UNDERSTANDING AND REDUCING INEQUITIES IN SUBSTANCE USE TREATMENT ACCESS AND UTILIZATION

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C-DIAS PSMG VIRTUAL GRAND ROUNDS

TUESDAY, 10/31/2023

1-2:30PM EST

POSITIONALITY STATEMENT

- Black, cisgender, heterosexual, female who immigrated from Jamaica, West Indies to the United States at the age of 13. Grew up in Cambridge, MA.
- Clinical Psychologist by training and PTSD + substance use disorder (SUD) treatment researcher with a focus on racial and ethnic minoritized populations (e.g., Black and Hispanic people).
- Thus, many of the examples described will focus on race and/or ethnicity.

DEFINING OUR TERMS

- Race, Ethnicity, Culture
- Intersectionality
- Health Disparities + Health Equity
- NIMHD Minority Health and Health Disparities Framework
- Social Determinants of Health Framework

DEFINITIONS: RACE, ETHNICITY, CULTURE

Race

1. **White** – person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
2. **Black** – person having origins in any of the Black racial groups of Africa
3. **American Indian or Alaska Native** – person having origins in any of the original peoples of North and South America (including Central American) and who maintain tribal affiliation or community attachment.
4. **Asian** – person having origins in original peoples of the Far East, Southeast Asia, or the Indian subcontinent.
5. **Native Hawaiian-Pacific Islander** – person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

US Office of Management and Budget (US OMB) Definitions

DEFINITIONS: RACE, ETHNICITY, CULTURE

- **Ethnicity**
  - **Hispanic or Latino** – people of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race
- US Census Bureau classifies people according to race and ethnicity (Hispanic or Latino vs. Not Hispanic or Latino)
  - E.g., Non-Hispanic Black or Hispanic Black or White
- **Culture**
  - Important concept: Broader than race/ethnicity.
  - "Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." (The United States Department of Health and Human Services Office of Minority Health)

INTERACTION BETWEEN RACE AND ETHNICITY AND OTHER SOCIAL IDENTITIES

- Beyond concerns about the limitations of the term race:
  - Important to tease apart the interactions between race/ethnicity and other aspects of social identities (e.g., sex/gender, sexual orientation, socioeconomic status, etc.)

INTERSECTIONALITY

- *"Multiple marginalized or disadvantaged social statuses (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual's lived experience to reflect interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, classism, colonialism, sexism, heterosexism, ableism etc.)."*

Source: Alvidrez, J., Greenwood, G. L., Johnson, T. L., & Parker, K. L. (2021). Intersectionality in Public Health Research: A View From the National Institutes of Health. *American journal of public health*, *111*(1), 95–97.

HEALTH DISPARITIES

- Differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific populations in the United States
- Types of differences in health outcomes that are closely linked with social, economic and environmental disadvantage
- These differences affect groups of people who have experienced greater obstacles to their health (linked to discrimination/exclusion) based on their social characteristics including gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation etc.

Sources: Braverman, P. (2014); USDHHS (2022), Healthy People 2030.

