BEHAVIORAL HEALTH RESOURCE

Advancing Equity in Substance Use Disorder (SUD) Treatment

SAMHSA
Substance Abuse and Mental Health Services Administration

Advancing Equity in Substance Use Disorder Treatment

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Contents

Background

Several health disparities exist among racially/ethnically minoritized and other historically marginalized populations who live with substance use disorder (SUD). These disparities are evident in patterns of substance use; in social, legal, and health consequences of use; and in treatment and recovery access and effectiveness. The strategies and actions proposed to address these deficits are complex and multifaceted, and may involve research, policy evaluation and implementation, training, and the development of novel approaches to address practice issues. Populations affected include American Indians/Alaska Natives (AI/AN), Blacks/African Americans, Hispanics/Latinos, and people who are lesbian, gay, bisexual, transgender, queer/questioning, and/or intersex (LGBTQI+). Another important factor is poor SUD health literacy among persons who are at risk for or in need of SUD services.

In an effort to understand the extent of these disparities related to SUDs, this document has the following goals:

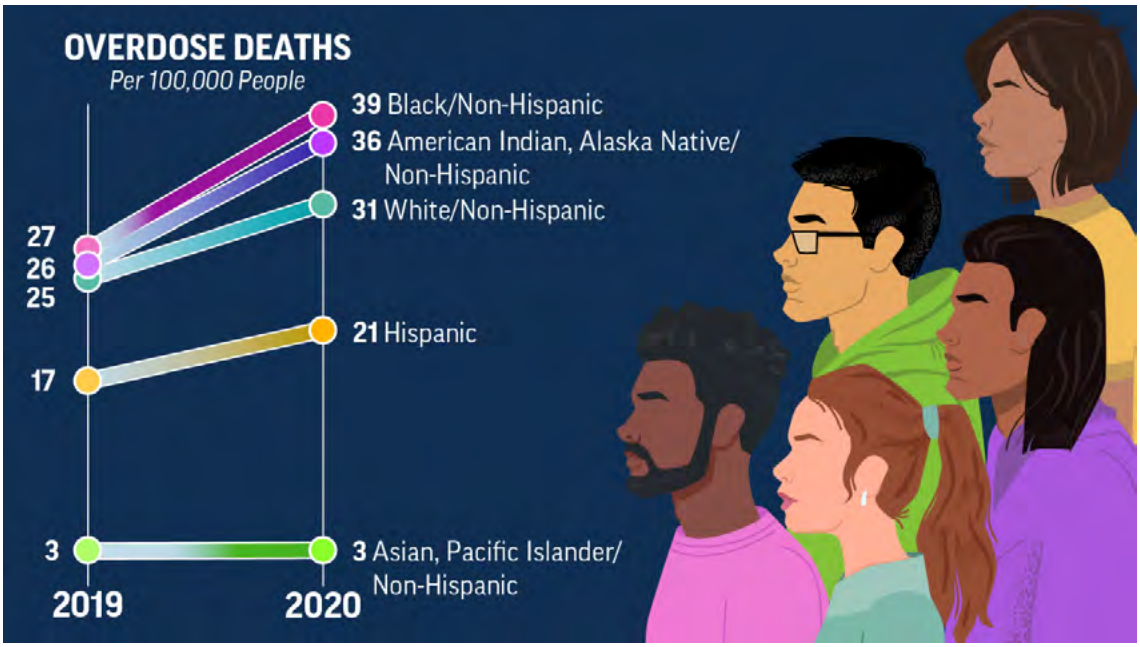
- Gaining insight on how to reduce disparities in SUD treatment systems
- Determining whether increased presence of under-represented/ marginalized populations in SUD research or incremental gains via increased delivery of direct services (i.e., through counselors) will improve outcomes
- Understanding how expanded access to SUD treatment will improve outcomes
- Ascertaining whether SUD health literacy will improve equity in historically marginalized populations

State of Health Disparities Among Various Racial and Ethnic Groups and Marginalized Populations With SUD in the United States

DISPARITIES IN SUBSTANCE USE PATTERNS

According to the U.S. Centers for Disease Control and Prevention (CDC) (2023), drug overdose data shows disturbing trends and increasing disparities between various population groups. Between 2019 and 2020, overdose mortality rates, defined as the number of deaths from drug overdose per 100,000 people, went up 44% for Black/Non-Hispanic people and 39% for American Indians and Alaska Natives (AI/AN), while they increased 24% for Hispanics and Whites (Figure 1). Additionally, compared to their White counterparts, a lower percentage of racial, ethnic, and other minority groups had access to treatment for SUDs. This inequity was worse in areas with more income inequality.

Figure 1. Overdose Deaths by Race and Ethnicity from 2019-2020



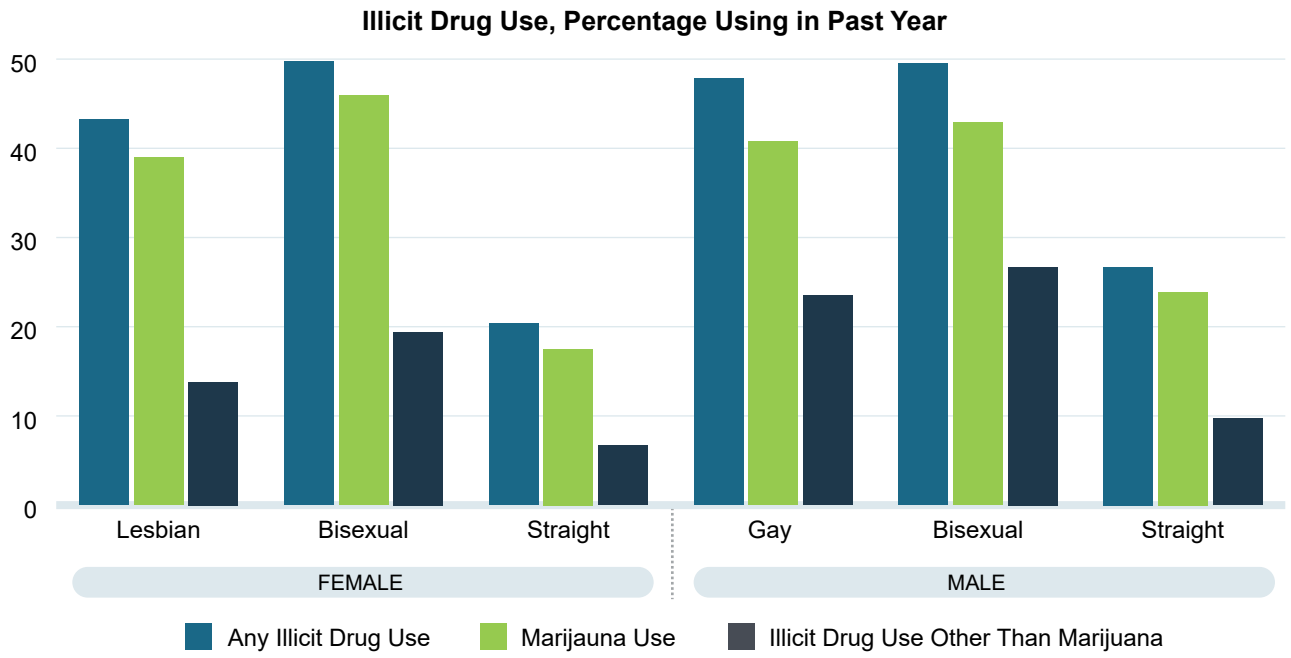
Source: CDC, 2023

Numerous studies have outlined the incontrovertible truth regarding health disparities related to substance use in the United States. Historically, racially and ethnically minoritized populations with SUD experience distinct use patterns and disparate rates of long-term health consequences, criminalization, and limited treatment access compared to their White counterparts (McCuistian et al., 2021). In particular, Indigenous, Black, and other communities of color have experienced inequitable effects of the overdose crisis in the United States communities, and this has been well established (Lopez et al., 2022). James and Jordan (2018) have stated that much of the social and political attention surrounding the nationwide opioid epidemic has focused only on the dramatic increase in overdose deaths among White, middle-class, suburban, and rural users, while the effect of the epidemic on Black communities has been mostly unrecognized. Even though the rates of opioid deaths from 2013 to 2018 have been rising precipitously among Black people (43%) versus Whites (22%), the opioid epidemic is still conceptualized as a White epidemic (James & Jordan, 2018).

