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Culturally Modified Substance Use Disorder Approaches for Reducing Health Disparities

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Abstract

Black, Latinx, and Native American individuals face substantial health disparities in the experience and treatment of substance use disorders. Innovative culturally modified interventions have been developed to deal with these issues, and they are reviewed in this article. Among these promising approaches, studies involving Oxford House self-run recovery homes have been found to reduce health disparities among Black, Latinx, and Native American groups. More research is needed to identify the mechanisms facilitating successful recovery outcomes among those in recovery.

Keywords: Reduced Health Disparities; Culturally Modified Interventions; SUD; CBT

Abbreviations

SUD: Substance Use Disorder; AIM: Adults in the Making; CBT: Cognitive Behavioral Therapy.

Introduction

Culturally Modified Substance use Disorder Approaches for Reducing Health Disparities

In 2020, 15.4% of Black and 13.5% of Latinx individuals over 18 years old had a substance use disorder (SUD), which is comparable to rates among the White population [1]. Native Americans have higher SUD prevalence rates than any other ethnic or racial group and reduced access to SUD treatment [2,3]. In addition, Black, Latinx, and Native American individuals encountered more health disparities in SUD treatment than their White counterparts [4-11]. In this article, health disparities among Black, Latinx, and Native American individuals in SUD treatment are reviewed, along with several promising culturally modified interventions. We also describe a series of innovative studies involving those living in self-governed recovery homes called Oxford Houses.

Health Disparities among Black, Latinx, and Native American Individuals in the Experience and Treatment of SUDs

Black individuals report less alcohol use than White individuals but report higher levels of symptoms related to alcohol dependence and experience higher rates of alcohol-induced illnesses and injuries [11]. Additionally, Black individuals experience higher rates of premature death due to SUDs and display more substance-use-related impairment than White individuals [9]. In a study of adults using stimulants in rural areas, Black participants reported less availability, access, and acceptability of mental health and SUD treatment services and were less likely to seek treatment than White participants [6]. These studies indicate

that Black individuals experience and present substance use disorders differently than White individuals and are less likely to access treatment.

Latinx individuals also encounter SUD treatment health disparities. Even though their prevalence rates are similar to the general U.S. population, Alvarez, et al. [12] found that those who are Latinx are less likely to access SUD treatment, have poorer outcomes in treatment, face more challenges accessing treatment, and are more likely to drop out of treatment prematurely compared to White individuals. Other studies have also found that Latinx individuals underutilize treatment [13,14], regardless of the type of treatment [15]. Latinx individuals are significantly less likely to perceive a need for treatment, which may help explain their underutilization of treatment services [15].

Native American individuals also encounter health disparities in the experience and treatment of SUDs. Native American individuals have higher prevalence rates for SUDs than any other racial or ethnic group [2,3]. According to the Alaska Native Epidemiology Center [16] between 2012-2015, the rate of alcohol-related mortality rate was 9.9 times higher for Alaska Native individuals compared to White individuals living in Alaska. Native American individuals living on reservations face barriers when accessing SUD treatment, as both prevalence and poverty rates tend to be high [17]. Furthermore, poverty rates are high for Native American individuals living in urban areas [18,19]. Many Native American individuals have experienced historical traumas that have influenced substance misuse over generations, such as forced relocations and entry into boarding schools, discriminatory laws against spiritual practices, and broken treaties from the U.S. government [17,20].

Several studies have simultaneously examined different racial and ethnic groups. For example, Wells, et al. [10] found that Black and Latinx individuals experience more health disparities and face more barriers to healthcare than White individuals. Additionally, Mays, et al. [7] found that Black and Latinx individuals experience higher levels of discrimination in SUD treatment facilities than White individuals, and discrimination in these treatment centers is associated with feeling unsatisfied with the treatment that was received, and leaving treatment prematurely. Mennis, et al. [8] found that Black and Latinx individuals were less likely to complete treatment than White individuals; these disparities were most prevalent for Black individuals who used alcohol or methamphetamine and Latinx individuals who used heroin.

