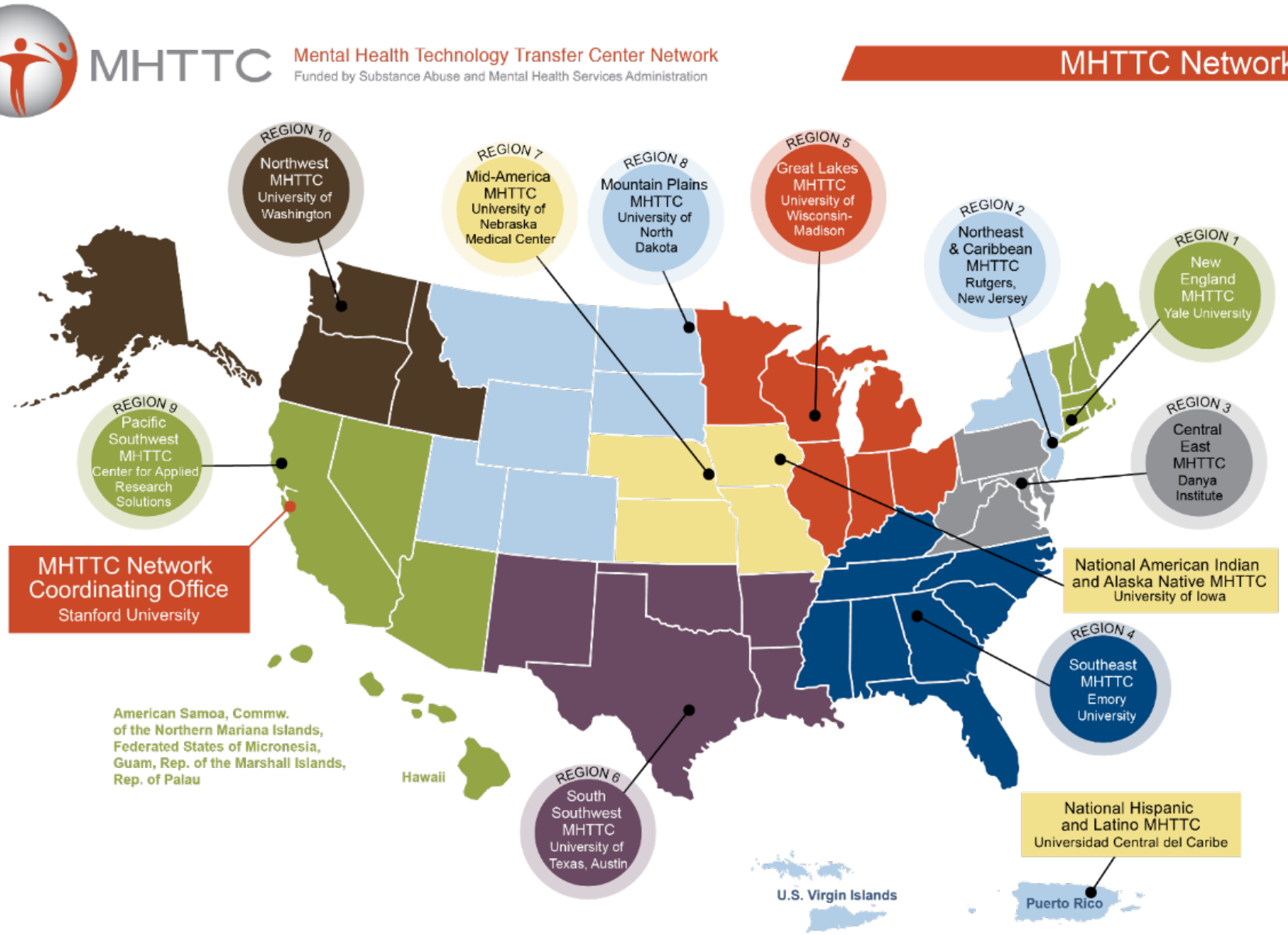
Substance Abuse and Mental Health Services Administration

