VA | U.S. Department of Veterans Affairs

Cultural Competence and Integrated Care for Substance Use Disorders

The Best SUD Care Anywhere! Webinar Series

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The Panelists

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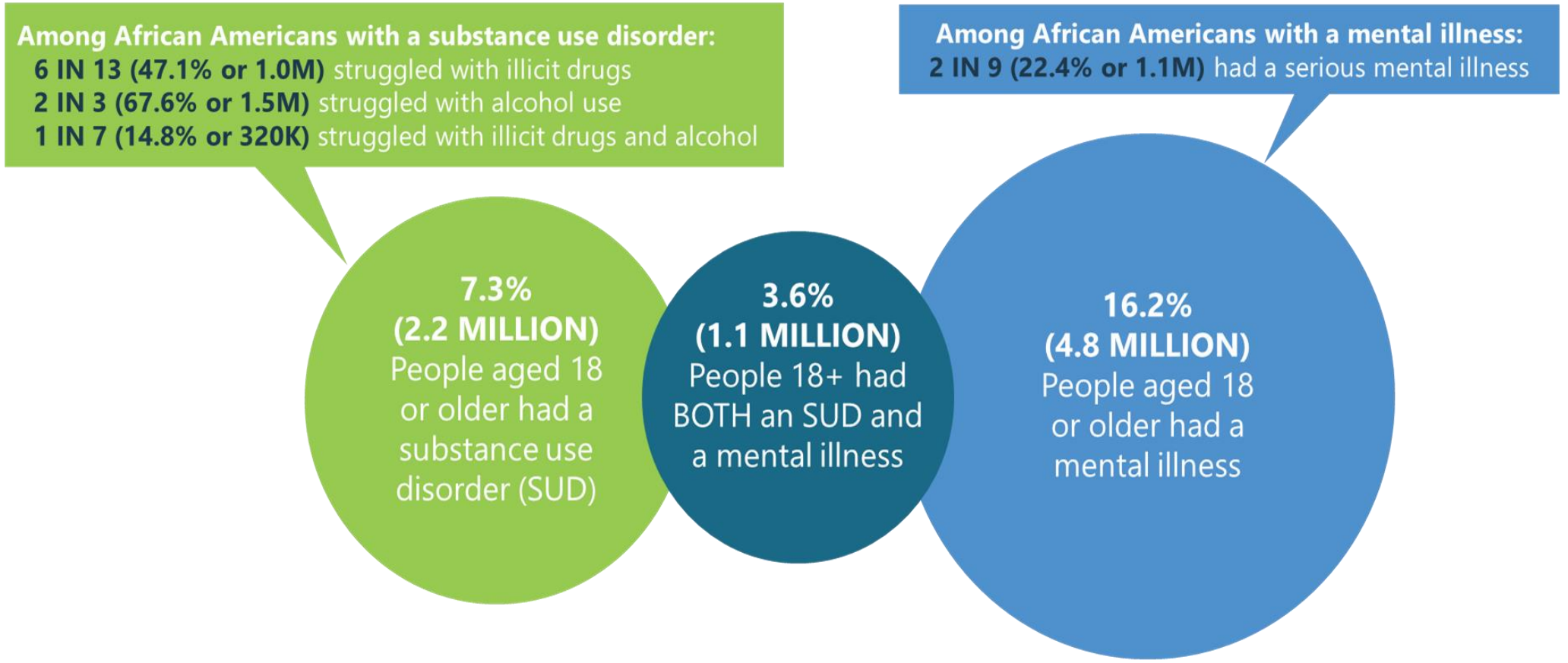
Webinar Objectives

After participating in this webinar, attendees will be able to:

- Define the concepts of systemic racism and cultural competence.
- Cite societal and SUD-specific evidence of harms wrought by systemic racism.
- Identify means to enhance practice and manage biases.
- Distinguish the physiological and mental health impacts of race-based stress

Mental Illness and Substance Use Disorders among African American Adults (>18 y.o.) (SAMHSA)

PAST YEAR, 2018 NSDUH, African American 18+



In 2018, **5.9M** African American adults had a mental and/or substance use disorder.

