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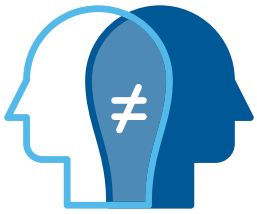


THE WEAPONIZATION OF WHITENESS IN CHILD WELFARE

The Misdiagnosed and Overmedicated Children in Foster Care

by MJ (Maleeka Jihad)

PART 3

This article is the third in a three-part series for *The Guardian*: The Weaponization of Whiteness in Child Welfare, featuring Guardian contributor MJ (Maleeka Jihad) and various experts in child welfare as co-contributors. You can find the first two articles in the series in the Fall and Winter 2022 issues.

> ***APA's Commitment to Change: Racial Equity Action Plan***
> *In October 2021, the American Psychological Association (APA) issued a formal apology to communities of color for its role in promoting, perpetuating, and failing to challenge racism, racial discrimination, and human hierarchy in the United States. In the apology, APA acknowledged that the organization failed in its role leading the discipline of psychology, was complicit in contributing to systemic inequities, and hurt many through racism, racial discrimination, and denigration of people of color, thereby falling short on its mission to benefit society and improve lives. APA accepted responsibility for and owned the actions and inactions of APA itself, the discipline of psychology, and individual psychologists who stood as leaders for the organization and field.*[1]

Introduction

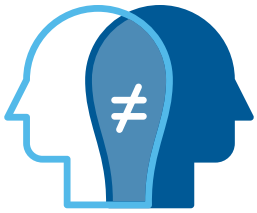
There is an understanding among professionals working within the family policing system that most children entering foster care have experienced trauma — either from their home environment, system involvement (including being removed from their home), or from an out-of-home placement (such as a group home or residential treatment facility). Such children may face the challenges of suffering from a developmental trauma disorder (DTD). DTD is a diagnosis that involves a child encountering multiple complex traumas.[2] Identified traumas may include abuse, neglect, grief, and/or a traumatic medical experience.

Emotional effects of trauma include:

- Problems concentrating
- Problems with memory
- Social withdrawals
- Fear
- Sadness
- Feeling nervous, jumpy, or on high alert
- Irritability or anger
- Difficulty sleeping
- Intrusive thoughts, flashbacks, or nightmares

1 Read the APA's Race Equity Action plan here: https://www.apa.org/news/press/releases/2022/08/racial-equity-action-plan.

2 Schmid M, Petermann F, Fegert JM. Developmental trauma disorder: pros and cons of including formal criteria in the psychiatric diagnostic systems. BMC Psychiatry. 2013 Jan 3;13:3. doi: 10.1186/1471-244X-13-3. PMID: 23286319; PMCID: PMC3541245.



- Trouble feeling positive emotions[3]

Common psychological diagnoses resulting from the effects of trauma may include:

- Post-Traumatic Stress Disorder (PTSD)
- Operational Defiant Disorder/Conduct Disorder (ODD)
- Acute Stress Disorder (ASD)
- Secondhand Trauma
- Reactive Attachment Disorder (RAD)
- Disinhibited Social Engagement Disorder (DESED)
- Adjustment Disorders
- Depression
- Borderline Personality Disorder[4]

RACE-BASED TRAUMATIC STRESS (RBTS): A theory developed by psychologist Robert T. Carter, which describes the effects on people of color after experiencing acts of racism as consistent with systems of post-traumatic stress disorder.[5] Racial trauma refers to the mental and emotional injury caused by encounters with racial bias, ethnic discrimination, racism, and hate crimes.[6]

Overuse of Psychotropic Mediations on Children in Foster Care

Psychotropic medications are disproportionately prescribed to children in foster care, compared to children not in care.[7] It is estimated that 30-52% of children and adolescents in foster care are prescribed psychotropic medication.[8] In 2021, the American Academy of Pediatrics reported psychotropic medication use is two to twenty-seven times higher among children in foster care as compared to non-foster (Medicaid-insured) children.[9] "One in every three children in foster care [35%] are on psychotropic medications designed to alter their mental status or mood, a significantly higher percentage than children who are not in foster care within the Medicaid program [8%]."[10]

Medication combinations at any age increased the risk of adverse side effects. Youth under the age of ten are substantially at greater risk of adverse drug reactions.[11] African American children and youth represent 23% of the foster care population yet comprise only 14% of the child and adolescent population.[12] As part of the foster care population, they are at risk of being given five or more psychotropic drugs at a time, with some younger than five.[13]

3 Recognize & Rise. "Recognize Emotional Trauma and Find Support." Available at: https://recognizeandrise.org/emotional-trauma/.

