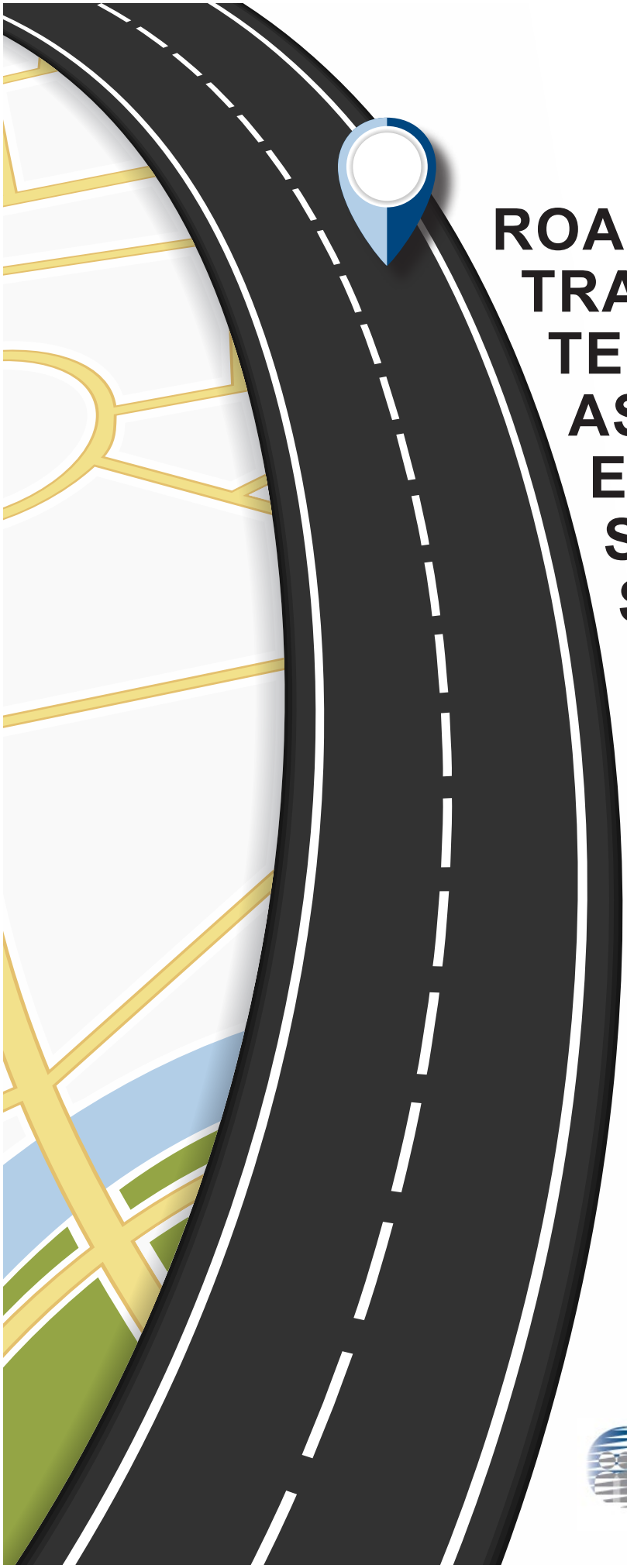

ROADMAP FOR TRAINING AND TECHNICAL ASSISTANCE EFFORTS IN SUBSTANCE USE SERVICE ADMINISTRATION

A journey to Culturally and Linguistically Appropriate Services (CLAS)

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

SAMHSA
Substance Abuse and Mental Health Services Administration

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ABOUT US

The ATTC CLAS Standards Workgroup is made up of members from the various Regional and National Centers across the ATTC Network. The workgroup was established to address a coordinated effort across the ATTC Network on the National Standards for Culturally and Linguistically Appropriate Services.