Context: The Climate

- **The COVID-19 pandemic**
  - Disparities in infection and death rates for Black/African Americans and Native Americans

- **Ongoing racial injustice:** Traumatic for many people of color, particularly Black/African Americans
  - Your co-workers, the Veterans you treat, your family, your friends, your community

- Each would be difficult enough separately, but **combined** have even greater effects

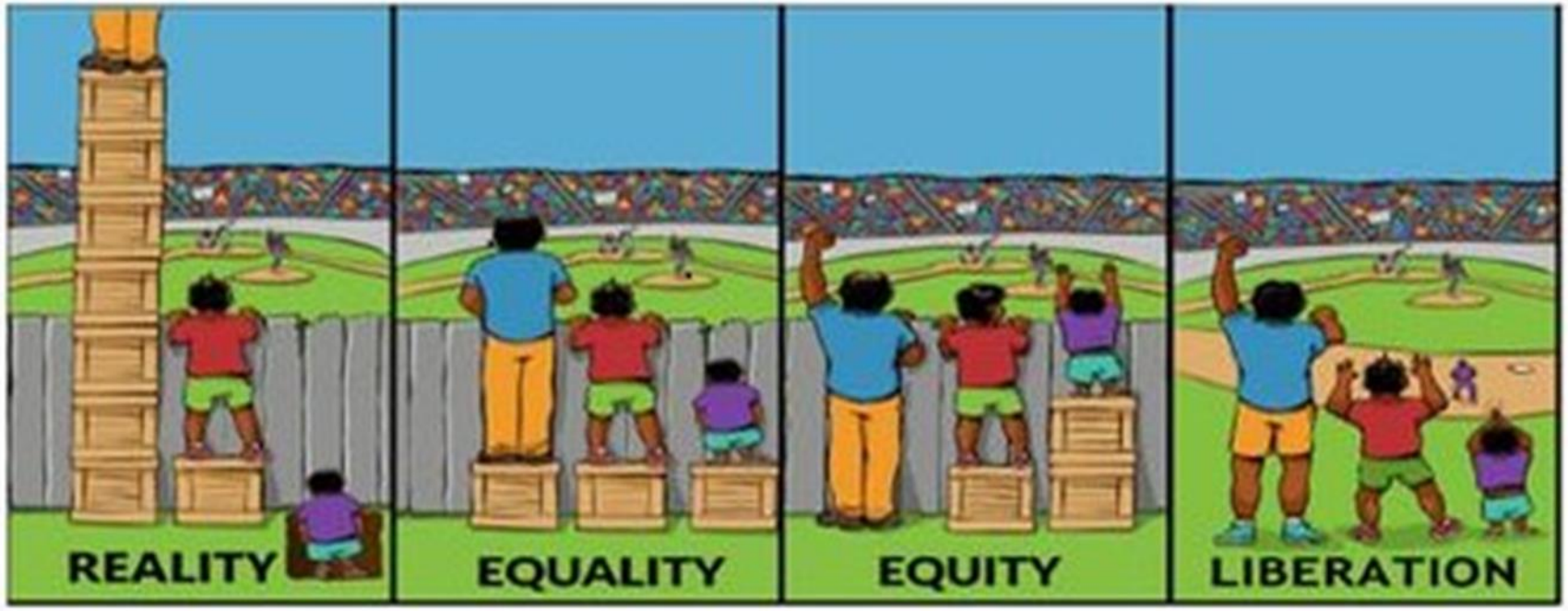
Cultural competence (National Center on Cultural Competence, 1998)

- Defined **values and principles**, and **demonstrate** behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Capacity to (1) **value diversity**, (2) conduct **self-assessment**, (3) manage the **dynamics of difference**, (4) acquire and **institutionalize cultural knowledge**, and (5) **adapt** to diversity and the cultural contexts of communities they serve.
- Incorporate the above **in all aspects** of policy-making, administration, practice and service delivery, systematically involve consumers, families and communities.

