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BRIEF
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Addressing Substance Use and Social Needs of People of Color with Substance Use Disorders

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KEY POINTS

In this brief, we highlight the experiences and practices of substance use treatment providers and their human services partners when serving people of color. We selected providers who focused on serving people of color, and this study was not intended to assess outcomes or effectiveness of any of the practices highlighted.

- Treatment providers highlighted several practices that promoted active and positive participation in their programs by people of color:
  - Incorporate the community's cultural values into organizational structures and treatment models.
  - Engage the community in designing programs and services and hire staff that reflect the community.
  - Address the comprehensive health, social, and economic needs of participants.
  - Incorporate harm reduction services and healing-centered approaches in the continuum of care.
- Providers described several constraints when serving communities of color:
  - Structural barriers such as poverty, racism, and differential access significantly impede meeting clients' social and economic needs.
  - Challenges retaining program staff with the appropriate language and cultural skills.
  - A complex patchwork of funding streams.
  - A lack of data and limited internal capacity for data analysis and program evaluation.
- Providers emphasized that success required working with the strengths of the communities they serve and that every community has protective factors. More research is needed to understand how federal, state, and local policies and programs can maximize the strengths of communities of varied backgrounds, while also implementing evidence-based practices.

INTRODUCTION

People of color have more unmet needs for substance use disorder (SUD) treatment services, and hey experience worse outcomes when they access such services compared with non-Hispanic White people (Acevedo et al. 2012; Dickerson et al. 2010; Evans et al. 2012; Guerrero et al. 2013; Mulvaney-Day et al. 2012; Pinedo 2019; Yu and Warner 2013). Research identifies structural racism, poverty, and differential access to health care as some of the causes of these disparities, (Weinstein et al. 2017). Another major source of disparity is the inequitable ways in which substance use policies and treatment resources are designed (Government Accountability Office 2017; U.S. Commission on Civil Rights 2019; Farahmand et al. 2020). In particular, the long-standing criminalization of substance use has unduly affected communities of color, primarily Black and Native American people (Farahmand et al. 2020; Kleinman and Morris 2021; Simon et al. 2020). Disproportionate to their numbers in the general population, individuals from communities of color have been arrested, convicted, and incarcerated more often for drug charges than their White counterparts (Fellner 2009; Meng 2015; Provine 2008). Moreover, SUD treatment systems and related human services programs are inadequately equipped to address the types of health and social needs that people of color are more likely to experience, such as the consequences of criminal justice involvement resulting from substance use (Cook and Alegría 2011).

Existing research suggests that multiple barriers contribute to racial and ethnic disparities in receipt and outcomes of SUD care (Cook and Alegría 2011). These barriers include but are not limited to, stigma, discrimination, limited availability or affordability of SUD treatment options, unmet social needs, and limited availability of culturally and linguistically effective providers. Many of these barriers are common for people with a SUD, but these obstacles have an outsized effect on people of color because of systemic and structural inequities. Little is known about the steps policymakers and programs can take to reduce inequities in treatment access and outcomes. For example, recent gains in health insurance coverage following health reforms, such as the Affordable Care Act, reduced the uninsured rate among non-Hispanic Black people and Hispanic people by about 5 percentage points, which is comparable to or greater than the reduction among non-Hispanic White people (Wehby and Lyu 2018). However, such gains have not been associated with reductions in SUD treatment disparities in some communities of color (Creedon et al. 2016). Relatively little research and policy attention have been devoted to identifying models of culturally and linguistically effective care that address SUD and social service needs among diverse people of color.

This study sought to understand more about the barriers people of color face when accessing SUD treatment. It also explores how integrating human services with SUD treatment and wraparound services affects engagement in and outcomes of such programs for people of color. To address current knowledge gaps, we interviewed representatives from 27 community-based substance use treatment and prevention programs serving predominantly people of color across the United States. In our interviews, we aimed to learn about care and services that engage and support people of color in treatment, as well as recovery support services for SUD. This brief summarizes common approaches the programs take and the challenges they face in their work.

METHODS

Findings from this brief are based on qualitative data collected from May to December 2020 via semi-structured virtual interviews with staff at 27 community-based programs that deliver substance use services. We identified eligible programs through an environmental scan and our professional networks and used snowball sampling, whereby interviewees suggested other programs to include in the study. Program selection criteria included geographic variation, the inclusion of culturally and linguistically appropriate services, provision of or referrals to treatment for SUD, and a focus on racially and ethnically diverse populations. The programs served multiple racial and ethnic groups, and participants enrolled in their programs included: American Indian and Alaska Native people, Asian American people, Native Hawaiian and Pacific Islander people, Black people, Hispanic/Latino people, and White people. While programs were available to people of different racial and ethnic groups, many of the programs designed their services to meet the unique cultural needs of people of specific backgrounds. These programs' participants often faced other barriers to equitable treatment access because of life experiences or identities. For example, many were immigrants, were experiencing homelessness, or had some involvement in the criminal justice system.

The interview topics included programs' approaches to serving people of color, their outreach to the community, the ways in which programs integrate culturally and linguistically appropriate practices and address participants' social needs, funding streams, and policies or resources needed to support people of color with SUD in treatment and recovery. We recorded, transcribed, and analyzed discussions using NVivo qualitative data analysis software. Our study findings cannot be generalized to other communities and providers because we did not draw a representative sample of programs serving people of color. Our findings are limited by the lack of community engagement in guiding the research. In addition, in part because of program closures resulting from the COVID-19 pandemic, we had limited participation among programs primarily serving Asian American, Native Hawaiian, and Pacific Islander people; programs serving American Indian and Alaska Native people; and programs in the South. More details on the study's methodology can be found in the Methodological Appendix.

COMMON APPROACHES TAKEN BY THE STUDY PROGRAMS

The programs we studied agreed on several key approaches to effectively engage and meet the needs of participants of color. The programs purposefully incorporated the culture of participants in their appropriate approaches to care. They were community-centered in how they structured and implemented treatment models. Further, the study programs sought to offer comprehensive and holistic care that addressed not only substance use but also the health and social needs of program participants and their families. The programs largely incorporated harm reduction and healing-centered principles, which is defined as "holistic[ally] involving culture, spirituality, civic action, and collective healing. A healing-centered approach views trauma not simply as an individual isolated experience, but rather highlights the ways in which trauma and healing are experienced collectively" (Ginwright 2018). We describe some of these approaches in greater detail in the following pages.

Incorporating culture into organizational structures and treatment models

Several program managers highlighted that many current evidence-based and standard treatment models were not developed for the unique situations of people of color or tested with these populations. Therefore, in response to community and participant needs, program staff modified multiple aspects of their care, including the programs' organizational structures, treatments, and services, and how those services account for intersecting cultural identities and the historical context of substance use in a person's culture.