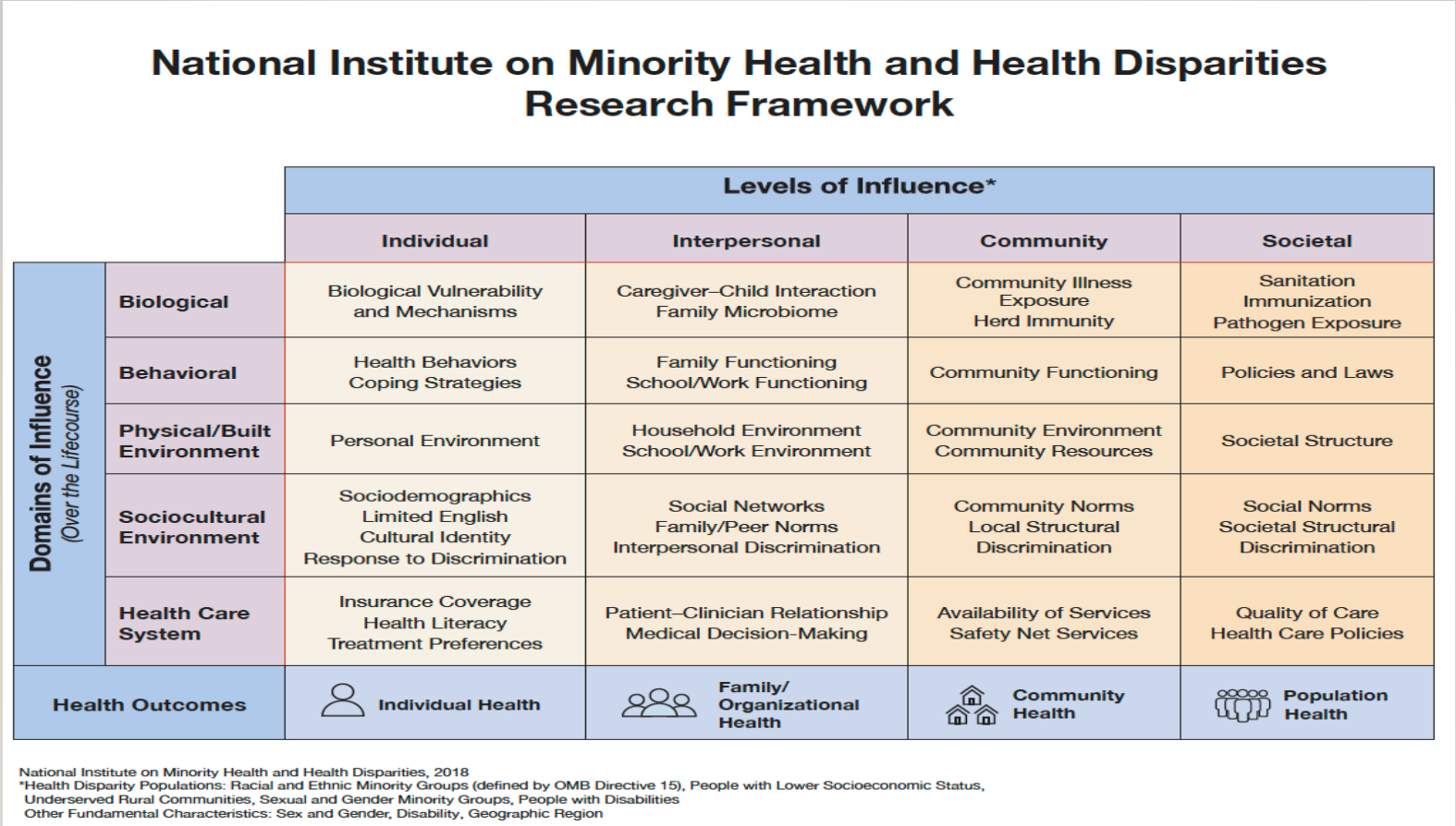
HEALTH EQUITY

Health equity is the attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities

Source: Braverman (2014); USDHHS (2022). Healthy People 2030. https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

NIMHD RESEARCH FRAMEWORK



National Institute on Minority Health and Health Disparities Research Framework

		Levels of Influence*			
		Individual	**Interpersonal**	**Community**	**Societal**
Domains of Influence *(Over the Lifecourse)*	**Biological**	Biological Vulnerability and Mechanisms	Caregiver–Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen Exposure
	Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
	Physical/Built Environment	Personal Environment	Household Environment School/Work Environment	Community Environment Community Resources	Societal Structure
	Sociocultural Environment	Sociodemographics Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Social Norms Societal Structural Discrimination
	Health Care System	Insurance Coverage Health Literacy Treatment Preferences	Patient–Clinician Relationship Medical Decision-Making	Availability of Services Safety Net Services	Quality of Care Health Care Policies
Health Outcomes		**Individual Health**	**Family/ Organizational Health**	**Community Health**	**Population Health**

National Institute on Minority Health and Health Disparities, 2018
*Health Disparity Populations: Racial and Ethnic Minority Groups (defined by OMB Directive 15), People with Lower Socioeconomic Status, Underserved Rural Communities, Sexual and Gender Minority Groups, People with Disabilities
Other Fundamental Characteristics: Sex and Gender, Disability, Geographic Region

Source: National Institute on Minority Health and Health Disparities. (2017). NIMHD *Research Framework*. https://nimhd.nih.gov/researchFramework