Population-based survey data from the National Survey on Drug Use and Health (NSDUH) show that AI/AN populations have disproportionately high rates of SUDs. While the median age of onset for SUDs in the United States is around 20 years of age, research indicates that onset occurs several years earlier for North American Indigenous (i.e., American Indian) adolescents. Nicotine, alcohol, and marijuana are the three most used substances documented among Indigenous youth and often precede other "heavy" illicit substances (Hautala et al., 2019).

Via meta-analyses, Coulter, and colleagues (2019) revealed that compared with heterosexual youth, sexual minority youth (SMY) (i.e., gay, lesbian, and bisexual youth and youth with same-gender attractions or sexual behaviors) have 123% to 623% higher odds of lifetime substance use. In a report published in 2017 by the CDC, the prevalence in the use of cocaine, inhalants, heroin, and methamphetamine was higher in students that identify as gay, lesbian, and bisexual than among heterosexual students (Kann et.al., 2017). Among adults, data has shown that sexual minority adults were more likely to have an SUD or drug use disorder (DUD) within the past year than heterosexual adults (SAMHSA, 2023). Further, stigma and discrimination are the fundamental causes behind SMY health disparities in substance use; thus, developing interventions to reduce stigma and discrimination is critical.

Figure 2. Sexual Identity and Illicit Drug Use Among Adults Aged 18 or Older in the United States



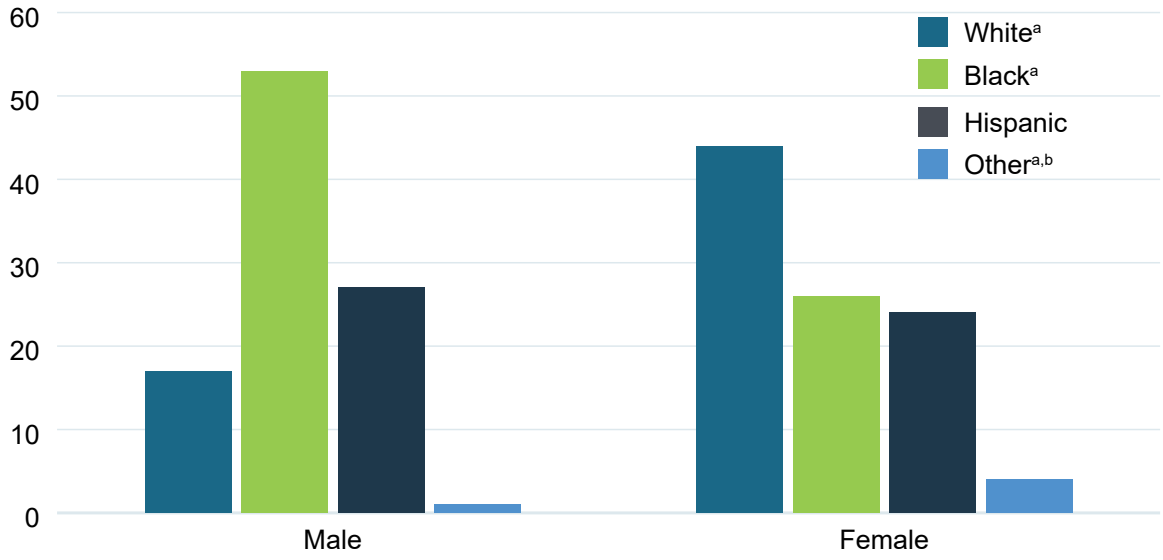
Source: SAMHSA 2023

INEQUITIES IN HEALTH, SOCIAL, AND LEGAL CONSEQUENCES OF USE

Inequities faced by racial, ethnic, and historically marginalized populations in relation to substance use are evident not only regarding health but also regarding social and legal injustices. The Sentencing Project, an advocacy organization dedicated to minimizing imprisonment and criminalization by promoting racial, ethnic, gender, and economic justice, and the U.S. Bureau of Justice Statistics have noted racial differences in criminal justice system involvement due to racial bias in arrest and incarceration rates (Hollender et al., 2021). However, the extent to which criminal justice system disparities exacerbate racial disparities in medications for opioid use disorder (MOUD) initiation has not yet been estimated (Hollender et al., 2021).

A recent study by the United States Sentencing Commission found demographic differences in sentencing for federal drug trafficking offenses. White males were found to be more likely to receive a probation-only sentence compared with males of other groups; Black and Hispanic males received longer incarceration lengths in comparison to white males; and Black and Hispanic females were less likely to receive a probation-only sentence compared to white females (United States Sentencing Commission, 2023, p. 27-28). A 2023 Special Report by the Bureau of Justice Statistics also found differences in sentence lengths based on race and ethnicity (Bureau of Justice Statistics, 2023, p. 17).

Figure 3. Percent of Persons in Federal Bureau of Prisons Custody for Drug Offenses Sentenced to 20 Years or More, by Sex and Race or Ethnicity, Fiscal Year 2018



a. Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic white persons and "black" refers to non-Hispanic black persons). Defendants self-reported race and ethnicity during the presentence interview. Data were collected for one race and one ethnicity category

b. Includes Asian, Native Hawaiian, or Other Pacific Islander persons and American Indian or Alaska Native persons.

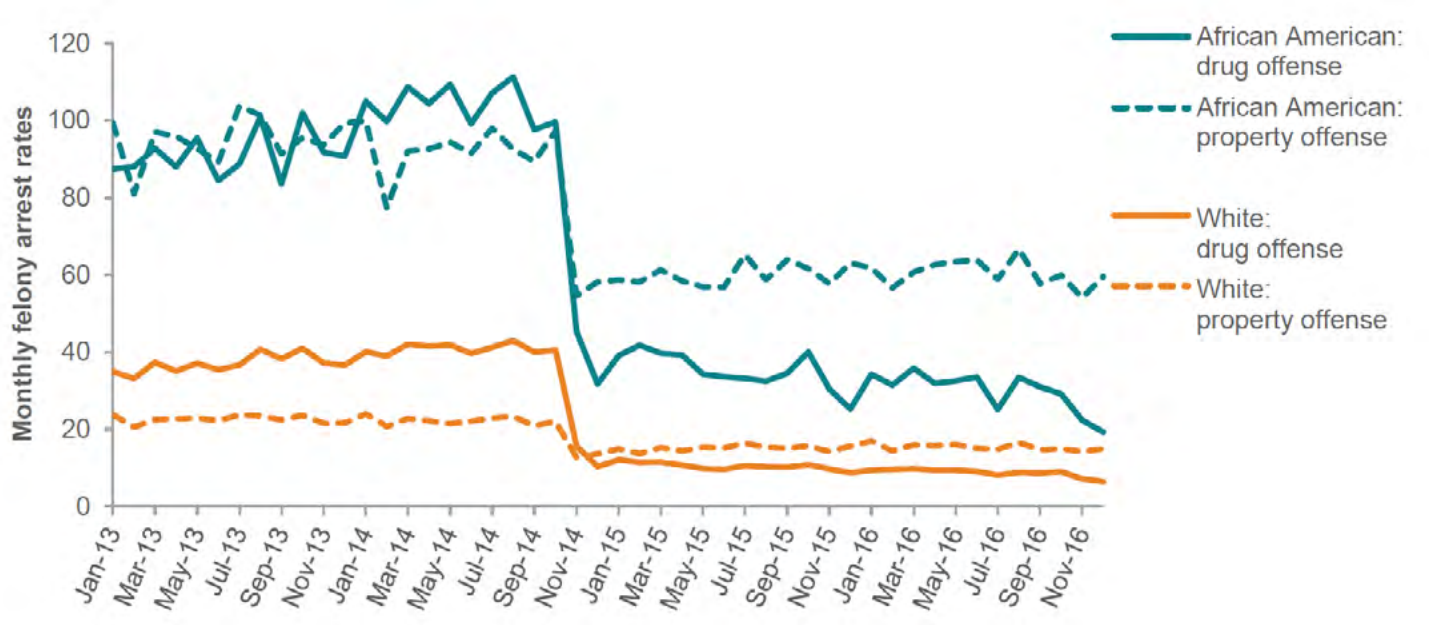
Source: Bureau of Justice Statistics Special Report, July 2023