Interviewees shared that organizations must be built intentionally to provide culturally effective care, including the staffing, policies, and organizational culture. They also described offering training to continually equip their staff to serve participants from diverse cultures. However, they warned that cultural competency cannot be achieved through training alone; several interviewees discussed setting an expectation of cultural humility among their staff, in which staff observe how participants respond to them and adjust if they are not connecting or the participant seems offended (see Box 1 for definitions of cultural competency and cultural humility). This approach requires continual coaching, but it also allows conflict resolution and personal growth among staff as they work through issues to ensure they effectively serve participants.

Box 1. Cultural competency and cultural humility

Cultural competency is a "means for attending to the culturally diverse backgrounds of patents, providing person-centered care, and reducing health disparities" (Lekas et al. 2020). Cultural competency is a centerpiece of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, developed by the U.S. Department of Health and Human Services, Office of Minority Health.

Cultural humility refers to "an orientation towards caring for one's patients that is based on: self-reflexivity and assessment, appreciation of patients' expertise on the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning" (Lekas et al. 2020).

Interviewees spoke about the importance of considering race, ethnicity, and language when matching program participants with providers and incorporating cultural preferences in their care. This often meant understanding participants' spiritual or religious beliefs, particularly in addressing how someone's culture might affect mental illness and substance use. Many study programs incorporated culturally significant activities in treatment, such as Indigenous healing practices. Program leaders also emphasized that when customizing care, providers must consider a person's multiple intersecting identities and the historical context of substance use in their culture, which is often rooted in disenfranchisement and trauma. The historical context of substance use differs by culture, often because of underlying differences in access to health care and health insurance coverage. Multiple interviewees spoke of the historical trauma faced by American Indian and Alaska Native populations, specifically, and its connection to their substance use and implications for their care. In addition, people with multiple marginalized identities can be subject to more stigma and discrimination (López and Gadsden 2016).

With respect to language, interviewees highlighted the importance of providing services and materials in participants' preferred languages. Programs understood which languages were used and preferred by the communities they served, and they were aware of cultural differences within a language. Bilingual and bicultural staff, including providers, case managers, and peer support

workers, were critical to being able to serve participants with limited English proficiency or preferences for non-English languages. When other services were needed, such as housing or family support services, programs tried to refer participants to organizations that could provide linguistically appropriate assistance.

Engage the community in program design and staffing

Typically, programs used multiple strategies to engage the communities they served, including hiring from the community, continually seeking community members' input, and creating multiple low-barrier pathways to services and treatment. We repeatedly heard programs express the importance of employing staff at every level who reflect the community through their language skills, culture, and lived experience. Some interviewees found employing peers was the most effective way to reach and engage participants with substance use issues. Several organizations reported that they employed staff who were former program participants and who worked their way up to leadership positions.

Program staff also frequently sought input through surveys, focus groups, or community advisory groups to be flexible and responsive to the needs of participants and communities. This meant the programs were constantly adapting, expanding, or modifying services. For example, some interviewees described how demographic shifts in their participant populations required them to develop new capacities and partnerships, such as programming for children, adolescents, and youth.

Further, many study programs take a "no wrong door" approach to create multiple pathways to SUD treatment and supportive services. For instance, participants can access treatment by walking into a program's facilities; engaging with a community outreach team; or receiving internal referrals or referrals from other community-based organizations, social service agencies, or the legal system. Programs also tried to remove or minimize barriers to treatment, for example, by not requiring proof of health insurance or a picture ID. Some programs also used mobile clinics and employed community health workers in their outreach.

Addressing comprehensive health, social, and economic needs

Many interviewees strongly emphasized the need to address not only the whole person struggling with problematic substance use, including their health, social, economic, and emotional needs but also the families in which they are embedded. Doing so can support a person's well-being in treatment and recovery, as well as while they are using substances. As such, many study programs tried to act as a one-stop shop, providing physical and mental SUD treatment and social services in one location. As one interviewee suggested, this was important for participants who might lack health insurance coverage; have difficulty navigating complex health care and human services systems; have comorbid physical, mental, and SUDs; or have unmet social or economic needs. Such participants might distrust health care and human service systems or might face barriers to accessing services (for example, lack of transportation, internet access, or language assistance).

During intake, program staff often assessed clients' health and social needs. Programs partnered with various mental health and SUD, physical health care, and human services providers to fill the gaps in services they might not offer in-house and help participants navigate services in the community. Programs worked to provide participants with or refer them to the full continuum of SUD services, from harm reduction and early intervention to treatment and recovery services. Some

programs incorporated family members in treatment, and several offered residential programming for parents with children. Participants' needs determined services and program offerings. For example, programs offering reentry services might have provided or coordinated access to legal assistance; job skills training; temporary housing; parenting, financial literacy, and other basic life skills training. Many programs had food pantries on site, offered child care and transportation assistance, and created opportunities for participants to engage in positive social interactions and recreational activities. Several programs supported connections to human services and benefits (for example, the Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children; and Temporary Assistance for Needy Families.). Staff did this through direct enrollment assistance, case management, or referrals to other organizations. A few programs reported working with child welfare agencies—either receiving treatment referrals for parents or supporting the reunification of children with parents.

Using harm reduction and healing-centered approaches

Interviewees reported that their participants faced considerable stigma in seeking help for SUDs and mental health conditions. In turn, that stigma negatively affected many aspects of their lives, such as their ability to find housing and employment. Interviewees described the importance of using harm reduction framing to help program participants overcome this barrier. Interviewees most commonly described harm reduction approaches as meeting people where they are in their SUD treatment journey. This involved listening to participants and respecting, supporting, and addressing their needs and goals, even those unrelated to substance use, which also helped cultivate trust. Several interviewees recognized that abstinence might not be a realistic goal, and many study programs allowed participants to reenter treatment or receive other services if they terminated treatment. The harm reduction services the study programs offered included wound care, syringe exchange services, overdose reversal training and medications, and testing and treatment for infectious diseases such as HIV and hepatitis C.

Many interviewees also recognized that people who have unhealthy substance use and are from communities with a history of systemic racism or other institutionalized barriers often have faced or are facing traumatic experiences. Such experiences might involve abuse, neighborhood violence, criminal justice involvement, racism and discrimination, and intergenerational trauma. Thus, programs we interviewed tried to implement healing-centered care by addressing trauma. They used asset-focused, strengths-based, and trauma-informed approaches, which they hoped would successfully engage participants in treatment and support their long-term recovery. Program staff also said supporting participants required pairing evidence-based therapies (such as cognitive behavioral therapy) with deep empathy and kindness. In addition, interviewees said many staff also had traumatic experiences and might be retraumatized through their work. Therefore, program leaders took a trauma-informed approach to engage with staff.