A review of epidemiological findings on alcohol-related health disparities found that Latino men experienced more alcohol-related problems than other ethnic or racial groups, and both Latino and Black men had higher rates of cirrhosis mortality than White men [3]. A study examining disparities among criminally justice involved individuals who were receiving SUD treatment found that Black and Latinx patients were at a higher risk of recidivism after beginning outpatient treatment than White patients, even when substance use, prior criminal history, sex, and socio-economic status were accounted for [21].

The authors suggest that Black and Latinx patients may benefit from additional treatment support to decrease criminal justice involvement. Another study that examined performance measures and disparities in SUD treatment found that Black and Native American individuals had significantly lower treatment engagement levels than White individuals [21]. Racial and ethnic minority groups may benefit from culturally tailored interventions rather than just Western biomedical SUD approaches [22].

Culturally Specific Factors

As indicated above, Black, Latinx, and Native American persons systematically experience more barriers to obtaining alcohol and SUD treatment services than their White counterparts. Fewer studies have examined culturally specific factors that relate to SUD and treatment. One such factor is religiosity/spirituality, which is higher among Black populations [23], and this might help explain their higher mutual help group participation rates [24]. Black Americans place a higher value on social relationships, and this communitarian perspective [25-27] places the group's needs over personal ones [28], which may help Black Americans adapt and thrive in mutual help-based SUD interventions.

Studies have also found similar findings for Latinx and Native American individuals. For example, familism, communalism, quality interpersonal relationships, and ethnic culture can serve as protective factors against substance use and relapse for Latinx individuals [29-32]. Schwartz. et al, [27] and Lopez, Lopez-Tamayo, et al. [33] found that higher affiliation to Latin and Hispanic culture(s) serves as a protective factor against alcohol use. The immigrant paradox posits that the longer Latinx immigrants live in the U.S., the higher their substance abuse rates. Spirituality, communalism, ethnic identity, education, and engagement in traditional practices can help mitigate substance use and related issues for Native American individuals [20, 34-36].

Culturally Modified Interventions

To deal with the reviewed health disparities, the following section will review cultural accommodations and adaptations of SUD interventions for racial and ethnic groups. For example, Brody, et al. [37] assessed a family-centered approach called the Adults in the Making (AIM) prevention

program that focused on contextual risk factors, including parent-child conflict, affiliations with deviant companions, and perceived racial discrimination. The program consisted of six weekly sessions in a row, each with one-hour sessions with the adolescents and parents separated and one-hour sessions with the adolescents and parents together, totaling 12 hours of sessions. Follow ups occurred at 6, 16, and 27 months after the pre-test and results showed that the AIM prevention program successfully discouraged Black adolescents from using alcohol and other drugs.

Paris, et al. [38] developed a culturally modified web-based cognitive behavioral therapy (CBT) intervention, which was delivered in Spanish and focused on cultural values, such as respect, trust, and familism. Spanish-speaking individuals in outpatient treatment were given access to the culturally modified CBT intervention, which significantly reduced the days of Latinx individuals using their drug of choice six months later compared to those who only received outpatient treatment. In another study, Spanish-speaking Latinx patients leaving residential treatment were provided a smartphone equipped with a recovery tool that was culturally modified (delivered in Spanish and focused on cultural, social, linguistic, and accessibility factors), which led to significantly lower rates of substance use, depression, and anxiety for individuals still using the recovery tool after six months [39]. Finally, Lee, et al. [73] culturally adapted motivational interviews for Latinx individuals, which were adapted in three main ways: establishing rapport in a culturally appropriate manner, including culturally specific content, and focusing on unique risk factors. Both the culturally adapted and traditional motivational interviews were a single session that averaged 65 minutes long. The culturally adapted motivational interviews led to significantly greater reductions in alcohol-related consequences three months later compared to traditional motivational interviews.