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

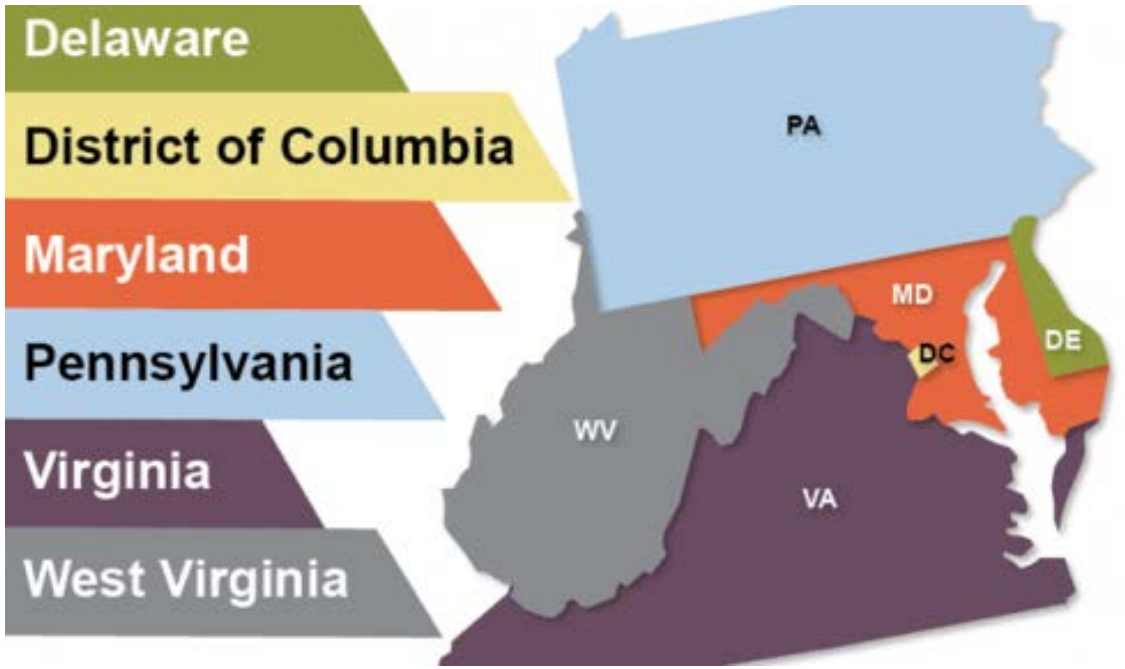
- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered and trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

MHTTC Network



Central East Region 3



Central East (HHS Region 3)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

The opinions expressed herein are the views of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

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Presented 2023

Management of Psychotic Disorders in the Black Community

- Psychotic disorders, such as schizophrenia, are among the most severe mental health conditions
- Black people have experienced overdiagnosis of psychotic disorders as well as disparities in treatment
- We thank CE-MHTTC for their partnership on the BPA Health Equity Webinar series.
- Content has both Central East region and national relevance.
- Our featured speaker is Ikwunga Wonodi, MD, MBA, DFAPA

Learning Objectives

1) Describe the features of psychosis

2) Distinguish psychotic disorders from affective and other disorders presenting with psychosis in the Black community

3) Describe the general framework of medication management

4) Discuss side effects of medications such as tardive dyskinesia.