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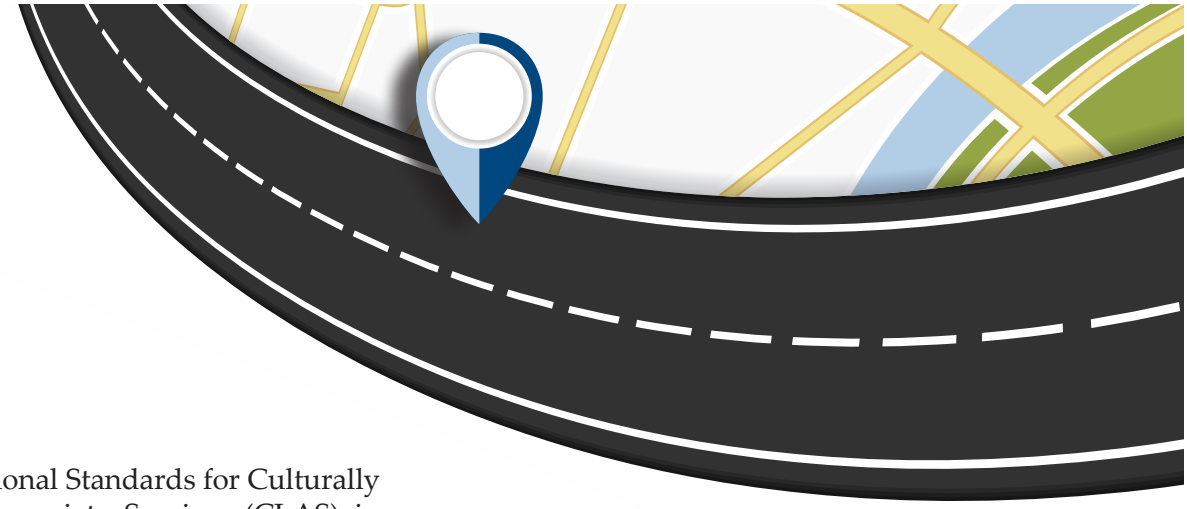


INTRODUCTION

The purpose of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care is to improve health quality. CLAS provides guidance to Health and Human Service (HHS) providers in the United States (US) to assist in developing a strategy to help eliminate health inequities, with the goal of individualized services to a diverse population. (https://www.thinkculturalhealth.hhs.gov/clas)

This white paper provides a roadmap for Addiction Technology Transfer Centers (ATTCs), funded by the Substance Abuse and Mental Health Service Administration through HHS, to guide our training and technical assistance efforts. This white paper, then, serves as a guide to support the work of the ATTCs.

Adherence to CLAS advances the health needs and preferences of the individuals served, with recognition that disparities in health and healthcare persist in the United States. These issues surrounding racial and ethnic health disparities are diverse and complex. The issues stem from many sources such as disparities in income, insurance coverage and usage rates, age and severity of conditions (Nelson, 2002). Most troubling is that racial and ethnic health disparities exist even when insurance status, income, age and severity of conditions are comparable (Nelson, 2002). For example, a study by Jacobson, Robinson, & Bluthenthal, (2007), found significantly lower outpatient addiction treatment completion rates among African Americans as compared to Whites. The authors attributed these lower outpatient completion rates to economic indicators such as employment, homelessness and Medicaid coverage (specifically Medi-Cal benefits) (Jacobson, et. al., 2007).

Today, the United States' health care system has still not achieved equity in health and healthcare, including the prevention, treatment and recovery from substance use disorders. Disparities not only occur within different races and ethnicities but can be viewed through socioeconomic status, age, location, gender, disability status and sexual orientation (Orgera & Artiga, 2018). According to Artiga, Foutz, Cornachione and Garfield (2016), more than 41% of nonelderly individuals now living in the US are people of color who face significant disparities in access to and utilization of care and as a result are more likely to delay or forgo needed care. It has been projected that people of color will make up over 50% of the US population in 2050 (Orgera & Artiga, 2018).

Racial and ethnic health disparities continue to occur across the life span and can potentially impact quality of care for the broader population over time. These disparities resulted in an estimated $93 billion in unnecessary medical costs and "$42 billion in lost productivity per year as well as economic losses due to premature death"(Orgera and Artiga, 2018). Further, the low representation of racial and ethnic minorities within healthcare professions complicates these disparities (Nelson, 2002).