CONSTRAINTS ON PROGRAM EFFECTIVENESS

Interviewees described various challenges to achieving their objectives, including structural barriers limiting their abilities to address social needs, difficulties training and maintaining staff, program funding issues, and limited capacity to evaluate the effectiveness of program interventions.

Structural barriers to addressing unmet social and economic needs

Interviewees reported that resources to address social and economic needs are limited and that a lack of investment in communities of color adds to participants' needs *and* limits community resources to address those needs. Interviewees commonly described the lack of affordable housing, public transportation, and economic opportunities in communities of color as primary challenges for people in treatment and recovery. Stigma around people who use substances was another barrier for some interviewees trying to secure the full variety of services their participants needed, as human services providers might be reluctant, or unable, to serve people who use substances. For example, almost all interviewees mentioned that, in their experience, obtaining housing is difficult for people who have a history of substance use, have been involved in the legal system, or are receiving medication for a SUD. Additional research from the HHS Office of the Assistant Secretary for Planning and Evaluation found that only 22 percent of all eligible people in the United States received housing assistance of any kind in 2018 (Macartney and Ghertner 2021). Interviewees cited Housing First programming as critical to improving access to and outcomes of treatment for disadvantaged populations. But only a couple of study programs were able to offer Housing First units, and even then, the demand for housing far outpaced the supply. Interviewees also reported a lack of culturally and linguistically appropriate human services providers to which they could refer participants.

Though interviewees did not directly discuss other challenges, there are other common barriers that substance use and human services providers face in collaborating, which likely affect providers serving people of color. In other research, human services providers have reported difficulties sharing information about participant needs and progress because of privacy rules. Often, the priorities and objectives of substance use and human services providers might differ—such as a focus on the specific patient rather than the entire family—such that programs are unable to combine their services effectively (Waters et al. 2022a).

Challenges maintaining staff with language and cultural skills

Interviewees had difficulties hiring, training, and retaining staff that reflected their communities. Their biggest challenge was their inability to offer competitive wages, particularly for bilingual and multilingual staff. Some interviewees tried to compensate for workforce shortages by providing training. One organization created a leadership training program to recruit young Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQI+) professionals from communities of color to help them pursue professional credentials. Another organization provided training programs inside prisons and in the community to try to increase the availability of licensed drug and alcohol counselors with lived experience. However, most interviewees noted a lack of funding for staff training.

Several interviewees worked with state legislators and representatives to improve access to culturally and linguistically effective SUD treatment, promoting policies such as making clinician licensing and certification rules more flexible where appropriate, creating career pathways for community health workers, and allowing experience to substitute for educational credentials. Funding for peer recovery specialists was available in many states, though access could be challenging (Centers for Medicare & Medicaid Services 2007). Peer support services encompass a variety of activities and interactions between individuals who share similar experiences of being diagnosed with a SUD. Among other services, peer support providers share their own lived experience of recovery along with practical guidance. As of 2019, Medicaid covered some types of

peer support in 37 states, though it was unclear whether the organizations we spoke with were able to take advantage of Medicaid funding for this purpose (Medicaid and CHIP [Children's Health Insurance Program] Payment and Access Commission 2019). Peer support workers are people who have been successful in the recovery process and who in turn help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process (SAMHSA, 2022).

A complex patchwork of funding streams, inflexible funding, and a lack of knowledge about existing funding

Interviewees encountered various challenges with securing adequate funding to support the comprehensive, holistic care they endeavored to provide. The main challenges included managing a complex patchwork of funding streams and limited flexibility within that funding to provide necessary services.

Interviewees stated that there was no single funding source that could adequately cover the variety of services their participants needed. As a result, they had to piece together funding from federal, state, and philanthropic sources. The main sources of funding included Medicaid, grants from the Substance Abuse and Mental Health Services Administration, grants from other federal agencies (such as the Health Resources and Services Administration and the U.S. Department of Justice), and some private foundations. However, several interviewees noted few philanthropic organizations were interested in supporting substance use services. Most interviewees said Medicaid reimburses a large share of services for participants with SUD, including intensive case management services in some states. Interviewees from nearly all programs reported helping eligible participants apply for Medicaid if they were not already enrolled.

Even after obtaining funding, interviewees said they faced numerous funding gaps for certain services and populations. These funding challenges resulted in a constant need to fundraise and placed administrative burdens on the organizations. Interviewees reported managing 24 to 40 funding sources—each with its own objectives and requirements—and faced challenges blending and braiding multiple funding streams. Programs' patchwork of funding sources often hampered the creation and maintenance of fully integrated clinical and social services and supports, according to interviewees. Many interviewees, particularly those at organizations serving American Indian and Alaska Native, rural, and Hispanic participants, also commonly mentioned a shortage of behavioral health care providers.

In addition to being complex, the patchwork of funding for treatment and recovery services could be unstable. Many of the funding sources came from discretionary federal grants, which are often time-limited, must be implemented within a short time frame, and can unpredictably change amounts or purposes from year to year. The complex, unstable funding not only limited service provision but could also affect engagement with people of color. Some interviewees noted that short-term and inconsistent funding can perpetuate distrust in health care and other systems among people of color. Others viewed the lack of stable funding to address behavioral health and social services needs in communities of color as part of historical racism and structural oppression.

The second major challenge with funding streams was the limited flexibility to fund nontraditional services and support linguistically and culturally effective services, trauma-informed care,[*] and basic life necessities. For example, some interviewees stated that their state Medicaid program did not reimburse community health workers and culturally specific services (for example, sweat lodges, traditional healing groups, and drum circles used by American Indian and Alaska Native populations).[†] Interviewees noted that funding was particularly limited for residential treatment support beyond the first 30 to 90 days,[‡] and comprehensive recovery supports such as housing (Domino et al. 2019). Further, some interviewees noted that Substance Abuse and Mental Health Services Administration block grants or other local funding can be used to cover uninsured participants, including immigrants without documentation, but these grants often fall short of need. Finally, interviewees noted a lack of funding to provide needed support and care for their workforce, as staff often face mental health challenges related to their client's trauma. Though not discussed by providers we interviewed, funding sources might not cover efforts to transform organizations or institutions to help providers be more culturally responsive to the communities they serve.

The last issue programs faced is a lack of awareness of available funding sources and how they can use those sources. Some programs we interviewed were not aware that many federal funding sources allowed for overdose education, naloxone distribution, and certain harm reduction services, including wound care, syringe distribution, and overdose reversal training. It was unclear from our interviews the reasons for this lack of awareness. Notices of funding opportunities might not be distributed widely enough, through the right channels, or with enough response time to reach the providers we spoke to. Providers might not have the staffing or other capacity to seek out new funding sources, which could particularly be the case if existing funding is insufficient to pay for administrative costs. More research is needed to understand the extent to which providers serving people of color face greater barriers to accessing funds, or whether these barriers are common to all providers.