5) Identify barriers to the access of mental health services

6) Be familiar with resources for patient referral, family psychoeducation, and community support

Psychosis

- **Mental disorder characterized by a gross impairment in reality testing**
- Classic symptoms of psychosis
  - ✓Hallucinations – sensory perceptions in the absence of sensory stimuli
    - Voices, visions, odors, somatic/tactile perceptions
  - ✓Delusions – fixed, false beliefs, outside those of members of the individual's sociocultural group
    - Nonbizarre delusions (plausible, albeit unlikely) – being monitored by CIA, phones tapped
    - Bizarre convictions (implausible) – internal organs replaced by empty beer cans
  - ✓Formal thought disorder – disruption in form, or organization of thinking (speech)
  - ✓Negative symptoms
  - ✓Cognitive deficits

Diagnostic Evaluation

- Diagnostic evaluation proceeding with well-ordered differential diagnoses
- Detailed history from patient with corroborating information from relatives or social support groups
- Psychotic symptoms do not always mean a primary psychotic disorder, like schizophrenia is present
- Medical history, Review of Systems, Family history
- Social history – including time course and functional decline (ADLs, IADL)
- Psychiatric history – new onset vs. chronic vs. episodic
- Physical examination – including a neurological exam and MMSE
- Clinical investigations – CBC, CMP, Hgb A1c, ANA, Urine toxicology, RPR, HIV, Pregnancy screen, brain imaging, EEG, ECG

Psychiatric Disorders That May Present With Psychosis

Continuous Psychosis

- Schizophrenia
- Schizoaffective disorder, bipolar type (with prominent episodes of mania)
- Schizoaffective disorder, depressed type (with prominent depressive episodes)
- Delusional disorder
- Shared psychotic disorder

Episodic Psychosis

- Depression with psychotic features
- Bipolar disorder (manic or depressed)
- Schizophreniform disorder (<6 months' duration)
- Brief psychotic disorder (<1 month duration)

Key Diagnostic Questions

1. Has a reversible, organic cause been ruled out?
2. Are cognitive deficits prominent (delirium or dementia)
3. Is the psychotic illness continuous or episodic?
4. Have psychotic symptoms (active phase) been present for at least 4 weeks?
5. Is there evidence of a decline in level of functioning?
6. Are negative symptoms present?
7. Are mood episodes prominent?
8. Have there been episodes of major depression or mania?
9. Do psychotic features occur only during affective episodes?

Nonmedication Interventions

Multidisciplinary Teams – Interdisciplinary Approach

- Family therapy and psychoeducation
- Psychotherapy and community support services

Population health management - the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models.

- A population can be defined in several ways. It could be a local community or neighborhood, a state or region, or a nation. People who are served by a specific hospital or covered by an insurance provider could also constitute a population, as could people of the same age or with the same chronic condition.
- Once a population is defined, healthcare providers, insurers, and government and community organizations combine forces to coordinate care; provide preventive services; promote healthy behaviors; and collect, track, and measure health metrics and analyze results. These results include not just specific healthcare interventions but also data such as environment, culture, and behavior. Accumulated data indicate that these factors, or social determinants of health (SDOH), far outweigh medical care or genetic predisposition in impacting health outcomes.

What Are the Components of Population Health?

1. Care Integration; 2. Care Coordination; 3. Teamwork; 4. Patient Engagement; 5. Data Analytics and Health Information Technology; 6. Value-Based Care Measurement.

Determinants of Mental Health

- Individual Biology
- Individual Behavior
- Social Environment
- Physical Environment
- Access to Quality Care
- Policies & Interventions

    - Social Determinants of Health (SDOH)

Social Determinants of Health (SDOH)