The first study to investigate racial and ethnic disparities in driving under the influence (DUI) arrests post-treatment and to include community characteristics in the analysis was published by Miles and colleagues (2020). This study identified specific racial and ethnic disparities in DUI arrest outcomes. For instance, their results indicated that:

- Latino clients receiving outpatient substance use treatment were at greater risk than their White counterparts **of being arrested for a DUI in the year following treatment**, likely due to the possibility that Latino clients enter treatment with greater symptom severity.
- Clients living in communities with a **higher proportion of Black residents** were significantly more likely than residents who did not live in these communities to have a DUI arrest in the year after beginning treatment, which may be the result of limited access to treatment facilities that accept Medicaid or timely access to outpatient SUD treatment services after accessing inpatient treatment.
- To the authors' knowledge, this study is the first to identify an **increased risk for post-treatment DUI arrest** among clients living in communities with a higher proportion of Black residents.
- Reducing criminal justice involvement (e.g., arrests, convictions, incarceration) is frequently used as a treatment outcome to determine treatment effectiveness.
- Clients were retained in publicly funded outpatient treatment longer if they received care in settings that were more **culturally tailored**.

On the state level, legislation has been passed that inadvertently highlights the persistent racialized criminalization present in the legal system regarding substance use. Lopez and colleagues (2022) acknowledged the baseline adversities that all marginalized people who use drugs (PWUD) encounter as they interface with services, health care, and the police, and this baseline reflects the deeply embedded systems of punishment directed at poor, marginalized, and racialized communities. Specifically, they discussed the outcome of the passing of Good Samaritan legislation in Maryland in 2015, which provides protection from arrest, charge, or prosecution of misdemeanors when evidence of these misdemeanors was obtained during the time someone is seeking medical assistance. During interviews conducted with PWUD, some participants reflected on differential applications of the law for people of color. This was rooted in lack of trust based on histories of disproportionate policing and criminalization of communities of color and direct experience with the prison system. Another example is Proposition 47 (Prop 47), passed in California in 2014, which reclassified certain drug and property crimes from felonies to misdemeanors (Lofstrom & Martin, 2020). An analysis by Ferrer and Connolly (2018) found that in California, Prop 47 increased the relative disparity between Black and White drug felony arrests. They found that before Prop 47, the percentage of all drug arrests was greatest for Black people, and the portion that were reclassified to misdemeanors was smallest for Black people. Although data suggests a decrease in racial disparities following Prop 47, significant disparities clearly remain in that throughout California almost all counties show an arrest rate for African Americans at least double that of Whites, while 13 counties have rates at least five times that of Whites (PPIC, 2020).

Figure 4. Effect of Proposition 47 on Arrests of African Americans



Source: PPIC, 2020

In addition, Ferrer and Connolly found that although Black people were twice as likely as Whites to be arrested on a felony drug charge before Prop 47, they became three times as likely as Whites to experience this outcome 1 year after the law was implemented.

DISPARITIES IN PREVENTION, EARLY INTERVENTION, TREATMENT, AND RECOVERY ACCESS

When it comes to the initiation of substance use and progression to regular use, Hautala and colleagues (2019) observed that this occurs several years earlier for Indigenous youth, compared to youth of other ethnic and racial groups. The authors stated that there is not much currently known about the developmental course of SUD onset and how it fits within broader patterns of substance use among Indigenous youth. Other researchers have identified several barriers, including access problems from lack of insurance, services unavailable in their native language, greater stigma, and historical mistreatment in healthcare settings, which may sow distrust of mental healthcare professionals. These barriers contribute to higher levels of unmet behavioral health needs among racial and ethnic minorities (Mays et al., 2017). Compared to Whites, ethnic and racial minorities report being subjected to discrimination more often. Common reasons given for this discrimination include ethnicity and/or race, type of insurance, ability to pay, and language (Mays et al., 2017). Further exploration is warranted to determine whether there is a relationship between seeking SUD treatment by racial, ethnic, and other marginalized communities and perceived occurrences of discrimination, dissatisfaction, treatment noncompliance, and dropping out (Mays et al., 2017).

One particular study by Skewes and colleagues (2022) reported findings from a 7-year community-based participatory research (CBPR) project that aimed to understand substance use and recovery among tribal members from a rural AI reservation with high rates of SUD and limited opportunities for treatment. The authors acknowledged that as the result of generations of historical oppression and systemic racism, AI/AN communities experience serious health disparities associated with SUD. They wrote that cultural leaders in particular described substance use as symptomatic of the historical and cultural trauma the community has endured from centuries of colonization, genocide,