- Cultural competence is a **PROCESS**, not an end point to achieve.

Systemic Racism Video

In Today's Reality, Systemic Racism Exists



Let's empathize with our patients and

ACKNOWLEDGE SYSTEMIC RACISM EXISTS…

Treatment divide by race/ethnicity and payment

- Black and white adults have similar rates of opioid misuse (Lagisetty et al., 2019).
- Methadone maintenance treatment (MMT) and Buprenorphine maintenance treatment (BMT) are the treatment of choice for patients with opioid use disorder (OUD) (Manhapra et al., 2017).
- 13.4 million buprenorphine visits occurred between 2012-2015. Buprenorphine visits increased from 585,568 patients self-paying in 2004-2007 versus 5.3 million self-paying in 2012-2015. During this timeframe buprenorphine prescriptions were received more by white patients than other patients from different races/ethnicities (12.7 million vs. 363,000 prescriptions) (Lagisetty et al., 2019).

Treatment divide by race/ethnicity and payment (cont'd)

- Most common payment method—self-pay and private insurance. In this study, white patients and those with private insurance or use self-payment methods were the majority of those receiving buprenorphine treatment. This result is consistent with other researchers (Hansen et al., 2016, conducted a study in NY with similar results).
- The authors reported that in a Parran et al. (2017) study about 50% of physicians in Ohio accepted cash only for buprenorphine treatment.
- The current study outlined that accepting cash only payments may be commonplace and related to financial constraints for low income patients. In addition, "Black Patients had statistically significantly lower odds of receiving buprenorphine prescription at their visits…" (Lagisetty et al., 2019, p. 979).

Retention in treatment

- Previous studies found that there is a high early drop out rate with buprenorphine, nonetheless with longer follow-up, treatment engagement and retention in treatment is notable for some patients.
- In their current study of patient retention, specifically for patients with OUD in the VHA initiating buprenorphine treatment nationally, Manhapra and colleagues (2017) demonstrated that after one year almost two thirds of patients continued to be engaged in treatment and after three years almost one third of patients continued in treatment.

Retention in treatment (cont'd)

- The only demographic between group differences found were in black race… "sample who identified as black were substantially less likely to be among those retained for more than 3 years compared to the proportion in the 30 days or less group…" (p. 4) (Manhapra et al., 2017).
- "it was especially notable that few individual patient characteristics were associated with substantially more prolonged OAT retention with the exception of black race, overall medical severity indicated by the Charlson comorbidity index, and frequent emergency room visits during the first year of treatment, all of which were independently associated with a shorter duration of participation." (p.4) (Manhapra et al., 2017).

Treatment divide

- Black patients faced two obstacles—they were initiated on buprenorphine treatment less frequently and maintained in treatment for shorter timeframes when compared to other racial groups (Manhapra et al., 2017).
- A recent national study by Goedel and colleagues (2020) found “substantial inequities in capacity to provide methadone and buprenorphine along racial lines in the US…” p. 6. Methadone was prescribed more frequently in counties where Black and other non-White residents were unlikely to interact with White residents and buprenorphine was prescribed more frequently in counties where Whites were unlikely to interact with Black and other non-White residents.

Treatment divide (cont'd)

- The researchers also cited a separate 2016 VHA study by Manhapra and colleagues which outlined that Black patients were "less likely to receive buprenorphine than their White counterparts" p.7. This was attributed to differences in local medication assisted treatment availability (Goedel et al., 2020).
- Lastly, Hansen and colleagues (2016) conducted a study in New York city which demonstrated that while methadone treatment rates declined in 2011 and returned to previous rates in 2013, buprenorphine treatment rates increased. This was particularly notably in high income, predominantly White social areas while social areas with predominantly Black and other non-White residents had lower rates of buprenorphine treatment.
- Opioid overdose rates are rising, as a result, it is important that we address the racial/ethnic differences in treatment and access to care with research and policy changes (Lagisetty et al., 2019).