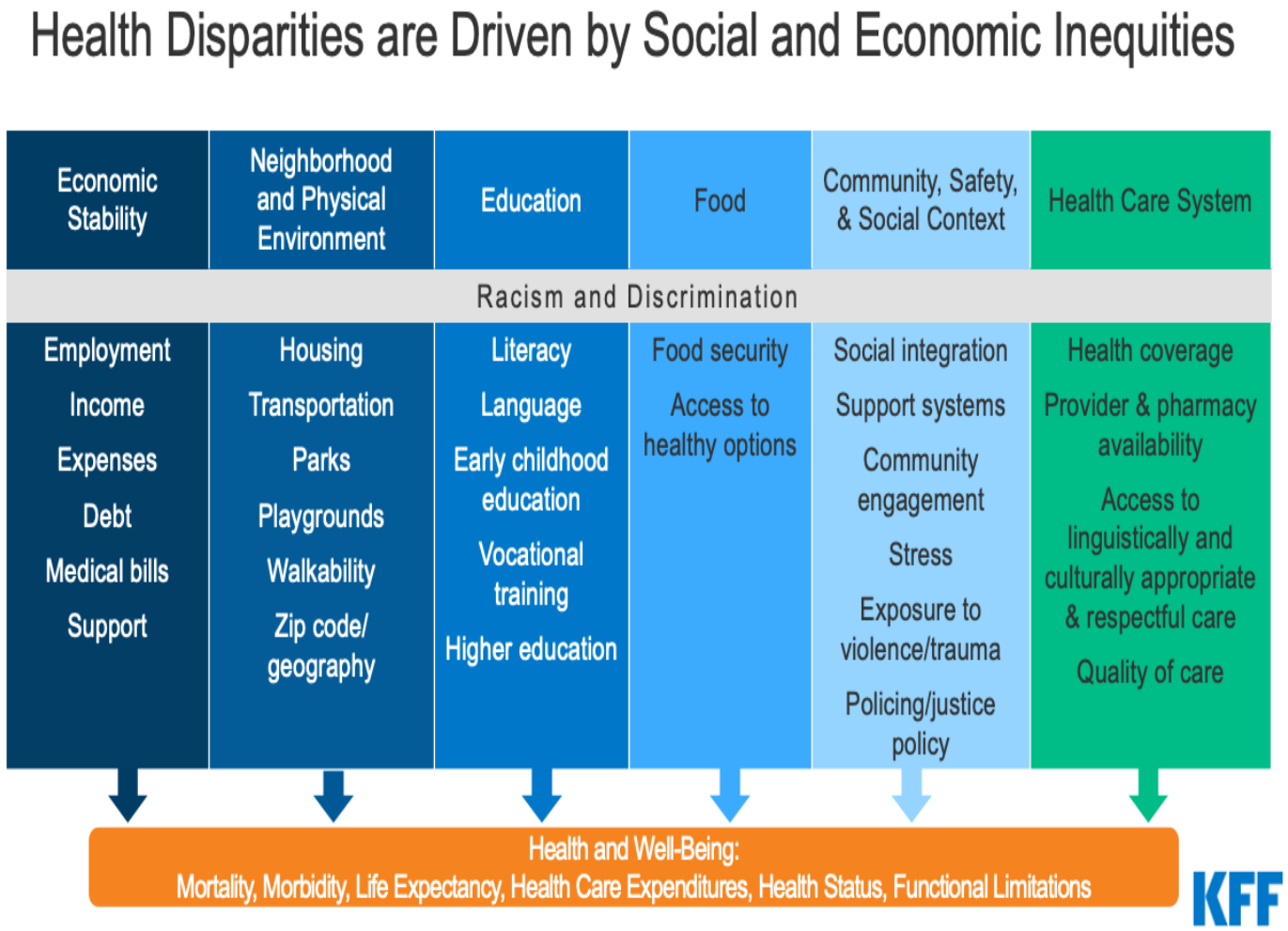
The social determinants of health are the complex, integrated and overlapping social structures, policies, and economic systems that affect health and quality of life outcomes

…conditions in which people are ***born, grow, work, play, live, worship and age***, and the wider set of forces and systems shaping the conditions of daily life.

These circumstances are shaped by the ***distribution of money, power, and resources*** at national, and local levels. The SDOH are ***mostly responsible for health inequities*** **-** the unfair and avoidable differences in health status seen within and between populations.