SOCIAL DETERMINANTS OF HEALTH (SDOH) FRAMEWORK

Source: U.S. Department of Health and Human Services. (2022). *Social Determinants of Health*. https://health.gov/healthypeople/priority-areas/social-determinants-health

RACIAL AND ETHNIC DISPARITIES IN SUBSTANCE USE DISORDERS (SUDS)

- Prevalence Rates of SUDs
- Consequences of SUDs
- Access to and Utilization of SUD Tx
- Efficacy/Effectiveness of SUD Tx (i.e., Treatment Outcomes)
- Clinical and Research Suggestions/Recommendations

PAST YEAR SUD DIAGNOSIS RACE AND ETHNICITY

In 2021, among persons aged 12 or older:

- American Indian or Alaska Native (27.6%) or Multiracial people (25.9%) were more likely to have a SUD than other racial and ethnic groups.

The rates for the other racial and ethnic groups were:

- Black or African American (17.2%)
- White (17%)
- Hispanic or Latino (15.7%)
- Native Hawaiian or Other Pacific Islander
- Asian (8.0%) – significantly lower than all other racial/ethnic groups.

SAMSHA.gov. Results from the 2021 National Survey on Drug Use and Health.

SOCIAL AND HEALTH CONSEQUENCES OF SU AND SUD VARY BY RACE/ETHNICITY

- Racial and ethnic minoritized populations are at ***greater risk*** for developing negative social, criminal justice, and health-related consequences related to their SUDs compared to their White counterparts:

- **Social and Criminal Justice Consequences**
  - Disproportionate rate of drug-related sentencing for NH Black/African-American people
  - Alcohol-attributed violence (e.g., IPV):
    - Native American people are at greater risk for alcohol-related trauma (e.g., IPV, rape, and assault) and alcohol-related deaths (accidents, suicide, and homicide) compared with all other racial and ethnic groups.

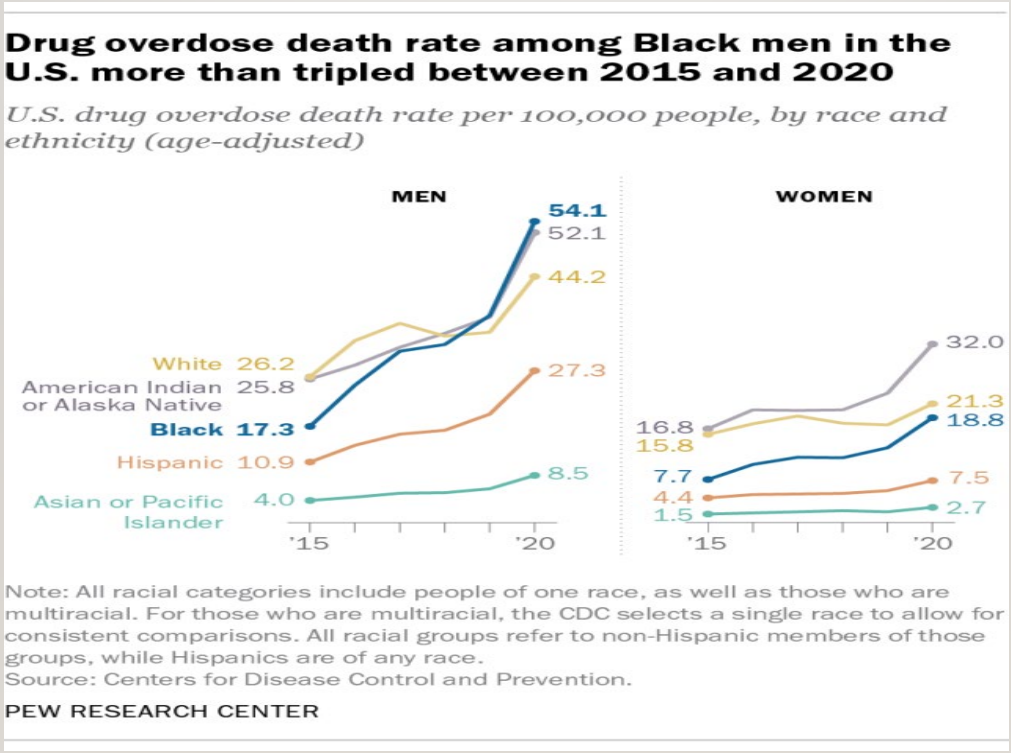
Sources: Chartier & Caetano (2010); Hinton et al. (2018); Keyes et al. (2012)