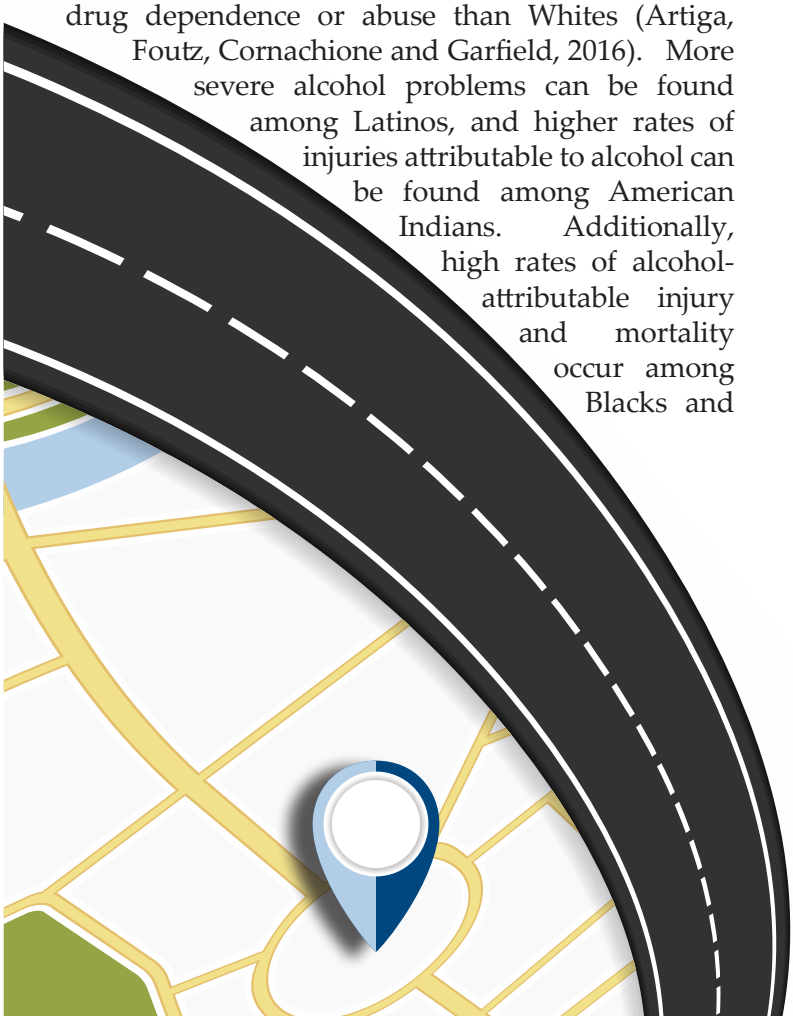
Anticipated demographic changes in the U.S. population over the next several decades magnify the importance of addressing racial and ethnic health disparities (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016).

In 2013, the Department of Health and Human Services updated the national standard for Culturally and Linguistically Appropriate Services (CLAS) which seek to ensure people receive appropriate care in all health care settings (Orgera & Artiga, 2018). This must include quality care for those individuals seeking assistance for substance use disorders (SUDs).

BACKGROUND

Minority groups, as addressed in this paper, are defined within the context of differences between individuals (Jones & Dovidio, 2018). This includes the objective inclusion of different individual identities as determied by surface, or outward characteristics (e.g., race, gender, age), or internal characteristics (e.g., culture, ethnicity, sexual orientation, religious or political beliefs, education level). The perception of diversity also includes social acceptance, as demonstrated through egalitarian behavior (e.g., shared decision-making), acknowledged by both the majority and minority within the unit and the inclusion of different perspectives and thought processes throughout all proceedings (Jones, & Dovidio, 2018; Jhutti-Johal, 2013; Roberge, & Van Dick, 2010). It is prudent to include "hard to reach" populations in this definition in an effort to broaden our definition of diverse and vulnerable populations.