- Avoidable differences in health between different groups of people
- Are the result of unfair systems that negatively affect people's living conditions, access to healthcare, and overall health status

Health Disparities



Health disparities are **preventable circumstances**

- Burden of disease, injury, violence
- Opportunities to achieve optimal health
- Based on social factors such as income, ethnicity, education, age, and gender

Barriers to Black Mental Health

1: High Costs Of Mental Health

Despite the Affordable Care Act, around 12% of African Americans are uninsured, and even those with health insurance often don't have mental health services covered or have expensive co-pays or deductibles.

Some therapists choose not to take insurance and many people do not understand how to use out of network benefits to cover the cost of sessions. Paying out of pocket often isn't an option for a lot of Black people, and that lack of financial means stops them from being able to consistently engage in mental health care.

2: Familial Shame Around Mental Health

3: Cultural Stigma Of Mental Illness

4: Lack of Diversity In Health Care

5: Poor Competency Among Non-Black Clinicians

6: Whiteness As A Foundation to Mental Health Care

"The DSM-5 generally does not account for cultural factors that influence symptomatology, and diagnoses that speak to cultural issues such as racial discrimination or acculturation," "Counseling, psychology, and social work training programs hardly ever include the voices of Black mental health theorists, researchers, and practitioners."

7: Distrust of the Medical Industry

8: Difficulty Navigating The Process (Accessibility, Availability, and Appropriateness of Services)

9: Racism (Individual-level racism [racial prejudice]; Institutional racism; Cultural racism)

10: Negative Past Experiences

Mental Health in African American Men

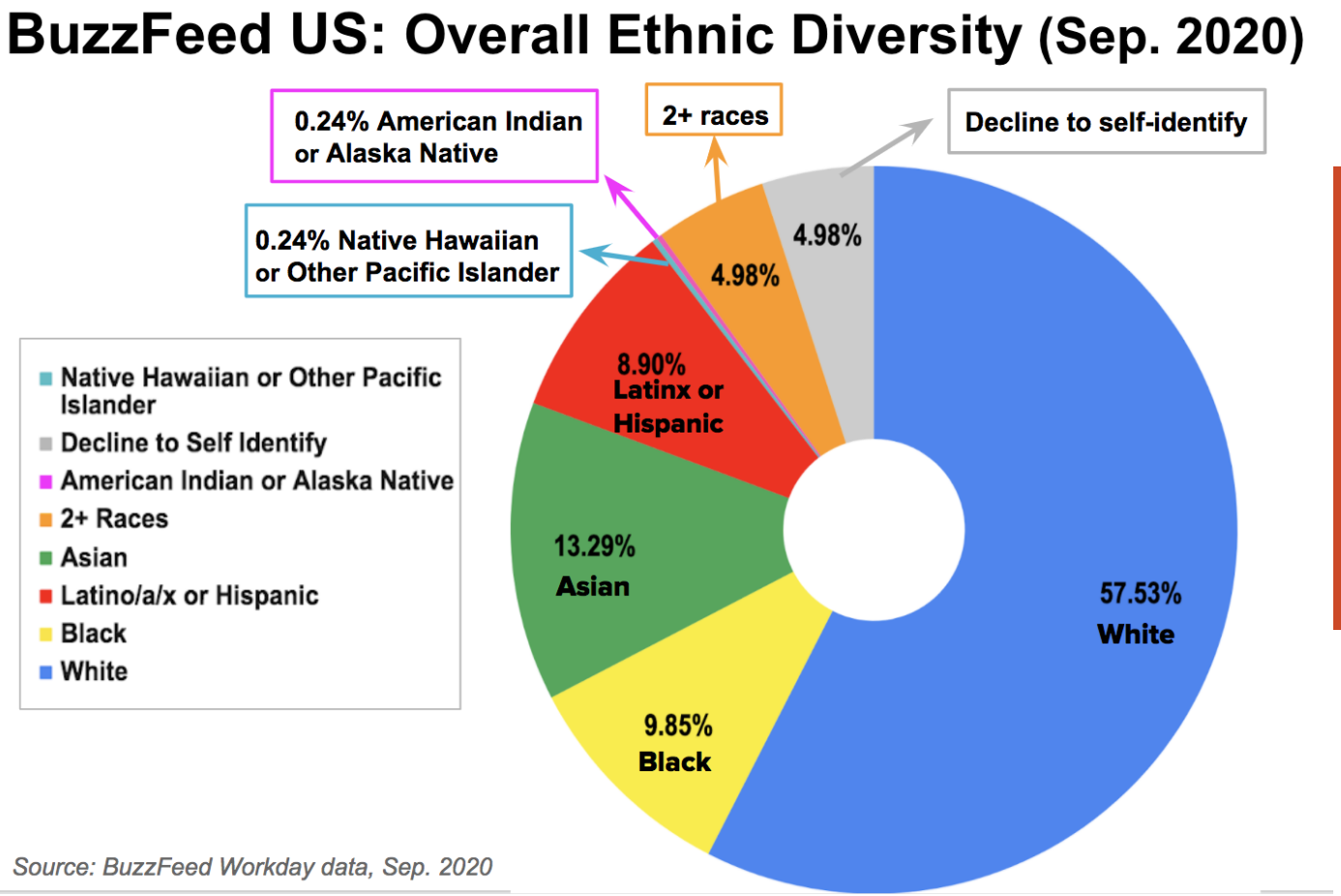
- ❑ <50% seek treatment for depression
- ❑ More likely than whites to persist > 1 yr and have severe impairment
- ❑ Treatable with appropriate medication and/or psychotherapy (talk therapy)
- ❑ Later entry into treatment, especially at crisis or emergency phase
- ❑ Higher rates of inpatient care, especially involuntary
- ❑ More likely to be misdiagnosed with psychosis
- ❑ More likely to be prescribed antipsychotic medications (outpatient)
- ❑ Higher incidence of movement disorders