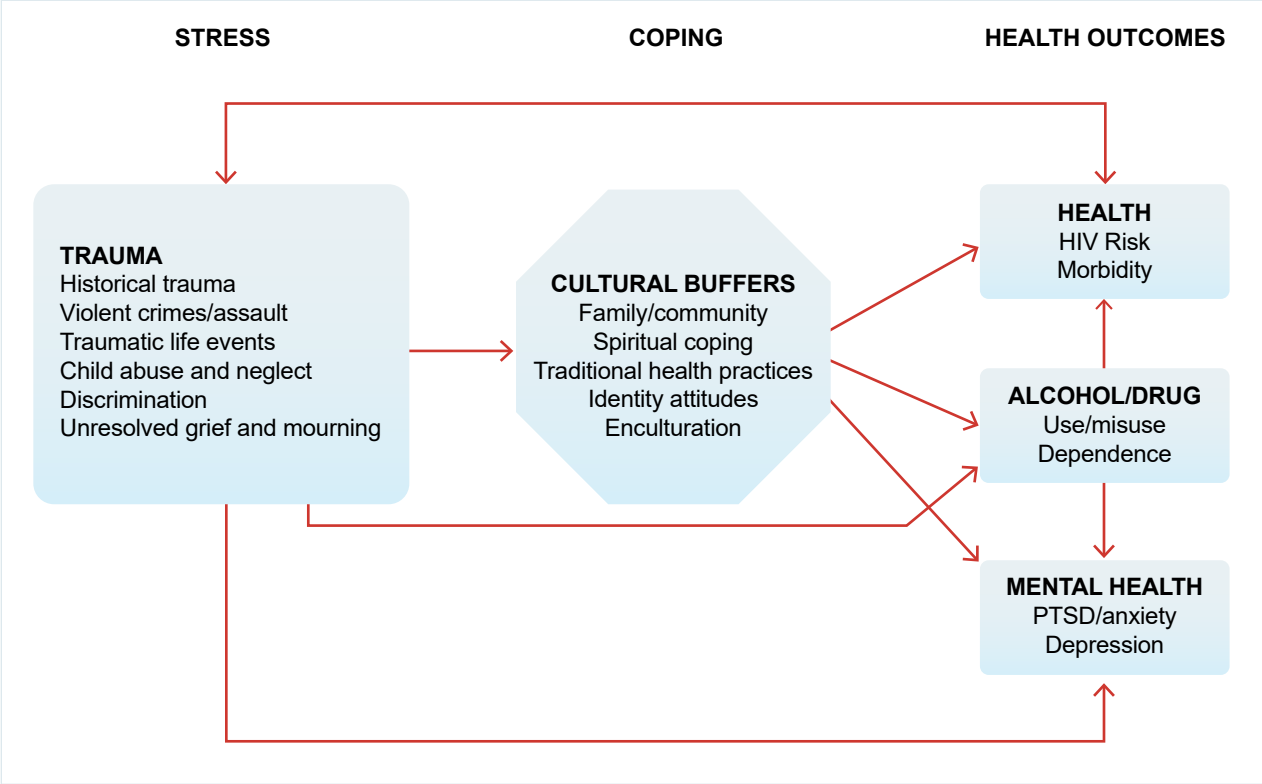
and racist oppression. As a result, there was a loss of Native identity, driving individuals to turn to substance use as a way to cope and find a sense of belonging; therefore, interventions should be grounded in Native culture and values.

ROLES OF SOCIAL DETERMINANTS OF HEALTH, STRUCTURAL RACISM, AND IMPLICIT BIAS

In an effort to further understand inequity related to SUDs, the roles of social determinants of health (SDOH), structural racism, and implicit bias must also be examined. Health disparities in AI/AN communities have been attributed, in part, to disparities in SDOH, systemic racism and discrimination, and historical and contemporary experiences of trauma (Gameon & Skewes 2021). Gameon and Skewes also outlined the fact that while certain risk factors are associated with adverse health outcomes in AI/AN communities, there are also protective factors associated with better outcomes. Walters and colleagues (2002) proposed the Indigenist Stress-Coping Model to conceptualize the impact of risk factors (e.g., discrimination, traumatic life events, unresolved grief, and mourning)

and protective factors (e.g., ethnic identity, traditional practices, and family/community support) on physical health, mental health, and substance use outcomes among AI/AN people (Figure 5). This model provides a useful framework for exploring the complex relationships between trauma, resilience, and substance use in AI/AN communities, while also incorporating the impact of collective experiences, such as historical trauma, on individual-level health outcomes (Gameon & Skewes, 2021).

Figure 5. The Indigenist Stress-Coping Model



Source: Walters et al., 2002

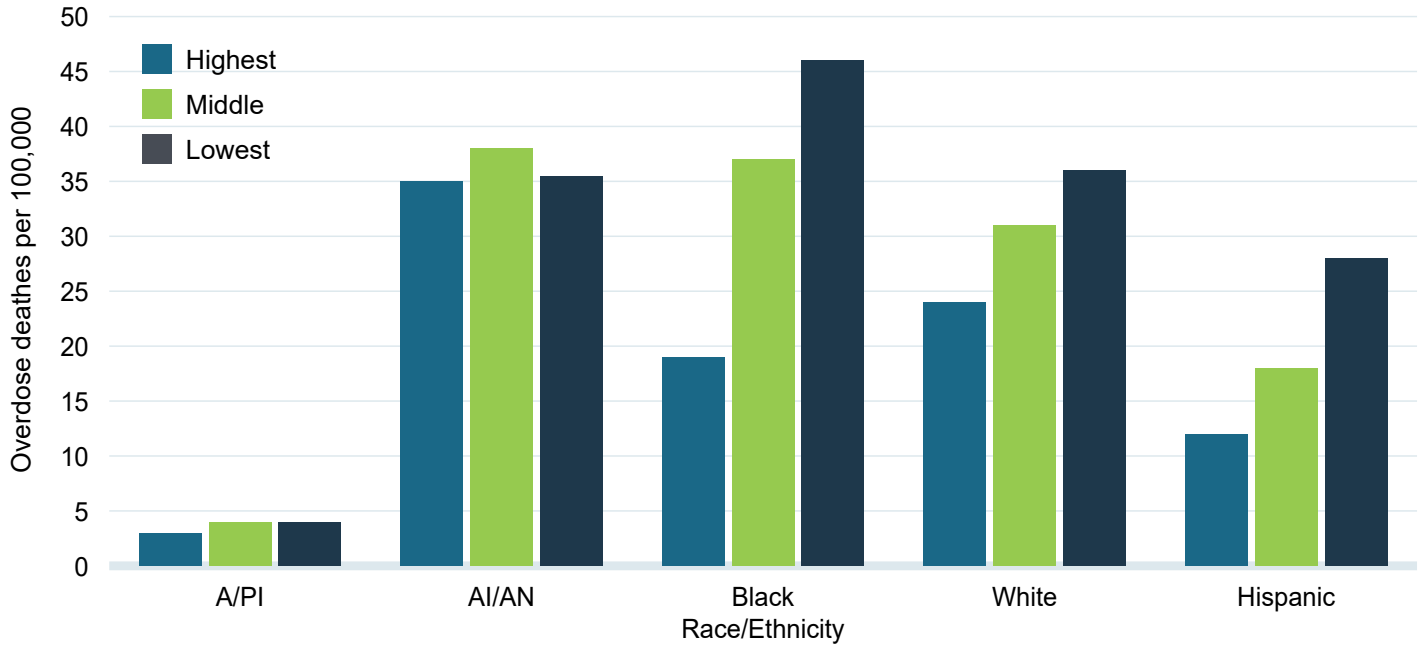
For other racial, ethnic, and historically marginalized groups, it has been shown that racial discrimination is a major SDOH that elicits substantial and prolonged stress and negative affect, which are prevalent risk factors in the development of substance misuse (McCuistian et al, 2021). These authors found that racial, ethnic, and marginalized groups:

- Experience disparities in treatment access, with White individuals with SUD more likely to have access, insurance, and employment means (work release) to seek treatment at rates higher than Black/African American, Latin American/Hispanic, and Indigenous groups.
- Are 37% less likely to complete substance use treatment programs than White counterparts, which could be related to cultural, psychological, and socioeconomic factors that limit attendance and successful completion.

Inequities in SDOH have exacerbated health disparities in overdose rates, particularly among Black and AI/AN people. Kariisa et al. (2022) observed that disparities in overdose mortality rates are not fully explained by substance use patterns and might instead result from unequal access to substance use treatment services, socioeconomic inequities, and SDOH. Their findings included how additional obstacles faced by Black and AI/AN people when accessing substance use treatment, including the impacts of income inequality (e.g., housing instability, transportation access, and insurance status), long-standing mistrust in the health care system,

stigma, and bias contribute to treatment access barriers. They also noted that higher drug use has been reported in areas with more economic distress, which increases the risk for fatal overdose. 2020 overdose mortality rates increased with rising income inequality ratios (the ratio of household income in the 80th percentile to that in the 20th percentile) across most ethnic/racial groups, but Hispanic and Black persons were more affected (Figure 6).