Substance use problems and substance use disorders affect all populations, however there may be a disproportionate impact on minority populations and minority health. American Indians and Alaska Natives are more likely to report alcohol or illicit drug dependence or abuse than Whites (Artiga, Foutz, Cornachione and Garfield, 2016). More severe alcohol problems can be found among Latinos, and higher rates of injuries attributable to alcohol can be found among American Indians. Additionally, high rates of alcohol-attributable injury and mortality occur among Blacks and Latinos (Acevedo et al, 2018; Manuel et al., 2015). In sexual minority groups, disparities were most pronounced in young adulthood for gay/lesbian individuals and mid-adulthood for bisexual men, but bisexual women uniquely experience disparities across all ages (Schuler et al, 2018). Given the disproportionate negative impact of SUDs on racial/ethnic minority populations, it is critical that SUD treatment be equitable (Acevedo et al., 2018).



Recommendations to achieve health and health care equity for diverse populations includes (1) an increased effort to recognize non-conscious stereotyping and prejudice among health professionals toward diverse populations, (2) increased access to healthcare, (3) the use of linguistically and culturally appropriate assessment tools offered with language assistance as applicable, (4) effective policy change, (5) a diverse workforce, (6) improve efforts to conduct research with diverse populations, and (7) an increase in interprofessional collaboration to address SUDs.

RECOMMENDATIONS

1 Increase awareness and recognition of non-conscious stereotyping and prejudice toward racial and ethnic disparities in health care.

Stereotyping and prejudices can be linked to socio-economic factors and psychological processes. Over time these stereotypes and prejudices may become invisible to healthcare providers but nonetheless be conveyed through non-verbal behaviors, speech errors and avoidance behaviors. These actions can greatly impact diagnosis and treatment of minority patients. Therefore healthcare providers must engage in ongoing cultural competence training that includes instruction in the social psychology of stereotyping and prejudice (Stone & Moskowitz, 2011).

2 Encourage full consideration of access to care.

Full access to care includes access to treatment, recovery and prevention services. Timely SUD treatment should be made available to all racial/ethnic groups. Differences exist within geographic communities and community characteristics such as racial/ethnic composition, socioeconomic status, economy, and distance from treatment centers may influence the receipt of SUD treatment services (Acevedo et al., 2018). For example, although SUDs appear to be equally prevalent among Whites, Latinos and Blacks, there is a disproportionate impact

on minority groups such as higher rates of alcohol-attributable injury and mortality for Blacks and Latinos.

Significant barriers still exist in SUD treatment and ongoing research continues to identify new problematic areas. Professionals working with SUD treatment note an overall lack of treatment service options and recovery support services. These include a lack of technologic resources such as technologic support tools, which could improve access to care for rural and underserved communities, and a lack of recovery support services such as recovery housing. Leadership and collaboration are needed to break down barriers in the SUD field and professionals continue to need additional training, education and instruction in the use of evidence-based practices (Ashford, Brown & Curtis, 2018).