Lack of data and capacity for analysis and evaluation

Interviewees reported having limited resources, bandwidth, and expertise to track metrics and evaluate program effectiveness. For instance, some interviewees noted that their organizations lacked the funding to hire staff with expertise in data collection, analysis, and evaluation. They were interested in tracking participant experiences, well-being, and outcome metrics (for example, recurrence of misuse, overdose, and cost of care) to create a feedback loop through which they could use results to improve services and build a business case for further funding. Program staff also wanted to demonstrate effectiveness in ways that promoted and expanded funding and reimbursement from mainstream payers. Though some interviewees reported that a state quality assurance department monitored their programs, few had been able to conduct robust formal

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[*] The availability of funding for trauma-informed care varies by state, the service being provided, the type of provider, and other factors. See "Financing Trauma Informed Care," available at https://www.thenationalcouncil.org/wp-content/uploads/2019/11/Financing-Trauma-Informed-Primary-Care.pdf?daf=375ateTbd56.

[†] In its most recent Section 1115 waiver extension application, Arizona requested an approval from the Centers for Medicare & Medicaid Services to reimburse traditional healing services provided to tribal members. See Douglas A. Ducey's (governor of Arizona) letter to Alex M. Azar (secretary of the U.S. Department of Health and Human Services), regarding renewing Arizona's Medicaid demonstration, December 21, 2020: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa8.pdf.

[‡] Funding for residential treatment also reportedly had limitations; program staff in some states reported they can only bill for one service per day for residential treatment participants.

evaluations that could be used to increase program fundraising, in part because these types of evaluations are not normally expected of such programs. Many interviewees were also interested in community-engaged and community-led research.

DISCUSSION

The programs included in this study employed several approaches to addressing substance use and SUDs among people of color, including (1) incorporating culturally and linguistically effective practices; (2) being community-centered; (3) offering comprehensive services that address participants' SUD(s), health care, and social needs; and (4) using harm reduction and healing-centered approaches to care. However, providing this type of care is resource intensive, involves significant organizational capacity, and requires flexible and sustainable funding. Though program leaders in the study have been creative and resourceful in advocating for funds and policy changes, many reported ongoing structural hurdles. These barriers included a lack of government investment in communities of color, challenges maintaining staff with appropriate language and cultural skills, funding sources that are complex and not well aligned, and limited data and capacity to evaluate programs and build a business case for fully funding the community-driven, harm-reducing, holistic, and culturally effective care they strive to provide.

The findings from this study are not generalizable, but they provide a framework for culturally appropriate services to support people with SUDs, including their families. The study also demonstrates more research and evidence are needed to understand how the approaches described here can lead to better outcomes. Many of the structural barriers that interviewees outlined apply to substance use and human services programs generally. For example, a prior ASPE study found that rural communities lack resources, including treatment services, and this can impede child welfare agencies from supporting parents struggling with problematic substance use (Clary et al. 2020). Stigma associated with substance use and workforce challenges—including general shortages and lack of experience with SUDs—are also barriers to identifying human services participants with SUD and referring them to treatment (Waters et al. 2022b; Clary et al. 2020; Radel et al. 2018). Inflexible rules—many related to funding—do not permit programs to address the unique conditions of families dealing with problematic substance use (Clary et al. 2020; Radel et al. 2018). These barriers are amplified by the intersectionality of historical issues related to race, ethnicity, language, and immigration status. In particular, people of color facing substance use problems often have a multitude of unmet social needs, and they interact with multiple systems concurrently. As described by the programs studied, providers serving these communities have to navigate funding streams, policies, and other aspects of these systems. More research is needed to understand how these barriers can be overcome through policy mechanisms at the federal, state, and local levels.

Even with these complex challenges, interviewees described the importance of working with the strengths of the communities they served. Every community has protective factors that can support individuals and families facing substance use problems, such as churches, community-based organizations, civic associations, grassroots organizations, and libraries. The interviewees believed they were most successful when their approach worked with those protective factors. More research is needed to understand how federal, state, and local policies and programs can maximize the strengths of communities of varied backgrounds, while also implementing evidence-based practices.

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METHODOLOGICAL APPENDIX

Study Participants

We began this study with an environmental scan and literature review of promising approaches to address substance use in communities of color, and we identified culturally and linguistically effective services as a promising approach to effectively serve people of color with substance use issues. Therefore, we use the provision of such services as a key criterion for selecting programs and models for this study. We identified the following racial and ethnic groups as the focus of this study: American Indian and Alaska Native; Asian American, Native Hawaiian, and Pacific Islander; Black; and Hispanic/Latino populations. Another program selection criterion was that the program offered medication treatment, either methadone or buprenorphine treatment, to clients with opioid use disorder or referred clients to medication-assisted treatment. (Addressing opioid use disorder was one of the original focuses of this research, which was later expanded to include SUD more broadly.) An additional criterion for program selection was that the program addressed clients' social needs. After careful examination of the equity implications of various approaches to substance use in communities of color and in consultation with the project officers, we decided to exclude from the study approaches involving or led by the criminal legal system (e.g., drug courts) because evidence shows their harms outweigh their benefits (Gallagher, Wahler, and Lefebvre 2019).

We identified eligible programs through the environmental scan and our Office of Minority Health representatives' and project teams' professional networks. We used the snowball technique, whereby study participants made recommendations for other individuals, programs, and models to include. Though we started the project focusing on eight distinct geographical areas with racially diverse populations, we shifted to focus on programs across geographic areas that primarily serve American Indian and Alaska Native; Asian American, Native Hawaiian, and Pacific Islander; Black; and Hispanic/Latino populations because of difficulties of travel and engaging substance use programs during the pandemic.

We reached out to representatives of 70 models and programs of substance use care for people of color across 18 states and the District of Columbia. The 27 programs whose staff participated in this study were in California, Colorado, Illinois, Indiana, Massachusetts, New Mexico, Ohio, Oregon, Pennsylvania, the District of Columbia, and Washington. The additional 43 programs that declined or did not respond to our invitation to participate were in Arizona, Georgia, Maryland, New Jersey, New York, North Carolina, South Dakota, and Tennessee. Program selection and exclusion criteria resulted in a sample selection of programs highly attuned to clients' and communities' needs and clinical evidence; they likely do not represent programs from these communities.

Staff from almost all of the programs study reported that their programs served more than one racial or ethnic group; nine programs serve American Indian and Alaska Native populations; 10 served Asian American, Native Hawaiian, and Pacific Islander populations; 12 served white populations; 16 serve Black populations; and 20 served Hispanic/Latino populations. We also found that populations served by programs in our study intersect with other marginalized groups, such as people identifying as LGBTQIA+, immigrants, people experiencing homelessness, and people involved in the criminal justice system. Table A1 reports the number of programs in our study that targeted their services to specific racial and ethnic groups. While programs were available to people

of different race and ethnic groups, many of the programs designed their services to meet the unique cultural needs of people of specific backgrounds.