Figure 6. Overdose Deaths by Level of Economic Distress



Source: Kariisa et al., 2022

James and Jordan (2018) explain that historically, substance misuse by people of color has been considered criminal rather than medical. They go on to state that Black overdose mortality not being discussed nationally is a way in which Black people are further marginalized. Other research has investigated how zoning practices, redlining, and divestment spawn barriers to an individual's recovery from substance misuse (Swan et al., 2021). Researchers determined that community-level SDOH factors, including income, rates of health insurance, and income inequality, were associated with long-term recovery from alcohol use disorder, especially for those in disadvantaged communities (Swan et al., 2021).

Methods and Evaluation

A selection of articles for subject relevance was limited to those from the United States published from 2018 to 2023. Removing duplicates resulted in 3,381 peer-reviewed journal articles and gray literature sources. The articles selected for relevance and content are included in the references.

Methods

The formative research for this resource consisted of a literature search and review of peer-reviewed and gray literature. A systematic search was done via PubMed and EBSCO databases and on the CDC, SAMHSA, and National Network to Eliminate Disparities in Behavioral Health websites. Search terms used included: inequity, racism, substance use disorder, substance abuse treatment[1], drug prevention, performance measures, data analysis, and evidence-based practices.

Evaluation Questions

What are prevention, early intervention, treatment, and recovery systems doing to improve equity and address the needs of groups that have been historically marginalized?

An analysis by Sahker et al. (2019) observed that while racial, ethnic, and sex differences in screening, brief intervention, and referral to treatment (SBIRT) outcomes exist, racial/ethnic differences within sex groups remain unclear. They attempted to quantify the differences within ethnicity/race and sex in alcohol and drug use after SBIRT screenings. The authors used health service data from four federally qualified health centers (FQHC) to assess the racial, ethnic, and sex differences in the impact of SBIRT screening on drug and alcohol use between visits. They deduced that SBIRT helps to address health services equity among male and Black groups. The authors suggested that public health policies should encourage universal substance use screening and interventions for underserved groups in clinical facilities.

The National Association of County and City Health Officials (NACCHO, n.d.) conducted a literature review on tools and resources on health equity in the response to drug overdose. They found that as well as race and ethnicity, more focus on health disparities across and within populations,

1 *Substance abuse treatment* was included as a search term because it is still common in the literature. However, the authors would like to recognize that it is no longer an appropriate term and the use of proper terms can reduce harmful stigma and negativity around SUD. For more information, see Words Matter: Preferred Language for Talking About Addiction.

including but not limited to sex- and gender-based, LGBTQI+, and immigrant populations, is warranted. The resources and tools listed below are a selection of those provided by NACCHO to help health departments consider root causes and the interconnected system of upstream inequities when addressing drug overdoses in their jurisdictions.

Programs & Interventions	Planning & Implementation	Outreach & Awareness
PolicyLink Health Equity: A guide developed to support health equity leaders seeking to transform public health institutions and embed health equity into their day-to-day practices	**National Overdose Prevention Network: Health Equity Tool**: Tool to organize organizational responses to health equity challenges	**Frameworks Institute: Equity:** Resource repository providing information on issues ranging from justice reform to residential segregation and health disparities
Local and Regional Government Alliance on Racial Equity: Tools & Resources: A resource outlining tools for racial equity that capture an overall approach to integrating racial equity into routine decision making	**ETR: Health Equity Framework**: Framework for promoting health equity designed for researchers and practitioners working across public health and the social sciences	**Advancing Health Equity: A Guide to Language, Narrative, and Concepts**: This guide was prepared by the American Medical Association and Association of American Medical Colleges

What strategies are grantees using to ensure a culturally diverse workforce in their programs?

One notable example of an organization committed to ensuring their staff acknowledges and understands the value of the diverse communities they serve comes from an article published in 2021 by the Pew Charitable Trusts. They interviewed officials from the Massachusetts Department of Public Health to discuss how culturally and linguistically effective care is a guiding principle in their work to prevent, assess, and treat opioid use disorder (OUD). The following outlines the strategies officials have implemented to best serve their communities:

> "Through federal State Opioid Response Grant dollars, we were able to put together a training on the "Two-Eyed Seeing Approach" for medication for OUD, which integrates Western medicine with tribal and Native American medicine, and on engaging tribal elders."
>
> *— Jen Miller, State Opioid Response program manager, Bureau of Substance Addiction Services, Boston, Massachusetts*

- Using the national culturally and linguistically appropriate services (CLAS) standards — principles developed by the U.S. Department of Health and Human Services that are intended to help eliminate health care disparities — as a performance management and quality improvement framework for designing services to be equitable and respectful of the diverse beliefs and needs of their communities.
- Realizing that they cannot provide culturally and linguistically effective services if their workforce is not: (a) representative of the folks they want to serve and (b) well-trained to serve diverse communities.
- Initiating the BACE (Black Addiction Counselor Education) and Latino Addiction Counselor Education programs to address the need for a more diverse substance use counselor workforce by providing flexible and affordable education required for licensure for people who identify as Hispanic or Latino; BACE is designed to be very similar, with its own curriculum focused specifically on unique cultural values and perspectives for Black and African individuals doing this work and getting services.
- Offering specific training on cultural humility through the Institute for New England Native American Studies for their workforce, community members, and providers while collaborating with Native American communities" (Pew, 2021).

To what extent could evidence-based practices (EBPs) and promising practices on equity be used to improve equity in the Substance Use Prevention, Treatment, and Recovery Services Block Grant program?