PUBLIC HEALTH AND SOCIAL CONSEQUENCES OF SUD VARY BY RACE/ETHNICITY

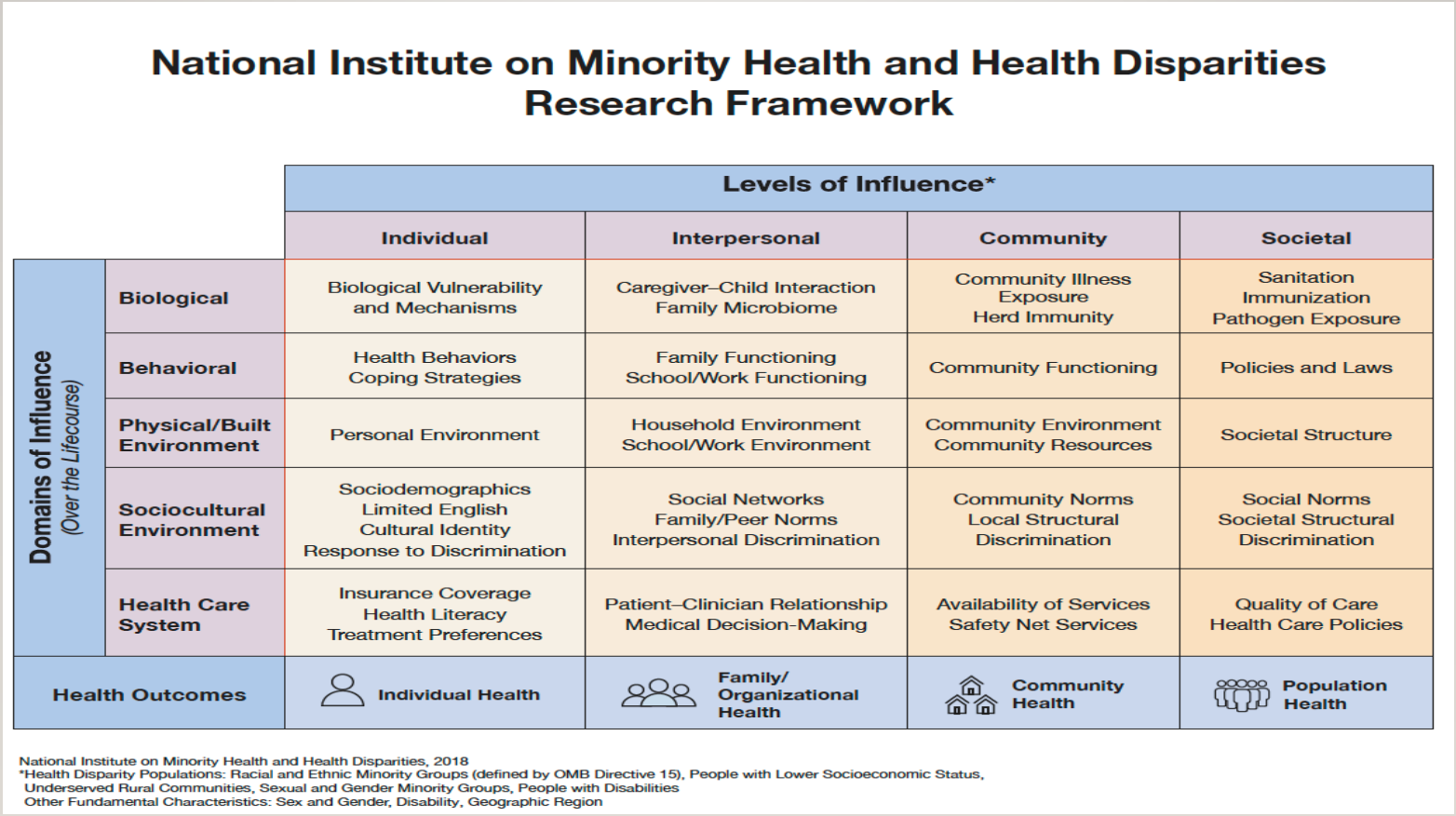
- **Health Consequences**
  - Black and Hispanic men are more likely to develop and die from smoking related diseases compared to NH White people.
  - Hispanic and Black men more likely to have report alcohol-related injuries and accidents and are more likely to develop alcohol-related liver disease compared to NH White people.
  - Rates of alcohol-related esophageal pancreatic cancers are higher for NH Black men than White men.
  - Use of alcohol and drugs are significant factors in the transmission of HIV because of frequent pairing with sexual activity.
    - Greater risk and exposure in racial and ethnic minoritized communities.

