Understanding and Challenging Barriers to Substance Use Treatment When Counseling People of Color

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Presenter Information

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U.S., HHS, Administration on Children, Youth and Families, Family and Youth Services Bureau, Family Violence Prevention and Services Program:

Special Issue Resource Center Dedicated to Addressing the Intersection of Domestic Violence, Trauma, Substance Use, and Mental Health

- Comprehensive Array of Training and Technical Assistance Services and Resources
- Research and Evaluation
- Policy Development and Analysis
- Public Awareness
NCDVTMH is supported by Grant #90EV0437-01-00 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, Family Violence Prevention and Services Program (FVPSA), U.S. Department of Health and Human Services. Points of view in this document are those of the presenters and do not necessarily reflect the official positions or policies of the U.S. Department of Health and Human Services.
Our work is informed by...
Learning Objectives

As a result of this session, participants will be able to:

▪ Identify at least three unique risk factors or barriers faced by people of color

▪ Contextualize symptoms of substance use disorders as coping responses that aid in self-protection and survival for individuals impacted by structural and interpersonal violence

▪ Identify at least two strategies for cultural adaptation of evidence-based interventions
Contextualizing Substance Use Disorders for People of Color

Unique Risks and Barriers
Symptoms as Threat Responses
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HUMAN
Skills, education, self-efficacy, hopefulness, personal values.

SOCIAL
Family, intimate relationships, kinship, social supports.

PHYSICAL
Physical health, safe housing, basic needs, financial resources.

COMMUNITY
Anti-stigma, recovery role models, peer-led support groups.

Recovery Capital
(White & Cloud, 2008)
Unique Risks and Barriers: Collective Trauma

- **Collective Trauma** (National Indigenous Women’s Resource Center & NCDVTMH, 2014)
  - Cultural, historical, political, and economic trauma that impacts individuals and communities across generations

- **Racial trauma**
  - Discrimination is a salient risk factor for substance use disorders (Otiniano Verissimo et al., 2014; Gibbons et al., 2010)
  - Allostatic load – cumulative burden of chronic stress and life events (Suvarna et al., 2020; Berger & Sarnyai, 2015)

- **Migration trauma**
  - 4-points of trauma potential: pre-migration, during transit, arrival, settlement (Perez Foster, 2001)
  - Acculturation correlated with increased substance use concerns (Ahmmad & Adkins, 2020; German et al., 2009; Martinez, 2006)
Unique Risks and Barriers: Adverse Childhood Experiences

Image source: [www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html](http://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html) accessed 6/3/19
Unique Risks and Barriers: Structural Violence

- High recognition of need for services but limited access (Wells et al., 2001)
  - Increased wait times (Grant, 1997; Redmond et al., 2020)
- Experiences of discrimination and maltreatment by treatment staff (Wells et al., 2001)
  - Decreased satisfaction with services (Tonigan, 2003)
- Reduced treatment access, engagement, retention, and satisfaction with care (Schmidt et al., 2006)
Unique Risks and Barriers: Structural Violence (cont.)

Economic disenfranchisement

- Barriers to employment and reduced income access (Petry, 2003)
- Insurance coverage
  - Disproportionate barriers even when insurance status is controlled. One national analysis found that uninsured white individuals accessed specialty SUD treatment 3x more than uninsured people of color (Wu et al., 2003)
- Treatment deserts
  - Also tend to be food deserts, pharmacy deserts, lack educational and economic opportunities, etc.
  - Counties with higher proportions of Black residents and residents who were uninsured were also found to have less treatment programs that accepted public insurance or were publicly-funded (Cummings et al., 2014)
Unique Pathways to Treatment Drive Health Disparities

- Disproportionate criminal legal system involvement contributes to health disparities (Iguchi et al., 2005)

- Black and Latinx youth (N = 4,733), as compared to white counterparts, were found to be significantly more likely to (Shillington & Clapp, 2003):
  - Be referred to treatment via criminal legal system
  - Be mandated to treatment ( >67% vs. ~50% )
  - Use cannabis (and not use drugs intravenously)
  - Be released from treatment with an “unsatisfactory” status
Power Threat Meaning Framework

(Johnstone & Boyle, 2018)
Intersectionality: Race and Gender

A systematic review by Redmond et al. (2019) of Black women’s treatment barriers found themes of:

- Economic disenfranchisement
- Family support
- Discrimination by staff
- Lack of trauma-informed and trauma-care services
Intersectionality: Gender-Based Violence to Prison Pipeline

Key findings from The Sexual Abuse to Prison Pipeline report:

- Girls are one of the fastest growing populations under correctional control
- Disproportionately impacts girls of color
- Largely due to effects of trauma (substance use)
- 45% of girls in juvenile legal systems have 5+ ACEs
Intimate Partner Violence: Substance Use and Mental Health Effects

Victimization by an intimate partner increases one’s risk for depression, PTSD, substance use and suicidality

- PTSD, Major depressive disorder, Self-harm: 3x
- Suicide attempts: 4x
- Substance use disorder: 6x

High rates of DV among women accessing substance use disorder treatment

- Report DV in their lifetime: 47%-90%
- Report DV in the past year: 31%-67%

References:
Wagner et al., 2009; Bennett et al., 1994; Hemsing et al., 2015; Smith et. al., 2012; Ogle et al., 2003; Eby, 2004; LaFlair, et al., 2012; Bueller et al., 2014; Nuttrock et al., 2014; Nathanson et al., 2012; Lipsky et al., 2008; Breiding et al., 2014; Bonomi et al., 2009; Gonzalez, et al., 2014; Khalifeh, et al., 2015; Friedman et al., 2007
SUD as a Tactic of Abuse: Substance Use Coercion

DV is often targeted toward undermining a partner’s substance use disorder treatment and recovery

60% of the 3,224 National Domestic Violence Hotline callers who had sought help for substance use said their partners had tried to prevent or discourage them from getting help.

26% Had used substances to reduce the pain of DV.

27% Had been pressured or forced to use substances or made to use more than they wanted.

24% Were afraid to call the police because their partner said they would be arrested or not believed.

38% Said their partner had threatened to report their substance use to authorities to prevent them from getting something they wanted or needed (e.g. protection order or custody of their children).

n = 3,224
NCDVTMH & NDVH
Warshaw et al., 2014
Trauma increases the risk of developing a substance use disorder, while a substance use disorder increases an individual’s risk for being targeted by an abusive partner.

**Stigma** associated with substance use contributes to the effectiveness of abusive tactics and can create barriers for survivors when they seek help. This is further amplified in the context of **structural violence**.
Interpersonal and Structural Violence

- Health
- Mental Health, Suicide
- Substance Use
- Intergenerational
- Interpersonal
- Economic

- Traumatic Effects of Abuse

- Ongoing Coercive Control

- Traumatic Legacies of Historical Trauma

- Ongoing Structural Violence

- Health & MH
- Economic
- Social
- Legal
- Cultural, Spiritual
- Environmental
- Transgenerational

- Undermining Sanity and Sobriety
- Undermining parent-child attachment
- Controlling Access to Resources

Policies and systems that perpetuate structural violence and discrimination
How can an Accessible, Culturally Responsive, and Trauma-Informed (ACRTI) approach help?

- Integrates accessibility as a fundamental goal
- Normalizes human responses to individual and collective trauma
- Offers a more holistic approach
- Nurtures empathic connections
- Fosters understanding of our own responses and their potential impact
- Recognizes the role of culture, social context, and structural violence, as well as sources of healing, resilience, and community
Culturally Specific Sources of Support, Healing, and Resilience

Yet despite these complex risks and barriers, some evidence suggests that people of color experience similar recovery outcomes at follow-up.

Points to culturally-specific sources of resilience and healing.

(Schmidt et al., 2006)
Culturally Specific Sources of Support, Healing, and Resilience

How can we include culturally-specific sources of health while avoiding cultural stereotyping and appropriation*?