Table A1. Race and Ethnicity of the Populations Served by the Study Programs

Racial and ethnic group	Number of Programs
American Indian/Alaska Native, non-Hispanic	9
Asian, non-Hispanic	10
Black or African American, non-Hispanic	16
Hispanic /Latino, any race	21
Native Hawaiian or other Pacific Islander, non-Hispanic	13
White, non-Hispanic	9
Total programs	27

Source: Authors' calculations of estimates provided by study interviewees and publicly available information.
Note: Total adds up to more than 27 because each program reported serving multiple racial and ethnic groups.

Data collection and analysis

We conducted interviews virtually via Zoom between May and December 2020 using a semistructured interview guide, available upon request. The discussion topics included programs' approaches to serving people of color, their outreach to community, the ways in which programs integrate culturally and linguistically effective practices and address clients' social needs, programs' funding streams, and policies or resources needed to support people of color with substance use in treatment and recovery. Because the interviews were conducted amid the COVID-19 pandemic, we also collected data on ways in which substance use programs and their clients have been affected by the pandemic; these findings are presented in a forthcoming companion brief. In addition, we conducted a town hall meeting where we invited all study participants to provide feedback on preliminary findings from the interviews and give further input on policies and strategies to effectively address substance use in communities of color. We recorded, transcribed, and analyzed discussions using NVivo qualitative software to identify key themes, common facilitators and challenges, and policy ideas.

Limitations

Our study has several limitations. Our study findings are limited by the lack of community input, including from program staff, clients, and other local stakeholders, into the research questions and design. In addition, despite our efforts to include several dozens of substance use programs across the country serving various populations of color, the pandemic considerably limited the number of programs that agreed to participate in the study, particularly those serving Asian American and Pacific Islander patients across various ethnic groups (four out of the 13 programs contacted participated), programs serving American Indian and Alaska Native communities (one out of 14 participated), and programs in the South (zero out of four participated). Also, programs that participated in the study were all located in states that expanded Medicaid eligibility under the Affordable Care Act, which could mean the communities these programs serve have more resources and fewer barriers to receipt of needed substance use treatment, health care, and social services. As such, our study programs do not represent substance use programs that primarily serve people of color across the nation. Lastly, our interviewees were primarily upper management and leadership

program staff, and we did not interview clients, community members, or other staff. As such, important perspectives and experiences may not have been captured, particularly from participants in substance use programs.

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Office of Minority Health

ISSUE BRIEF

November 13, 2023

SUBSTANCE USE AND SUBSTANCE USE DISORDERS BY RACE AND ETHNICITY, 2015-2019

KEY POINTS

- National survey data from 2015-2019 show that, across all reported racial/ethnic groups, more of than half of adults aged 18 years or older reported any past-year alcohol use.
- The next most commonly used substance in the past year was marijuana, ranging from 7.5% for Asian adults to 25.6% for adults with more than one race, with a median of 15.9% for White adults.
- Rates of heavy alcohol use in the past month ranged from a low of 2.4% of Asian adults to a high of 7.7% for White adults, with a median of 5.1% for Hispanic adults.
- Past-year substance use disorder (SUD) rates were 4.3% for Asian adults, 7.3% for Native Hawaiian or other Pacific Islander adults, 7.5% for Hispanic or Latino adults, 7.6% for Black or African American Adults, 8.2% for White adults, 10.8% for adults identifying as more than one race, and 12.2% for American Indian or Alaska Native adults.
- Alcohol use disorder was the most prevalent SUD for every racial and ethnic group, in many cases at levels two or more times higher than those for all other SUDs combined.

INTRODUCTION

The drug overdose death crisis in the United States has expanded and worsened over time, and is estimated to account for nearly 841,000 deaths since 1999 (CDC, 2021; Mattson et al., 2021). Opioids have contributed to significant increases in overdose deaths, starting in 1999 with prescription opioids and followed by waves involving heroin and then synthetic opioids (CDC, n.d.). While synthetic opioids (primarily illicitly manufactured fentanyl) continue to play a major role in overdose deaths, recent years have seen a significant increase in deaths involving stimulants like methamphetamine and cocaine (Mattson et al., 2021). Data have also shown widening disparities in overdose deaths by race and ethnicity. For example, stimulant-involved overdose deaths have increased faster among Black/African American and American Indian and Alaska Native (AI/AN) populations compared to all other racial/ethnic groups (Kariisa et al., 2021). In addition, the opioid overdose death rate for Black/African American individuals increased by 38% from 2018 to 2019 in four U.S. states, while the rates for other racial/ethnic groups decreased or stayed the same in those same four states (Larochelle et al., 2021).

The drivers of, and issues associated with, these alarming trends are complex. One factor contributing to disparities is systemic inequity rooted in policy. Substance use policies in the United States have been shaped in part by historic racism and have, in turn, driven disparities in health and well-being between people of color and White people (GAO, 2017; Commission on Civil Rights, 2019). For instance, the criminalization of substance use has led to disproportionate criminal justice involvement, particularly among Black/African American people who are disproportionately targeted, arrested, convicted, and incarcerated on drug charges

(Fellner, 2009; Lopez, 2014; Provine, 2008). The criminal justice approach has also negatively affected people of other race and ethnicity groups, including Hispanic/Latino and Asian people (Meng, 2015; Provine, 2008). In addition, studies suggest that the impact of family separation and historical trauma due to the Federal Government's forced assimilation of American Indian children in non-Native boarding schools and placement in non-Native homes has led to higher rates of alcohol and drug use and incarceration among this population (NARF, 2007; Zephier Olson & Dombrowski, 2020). Further, some suggest that the rise in prescription opioid-involved overdose deaths led to the opioid epidemic being framed as a problem of White, rural communities (Dasgupta et al., 2018). Approaches to address the drug overdose death crisis that are limited to prescription opioids may exclude the overdose experiences of some people of color, whose overdose mortality is often driven by substances other than opioids, such as cocaine (Shiels et al., 2018).

A vast body of research shows that communities of color have less access to substance use disorder (SUD) treatment than does the White population, and that barriers to accessing substance use care for people of color may contribute to racial and ethnic disparities (differences not attributable to clinical need, preferences, or both) in health care service use and outcomes (Acevedo et al., 2012; Arndt, Acion, & White, 2013; Dickerson et al., 2010; Evans et al., 2012; Garrison et al., 2019; Guerrero et al., 2013a; Guerrero et al., 2013b; Lewis et al., 2018; Mancini et al., 2015; Mennis & Stahler, 2016; Mulvaney-Day et al., 2012; Pinedo, 2019; Yu & Warner, 2013). These findings hold true and are particularly troubling for subgroups, such as adolescents (Alegria et al., 2011; Cummings et al., 2012; Saloner et al., 2014), pregnant women (Salameh et al., 2019), and people who are incarcerated (Kerrison, 2018; Mansion & Chassin, 2016; Spinney et al., 2017). Despite efforts to increase access to care through the Affordable Care Act, early health insurance coverage gains were not associated with reductions in racial and ethnic disparities in substance use treatment access (Creedon & Cook, 2016). Even when treatment is received, there may be differences in the type of treatment provided. For example, studies show that Black/African American people have higher odds of methadone maintenance treatment for opioid use disorder than White people, but have lower odds of buprenorphine treatment, which can be prescribed in office-based settings (Hansen et al., 2016; Lagisetty et al., 2019).