Working with Native Americans, Venner, et al. [40] found high abstinence rates using culturally adapted evidence-based treatments involving motivational interviewing and a community reinforcement approach. The treatment included 16 to 20 individual sessions, and examples of the cultural modifications included culturally consistent greetings, images, and language, aspects of spirituality, and two of the counselors being Native American. A culturally appropriate Drum-Assisted Recovery Therapy for Native Americans, focusing on drumming and talking circles, was found to be positively accepted by participants [18]. The program consisted of 12 weekly three- hour sessions, totaling 36 hours, and participants had lower rates of marijuana and daily alcohol use and better physical health at the end of the program. Allen, et al. [41] and Rasmus, et al. [42] have described the People Awakening project, which originated in 1994 and is a long-term collaboration between Native American communities and researchers. This innovative program uses cultural strengths, including a focus on spirituality, family, individuality, and community , and it has been effective in protecting Native American individuals from alcohol use disorder and suicide [41,43]. Given the health disparities among various racial and ethnic groups with SUDs, there is a need to find ways to disseminate more culturally tailored intervention resources. One possible way of doing this is through ubiquitous community-based recovery homes, which are drug- and alcohol-free.

Community-Based Oxford House Recovery Homes

Recovery homes comprise the largest network of post-treatment support options for individuals recovering from alcohol and drug use [44]. There are many types of recovery homes, but Oxford Houses are the largest network of recovery homes in the U.S., with over 3,400 homes and over 28,000 beds [45].

Oxford Houses are democratically run and require residents to pay their share of the rent and utilities, follow the democratic house rules, and abstain from drugs and alcohol [46]. There is positive evidence regarding the outcomes of this community-based intervention. For example, Jason, et al. [72] conducted a randomized control trial examining the effectiveness of Oxford Houses. At the two-year follow-up, those in the Oxford House group had significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates than the control group [72]. In another study [47], criminally-justice-involved individuals with substance use disorders were randomized to either Oxford Houses, a therapeutic community, or a control condition. At the 2-year follow-up, those in the Oxford House condition achieved significantly higher continuous alcohol sobriety rates. In addition, net overall benefits per person were $12,738 for the Oxford Houses, $3,804 for the control condition, and minus $7,510 for the therapeutic community.

A series of studies reviewed below have also found that Oxford Houses reduce SUD health disparities. Bishop, et al. [48] conducted a survival analysis that found that Black individuals tended to stay in Oxford Houses longer than White individuals. In a subsequent study in Oxford Houses, Harvey, et al. [49] found longer stays and lower relapse rates among Black residents compared to White residents. In a third sample of Oxford House residents Jason, et al. [50] found that Black residents of Oxford Houses experienced more improvement in recovery capital levels over time than other racial and ethnic groups.

Recovery Capital is the sum of all the resources one gains and utilizes in their recovery journey [51]. Brown, et

al. [52] found that Black residents reported a significantly higher number of resources gained while living in an Oxford House compared to White residents. In addition to staying longer and having better substance use outcomes, another study within Oxford Houses found that Black residents have significantly higher employment rates than White residents [53]. In addition, larger Oxford House sizes and involvement in 12-step meetings predicted abstinent social networks among Black participants [28]. These studies show that Oxford Houses may begin the process of reversing some health disparities among Black residents living in these recovery homes.

A series of studies focusing on Latinx individuals in Oxford Houses have also found encouraging reductions in health disparities. In a qualitative study, Latinx residents reported being apprehensive before living in an Oxford house but found that once living in the home, they were re-assured as they found abundant support, acceptance, and community [54]. In another study, semi-structured interviews were conducted with 12 Latinx Oxford House residents, which found themes including personal motivation and readiness to change, mutual help, sober environments, social support, and accountability [29]. Consistent with a broad conceptualization of recovery, outcomes included abstinence, new life skills, and increased self-esteem/sense of purpose. The study's findings suggest that English-speaking, bicultural Latinx residents have positive experiences in these programs.