Surgeon General's Report on Mental Health: Race, Culture & Ethnicity

- Striking disparities in mental health care for people of color
  - Less likely to receive services
  - Poorer quality of care
  - Underrepresented in mental health research

- Disparities impose great disability burden on people of color

Examples



Of the 30 million uninsured Americans, about half are people of color, according to Brookings.

African American, American Indians and Hispanic groups are more likely to die of diabetes.

For heart disease, cancer, and diabetes, African Americans have the highest death rates while Asian/Pacific Islanders have the lowest.

Ethnicity/Race, Paranoia, and Hospitalization for Mental Health Problems Among Men

Arthur L. Whaley, PhD, DrPH

Objectives. I tested the hypothesis that Black men with high levels of distrust (i.e., mild paranoia) are at greater risk of hospitalization for mental health problems than their White counterparts.

Methods. Secondary analysis was conducted of data from a subsample of 180 men in an epidemiological study. Mental health hospitalization was the outcome and ethnicity/race, mild paranoia, and their interaction were main predictors in a logistic regression analysis. The ethnicity/race by mild paranoia interaction tested the study hypothesis.

Results. The ethnicity/race by mild paranoia interaction was statistically significant. Contrary to the hypothesis, Black men with mild paranoia were less likely to be hospitalized.

Conclusions. Black men's lack of trust regarding the mental health system may cause them not to seek services. Factors critical to increasing their trust are acknowledgment of racial biases in the mental health system and sincere efforts to eliminate racial disparities in mental health treatment. (*Am J Public Health.* 2004;94:78–81)

Prevalence studies of inpatient samples have revealed that paranoid schizophrenia is a common diagnosis given to Blacks.[1,2] Several researchers attribute these findings to biases associated with racial stereotypes, especially those about Black men. The stereotype that Black men are prone to violence contributes to the misdiagnosis of paranoid schizophrenia.[3,4] Racial stereotypes of violence often operate at the unconscious level in mental health clinicians' diagnostic judgments about Black men.[5] The racial stereotyping of Black men, which has been euphemistically labeled "racial profiling," has