Sources: Chartier & Caetano (2010); Keyes et al.. (2012); Witbrodt et al., (2014); Zapolski et al., (2014;

OPIOID OVERDOSE EPIDEMIC



NIMHD RESEARCH FRAMEWORK



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TRAUMA AND STRESS

- ***Immigration Loss -*** immigration can be traumatic; loss of loved ones and extended networks; poor living conditions; trauma exposure en route to new country.
- ***Acculturative Stress –*** adaptation to new culture, language, and customs can be stressful.
- ***Socioeconomic Stress –*** often experienced by racial/ethnic minorities who feel disempowered because of inadequate financial resources and limited social class standing.
- ***Minority Stress*** – which refers to chronic stress that racial and ethnic minorities experience from ongoing racism and discrimination (debate in the field regarding whether we should consider these experiences trauma (i.e., racial trauma)

DATA ON ACCESS AND UTILIZATION

ACCESS TO AND UTILIZATION OF SUD TREATMENT

- Data from the 2021 National Survey on Drug Use and Health (NSDUH) revealed that among those (12 years and older) who needed treatment for past-year illicit drug use:
  - White people had higher rates of utilization at any type of treatment facility than Black people (23.5% versus 18.6%) (SAMHSA, 2021)
- Black and White adults were equally likely to access the emergency department (ED; which is often the front-line of care for many people with SUD; SAMHSA, 2021).

ACCESS TO AND UTILIZATION OF SUD TREATMENT

- Pooled data from the 2016 to 2018 National Hospital Ambulatory Medical Care Surveys showed that Black patients with SUD using the ED waited 35% longer for their care than White patients (Goldfarb et al., 2023)*
- After entering treatment, the 2014 US TEDS-D data suggests that Black people are more likely to drop out and less likely to complete a treatment episode than White people (Mennis et al., 2019).
- Consequently, Black people may suffer more mental and physical health burden from their SUD compared to their White counterpart.

Sources: Goldfarb et al. (2023); Mennis et al. (2019)

ACCESS TO MEDICATIONS FOR OUD (MOUD)

- Timely access to evidence-based medications for opioid use disorder (MOUD; methadone, buprenorphine, and naltrexone) is imperative to prevent overdose and death.
- Yet, disparities also persist in access to, imitation, and continuation of MOUD.

Sources: Dunphy et al., 2022; Stahler et al. 2021; Lagisettey et al.,2019; Farahmand et al., 2020

ACCESS TO MEDICATIONS FOR OUD (MOUD)

- Pooled data from Medicaid claims data from the years 2017-2019 showed that racial and ethnic minority groups (Black, AI/NA, Asian, Hawaiian/Pacific Islander) diagnosed with OUD were less likely to receive Bupenorphine and Vivitrol prescriptions compared to their White counterparts (Dunphy et al., 2022).
- Pooled data from the SAMSHA US TEDS-D data from 2015-2017, revealed that Black patients were less likely to receive MOUD than White Patients in residential treatment (Stahler et al., 2021)
- Poor racial and ethnic minority people may be more likely to receive Methadone, which requires higher levels of oversight and daily clinic visits which may exact an undue burden >> lower likelihood of tx completion (Farahmand et al., 2020; Hansen et al., 2013)

Sources: Barnett et al; 2023; Dunphy et al., 2022; Stahler et al. 2021; Lagisettey et al.,2019; Farahmand et al., 2020

DATA ON SUD TREATMENT OUTCOMES

SUD TREATMENT OUTCOMES FOR RACIAL ETHNIC MINORITIZED (REM) POPULATIONS

- Findings on differences in SUD treatment outcomes are mixed.
- Two meta-analyses, different conclusions:
  - One meta-analysis found race/ethnicity was not associated with changes in SU frequency after receiving CBT for SUD (Magill et al., 2019)
  - Another meta-analysis found that CBT for SUDs impact was stronger for NH White clients than for Black and Latino clients (Windsor et al., 2015)
- Data from 2015-2017 (n = 72,242), TEDS-D found Black clients improved less than White clients (Sahker et al., 2020).
- More research is needed in this area.