Despite these noted disparities, limited research exists on identifying models of culturally and linguistically effective care that address SUD and social service needs among diverse people of color. Organizations providing SUD treatment experience limited resources, bandwidth, and expertise to track metrics and evaluate program effectiveness, which could help build the business case and evidence base for culturally responsive approaches (Bui et al., 2022).

In this brief, we assess whether and how rates of substance use and SUD among adults (ages 18 and older) differ by race and ethnicity. We combined five years of data, 2015-2019, from the National Survey on Drug Use and Health (NSDUH) to create sample sizes large enough to examine specific racial and ethnic groups for specific categories of drug use. Understanding substance use and SUD by race and ethnicity is critical to informing equitable policy and culturally effective prevention, treatment, and recovery efforts that can help address disparities in health and well-being.

METHODS

The NSDUH is an annual, nationally representative, cross-sectional survey of the United States civilian, non-institutionalized population ages 12 and older administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The NSDUH is the primary source of information on the prevalence, patterns, and consequences of alcohol and drug use among the survey population. The sample includes civilian residents of households, shelters, rooming houses, dormitories, military bases, and people without a permanent residence. After obtaining informed consent from respondents, the NSDUH uses computer-assisted self-interviews to collect data on substance use, including substances used and information about misuse.

We focused this analysis on the 214,505 respondents aged 18 years and older who completed the NSDUH between 2015 and 2019. We used data starting in 2015 due to a partial redesign of NSDUH in 2015 that resulted in substance use estimates from 2015 and later no longer being comparable to 2014 and earlier estimates. In addition, underlying survey instrument related changes and the challenges of fielding the NSDUH amid the COVID-19 pandemic resulted in SAMHSA issuing guidance to researchers to not combine 2020 data with prior years. This prevented us from using the 2020 and 2021 NSDUH.

We analyzed use of alcohol, marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, pain relievers, sedatives, stimulants, and tranquilizers in the past year. Because pain relievers, sedatives, stimulants, and tranquilizers can be prescribed for medical treatment, estimates in this analysis show self-reported misuse (i.e., use of these drugs in any way not directed by a doctor, such as use without a prescription of one's own or use in greater amounts, more often, or longer than directed).[1]

We also computed rates of heavy alcohol use in the past month, defined as consuming five or more drinks on the same occasion for men or four or more drinks on the same occasion for women on each of five or more days in the past 30 days. Further, "occasion" is defined as the same time or within a couple hours of each other.

SUDs occur "when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home" (SAMHSA, 2020a). SUD was defined in the NSDUH as meeting criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition.

We estimated substance use and SUD by self-reported race and ethnicity. Aligned with Office of Management and Budget standards, NSDUH asks respondents about Hispanic, Latino, or Spanish origin or descent and asks about race (CBHSQ, 2019). Respondents may choose multiple race categories. Further, NSDUH allows respondents to provide more specific information for those who identify as Asian (Asian Indian; Chinese; Filipino; Japanese; Korean; Vietnamese; and Other Asian) and/or Hispanic, Latino, or Spanish (Mexican, Mexican American, Mexicano, or Chicano; Puerto Rican; Central or South American; Cuban or Cuban American; Dominican (from Dominican Republic); Spanish (from Spain); and Other). We used the race and ethnicity combination variable in the publicly available NSDUH dataset, which classifies respondents by Hispanic, Latino, or Spanish ethnicity and the following racial categories, which exclude those who identified as Hispanic/Latino: White, Black/African American, AI/AN, Native Hawaiian or other Pacific Islander (NHPI), Asian, or two or more races. The NHPI classification includes respondents who reported that they were Native Hawaiian, Guamanian or Chomorro, Samoan, and/or other Pacific Islander.

We compared estimates across racial and ethnic groups using unadjusted logistic regression. For each substance use, misuse, and use disorder outcome, we estimated prevalence levels for each racial/ethnic group, ordered them from lowest to highest, and identified the median group. We then used the median group as the reference level, allowing us to estimate which remaining groups had prevalence levels significantly lower or higher than the median. We conducted the analysis using Stata/MP 18 (StataCorp) and followed NSDUH guidelines for calculating and reporting (including suppressing) estimates, including the application of survey weights and variation estimation procedures accounting for the complex, multistage design of the survey.

Limitations

Because of the dataset used, this analysis has several limitations. First, the NSDUH data are self-reported and thus subject to recall and social desirability biases, which may vary by racial or ethnic group and type of substance use. For instance, one study found that social desirability concerns were more likely to affect drug use reporting quality in survey data for Black/African Americans respondents than for those from other

racial/ethnic groups--a difference that could be attributed to greater concerns with privacy and confidentiality given the population's historical experiences of oppression, discrimination, and exploitation; distrust of medical researchers; and greater risk of criminal prosecution for drug-related offenses (Johnson & Fendrich, 2005). Such issues may lead to under or overreporting (CBHSQ, 2015). However, NSDUH response rates are fairly high, ranging from 69.3% in 2015 to 66.6% in 2018 (CBHSQ, 2016, 2018, 2019). Second, the sample excludes active-duty military personnel, people in prisons and jails, and people who do not have homes and do not use shelters (CBHSQ, 2019). The literature has documented evidence showing that due to not including individuals who are incarcerated, experiencing homelessness, or hospitalized OUD rates in the NSDUH are 2-3 time lower than what it might be (Keyes et al., 2022). Specifically, recent analyses of other data sources have estimated that as many as 6-7 million United States adolescents and adults may meet criteria for OUD. If this suggests an overall underestimation based on the NSDUH data, a potential implication is that it could bias differences by race/ethnicity in unknown ways because we cannot assume such an underestimation would be proportionate to race/ethnicity. However, this limitation is not unique to NSDUH and is also applicable to other survey data as well. Third, this brief attempts to study patterns by specific racial and ethnic groups, but enormous heterogeneity exists within these groups (e.g., related to culture, language, age, citizenship, and immigration status). Because the publicly available NSDUH data exclude data for more specific subgroups, our ability to address this heterogeneity is limited, and sample size limitations make analysis of smaller racial and ethnic groups imprecise.