Ethnicity and the Course of Tardive Dyskinesia in Outpatients Presenting to the Motor Disorders Clinic at the Maryland Psychiatric Research Center

Ikwunga Wonodi, MD, Helene M. Adami, MSW, Shawn L. Cassady, MD, Jay D. Sherr, PharmD, Matthew T. Avila, MA, and Gunvant K. Thaker, MD

Background: Although newly emergent tardive dyskinesia (TD) is less of a concern, about one-fourth to one-third of patients on or previously on chronic first-generation antipsychotic agents have TD. The long-term course and outcome, as well as their predictors, are unknown. Earlier studies identify ethnicity as one of the risk factors for the development of TD, and case reports have noted a preponderance of African-American males in cohorts of patients with tardive dystonia. The current study examines the anatomic distribution and course of TD in a cohort of schizophrenia patients of European and African descent with TD who were referred to the Motor Disorders Clinic (MDC).

Methods: We evaluated data collected on 1149 TD patients who were given a focused neurologic examination for movement disorders. Movements were evaluated with the MPRC Scale for Involuntary Movements (IMS). All patients met RDC-TD criteria for diagnosis of persistent TD. One to 10-year follow-up data on 528 patients were evaluated to examine the course of TD following recommendations made to referring primary clinicians. Suggested interventions to referring primary clinicians included dose reduction of first-generation antipsychotic medication, or switching to a second-generation antipsychotic.

Results: Initial evaluation included 701 European American (EA) patients and 448 African-American (AA) patients. AA patients had a significantly higher proportion of males [$\chi^2_{(1)} = 7.50$, $P < 0.05$]. EA subjects had a higher mean age than AA patients 42.8 ± 11.2 and 39.8 ± 10.4, respectively [$F_{(1,1147)} = 22.27$, $P < 0.05$]. Mean neuroleptic exposure (chlorpromazine equivalents) was similar in both groups after controlling for differences in age.