4 American Psychological Association. "Current Trauma Diagnoses." March 2007. Available at: https://www.apa.org/monitor/mar07/trauma.

5 Polanco-Roman L, Danies A, Anglin DM. Racial discrimination as race-based trauma, coping strategies, and dissociative symptoms among emerging adults. Psychol Trauma. 2016 Sep;8(5):609-17. doi: 10.1037/tra0000125. Epub 2016 Mar 10. PMID: 26963957; PMCID: PMC4982826. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4982826/#R10.

6 Mental Health of America. "Racial Trauma." Available at: https://www.mhanational.org/racial-trauma.

7 Behavioral Health State Court Leadership Brief. "Oversight of Psychotropic Medications Prescribed to Children in Foster Care." September 2022. Available at: https://www.ncsc.org/__data/assets/pdf_file/0022/83803/Oversight-of-Psychotropic-Medications-Prescribed-to-Children-in-Foster-Care.pdf.

8 Park, K., Okpych, N.J. & Courtney, M.E. Psychotropic Medication Use and Perceptions of Medication Effects Among Transition-Age Foster Youth. *Child Adolesc Soc Work J* 36, 583–597 (2019). https://doi.org/10.1007/s10560-019-00605-y.

9 American Academy of Pediatrics. "Children in Foster Care Much More Likely to be Prescribed Psychotropic Medications Compared with Non-Foster Children in Medicaid Program." October 2021. Available at: https://www.aap.org/en/news-room/news-releases/aap/2021/children-in-foster-care-much-more-likely-to-be-prescribed-psychotropic-medications-compared-with-non-foster-children-in-medicaid-program/.

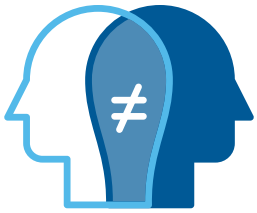
10 *Id.*

11 Patient Centered-Outcomes Research Institute. "Ensuring Foster Youth Are Only Prescribed Psychotropic Medication When in Their Best Interest." July 2019. Available at: https://www.pcori.org/sites/default/files/2019.07.14-PCORI-research-summary-memo.pdf.

12 Citizens Commission on Human Rights International. "CCHR Reports 1 Million Decline In US Children On Mind-Altering Drugs." February 2021. Available at: https://www.cchrint.org/2021/02/09/cchr-reports-1-million-decline-in-us-children-on-mind-altering-drugs/#_edn9.

13 *Id.*

14 Medicaid and CHIP Payment and Access Commission. Use of Psychotropic Medications among Medicaid Beneficiaries. June 2016. Available at: https://www.macpac.gov/wp-content/uploads/2015/06/Use-of-Psychotropic-Medications-among-Medicaid-Beneficiaries.pdf.



Side Effects of Psychotropic Medications (in children and adolescents)

- Breast tissue development (in males)
- Uncontrollable weight gain
- Type II diabetes
- Suicidal ideation
- Uncontrollable muscle spasms
- Brain shrinkage
- Seizures
- High cholesterol
- Kidney and liver damage
- Sudden unexplained death[15]

PSYCHOTROPIC MEDICATIONS (AKA "PSYCH MEDS") ARE MEDICATIONS USED TO TREAT A PERSON'S THINKING, MOOD, OR BEHAVIOR.