* Cultural appropriation is: “the act of taking or using things from a culture that is not your own, especially without showing that you understand or respect this culture.”
(Cambridge Dictionary, 2021)
Pause -
please return in 5 min
Evidence-Based Practice (EBP) and Culturally Responsive Treatment

Highlighted Evidence
Culturally-Specific EBP’s
Cultural Adaptation of EBP’s
Barriers to Research Evidence

- Lack of diverse samples (Hall, 2001)
- History of abuse and exploitation of people of color in research
- Even with diverse samples, outcomes rarely reported by racial or ethnic identity
- Racial and ethnic identities categorized into broad categories
  - Homogenization
  - Assumptions about salient experiences or identities
- Potential for experimental research design methods to conflict with values and priorities of culturally specific group
Selection of EBP’s with Diverse Samples

- Seeking Safety: integrated treatment for SUD and PTSD
  - Meta-analysis by Lenz et al. (2016a; N = 1,997)

- Helping Women Recover and Beyond Trauma: gender responsive (for women) integrated treatment for SUD and trauma
  - Published research: [www.stephaniecovington.com/research-papers.php](http://www.stephaniecovington.com/research-papers.php)

- Cognitive-Behavioral Therapy (CBT) (Miller et al., 2016)
  - Relapse Prevention Therapy (77% POC in sample). Mindfulness-Based Relapse Prevention was found to be more effective for women of color than traditional relapse prevention (Witkiewitz et al., 2013).
  - Brief Marijuana Dependence Counseling (BMDC) (CBT/MET)
  - Matrix Model (CBT and family support); intensive outpatient for stimulant use d/o
Motivational Interviewing / Motivational Enhancement Therapy (MI/MET)

- Meta-analysis by Lenz et al. (2016b; N = 3,842)
- Adolescents - meta-analysis by Jensen et al. (2011; N = 5,471)
- ≥75% Black sample – literature review by Montgomery et al. (2011; Black n = 4,211)
- Meta-analysis by Hettema et al. (2005; 72 studies) found larger effect sizes for people of color
- Peer Support (PS) employed peer specialists to deliver brief MI in urban health clinic (after being screened during routine medical visit) (Bernstein et al., 2005; n = 1175; 86% POC; 46% experiencing homelessness)
- Recommendations for culturally adapted SBIRT (Manuel et al., 2015)
Selection of EBP’s with Diverse Samples: Youth

- Adolescent Community Reinforcement Approach (ACRA)
- Functional Family Therapy (FFT)
- Combined MET/CBT
- Multi-Dimensional Family Therapy (MDFT)
- Multi-Systemic Family Therapy (MSFT)
- Teen Marijuana Check-Up (TMCU)

Stoner (2018)
Culturally Specific Interventions: Youth

Meta-analysis by Steinka-Fry et al., 2017 (n = 424):

- Culturally sensitive interventions yielded statistically significant decrease in substance use
- Used group or individual and family formats
- Interventions included:
  - Culturally Accommodated Cognitive Behavioral Therapy (A-CBT)
  - Structural Ecosystem Therapy (SET) - Brief Strategic Family Therapy (BSFT)
  - Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA)
  - Multi-Dimensional Family Therapy (MDFT)
  - Adolescent Portable Therapy (APT)
  - Cherokee Talking Circle (CTC)
Culturally Specific Interventions: Adults

- Generally, culturally adapted EBP’s have been found more effective (medium effect size) when compared to unadapted EBP’s (Hall et al., 2016)
- Promising interventions:
  - Culturally Congruent Intervention for African Americans (CCIAA)
  - Promotora-Delivered Intervention (PDI) for Heavy Drinkers
  - Celebrating Families!/¡Celebrando Familias! (CF)
  - Motivational Interviewing and Community Reinforcement Approach (MICRA)
  - Culturally Adapted Motivational Interviewing (MI)
  - Drum-Assisted Recovery Therapy for Native Americans (DARTNA), which incorporates the Medicine Wheel and Twelve Steps Program (MWTSP)
  - Boston Consortium Model (BCM)

Stoner (2018); Amaro et al. (2005)
Methods in Evidence-Based Adaptation

Image source: https://nationallatinonetwork.org/exploring-community-evidence/what-is-community-centered-ebp
Main Reasons for Cultural Adaptation

1. Ineffective clinical engagement
2. Unique risk or resilience factors
3. Unique symptoms of a common disorder
4. Nonsignificant intervention efficacy for a particular subcultural group

(Castro et al. 2010)
Heuristic Framework

Engagement

- Awareness of treatment availability
- Entry into treatment
- Participation in treatment activities
- Completion of treatment

Outcomes

Action theory
- Common mediator (supportive parenting)

Conceptual theory
- Common outcome (depression)
- Unique outcome (immigration distress)

(unique mediators)

(Castro et al. 2010, fig. 1)
Cultural Adaptation: Top Down vs. Bottom Up Approaches

- **Top-Down**: an EBP that was developed for one group is modified for use with other groups.
- **Bottom-Up**: a practice that is developed within the perspectives, values, history, traditions, and realities of a group’s specific cultural context.