FINDINGS

Rates of Substance Use and Misuse by Race and Ethnicity

Our analysis of NSDUH data for adults ages 18 and older shows the rates of past-year alcohol use, substance use, and substance misuse were often similar across racial and ethnic groups, though there were some notable differences (***Table 1***). Here we summarize differences that were statistically significant at $p<0.05$. For any past-year alcohol use, Black/African American adults were the median group with a self-reported rate of 61.8%. Asian adults (55.4%, $p<0.001$) and AI/AN adults (56.5%, $p<0.05$) reported statistically significant lower rates, while White adults (74.1%, $p<0.001$), adults with more than one race (68.6%, $p<0.001$), and Hispanic adults (64.0%, $p<0.001$) all reported significantly higher rates. For heavy drinking in the past month, Hispanic adults were the median group with a rate of 5.1%. Asian adults (2.4%, $p<0.001$) had a significantly lower rate of heavy drinking, while AI/AN adults (6.6%, $p<0.05$), White adults (7.7%, $p<0.001$), and adults with more than one race (8.1%, $p<0.001$) had higher heavy drinking rates.

For past-year marijuana use, White adults were the median group (15.9%). Asian adults (7.5%, $p<0.001$) and Hispanic adults (13.2%, $p<0.001$) were significantly less likely than the median group to have used marijuana in the past year. On the other hand, Black or African American adults (18.2%, $p<0.001$), AI/AN adults (22.0%, $p<0.001$), and adults with more than one race (25.6%, $p<0.001$) all had significantly higher rates than White adults.

For past-year cocaine use, White adults were again the median group with a use rate of 2.2%. Only Asian adults had a significantly lower rate (1.0%, $p<0.001$), and only adults with more than one race (3.8%, $p<0.001$) had a significantly higher rate. All other groups ranged from 2.0% to 2.6%--rates that were not significantly different than the reference group.

For past-year heroin use, Black or African American adults had the median use rate of 0.3%. Only Asian adults had a significantly lower rate at less than 0.1% ($p<0.001$). Rates for the remaining groups ranged from 0.2% to 0.5% and were not significantly different than the median group.

White adults had the median past-year use rate for methamphetamines (0.8%). Asian adults (0.1%, p<0.001) and Black/African American adults (0.3%, p<0.001) both had significantly lower rates compared to the median, while adults with more than one race (1.1%, p<0.05) and AI/AN adults (2.7%, p<0.001) had significantly higher rates than the median.

Hispanic adults were the median group for past-year rate of hallucinogen use (1.8%). Black/African American adults had a significantly lower use rate (1.4%, p<0.01), while White adults (2.0%, p<0.05), AI/AN adults (2.6%, p<0.05), and adults with more than one race (4.2%, p<0.001) all had significantly higher rates.

Table 1: Self-Reported Substance Use and Misuse in the Past Year among Adults Ages 18 and Older, by Race and Ethnicity, 2015-2019 (percent of racial or ethnic group population)

	White, Non-Hispanic	Black/ African American, Non-Hispanic	American Indian or Alaska Native, Non-Hispanic	NHPI, Non-Hispanic	Asian, Non-Hispanic	2 or More Races, Non-Hispanic	Hispanic/ Latino
Any alcohol use	74.1***	61.8[c]	56.5*	57.0	55.4***	68.6***	64.0***
Heavy alcohol use in the past month[a]	7.7***	4.6	6.6*	5.1	2.4***	8.1***	5.1[c]
Any marijuana use	15.9[c]	18.2***	22.0***	14.6	7.5***	25.6***	13.2***
Any cocaine use	2.2[c]	2.0	2.6	2.6	1.0***	3.8***	2.1
Any heroin use	0.4	0.3[c]	0.4	0.3	<0.1**	0.5	0.2
Any methamphetamine use	0.8[c]	0.3***	2.7***	1.2	0.1***	1.1*	0.7
Any hallucinogen use	2.0*	1.4**	2.6*	1.6	1.7	4.2***	1.8[c]
Any inhalant use	0.5	0.3*	1.1*	0.7	0.5[c]	1.0**	0.5
Pain reliever misuse[b]	4.3[c]	3.7**	5.8*	4.8	1.7***	6.2***	4.1
Tranquilizer misuse[b]	2.6*	1.3*	1.8[c]	1.7	0.7***	3.1**	1.9
Stimulant misuse[b]	2.4***	0.8***	1.4	1.5	1.2	3.3***	1.5[c]
Sedative misuse[b]	0.6***	0.2	0.4	0.1	0.2*	0.9***	0.4[c]

Sources: Estimates are from the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2015-2019.

a. Heavy alcohol use is defined as drinking 5 or more drinks on the same occasion for men or 4 or more drinks on the same occasion for women on each of 5 or more days in the past 30 days. “Occasion" means at the same time or within a couple hours of each other.

b. Because pain relievers, sedatives, stimulants, and tranquilizers can be prescribed for medical treatment, these measures show self-reported misuse. Misuse is defined as use of these drugs in any way not directed by a doctor (e.g., use without a prescription of one’s own or use in greater amounts, more often, or longer than directed).

c. For each substance, the group with the median use/misuse rate was used as the reference for tests of statistical significance.

*/**/*** The difference between this estimate and the estimate for the median reference group adults differs from zero at the 0.05/0.01/0.001 level, based on unadjusted logistic regression.

For past-year inhalant use, Asian adults had the median use rate at 0.5%. Black/African American adults were the only group with a significantly lower rate (0.3%, $p<0.05$). On the other hand, adults with more than one race (1.0%, $p<0.01$) and AI/AN adults (1.1%, $p<0.05$) both had significantly higher rates.

For rates of pain reliever misuse in the past year, White adults were the median group with a rate of 4.3%. Black/African American adults (3.7%, $p<0.01$) and Asian adults (1.7%, $p<0.001$) had significantly lower misuse rates, while AI/AN adults (5.8%, $p<0.05$) and adults with more than one race (6.2%, $p<0.001$) had significantly higher misuse rates.

AI/AN adults had the median rate of past-year tranquilizer misuse at 1.8%. Black/African American adults (1.3%, $p<0.05$) and Asian adults (0.7%, $p<0.001$) had significantly lower misuse rates, but White adults (2.6%, $p<0.05$) and adults with more than one race (3.1%, $p<0.01$) each had significantly higher misuse rates than the median group.

Hispanic adults had the median rate of past-year stimulant use (1.5%). Only Black/African American adults had a significantly lower misuse rate (0.8%, $p<0.001$), but both White adults (2.4%, $p<0.001$) and adults with more than one race (3.3%, $p<0.001$) had significantly higher misuse rates than the median group.

Finally, the median group for past-year rate of sedative misuse was Hispanic adults (0.4%). Asian adults (0.2%, $p<0.05$) had a significantly lower misuse rate, and again White adults (0.6%, $p<0.001$) and adults with more than race (0.9%, $p<0.001$) had significantly higher misuse rates than the median group.