Psychotropic medications (commonly) prescribed to children in foster care:

For Attention-Deficit/ Hyperactivity Disorder Diagnoses
Concerta
Focalin
Vyvanse
Intuniv
Strattera
Buspar
Xanax

For Depression/Anxiety Disorder Diagnoses
Zoloft
Prozac
Lexapro
Effexor
Wellbutrin

Other Medications

Risperdal
Abilify
Zyprexa[14]

Causes and Reasons for Misdiagnosis and Overmedication

There are many reasons why children are misdiagnosed with psychiatric disorders. The Diagnostic and Statistical Manual (DSM),[16] which is the guidebook for assessing mental health behaviors and treatment recommendations, has often been criticized for not accounting for cultural considerations, as well as its relationship with and influence of the pharmaceutical industry.[17] Professionals utilize the DSM in every aspect of mental health services, including providing criteria for private and Medicaid insurance billing and reimbursements.

People of color's justified mistrust in the mental health community is due to racial bias and lack of cultural respect endured from both medical and therapeutic practitioners; the general stigma surrounding mental health; and the high cost of therapy. Though racism is not explicitly identified in the DSM as a contributing factor for the mental health problems people of color experience in the United States, many mental health professionals of color (including social workers, psychologists, and therapists) continue to raise the matter within the psychology and social work disciplines. For example, a 2019 Rutgers University study found that African Americans are more likely to be misdiagnosed with schizophrenia.[18]

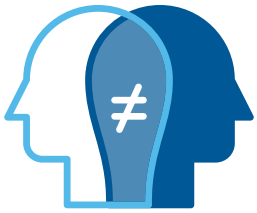
> *Drapetomania was a term introduced by Dr. Samuel Cartwright, a Louisiana medical physician that investigated and reported on diseases unique to Black people. Derived from the Greek words for "runaway slave" and "crazy", he defined drapetomania as a "disease*

15 Patient Centered-Outcomes Research Institute, *supra*, footnote 11.

16 The DSM is the handbook widely used by clinicians and psychiatrists in the United States to diagnose psychiatric illnesses. Published by the APA, the DSM covers all categories of mental health disorders for both adults and children. It contains descriptions, symptoms, and other criteria necessary for diagnosing mental health disorders. It also contains statistics concerning who is most affected by different types of illnesses, the typical age of onset, the development and course of the disorders, risks and prognostic factors, and other related diagnostic issues. A summary of the DSM is available at https://www.verywellmind.com/the-diagnostic-and-statistical-manual-dsm-2795758.

17 Very Well Mind. "Advantages and Disadvantages of the Diagnostic Statistical Manual." January 2023. Available at: https://www.verywellmind.com/dsm-friend-or-foe-2671930.

18 Science Daily. "African-Americans more likely to be misdiagnosed with schizophrenia, study finds." March 2019. Available at: https://www.sciencedaily.com/releases/2019/03/190321130300.htm.



> *of the mind" that made slaves run away from plantations.*[19] *In other words, an enslaved Black person's desire to be free from slavery was a curable mental disorder — suggesting a notion that the only happiness a Black person can achieve is from being a slave.*

In young African American males, the misdiagnosis of operational defiant disorder (ODD) is disproportionately higher than any other demographic groups.[20] This can be attributed to clinicians' negative stereotypes and perceptions about young black males and a lack of cultural competency.[21] A misdiagnosis of ODD may not only lead to incorrect treatment, but often ignores and prolongs the correct diagnoses and treatment for depression and/or attention-deficit/hyperactivity disorder (ADHD).[22] ODD diagnosis can be particularly stigmatizing with immediate and long-term implications for marginalization; misdiagnosis of ODD can have potentially adverse implications for healthy psychological, emotional, and social development in family and education systems.[23] Tracking educational, judicial, and incarceration data clearly demonstrates that African American males are disproportionately suspended and expelled from school compared to their peers and receive harsher sentences in judicial systems for the same offenses as their counterparts.[24] When the diagnosis of a mental disorder is used for purposes other than helping the client, it opens the door to unintended and problematic consequences.[25]

THERAPISTS BY ETHNICITY PERCENTAGE (IN THE UNITED STATES):

White (72.6%)

Asian (11.3%)

Hispanic or Latino (7.9%)

Black or African American (4.0%)[27]