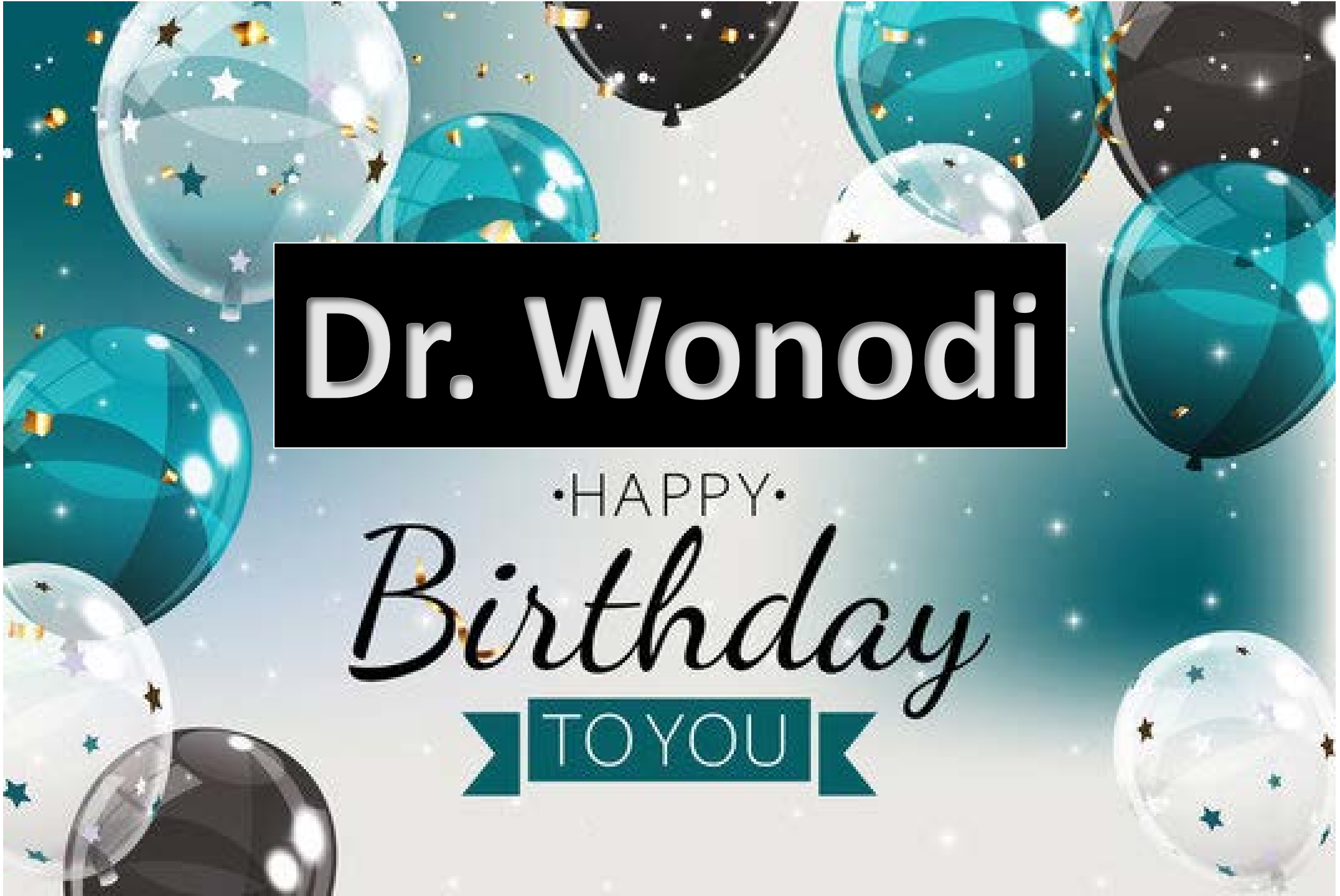
Follow-up data analyzed in 528 patients (329 EA and 199AA) showed a significant ethnicity by TD interaction [$F_{(1,504)} = 4.26$, $P < 0.05$]. Examination of body distribution of dyskinetic movements showed an effect of ethnicity. Subsequent analyses suggest EA patients experienced more improvement in TD over the course of follow up [$F_{(1,319)} = 22.39$, $P < 0.05$] compared with AAs [$F_{(1,189)} = 1.58$, $P > 0.05$]. These findings were unchanged when age, change in antipsychotic drug dose, and duration of follow-up were covaried.

Conclusion: Reports from earlier studies note ethnicity (African descent) as a risk factor in the development of TD. Our study findings suggest ethnicity might be an important factor in predicting a poor course of TD.

(*J Clin Psychopharmacol* 2004;24:592–598)

Tardive dyskinesia (TD) is an involuntary hyperkinetic disorder that affects 20% to 40% or more of patients treated chronically with first-generation antipsychotic (FGA) drugs.[1] The reported incidence of TD is 5% per treatment year for the first 5 years,[2] with the cumulative 5-year incidence rate being 20% to 26%.[1,2] The wide variation of 2% to 51%[3] in its reported prevalence can be attributed to the varied definitions of TD, the use of different methods of assessment, and the lack of control of predictor variables. TD is likely to be less of a public health issue in the future because of the increasing proportion of patients treated with second-generation antipsychotic (SGA) drugs, which have less risk for causing TD. However, at present, 1 of 4 patients with chronic psychosis previously treated with FGA has TD, and it is important to identify predictors of long-term outcome in these individuals. The literature on clinical predictors of long-term outcome, once TD has developed, is sparse.[4] Complicating the management of TD is the fact that

Questions


Dr. Wonodi
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TO YOU

Appreciation

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