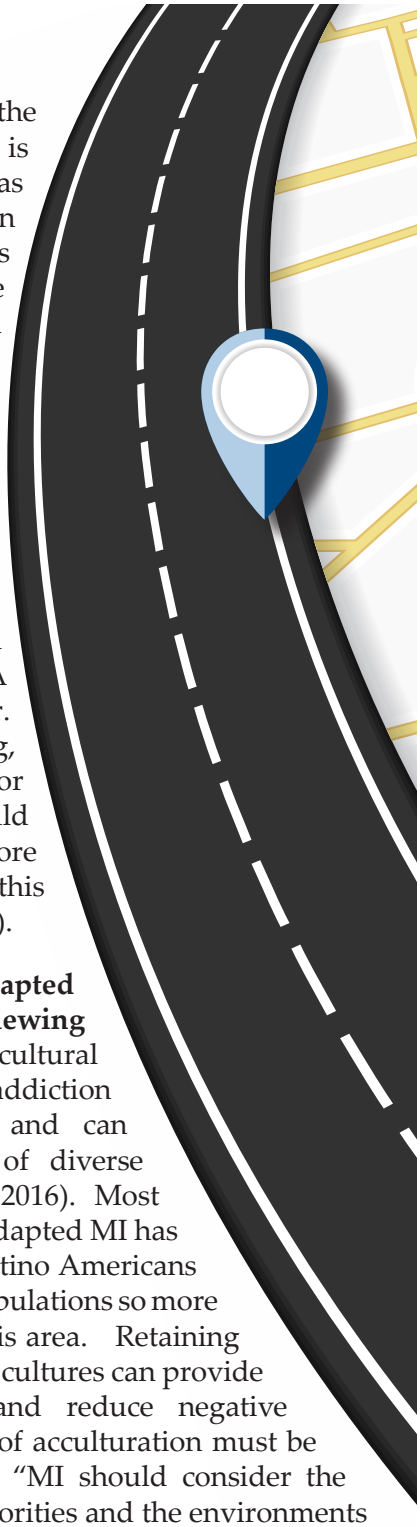
Providers should consider that patients' previous experiences accessing care services, or inability to access those services, may impact future expectations of access to care. Additional barriers like physical locality of the service center, hours and flexibility of services provided, safety of service area, lack of trust of service providers, and previously demonstrated lack of respect for diverse clients by a service organization, may inhibit engagement in needed services (Flanagan & Hancock, 2010).

Full access to care must also be considered within the context of integrated care. According to the SAMHSA-HRSA Center for Integrated Health Solutions:

> *People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care. The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs. (SAMHSA-HRSA, n.d.)*

3 Recommend development of culturally sensitive assessment tools.

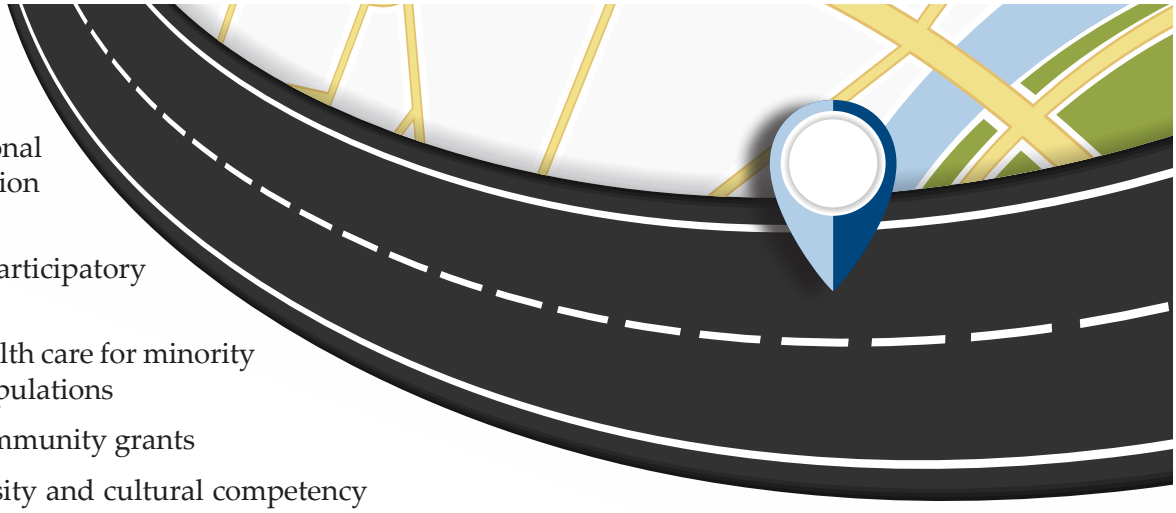
a. Adaptation of screening tools: The key to accurate identification of substance use problems in diverse populations is the use of appropriate screening tools. For example, the AUDIT screening tool is often recommended as a screening measure in primary care and has been examined for use in several racial and ethnic groups. Several other alcohol and drug screening measures are available for use in diverse populations and include the AUDIT-C, the ASSIST, the CAGE, the DAST-10, the NIAAA single-item screener and the NIDA single question screener. In addition to screening, cultural adaptations for brief intervention should be considered and more research is needed in this area (Manual et al., 2015).