> *Attention-Deficit/Hyperactivity Disorder (ADHD) is a mental health diagnosis given to those experiencing a deficit in dopamine, norepinephrine, and serotonin neurotransmitters, leading to erratic mood changes and difficulties in focusing attention. From 2003 to 2011, the diagnosis of ADHD) in children in the United States increased 42% from 2003 to 2011, resulting in questions about the validity of the diagnosis.*[26]

Barriers to competent therapeutic care for people of color include lack of culturally respectful providers from diverse racial and ethnic backgrounds. Often within the court systems, therapeutic treatment is mandatory, and the client is not permitted to choose the provider they want to work with. This can often lead to not only mistrust of the judicial system, but also lack of trust with the therapeutic provider. Court-ordered service providers often cause the client/patient to be less engaged and cooperative in treatment. Clients fear negative impacts resulting in family separation or family severance within dependency and neglect court cases.

19 DeBow's Review. "Diseases and Peculiarities of the Negro Race." 1851. Available at: https://www.pbs.org/wgbh/aia/part4/4h3106t.html.

20 Grimmett, *et al.* "The Process and Implications of Diagnosing Oppositional Defiant Disorder in African American Males." The Professional Counselor. Volume 6, Issue 2, Pages 147–160. Available at: https://tpcjournal.nbcc.org/wp-content/uploads/2016/07/Pages147-160-Grimmett.pdf.

21 *Id.*

22 *Id.*

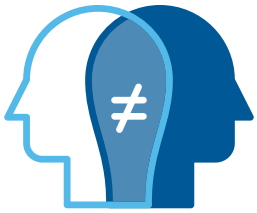
23 *Id.*

24 *Id.*

25 *Id.*

26 Pre-Collegiate Global Health Review. "The Global Misdiagnosis of ADHD and the Devastating Long-Term Effects." (August 2021). Available at: https://www.pghr.org/post/the-global-misdiagnosis-of-adhd-and-the-devastating-long-term-effects.

27 Zippia The Career Expert. "Therapist Demographics and Statistics in the US". Available at: https://www.zippia.com/therapist-jobs/demographics/.



Many White people are socialized to demonstrate non-racist values by not talking about race. However, this approach leaves such clinicians ill-equipped to have conversations about race with their clients of color, and so it is even less likely they will be able engage in productive conversations surrounding traumatic experiences of racism.[28]

Stories of Impacted People

Nate[29]

"There is no way to measure the damage of a child's brain on psychotropic medications"

Case Details/Placement History: Male. Colorado, USA. Entered foster care system in 2002 at age eight. Removed from his parents during a police raid at home. First placement: group home for two months. Second placement: maternal grandmother for six to seven months. Placed in over twenty foster homes placements after parents' rights were terminated. Final placement was a residential treatment facility. Aged out of system at eighteen years old.

Diagnosis/Medication History: Diagnoses: ADHD, ADD, Depression, Anxiety. First administered psychotropic medication at age nine. Had many different psychiatrists. All children in his foster homes were also on medications, including his younger brother, who was four years old at the time. Medications: Ritalin, Adderall, Strattera, Zoloft, Seroquel, and three others (did not remember the names). Three pills were administered two times per day. Medications caused younger brother to experience uncontrollable leg twitching. Nate did not like the way the medications made him feel. When he refused meds in his foster home, he was held down and forced to take them.

"I do not take any medications. I am even cautious when talking over the counter, Tylenol. I believe the body has ways to heal itself."

Sonia[30]

"I sincerely believe the reason why my two boys struggled with addiction throughout their adulthood, was due to them being forced to take psychotropic medications while in the foster care system."

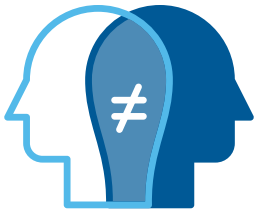
Case Details/Placement History: System involvement began in 2008, when her sons' (ages eleven and twelve) truancy case developed into juvenile delinquency case due to school suspensions and trespassing charges. One of her sons was placed in residential group home, and the other with his maternal grandmother.