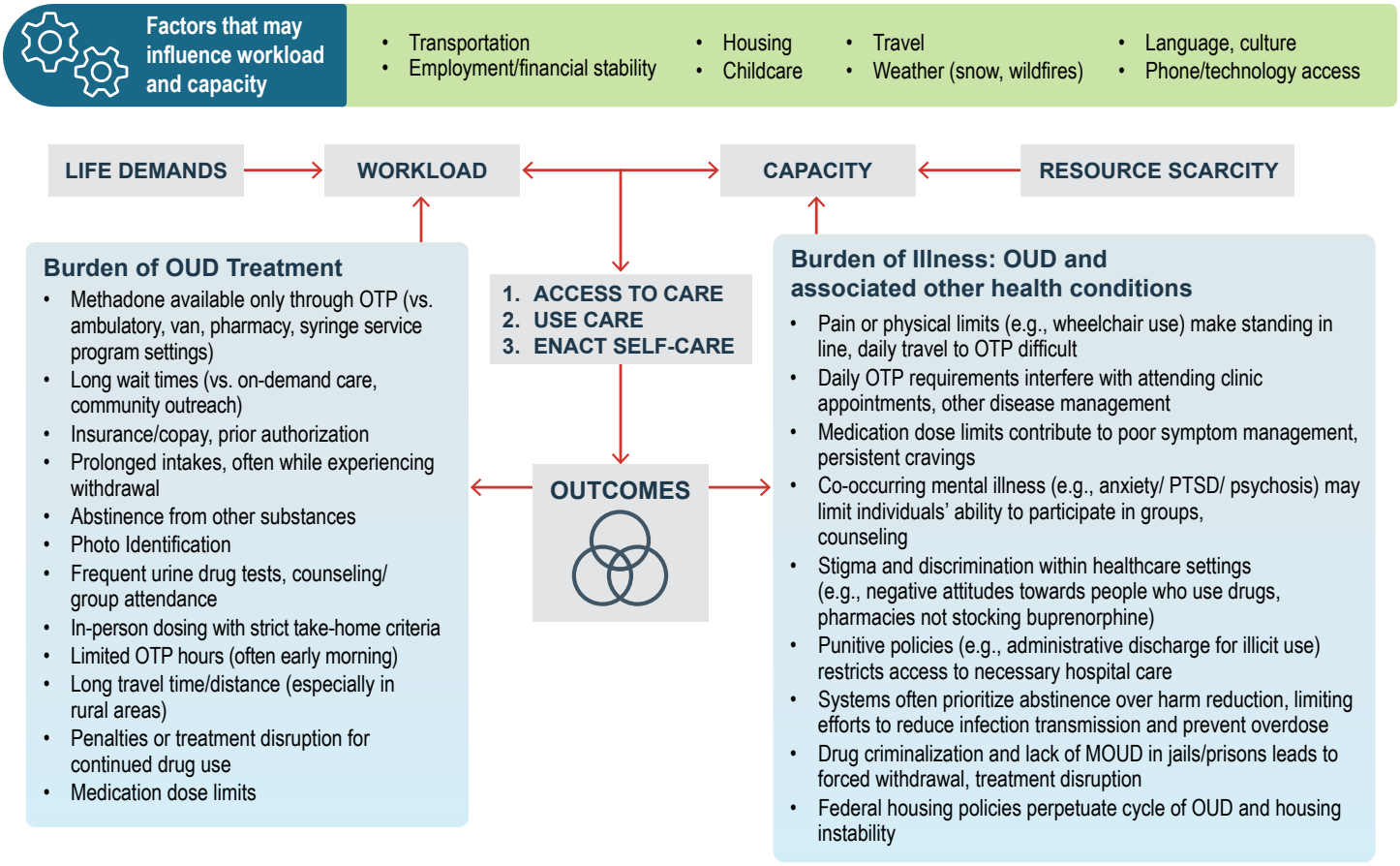
Which EBPs and promising practices (e.g., motivational interviewing, cognitive behavioral therapy, medication for opioid use disorders, solution-focused therapy, matrix model) for treating SUDs have demonstrated effectiveness?

There is no consensus on which evidence-based interventions or practices for treating SUDs are most effective among marginalized communities. However, there are several promising interventions worth consideration. A study by Venner et al. (2022) examined adaptation models to culturally tailor evidence-based interventions and used elements of community-based participatory research (CBPR). Utilizing Bernal and colleagues' (1995) Ecological Validity Framework, which has eight dimensions, the most common ways to culturally adapt interventions focused on language, content, context, and people. Efficacy trials with Hispanic or Latino

populations are emerging and revealed that Hispanic people and Latinos with greater cultural identity, parental familism, or discrimination at baseline improved significantly more with the culturally adapted evidence-based treatments compared to the treatments that were not culturally tailored.

Minimally disruptive medicine (MDM) is a framework that focuses on achieving patient goals while imposing the smallest possible burden on patients' lives. MDM recognizes the balance between patients' workload and capacity, allowing individualized consideration for patients' multiple health conditions, life demands, and available resources. Figure 7 highlights factors that may influence workload and capacity among people with OUD, highlighting how OUD treatment burden and illness burden interact and feed back to further affect both workload and capacity (Englander et al., 2023). There are other ways in which minimally disruptive OUD systems could lessen barriers. Some of these ways include using on-demand, no-wrong-door, real-time treatment. Systems can also revamp their policies and practices to facilitate shorter waiting times and decrease fragmentation in care.

Figure 7. Factors Influencing Workload and Capacity Among People with OUD

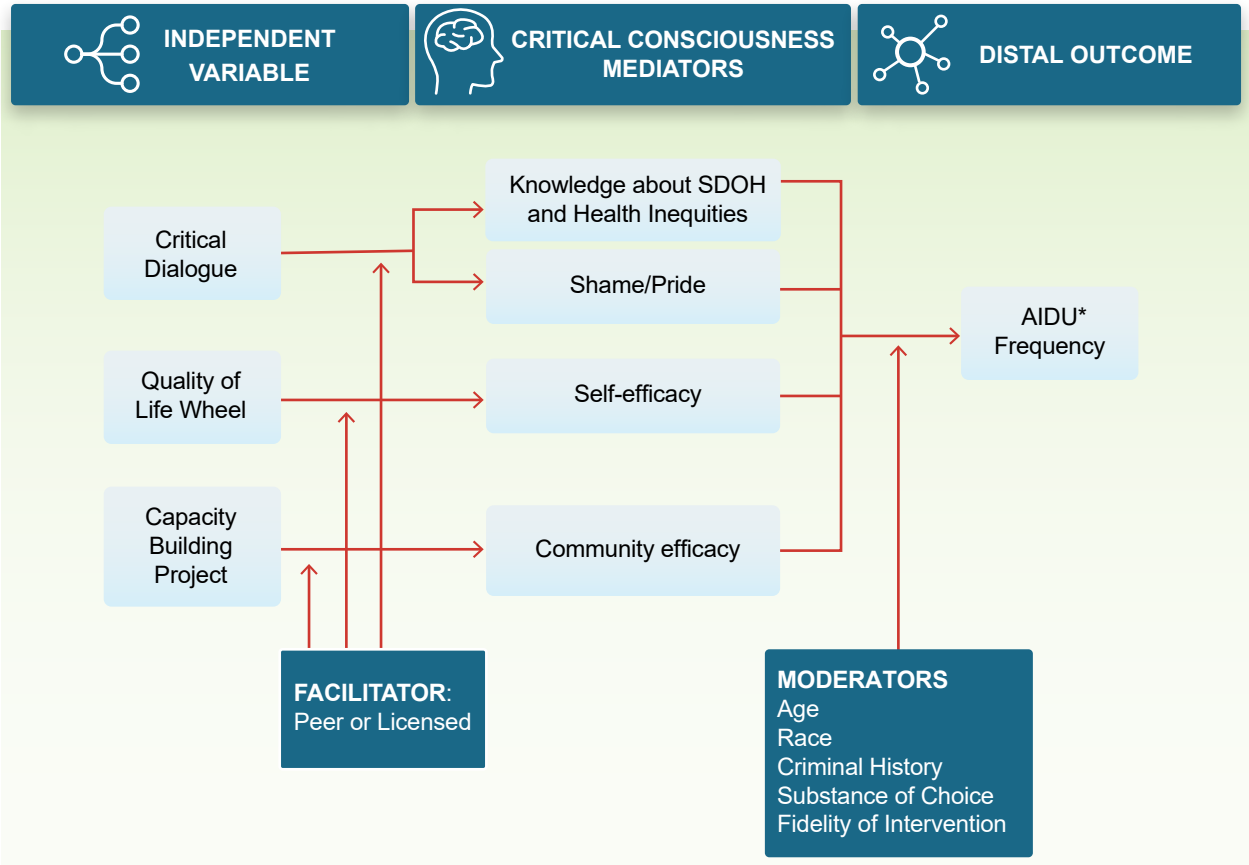


Source: Englander et al., 2023

Windsor and colleagues (2018) described the protocol of the first study using CBPR principles and multiphase optimization strategy to enhance a substance use intervention for a marginalized population. They reported on *Community Wise*, a multi-level behavioral health intervention conducted by the Newark Community Collaborative Board (NCCB). To create this intervention, NCCB partnered with service providers and residents of communities that had histories of incarceration and SUD. The goal was to lessen health inequalities related

to the use of illicit drugs and alcohol. Newark was selected because its residents consistently showed poorer health and socioeconomic outcomes compared to neighboring areas. *Community Wise* was envisioned as an efficient and effective model that could be replicated in the field and scaled up with high fidelity. Figure 8 displays the conceptual model developed collaboratively by the NCCB.