b. Use of culturally adapted motivational interviewing (MI): The need for cultural adaptations in addiction treatment is growing and can help meet the needs of diverse populations (Oh & Lee, 2016). Most work in this culturally adapted MI has been conducted with Latino Americans and American Indian populations so more research is needed in this area. Retaining traditional and religious cultures can provide strength to patients and reduce negative outcomes so the effects of acculturation must be considered. In addition "MI should consider the lived experiences of minorities and the environments in which they reside" (Oh & Lee, 2016).

4 Policy change

The U.S. Department of Health and Human Services (HHS), Office of Minority Health and within the six HHS agencies, including the SAMHSA funded Addiction Technology Transfer Centers (ATTCs) have carried out programs and developed policies to reduce disparities in health and health care for minority populations. These activities have included:



- Leadership and coordination of national health disparities action plans
- Community-based participatory research
- Access to quality health care for minority and underserved populations
- Dissemination of community grants
- Increasing the diversity and cultural competency of the health and human services workforce
- Integration of research and establishment of networks that connect funded institutions, researchers, and the community
- Improving the participation of racial and ethnic minorities in chronic condition research studies
- Strengthening state leadership and supporting programs to improve the health and health care for vulnerable populations across the lifespan
- Expanding diverse language-based programs
- Improving data collection and reporting on health disparities at the national and state levels
- Increasing access to and implementation of health information technology
- Improving health literacy
- Providing technical assistance and professional training to underrepresented populations
- Building capacity to address gaps in services
- Implementation of the CLAS Standards

U.S. Department of Health and Human Services (HHS), Office of Minority Health (2018).

5 Diverse workforce

The low representation of racial and ethnic minorities within healthcare professions complicates these racial and ethnic disparities (Nelson, 2002). Demographic changes in the US population over the next several decades magnifies the importance of addressing racial and ethnic health disparities (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016).

According to Cohen, Gabriel, & Terrell (2002), increasing the racial and ethnic diversity of the health care workforce is essential for the adequate provision of culturally informed and appropriate care especially in light of the population changes to our nation's burgeoning minority communities. In fact, a diverse health care workforce will help to expand health care access for the underserved, and allows us to address the disparities and inequities that are prevalent within minority communities. The nation should aggressively pursue reform to our education system, especially as it relates to precollege education (Cohen, Gabriel, & Terrell, 2002). In fact, it is incumbent on the existing educational leadership to facilitate the recruitment, admission and retention of minority students into the health and behavioral health educational pipeline (Tienda, 2001).

6 Improve efforts to conduct research with diverse populations

Ongoing research is needed to gain further understanding of how diverse populations experience substance use and substance use disorders. Researchers must build diverse, cohesive research teams that are cognizant of the specific needs of the population being studied. Current research goals and methods may not be congruent with priorities or realities of the population being studied. There may be a great deal of fear of exploitation on the part of the population. Researchers should build a community partnership that is sustainable and fosters mutual benefit, respect, trust; promote successful recruitment, active participation, and retention of participants; include gatekeepers who understand community needs and traditions of the population. Gaining understanding of the beliefs, knowledge, practices and social context of the population being studied is imperative (Lindenberg, Solorzano, Vilaro & Westbrook, 2001).

Covey, as cited in Lindenberg et al, 2001, identifies three indispensable ingredients for effective interpersonal relationships important for community partnership building:

a. Think "win win," or mutual benefit. What are the special and sometimes differing needs as perceived by the individuals, families, community, and institutions?

b. "Listen first to understand, then to be understood." Take time to listen and learn what is foremost in the minds of individuals, families, and community groups. What are their values and beliefs, what are their concerns? How they are dealing with their concerns? What are their resources, abilities, and motivations?