BARRIERS TO SUD TREATMENT

QUOTE

That's kind of like taboo. You know, we don't do that. We never did do that. If you look at the big picture—you look at your past, your history, where you come from—and you look at your future where the Whiteman's leading you, I guess you could make a choice: Where do I want to end up? And I guess a lot of people want to end up looking good to the Whiteman. Then it'd be a good thing to do: Go [to the] white psychiatrists in the Indian Health Service and say, "Rid me of my history, my past, and brainwash me forever so I can be like a Whiteman."

- —"Traveling Thunder" (cited in Gone (2007); p. 11)

Gone (2007) "We never was happy living like the Whiteman": Mental Health Disparities and Postcolonial Predicament in American Indian Communities.

BARRIERS TO TREATMENT FOR RACIAL + ETHNIC MINORITIZED PEOPLE (REMP)

INDIVIDUAL-LEVEL FACTORS (A FEW)

- Shame in asking for help
  - Traditional response might be to deny there is a problem or solve problem within the family.
  - May be a fear of "losing face"
- Fear of being stigmatized (public) and internalized stigma
  - Internalized negative views of those with SUD and receiving tx

SOURCE: Schmidt et al. (2009); Hussain et al., (2023); SAMSHA (2020).

BARRIERS TO TREATMENT FOR REMP
INDIVIDUAL-LEVEL FACTORS (A FEW)

- Mistrust of clinicians and physicians and MOUD
  - Given a history of and contemporary experiences of racism, discrimination, stereotyping etc.*
- Preference for non-medication treatments, traditional remedies and other culturally based forms of coping
  - Acupuncture, traditional herbal medicines
  - Religious healers etc.

Sources: Barnett et al., 2023; Hussain et al., 2021; Hall et al., 2022;

BARRIERS TO TREATMENT FOR REMP
INDIVIDUAL-LEVEL FACTORS (A FEW)

- Financial Barriers: Limited access to care because of limited or lack of health insurance coverage.*
- Limited awareness or knowledge of the kinds of SUD care available.
- Those with limited access to care are most likely to be recent immigrants, the uninsured, those who do not speak English

Sources: National Council for Mental Well-Being (2022); SAMSHA (2020);

BARRIERS TO TREATMENT FOR REMP *INTERPERSONAL/PROVIDER-LEVEL FACTORS (A FEW)*

- Provider biases (conscious or unconscious) that lead to:
  - Under-detection or misdiagnosis of mental health or SUD
  - Lack of confidence in working with underrepresented/REMP populations with SUD/OUD
  - Less effort exerted, misinterpretation of symptoms expressed by, and failure to communicate appropriately to REM people.
  - Lower likelihood of providing quality evidence-based care including screening, advice to quit, and or prescription for MOUD

Sources: Barnett et al., (2023); SAMSHA (2020); McGuire & Miranda (2008)

BARRIERS TO TREATMENT FOR REMP *COMMUNITY/SOCIAL LEVEL FACTORS (A FEW)*

- Live in geographic regions characterized by fewer addiction tx facilities, fewer and less well-trained providers.
- Characteristics of the available treatment (e.g., type of insurance accepted or not)
- Neighborhood disadvantage associated with service availability
- Involvement in the criminal justice system associated with fewer referrals to MOUD treatment.

Sources: Dunphy et al., 2022; Mennis et al., 2019; Stahler et al., 2021; Hollander et al., 2021)

SOLUTIONS?

What are some possible strategies to overcome barriers to access and utilization of treatment and improve treatment outcomes and health equity for REM populations with SUD?