Culturally modified houses may make Oxford Houses even more accessible to Latinx communities. Jason, et al. [55] studied Latino males who had completed a substance abuse treatment program and were assigned to either a traditional Oxford House or a culturally modified Oxford House. The traditional Oxford Houses consisted of a mix of races and ethnicities, with communication among residents occurring in English. The culturally modified Oxford Houses consisted of all Latino residents who interacted by speaking Spanish, English, or a mixture of the two. Findings indicated that the residents of both types of houses had increased income rates from employment [56]. However, those increases were higher for Latinos in culturally modified Oxford Houses. In addition, Latinos in both types of Oxford Houses drank less often and used fewer drugs, but the decrease in drinking was greater for Latinos living in traditional Oxford Houses [55]. Latinos who identified less with U.S. culture also decreased their drinking more. These results suggest that both traditional and culturally modified Oxford Houses are beneficial to Latinos in substance use recovery. In addition Jason, et al. [57] found that Latinx residents with higher collectivism scores spent less time and had less relapse in the culturally modified Oxford Homes compared to those in the traditional Oxford Houses.

As reviewed earlier, Native Americans are among the most at risk for SUDs. Kidney, et al. [58] found that Native Americans living in Oxford Houses were more likely to be on probation and to be assigned to these recovery homes by the court system than other ethnic or racial groups. In 2016, two Oxford Homes opened on the Suquamish Tribal reservation outside Seattle, WA. These two houses were culturally modified compared to a traditional Oxford House. For example, residents could participate in cultural and spiritual practices such as a sweat lodge and drumming circles instead of 12-step recovery meetings [71]. Additionally, the style of the Oxford House was seen as compatible with the tribe's self-governing way of living and worldview [71]. Through a series of interviews with these Oxford House residents, it was found that the democratic aspects of Oxford Houses tend to be similar to the tribe's style of governing. Residents in these two houses had a robust social network within the house with several sources of friendship, trust, and mentoring [59,60]. The results of this study indicate that culturally respectful recovery homes may be effective for Native Americans with SUDs.

Literature Gaps for Culturally Modified Substance Use Disorder Approaches

While the literature on culturally modified SUD interventions for Black, Latinx, and Native American individuals reveals successful outcomes, there are also significant gaps in the literature that hinder the effectiveness of interventions tailored to these populations. Guerrero, et al. [61] emphasize that culturally and linguistically responsive programs can enhance treatment outcomes for Latinx individuals, yet the specific practices that effectively support Latinx clients in completing treatment are poorly understood. Similarly, Burrow-Sanchez, et al. [62] highlights a significant literature gap regarding the difficulty of integrating cultural interventions into SUD treatment, including how to collaborate with leaders within the community effectively during implementation. This gap in the literature calls for more systematic research designs that can evaluate the effectiveness of culturally modified interventions.

The importance of culturally modified SUD interventions within treatment is well-documented, yet there remains a lack of systematic implementation across treatment programs. Gainsbury [63] highlights that while culturally tailored and modified treatments can improve recruitment and retention, there is a lack of evidence to be able to inform and guide implementation. While some studies have begun to explore the relationship between culturally modified interventions and treatment outcomes, there is still a lack of rigorous, methodologically sound trials that can guide best practices in culturally modified interventions. This indicates a need for research that not only identifies effective

cultural practices and culturally modified interventions, but also provides actionable frameworks and guidance for their implementation, especially in diverse treatment settings.

Structural barriers also significantly impact the accessibility and effectiveness of SUD treatments for Black, Latinx, and Native American individuals. Guerrero and Andrews [64] emphasize that linguistic challenges and limited knowledge of healthcare systems disproportionately affect racial and ethnic minorities, leading to longer wait times and lower retention rates in treatment programs. Furthermore, racial residential segregation often leaves Black, Latinx, and Native American populations underserved by primary care clinicians, which can hinder their access to substance use treatment [65]. These findings highlight the necessity of addressing structural barriers and inequities to ensure that treatment programs are not only culturally competent but also structurally accessible.