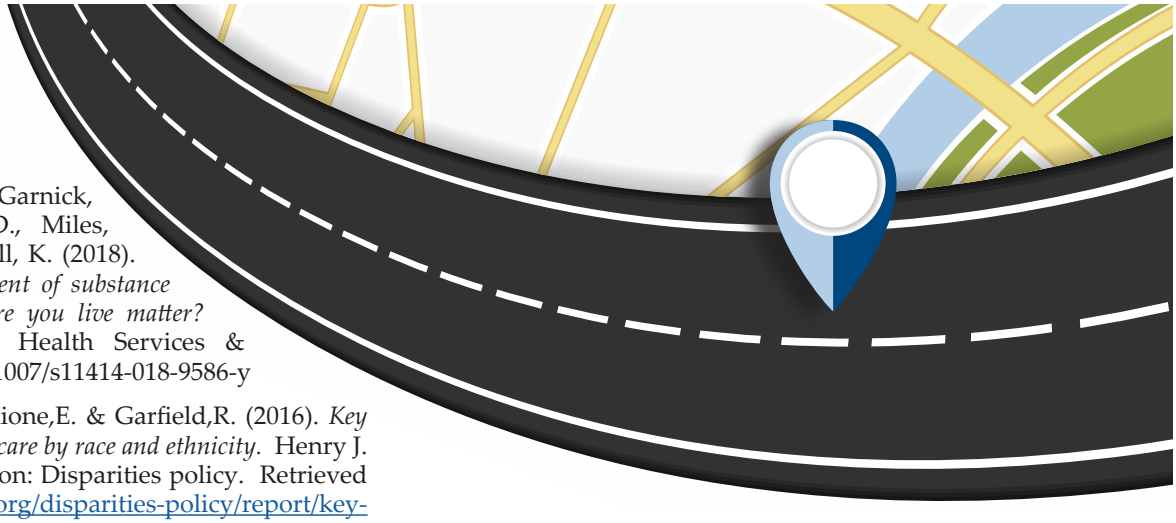
c. "Synergize." Work together as a team, celebrate differences, and use complementary talents and skills. (p. 134)

7 Increase efforts toward interprofessional collaboration in the prevention, treatment and recovery of SUDs

Healthcare providers should be encouraged to apply the Interprofessional Education Collaborative (IPEC) Core Competencies to work in the field of substance use disorders. An enhanced team approach to care for patients with SUDs can lead to high-quality, accessible, patient –centered care that will improve population health outcomes. The IPEC competencies provide an enabling framework for care providers and professionals from multiple disciplines to collaborate more effectively and creatively (IPEC, 2016).

The IPEC competencies encourage professions to develop and maintain a climate of mutual respect and shared values among disciplines; create awareness and acceptance of varied roles and responsibilities within multiple professions and embrace those differences to appropriately address the healthcare needs of diverse populations; communicate in a responsive and responsible manner that supports a team approach to care for those with SUDs; and apply team dynamics to plan, deliver and evaluate population-centered care and population health programs and policies that are safe, timely efficient, effective and equitable (IPEC, 2016).

As interprofessional colleagues grow in their collaborative efforts to improve treatment, prevention and recovery for patients with SUDs, they will begin to attain transdisciplinarity in the field. Addiction is a complex problem. It cannot be defined and understood from any one perspective. Achieving transdisciplinarity in the area of SUDs will blur the boundaries between disciplines, create new conceptual and theoretical frameworks and new methodological approaches that will trigger a deeper understanding of SUDs. This interprofessional call to action asks that we challenge old ideas and generate new questions and solutions for increased advocacy, policy change, funding opportunities, research and evidence-based practice in the area of substance use disorders.



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RESOURCE

Improving Cultural Competency for Behavioral Health Professionals. *A free and accredited e-learning program available through Health and Human Services, Office of Minority Health (OMH), written to develop knowledge and skills related to culturally and linguistically appropriate services (CLAS).* https://www.thinkculturalhealth.hhs.gov/education/behavioral-health