ENHANCING EQUITY
SUD PROVIDER TREATMENT STRATEGIES

- **Cultural Competence** – knowledge and respect for different cultural perspectives as well as skills in cross-cultural situations
- **Cultural Humility** – being open and willing to learn from others, willingness to engage in self-exploration and critique; acknowledging and accepting differences.
- **Assessment**
  - Racial, Ethnic, and Religious Identification
  - Exposure to Prejudice and Discrimination
  - Immigration Status; Acculturation and Assimilation; Language
  - Income; Educational Attainment; Neighborhood; SES Status
  - i.e., SDOH
- **Develop a "holistic" treatment plan (see SAMSHA, 2020)**

Sources: Campbell & Alexander (2002).; Haeny, McCuistian, Ruglass, Burlew (2023; under review); SAMSHA (2020); Straussner (2001).

ENHANCING EQUITY SUD TREATMENT RECOMMENDATIONS

Interpersonal/Provider

- Racial/Ethnic Matching of Clients and Therapists
- Language Concordance between clients and therapists
- Multicultural Programs and Staff
- Cultural and Structural Competency training
- Implicit Bias training of staff members.

Straussner (2001); Campbell & Alexander (2002); Haeny, McCuistian, Ruglass, Burlew (2023; under review)

ENHANCING EQUITY
SUD TREATMENT RECOMMENDATIONS

- **Community/Societal Changes**
  - Reduce social determinants of health (SDOH)
  - Increase access to mental health and SUD treatment in REM communities
  - Embed peer recovery specialists in health systems who can serve as resources to the patients.
  - Expand options for telehealth services

Sources: Dunphy et al., (2022); Goldfarb et al., (2023); Husain et al. (2023); Stahler et al., (2021);

EQUITY IN SUD TREATMENT RECOMMENDATIONS

- **Community/Societal Changes**
  - **Workforce Development**
    - Invest in, recruit, and retain REM providers.
    - Expand providers who can prescribed MOUD in REM communities
    - Cultural Competence, Cultural Humility, Implicit Bias Training, Trauma-Informed Care.
  - **Policies**
    - Expand access to addiction programs
    - Invest in Health disparities and Health Equity Research

Sources: Dunphy et al., (2022); Goldfarb et al., (2023); Husain et al. (2023); Stahler et al., (2021)

EQUITY IN SUBSTANCE USE TREATMENT RESEARCH (A FEW)

- Recruit sufficient racial and ethnic minority participants
  - To permit meaningful effect size analyses
- Assess for Measurement Equivalence
  - The degree to which a measure assesses the underlying construct similarly across various groups.
  - Without measurement equivalence, inferences made regarding racial and ethnic differences or lack of differences may be flawed.

Sources: Burlew, Peteet et al. (2019); Burlew, McCuistian, & Szapocznik (2021); Ruglass et al. (2020)

EQUITY IN SUBSTANCE USE TREATMENT RESEARCH (A FEW)

- Consider the caveats of race comparison designs
- Consider within-race differences
- Consider the potential disadvantages of combining racial and ethnic groups into one group for analyses

Sources: Burlew, Peteet et al. (2019); Burlew, McCuistian et al. (2021)

EQUITY IN SUBSTANCE USE TREATMENT RESEARCH (A FEW)

- Conduct research on treatment issues disproportionately affecting racial and ethnic minority(REM) people
- Expand the pipeline and increase racial/ethnic investigators' access to research funding
  - Underrepresentation of racial and ethnic minority PhDs and in particular doing SU research. [Training programs]
  - Despite similarities in education, training, and experience REM investigators are significantly less likely to receive NIH funding. [Trainings for reviewers; Revisioning of the NIH grant review system?]

NEED MORE RESEARCH ON PROTECTIVE/RESILIENCE FACTORS

- Fewer studies on strengths and positive factors that promote resilience in the face of adversity.
- Large majority of REM people drink and use socially and do not develop problems.
- What might some of the protective factors be?
  - Individual Factors
  - Family Factors
  - Cultural Factors
  - Social Factors

DISCUSSION Q&A

- How are you examining health disparities/health equity in your clinical work or research?
- Considering the NIMHD framework: which domains/levels of influence are you examining?
- What are the clinical/research implications of your work in terms of enhancing health equity for REM populations?

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