When it comes to culturally modified interventions for SUDs, there are many variations on what constitutes a culturally modified intervention. Based on the studies discussed, a culturally modified intervention can range anywhere from minor language adaptations to major changes within the intervention being modified. Future research involving these types of modified interventions should address the lack of a concrete definition for culturally modified interventions.

In addition to literature gaps for culturally modified SUD interventions for Black, Latinx, and Native American individuals, there are also limited research regarding the effectiveness of recovery homes for these populations. While many studies have examined Black, Latinx, and Native American individuals in Oxford House recovery homes, there is a need for more research regarding other types of recovery homes for these populations.

Conclusion

In this article, we have reviewed health disparities for Black, Latinx, and Native American individuals with SUDs. Several culturally modified SUD interventions represent innovative ways to reduce these health disparities by providing more congruent experiences, such as welcoming the involvement of extended family members and using more culturally compatible communication styles, characterized by emphasizing relationships and downplaying direct conflict to preserve harmony and respect. Thus, culturally modified interventions may allow individuals to experience a greater sense of comfort and affiliation or sense of community [55].

There is a need to know more about the process of social transition from SUD to recovery for racial and ethnic groups, in which the recovering individual must, in many cases, build and maintain a recovery-supportive identity. The "Social Identity Model of Recovery" Best, et al. [66] has established identity transition as an essential ingredient of successful recovery, in which the "addict identity" operative during active substance dependence is replaced by a new "recovery identity." The theoretical perspective explaining identity transition is expressed in terms of a change in the reference group(s) [67]. This theoretical perspective maintains that humans construct an identity ("who I am") from the reflected image they receive from others in their social environment, and this process might be easier to occur when there are others in the recovery community with a similar race. Focusing on social identity explicitly directs attention to factors that support the individual's progress in constructing this new identity. Best, et al. [66] go on to argue that social identity has long been recognized as being strongly linked to the lifestyles and worldviews of one's social relationships, that is, of whatever reference groups one is part of [68,69]. Although they identify the transition to new reference groups as the lynchpin of recovery, we know virtually nothing about this identity transition of recovery home residents from non-White racial and ethnic groups.

Little is also known about house contextual or interpersonal factors within these types of settings. If the processes and resources that enable Black residents in Oxford Houses to stay longer with enhanced recovery can be identified, they might provide SUD investigators with a better understanding of mechanisms that can be used to transform other treatment and community settings to enhance recovery of all residents. There are indications that home-level (social context) predictors play an important role in residents' recovery outcomes; for instance, more recovery progress is evident in homes where one's housemates are more highly recovered [51]. Such findings strongly suggest the importance of a "team effort," which suggests that home-level characteristics may affect the team-formation process (i.e., the relationships within the home). House-level characteristics that need to be examined include ethnic composition, residential stability (vs. turnover), financial condition, and recovery capital available (house-level averages of perceived quality of life, hope, social support, and supportive external individual networks). These community-based resources might be highly compatible with Black individuals, thus facilitating their access to recovery capital. This is important, given the calls for recovery support services to be culturally congruent with individuals' values, traditions, and belief systems [70]. Those culturally supportive settings may allow residents to experience a greater sense of comfort and affiliation or sense of community [55].

As indicated in this article, several promising culturally modified or adapted treatment approaches have been

available for those with SUDs. Studies reviewed suggest that Oxford Houses are effective in reducing SUD health disparities for Black, Latinx, and Native American individuals. That said, there are significant gaps in the literature regarding culturally modified substance use disorder approaches. Future research will help us better understand the types of relationships and relationship-building cultures that best facilitate recovery, under what circumstances, and for what types of individuals. There is a clear need to continue examining how these culturally modified SUD interventions might serve racial and ethnic groups more effectively.

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