Figure 8. The NCCB *Community Wise* Conceptual Model



* Rates of alcohol and illicit drug use (AIDU)

Source: Windsor et al., 2018

Meredith and colleagues (2021) described data collected from the Medical University of South Carolina's *Just Say Know* program. This program is a research-based alcohol and drug prevention program developed by researchers specializing in the neuroscience of addiction and youth substance use. The program was structured and gave results as follows:

- The *Just Say Know* program was given to 1,594 middle and high school students and the facilitator engaged students in an interactive, hour-long session covering brain basics and effects of substance use.
- Students took an eight-item, pre- and post-knowledge test to gauge learning and answered questions about attitudes toward the program and substance use.
- Ninety-four percent of the students reported that the program gave helpful information, 92% said it might influence how they approach substance use, and 76% stated they would cut back or delay substance use. Test scores increased by 78%.

Findings give preliminary evidence that a neuroscience-informed, cost-effective group preventive program might delay or lessen future substance use by youth.

In addition to the programs and practices mentioned above, SAMHSA has established several resources grounded in evidence-based practice for improving outcomes for individuals with SUD. The Evidence-Based Practice Resource Center (EBPRC) provides clinicians, policymakers, and communities with tools for improving substance use prevention, treatment, and recovery. The EBPRC website is comprised of toolkits, protocols, guide books, practical guides, and advisories by searchable topic area. The guide on Adapting Evidence-Based Practices for Under-Resourced Populations was developed to provide readily accessible strategies on cultural adaptations of evidence-based practices to help expand access and close the gap of SUD-related health disparities (SAMHSA, 2022). The goal is to provide a comprehensive approach towards recognizing and disseminating expert consensus on the science of substance use. SAMHSA has also implemented Partnerships for Equity (PE) for under-resourced groups with the main objectives of identifying measurable impacts; engaging diverse points of view; raising awareness; and developing and implementing a framework of multi-sector partnerships.

Current PE groups and projects include the following, with plans to expand to LGBTQIA+ and Asian American/Native Hawaiian/Pacific Islander groups:

PE in African Americans: Supporting Historically Black Colleges and Universities (HBCU) leadership and students with technical assistance to expand their behavioral health services and programs and increased activity and representation with the White House HBCU Interagency Working Group.

PE in Hispanics/Latinos: Train-the-trainer toolkit to support Community Health Workers/Promotoras de Salud in creating an anti-stigma campaign, available in English, Spanish, and Portuguese.

PE in American Indians/Alaskan Natives: Developing mentorship programs with experienced AI/AN behavioral health practitioners and creating quality career exposure opportunities with our Indian Health Service (IHS) partners.

What data (e.g., performance measures, demographic characteristics) are currently being collected on equity in SUD treatment and recovery?

How is the data being used to improve SUD treatment and recovery equity among marginalized populations?

Based on systematic racism theory, a study (Entress, 2021) sought to examine the relationship between race and treatment for OUD and represented three distinct phases of the treatment process: source of referral to treatment, whether the treatment plan includes medications for OUD (MOUD), and reason for discharge. To that end, data from the 2013 and 2017 Treatment Episode Data Set (TEDS) Discharges were used. The author found that that minority status was associated with a lower likelihood of referral to treatment by a clinician. In addition, minorities had a lower likelihood of MOUD as part of a treatment plan (although in 2013, the opposite was the case), and were less likely to end treatment because the treatment was finished.

Additionally, Kilaru and team (2020) conducted an analysis of commercial insurance claims from October 2011 to September 2016 to investigate the incidence of follow-up treatment following emergency department discharge after nonfatal opioid overdose and patient characteristics associated with receipt of follow-up treatment. They found that while only 11 percent of patients received outpatient, inpatient, or prescriptions for buprenorphine, Black patients were half as likely to obtain treatment following overdose compared with non-Hispanic White patients, regardless of whether the overdose was due to heroin or prescription opioids. These results show that despite the growing numbers of overdoses due to the opioid epidemic, few people are receiving appropriate aftercare, with clear disparities based on race.

Mays and team (2017) investigated discrimination occurring in substance misuse service visits and examined associations between perceived discrimination in substance misuse visits with experiences of treatment. Their population was ethnically diverse adults. They used data from the California Quality of Life Surveys I–III and found support for their hypothesis that reports of discrimination by patients were associated with ending treatment prematurely and perceiving treatment to be unhelpful. Their results demonstrated that for Latinos, Hispanics, and Whites, occurrences of discrimination were associated with perceptions that treatment was not helpful. For Black participants, instances of discrimination were associated with ending treatment early. More importantly, their findings suggest that substance use treatment outcome disparities may be affected by discrimination in health care.

In an article on cultural competency and substance use treatment, the Pew Charitable Trust (2021) sought to identify the cultural needs of patients. Oanh Bui, the culturally and linguistically appropriate services (CLAS) program coordinator of the Office of Health Equity at the Massachusetts Department of

Public Health said: “If we can disaggregate the data to break it down by race, ethnicity, and language to see the inequities in treatment for different groups/communities, then we would better understand patient needs and allocate the resources accordingly” (Pew, 2021). The officials also mentioned using the Public Health Data Warehouse. This is a research tool that lets one access data from multiple years, and it has assisted in linking data sets from the health department to data sets from other state agencies. Thus, researchers have discovered and analyzed patterns of nonfatal and fatal opioid overdoses.

Alternative approaches may be required to conduct meaningful SUD research on marginalized groups, as evidenced by McCuistian and team (2021). The authors described a set of best practices such as ensuring measurement equivalence, minimizing the use of disputable research designs (e.g., race-comparison designs, combining racial/ethnic groups in the analyses) and utilizing randomization methods that result in the equal assignment of racial/ethnic minorities across treatment arms.

What are gaps in addressing the needs of marginalized populations and the collection of equity-related data, and how could they be filled?

While it is encouraging that conversations addressing disparities in SUD for marginalized groups are occurring, there are still major gaps that must be filled. For instance, paradigm shifts in treatment and recovery processes are needed to better care for underserved populations, specifically women and African Americans (Kruger et al., 2022). To be more efficient and equitable, recovery services and treatment modalities should change from being male centered and pathology oriented. In order to create effective social change in recovery, programs must address the social determinants of substance misuse, addictive behaviors, and underlying structural inequalities resulting from the intersection of racism, sexism, and classism (Kruger et al., 2022).

According to Hautala and colleagues (2019), understanding developmental patterns of SUDs in concert with what we already know about Indigenous adolescent substance use patterns will generate a more holistic epidemiologic profile (e.g., onset, regular use, misuse/dependence). This can help translate basic research science into effective community-based prevention, intervention, and treatment programs. AI/AN communities themselves are calling for novel approaches that embrace Native culture, traditions, knowledge, and values (Skewes et al., 2022). Regarding recommendations for interventions, cultural leaders strongly advocated focusing treatment on reclaiming Native identity and spirituality, which they contend will indirectly resolve SUD, as substance use is incompatible with traditional ways of life. They also reported that historical trauma has manifested in oppression within marginalized communities (i.e., lateral oppression) from community members who sabotage or thwart recovery efforts and that connecting with a "lodge" or spiritual family could help overcome this barrier (Skewes et, al., 2022).