During her visit to the residential group home, her son told her he was placed on psychotropic medications due to behavior. "He just seemed out of it." Her son later reported he was told by group home staff he would not be allowed to socialize with the other residents if he did not take the prescribed medications. Her son also reported that staff threatened his visitations with his mother would be taken away if he did not cooperate with medication management at the treatment facility. "I was not informed (nor would I have approved)

28 Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM–5 framework: The UConn Racial/Ethnic Stress & Trauma Survey. Practice Innovations, 3(4), 242–260. http://dx.doi.org/10.1037/pri0000076.

29 Interview date: 2/7/23.

30 Interview date: 2/7/23.



my children to be put on any medications. I wanted them to receive real help. Not to be turned into zombies." Medications: Zyprexa and Strattera (did not remember the others). Side effects: migraines, visual hallucinations, audio hallucinations, tremors, cold sweats.

"Even as adults, my sons still have lasting side effects from the medications. Including migraines and auditory hallucinations."

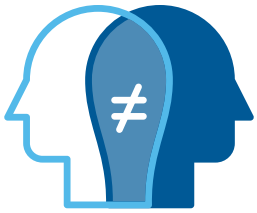
Solutions for Decreasing Misdiagnosis and Overmedication of Children Involved in the Family Policing System

- Advocate for a culturally respectful therapeutic treatment provider
- Ensure the treatment provider is familiar with foster care systemic issues, such as:
  - Race-related trauma
  - Separation trauma
  - Disenfranchised grief
  - Attachment disorders
- Advocate for a service provider from the client's community
- Verify the (psychological) assessment is culturally adapted

Advocate for culturally appropriate therapeutic mental health providers: *Professionals involved in the family policing system often express dissatisfaction about the lack of culturally competent therapeutic services providers for their clients. In reality, such culturally appropriate treatment providers may exist, but those clinicians may not contract with any governmental agencies (such as the department of human services or child protection services) because of the damage system involvement causes not only to families, but to entire communities (specifically of color). Though a therapist's agency may not obtain a governmental (service provider) contract, that does not preclude the child's attorney or guardian ad litem from advocating (in and out of court) to have a service provider that will best meet the client's mental health and medical needs.*

All therapeutic service providers are held to the moral and ethical standards of practicing within their scope of knowledge and care, including being aware and knowledgeable of the negative impacts of racism a client may endure within the multiple aspects of their lives. Many states have therapists that specifically work with people of color. In the state of Colorado, there is the Therapist of Color Collaborative, an organization that specializes in providing culturally respectful therapists paired with clients. Although this collaboration of therapists does not hold a contract with any governmental agencies, they often will obtain a single/independent contract with children and families that may be involved in dependency and neglect cases, as well as juvenile court-involved cases.[31]

31 For more information on the Therapist of Color Collaborative, visit https://www.therapistofcolor.com/.



Most importantly, attorneys must continue to question:

- Did the parent provide consent for their child to receive psychotropic medication?
- Do you have access to the *entire* file of the child's medical history and treatment?
- What is the child's current mental health diagnosis?
- What medications is the child currently receiving?
- What medications has the child been prescribed in the past?
- What are the possible side effects of the medications?
- What is the length of time the child is expected to receive this medication treatment?
- What are the other treatment options that do not include psychotropic medication? Have those options been considered and/or ruled out? Why/why not?
- What are the signs of "success"? How will we know the medication is working? ■

ABOUT THE AUTHOR:

MJ (Maleeka Jihad) is the Director of **MJ Consulting** and the nonprofit **MJCF: Coalition**, an agency focused on dismantling systemic racism in the family policing system through education, advocacy, and policy reform. MJ is the Director of the Family Justice Programs with the **Office of Respondent Parents' Counsel** (Denver, Colorado) where she provides national trainings and consultations to professionals as it relates to race, culture, and justice within dependency and neglect court cases and service providers. As an adjunct faculty member with the Graduate School of Social Work at the University of Denver, she teaches on race, privilege, social justice, therapy, leadership, as well as child and family law courses. Alongside her students, MJ is continuing her education by obtaining a PhD in Organizational Development with Social Justice Change specializing in Somatic Leadership Coaching (at Fielding Graduate School). MJ may be reached at mjihadlaw@gmail.com or 720-653-4372.