Disparities Impacting Care

- African Americans & Diversity: 13.3% of the US population
  - Immigrants from the Caribbean, African Nations, Central America and other countries
  - 27% live below poverty level
  - It is estimated that these data reflect roughly 2/3 of the AA population (lower SES, unemployed, or welfare recipients) and does not account for all
- Health Disparities: Similar rates of MH illness as general population
  - 1/3 receives MH care
  - Lower rates of MH outpatient service use including prescription treatment but higher rates of inpatient services
  - Rates of illicit drug use, slightly higher than national average (12.4% vs 10.2%). Rate of alcohol use slightly lower (44.2% vs 52.7%)
  - Rates of opioid OD less (6.6% vs 13.9%)

Disparities Impacting Care

- Compared with Whites, African Americans:
  - Less likely to receive care consistent with guidelines
  - More likely to use emergency department services
  - More likely to use primary care for MH services
  - Less frequent research participation
  - Higher rates of PTSD
  - More likely to be prescribed psychotropics at higher doses & less likely to be prescribed antidepressants compared to White Americans
- Other disparities affecting treatment:
  - Negative impact of institutional discrimination/racism, ongoing experiences, microaggressions
  - Criminalization of drug use
    - Discriminatory enforcement of drug laws/higher rates of arrests and incarceration
      - 264% more likely to be arrested for cannabis possession even though rates of use are the same as White Americans

Risk Factors Impacting Care

- Risk factors
  - Historically underserved/marginalized
  - Race-based stress/trauma (individual and intergenerational)
  - Adverse impact of stereotypes (i.e. expectations of rejection)
  - Inequity in education, health services, employment and housing opportunities
  - Living in high-stress environments
  - Degree of social supports

Barriers to Care

- Barriers
  - Mistrust of Medical and MH providers
    - Impact of discrimination on medical mistrust
    - History of experimentation
    - Perception of providers as not culturally competent or culturally sensitive
  - Fear of legal consequences
  - Provider
    - Cultural competency
    - Lack of providers from diverse ethnic/racial backgrounds
    - Understanding of values
    - Knowledge of historical and current cultural perspectives
    - Understanding/use of other supportive systems (i.e. spiritual, family, community)
  - Lack of community-based resources and tools

What Now? Treatment Considerations

- Beyond the medical model: Prevention/intervention strategies inclusive of:
  - Individual, family, community
  - Understanding function of:
    - Adaptive behavior patterns of substance use
    - Socio-political influences of substance use
    - Cultural implications of use (including cultural rituals of use)
  - Therapeutic process, interventions and goals adapted to worldview of AA client/patient
  - Therapeutic alliance/establishing trusting relationship
  - Guarded behaviors can be protective to avoid vulnerability to racism/discrimination
  - Culturally sensitive treatment materials
  - Drop out rates as clues: What are we missing?

Treatment Considerations (Cont'd)

- Culturally competent: discussing ethnic differences between patient/provider
- If referred/mandated, determine patient view of this
- Identify individual's expectations and worldview
- Egalitarian relationship (Patient is an expert on his/her life)
- Identify patient's responses to discrimination/racism in healthy/unhealthy ways.
- Also issues around racial identity
- Assess strengths and positive assets
- Determine what external factors might relate to presenting problem and involve supports as needed
- Assist in establishing realistic goals
- Discuss how historical and current events may be impacting the individual
- Whole Health/holistic approach

Assessments/Tools

- DSM-5 Cultural Formulation Interview
- Assessments for racial trauma
  - Trauma Symptoms of Discrimination Scale
- PHI

Personal Health Inventory

Use this circle to help you think about your whole health.

- All areas are important and connected.
- The body and mind have strong healing abilities.
- Improving one area can help other areas.
- The inner ring represents your values and aspirations. Your care focuses on you as a unique person.
- Mindful awareness is being tuned in and present.
- Your self-care and everyday choices make up the green circle.
- The next ring is professional care (tests, medications, supplements, surgeries, examinations, treatments, and counseling). This section includes complementary approaches like acupuncture and yoga.
- The outer ring includes the people and groups who make up your community.