Coulter and colleagues (2019) found few interventions for sexual and gender minority youth (SGMY) in peer-reviewed scientific literature regarding substance use. The scarcity of interventions is likely due to structural barriers such as the presence of anti-SGMY attitudes and policies and the historical lack of SGMY-affirmative school practices and funding directed toward SGMY health interventions. Authors believe that in order to advance the field of intervention science for SGMY more rapidly, researchers can engage in community-based research and use the existing literature to rigorously design, implement, and evaluate interventions to foster health equity for SGMY.

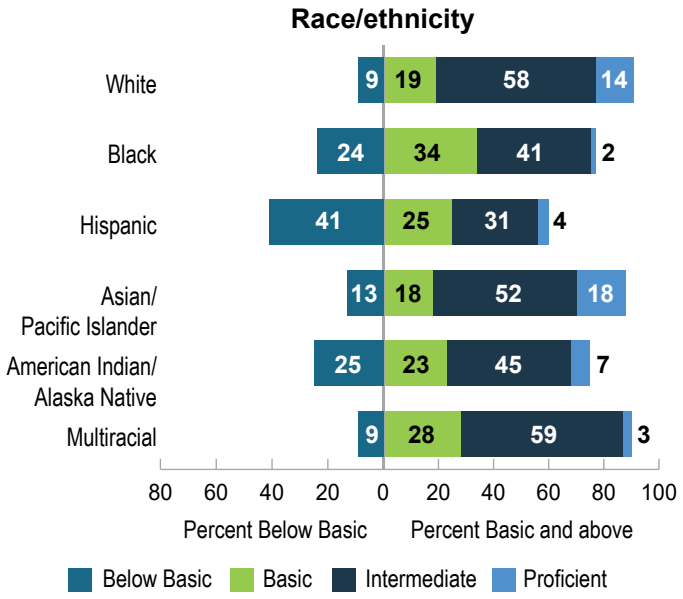
An exploration of an alcohol intervention approach for Hispanic and Latino heavy drinkers was done by Lee and colleagues (2021). Researchers discussed how policy interventions that combat structural racism and focus on increasing access to education and employment will help to minimize health disparities related to substance use. Further, understanding how structural barriers and structural racism impact health behavior can enrich the design and impact of interventions for socially disadvantaged Hispanic and Latino individuals.

What EBPs and promising practices for increasing SUD health literacy have demonstrated effectiveness in improving equity?

According to the CDC, (personal) health literacy is "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others" (CDC, 2023). Best practices build trust and further health equity. As of 2020, it was estimated that one third to one half of the U.S. adult population has low health literacy (Schillinger, 2020). Although low health literacy affects people across the spectrum of socio-demographics, it

disproportionally affects vulnerable populations, including people in lower socioeconomic groups, ethnic minorities, and those with limited English skills (Schillinger, 2020). The National Assessment of Adult Literacy (NAAL) 2003 was the first large-scale national assessment in the United States to contain a component designed specifically to measure health literacy. Results of the NAAL suggested significant differences in the distribution of health literacy skills by race and ethnicity, educational attainment, income, and language spoken before starting school (Kutner et al., 2006). Figure 9 shows the percentage of adults in each level of health literacy by race and ethnicity.

Figure 9. Adult Health Literacy by Race and Ethnicity



Source: Kutner et al., 2006

The U.S. Department of Health and Human Services published the National Action Plan to Improve Health Literacy in 2010 as a means to restructure the ways in which health information is created and disseminated. The report found that most of the evidence on interventions comes from simplifying and improving written materials, using video or other targeted approaches to patient education, and improving patient-provider communication. They also summarized approaches to improve health literacy, some of which are highlighted here:

- *Adopting User-Centered Design* — "Involving members of the target audience in the design and testing of communication products. This participatory design process results in improved outcomes, including those for people with limited health literacy."
- *Targeting and Tailoring Communication* — "Targeted approaches are adapted to meet the needs of specific groups of people, such as patients with limited literacy skills. Tailored programs and communication, on the other hand, are individually crafted based on the unique characteristics of each person" (Office of Disease Prevention, 2010, pg. 10-11).

Another example of efforts to improve health literacy was outlined by Green and team (2021). They formulated a study to improve understanding about the relationships between behavioral health literacy, stigma, and contact to inform efforts to increase public behavioral health literacy and decrease stigma. The stated goal was to explore how the structure of these relationships varied for different substance use. The authors postulated that stigma reduction efforts would be most successful when they match the level of literacy and prior contact with the condition.

STRATEGIES IN ACTION: Using Radio To Improve Health Literacy

"Radio Bilingue is the only Latino radio network in the United States, reaching out to listeners in nearly 80 communities across the country. The network features La Cultura Cura, a radio campaign that promotes health and wellness for Spanish-, Mixtec-, and Triqui-speaking farm workers and their families. Language and cultural barriers often keep this population from accessing health care and navigating the medical system. La Cultura Cura includes talk shows, feature news reports, educational messages, and mini radio dramas—all designed to create health behavior changes, community action, and public policy changes. An evaluation of a recent campaign found that 66 percent of listeners have discussed health programming with others."

— Office of Disease Prevention and Health Promotion, 2010

Key Findings

Demographics on Marginalized Populations and SUD

- Minoritized populations with SUD experience distinct use patterns and disparate rates of long-term health consequences, criminalization, and limited treatment access in comparison to Whites.
- Even though the rates of increase in opioid deaths from 2013 to 2018 have been rising steadily among Black people (43%) versus Whites (22%), the opioid epidemic is still conceptualized as a White epidemic.
- Data on AI/AN show that these populations have disproportionately high rates of SUDs, with an earlier age of onset.
- In comparison to heterosexual youth, sexual minority youth have significantly higher lifetime odds of substance use, with health disparities mainly due to stigma.

Grantee Treatment/Recovery Systems and Equity

- SBIRT has been shown to be useful at FQHCs in addressing health equity among Black populations.
- NACCHO has developed resources to aid health departments in bridging the gap in health equity for populations marginalized with regard to race, ethnicity, sex, and/or gender.
- Services that acknowledge diversity are being designed using national CLAS standards to provide a framework for performance management and quality improvement.
- Some state health departments are creating programs to face the need for more diversity among substance use counselors by providing specialized staff training on relevant cultural values.

Evidence-based and Promising Practices to Improve Equity in SUDs

- *Minimally disruptive medicine* is a framework that holds the promise of lowering barriers by using real-time, on-demand treatment initiation and ending practices and policies that contribute to long waiting times and disintegration of care.
- An innovative, multi-level intervention for behavioral health, *Community Wise* has the potential to lessen health inequalities related to illicit drug and alcohol use for communities that have histories of incarceration and SUD.
- The Medical University of South Carolina's *Just Say Know* neuroscience-based alcohol and drug prevention program shows promise in reducing future substance use by adolescents.

Research and Data Collection on Equity in SUDs

- Data sets such as TEDS Discharges have been used to examine the relationship between OUD treatment and race during the referral process, in treatment plans, and in discharge criteria.
- Findings from population surveys like the California Quality of Life Surveys I-III suggest that discrimination in health care may play a role in disparities in substance misuse treatment outcomes for groups that are marginalized.
- Best practices, such as ensuring measurement equivalence in SUD research design, will result in equal assignment of racial and ethnic minorities across treatment arms.

Evidence-based and Promising Practices on Health Literacy and SUD

- Results from the National Assessment of Adult Literacy 2003 suggested significant differences in health literacy by race and ethnicity, education, income, and native language.
- The National Action Plan to Improve Health Literacy 2020 designed methods to improve health literacy via interventions such as user-centered design to involve intended audience members and targeted and tailored communication based on specific population needs.
- Some researchers have formulated projects to improve understanding about relationships between behavioral health literacy and stigma.

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