An example of a bottom-up approach, from SAMHSA’s TIP 59 (2014):

> “Ho’oponopono is a form of group therapy used by Native Hawaiians; it involves family members and is facilitated by a Kūpuna (elder). A qualitative study by Morelli and Fong (2000) of Ho’oponopono with pregnant or postpartum women with substance use disorders (primarily methamphetamine use disorder) reported high client satisfaction and positive outcomes (80 percent were abstinent 2 years after treatment).”
Cultural Adaptation: Surface vs. Deep Adaptations

- **Surface** structure adaptations: Changes in EBP’s materials or activities that address observable aspects of culture, e.g., language, music, foods, clothing, etc.

- **Deep** structure adaptations: Changes based on deeper cultural, social, historical, environmental, and psychological factors that influence health behaviors of population.

(Resnicow et al., 2000)
Figure 6-1


- Endorse group work to promote values of strong kinship and emphasis on community.
- Promote cohesiveness through closed group formats (same group members from start to finish).
- If feasible, limit group participation to African-American women to enhance safety and comfort.
- Use meditative, spiritual, and experiential exercises to build upon internal strengths.
- Use opening and closing rituals, including a termination ritual at the end of the group.
- Incorporate African ancestry and cultural practices.
- Adapt language to involve recovery in context of family and community.
- Adopt culturally specific content in treatment modules including themes surrounding relationships, spirituality, family, ethnic, and cultural identity.
- Draw upon African-American history as a foundation of recovery, using examples from the work of artists, writers, musicians, heroes, spiritual and political leaders, etc.

Cultural Accommodation Model for Substance Abuse Treatment

Burrow-Sanchez et al. (2011) fig. 1
### Culturally Accommodation Model for Substance Abuse Treatment (cont.)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-Theme</th>
<th>Accommodation Practice</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>• Parental involvement and support</td>
<td>Treatment</td>
<td>C*: Infused role-plays that included relevant family situations</td>
</tr>
<tr>
<td></td>
<td>• Family Dynamics and Values</td>
<td>Content and Delivery</td>
<td>D: Increased contact with parents/adolescents via phone calls, mailings and an initial parent meeting.</td>
</tr>
<tr>
<td></td>
<td>• Family Risk Factors</td>
<td>Delivery</td>
<td></td>
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Enhancing Effectiveness for Survivors of Intimate Partner Violence

Based on NCDVTMH’s systematic review, the following can enhance existing EBPs:

1. Psychoeducation about the causes and consequences of IPV, and their traumatic effects
2. Awareness of mental health and substance use coercion, and sabotaging of recovery efforts
3. Attention to ongoing safety
4. Cognitive and emotional coping skill development to address trauma-related symptoms and support goals
5. A focus on survivors’ strengths as well as cultural strengths on which they can draw

Warshaw et al., 2013 (NCDVTMH)
In Sum

- Individual and collective trauma are risk factors for SUDs
- People of color face unique risks and barriers due to legacies of historical trauma and ongoing structural violence
- Culturally specific sources of healing and resilience aid in recovery
- Culturally responsive services are associated with better outcomes
- We can support culturally responsive SUD treatment by:
  - Implementing an ACRTI approach
  - Addressing barriers to access and retention, including discrimination
  - Selecting interventions with demonstrated efficacy or culturally-specific promising practices
  - Integrating trauma-care (when desired)
  - Cultivating a diverse workforce that reflects communities served
  - Using evidence-based methods for culturally adapting interventions
  - Advocating for health and community based approaches to SUD
Creating Culturally Resonant, IPV- and Trauma-Informed Practices and Institutions

Transforming the Conditions that Perpetuate Violence
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More ways to connect

www.nationalcenterdvtraumamh.org/newsletter-sign-up/
Twitter: @ncdvtmh
Instagram: @ncdvtmh
Facebook: www.facebook.com/ncdvtmh
Resources for Mental Health and Substance Use Treatment and Recovery Support Providers

At the National Center on Domestic Violence Trauma & Mental Health (NCDVTMH), one of our priorities is to support collaboration between the domestic violence (DV) field and the mental health and substance use disorder treatment and recovery fields. Our work is designed to enhance system responses to survivors of intimate partner violence (IPV) who are experiencing the mental health and substance use-related effects of IPV and other lifetime trauma. A 2012 study conducted by NCDVTMH in partnership with the National Association of State Mental Health Program Directors (NASMHPD) found that the majority of states who participated had a strong interest in further coordination and/or training on these issues.