Role of Cultural Identity

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

Source: Cultural Formulation Interview

Next Steps

- Whole Health
- Does your VA have a Diversity/Inclusion Team?
  - Generally or involved in behavioral health?
- Hiring and retention efforts
- Personal/professional commitment to learn and incorporate in practice
- Diversity as an important dimension of an assessment/intake appt

Resources

- Goedel, W., Shapiro, A., Cerda, M., Tsai, J., Hadland, S., & Marshall, B. (2020). Association of racial/ethnic segregation with treatment capacity for opioid use disorder in counties in the United States. *JAMA Network Open 3*(4), 1-10.
- Hansen, H., Siegel, C., Wanderling, J., & DiRocco, D. (2016). Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City. *Drug and Alcohol Dependence, 164*, 14-21
- Lagisetty, P., Ross, R., Bohnert, A., Clay, M., Maust, D. (2019). Buprenorphine treatment divide by race/ethnicity and payment. *JAMA Psychiatry 76(*9), 979-981.
- Manhapra, A., Petrakis, I., & Rosenheck, R. (2017). Three-year retention in buprenorphine treatment for opioid use disorder nationally in the veterans health administration. *The American Journal on Addictions*, *10*, 1-9.
- Manhapra, A., Quinones, L., Rosenheck, R. (2016). Characteristics of veterans receiving buprenorphine vs. methadone for opioid use disorder nationally in the Veterans Health Administration. *Drug Alcohol Depend*., *160*, 82-89.
- Parran, T.V., Muller, J.Z., Chernyak, E., Adelman, C., Delos Reyes, C.M., Rowland, D., and Kolganov, M. (2017). Access to and Payment for Office-Based Buprenorphine Treatment in Ohio, Substance Abuse: Research and Treatment, 11(1–6).
- Stevens, Patricia, and Robert L. Smith. *Substance Abuse Counseling: Theory and Practice*. Upper Saddle River, N.J.: Merrill Prentice Hall, 2018. Print.

Resources

- YouTube Video: https://youtu.be/YrHIQIO_bdQ
- Google Fences image: https://images.app.goo.gl/xh54VSAmmEhFrv9Z6
- SAMHSA: https://www.samhsa.gov/
- AATOD: http://www.aatod.org/
- ASAM: https://www.asam.org/
- 2018 National Survey on Drug Use and Health: African Americans: https://www.samhsa.gov/data/report/2018-nsduh-african-americans
- American Psychiatric Assn. Presidential Task Force to Address Structural Racism Throughout Psychiatry: https://www.psychiatry.org/psychiatrists/structural-racism-task-force
- Historically Black Colleges and Universities Center of Excellence in Behavioral Health: https://www.samhsa.gov/historically-black-colleges-universities-center-excellence-behavioral-health

- **OMHSP Discrimination, Bias and Equity Resources**

THANK YOU!

Your questions are welcomed!

Upcoming Webinars in the *Best SUD Care Anywhere!* Series

- 9/22/20: Effectiveness of AA in Recovery from SUD, Dr. Keith Humpheys presenting
- 11/24/20: Minimal Services Methadone Maintenance Treatment, Dr. Andrew Saxon presenting

Additional Webinars on Culturally Competent SUD care also are planned!

- 1/26/21: Patient-Treatment Matching in SUD Care, Dr. James McKay presenting
- 3/23/21: Twelve-Step Facilitation, Dr. Christine Timko presenting
- 5/25/21: Behavioral Couples Therapy, Dr. Elizabeth Epstein presenting
- 7/27/21: The VA/DoD Clinical Practice Guidelines for SUD Care, Presenters TBD
- 9/28/21: Treatment Planning in SUD Care, Dr. Jennifer Evans presenting
- 11/23/21: Motivational Enhancement Therapy, Dr. Jennifer Runnals presenting