The information that follows is intended to support mental health and substance use disorder treatment and recovery support providers in their work with survivors of IPV and their children. You will find toolkits, best practice guidelines, webinars, research reviews, and policy briefs to help inform your practice. These can be found below under:

www.NationalCenterDVTraumaMH.org
COMMITTED TO SAFETY FOR ALL SURVIVORS:

GUIDANCE FOR DOMESTIC VIOLENCE PROGRAMS ON SUPPORTING SURVIVORS WHO USE SUBSTANCES

GABRIELA A. ZAPATA-ALMA, LCSW, CADC
Palm Card on Substance Use Coercion

When You Can Talk Privately

“People have shared with us that their (ex-)partner pressured them to use substances, use in ways that they didn’t want to, or used their substance use as a way to control them. Using substances is a common way to deal with physical and emotional pain. If you can relate to any of this, know that we’re here to help.”

Common Forms of Substance Use Coercion

- Introduction to or escalation of substance use
- Forced use or withdrawal
- Self-medicating to cope
- Sabotaging treatment access or recovery efforts
- Using stigma to isolate, discredit, or threaten
- Blaming abuse on use

Validate and Affirm

- None of this is your fault
- You deserve to be treated with dignity and respect, no matter what
- I believe you
- You are not alone

“Would it be helpful to talk about some safety strategies and resources?”

Safety Plan: Access and Recovery

Collaboratively Strategize:

- Safe communication (telehealth, phone, mail, etc.)
- Stalking risk and appointment schedule
- Staying connected to services if pressured by a (ex-)partner to leave
- Maintaining control of medication(s), including MAR/MAT
- Threats to disclose or subpoena protected health information
- Legal documents that enable a (ex-)partner or social contact to exert control over the person

National Domestic Violence Hotline: 1 (800) 799-SAFE and 1 (800) 787-3224 (TTY)
RAINN National Sexual Assault Hotline: 1 (800) 656-HOPE
StrongHearts Native Helpline: 1 (844) 7NATIVE
Love is Respect (for teenagers): 1 (866) 331-9474 and 1 (866) 331-8453 (TTY)
Coercion Related to Mental Health and Substance Use
In the Context of Intimate Partner Violence:
A Toolkit for Screening, Assessment, and Brief Counseling
In Primary Care and Behavioral Health Settings

Carole Warshaw, MD and Erin Tinson, MSW, LSW
March 2018

Tools for Transformation:
Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations
An Organizational Reflection Toolkit

Carole Warshaw, MD, Erin Tinson, MSW, LSW, and Cathy Cave
April 2018
SAVING LIVES:
Meeting the Needs of Intimate Partner Violence Survivors Who Use Opioids

RESEARCH AND POLICY BRIEF | MAY 2019

BY:
Heather Phillips, MA
Sally Schaeffer, MPH
Rachel White-Dorrain, JD
Carole Warshaw, MD

A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors

Carole Warshaw, MD
National Center on Domestic Violence, Trauma & Mental Health

Cris M. Sullivan, PhD
Echo A. Rivera, MA
Michigan State University

February 2013

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Thank You!
Question & Answer
References and Resources


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National American Indian & Alaska Native Addiction Technology Transfer Center
https://attcnetwork.org/centers/national-american-indian-and-alaska-native-attc/home

National Hispanic and Latino Addiction Technology Transfer Center
https://attcnetwork.org/centers/national-hispanic-and-latino-attc/home


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SAMHSA’s Resources Cultural Competence [www.samhsa.gov/section-223/cultural-competency/resources](http://www.samhsa.gov/section-223/cultural-competency/resources)
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Southeast Addiction Technology Transfer Center: “From Minority to Priority” [https://attcnetwork.org/counters/southeast-attc/minority-priority-0](https://attcnetwork.org/counters/southeast-attc/minority-priority-0)


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