Rates of Past-Year Substance Use Disorder by Race and Ethnicity

The overall prevalence of past-year of any SUD including alcohol ranged from 4.2% for Asian adults to 12.2% for AI/AN adults. The median group was Black/African American adults, who had a prevalence of any past-year SUD of 7.6%. The 4.2% prevalence for Asian adults was the only rate significantly lower than the median ($p<0.001$). White adults (8.2%, $p<0.05$), however, as well as adults with more than one race (10.8%, $p<0.001$) and AI/AN adults (12.2%, $p<0.001$) all had significantly higher rates of any past-year SUD than the median group.

Of all individual SUDs, alcohol use disorder was by far the most prevalent (***Table 2***). For many groups, alcohol use disorder was two or more times more prevalent than all other SUDs combined. Hispanic adults had the median past-year alcohol use disorder prevalence at 5.8%. For Asian adults (3.5%, $p<0.001$) and Black or African American adults (5.2, $p<0.05$) the rate was significantly lower, while for adults with more than one race (7.4%, $p<0.05$) and AI/AN adults (9.2%, $p<0.001$), alcohol use disorder was significantly more common compared to the median group.

When examining the prevalence of having any of the remaining SUDs in the past year, excluding alcohol, rates were substantially lower across all racial/ethnic groups. The median group was NHPI adults, whose prevalence of any SUDs excluding alcohol was 3.0%. (By comparison, their alcohol use disorder prevalence was 7.3%.) Only Asian adults (1.2%, $p<0.01$) had a prevalence of any non-alcohol SUDs that was significantly lower than the median level for NHPI adults. Both AI/AN adults (5.0%, $p<0.05$) and adults with more than one race (5.2%, $p<0.01$), however, had rates that were significantly higher than NHPI adults.

Across the remaining individual SUDs, there were a number of statistically significant differences when comparing against the median racial/ethnic group for each substance. Prevalence levels were consistently quite low and similar across racial/ethnic groups, however, and for most substances, prevalence levels were no greater than 1.0%. An exception was marijuana use disorder, which ranged from 0.8% for Asian adults to 3.0% for adults with more than one race. The median group was Hispanic adults, who had a past-year prevalence

level of 1.6%. The 0.8% rate for Asian adults was significantly lower than this (p<0.001), as was the rate for White adults (1.3%, p<0.01). Black/African American adults (2.2%, p<0.001), AI/AN adults (2.3%, p<0.05), and the aforementioned group with the highest prevalence, adults with more than one race (3.0%, p<0.001), all had significantly higher levels of past-year marijuana use disorder than the median.

Table 2: Any SUD and Specific SUDs in the Past Year among Adults Ages 18 and Older, by Race and Ethnicity, 2015-2019 (percent of racial or ethnic group population)

	White, Non-Hispanic	Black/ African American, Non-Hispanic	American Indian or Alaska Native, Non-Hispanic	NHPI, Non-Hispanic	Asian, Non-Hispanic	2 or More Races, Non-Hispanic	Hispanic/ Latino
Any SUD[a]	8.2*	7.6[b]	12.2***	7.3	4.2***	10.8***	7.5*
Any SUD, excluding alcohol use disorder	2.8	3.4	5.0*	3.0[b]	1.2**	5.2**	2.7
Alcohol use disorder	6.2	5.2*	9.2***	5.5	3.5***	7.4*	5.8[b]
Marijuana use disorder	1.3**	2.2***	2.3*	1.5	0.8***	3.0***	1.6[b]
Cocaine use disorder	0.3	0.6***	0.5	0.4[b]	0.1*	0.5	0.3
Opioid use disorder	0.9	0.7[b]	1.2*	0.5	0.2**	1.4**	0.6**
Methamphetamine use disorder	0.4	0.1***	1.7***	1.0	0.1**	0.7	0.4[b]
Hallucinogen use disorder	0.1	0.1	0.2	<0.1	0.1[b]	0.2	0.1
Inhalant use disorder	<0.1	<0.1	<0.1	0.2	<0.1	<0.1	<0.1[b]
Tranquilizer use disorder	0.3	0.2	0.3	0.2[b]	0.1	0.5	0.2
Stimulant use disorder	0.2[b]	0.1***	0.3	0.4	0.1***	0.3	0.1***
Sedative use disorder	0.1	<0.1	0.1[b]	0.1	<0.1	0.1	<0.1

Source: Estimates are from the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2015-2019.

a. Any SUD includes respondents with alcohol use disorder or who report abuse of or dependence on any of the following illicit drugs: cocaine, hallucinogens, heroin, inhalants, marijuana, methamphetamine, pain relievers, sedatives, stimulants, and tranquilizers.

b. For each substance, the group with the median use disorder rate was used as the reference for tests of statistical significance.

*/**/*** The difference between this estimate and the estimate for the median reference group adults differs from zero at the 0.05/0.01/0.001 level, based on unadjusted logistic regression.

DISCUSSION

In this study of national survey data from 2015-2019, we examined United States adults' rates of substance use, misuse, and SUD across racial and ethnic groups, finding that rates were often similar across groups. At the same time, we did find statistically significantly differences between racial/ethnic groups for many substances when comparing to the group with the median level of use for each substance we examined. We also found that no one group tended to be the median across substances but that some groups were more likely to have the lowest and highest rates of use, misuse, and use disorder.

People with SUDs are at higher risk of adverse consequences of drug and alcohol use, such as health, social, and employment problems, incarceration, and death, and have the greatest need for services and treatment. Fortunately, SUDs are preventable and treatable with culturally and linguistically effective prevention, treatment, medication, harm reduction, and social services and supports.

Among the most notable differences in SUD rates by race and ethnicity were the higher rates of four different SUDs (alcohol, marijuana, opioid use disorder, and all SUDs combined) for those reporting two or more races and for AI/AN adults compared to the median group for each SUD. Virtually no research exists to understand unique risk factors or considerations for approaches to care for people with SUD who identify as two or more races. This is an important gap given that this population is rapidly growing and has elevated substance use and SUD rates (CBHSQ, 2021; Jones & Bullock, 2012). In addition, AI/AN adults also had a higher rate of methamphetamine use disorder than the median. With rates of stimulant-related overdose deaths having increased rapidly overall (CDC, 2021; National Institute on Drug Abuse, 2020), addressing the higher rate of methamphetamine use disorder among AI/AN adults in a culturally effective way is especially critical.

Other differences in SUD rates, though modest, are also important for clinicians and policymakers to study. Expanding policy attention to address these differences and disparities could help improve the nation's response to the epidemic's shift toward fentanyl, and methamphetamines; and increase attention to the options to avoid overdose in communities of color, where overdose mortality is often driven by substances other than opioids (Shiels et al., 2018).

As noted, AI/AN adults had a higher rate of methamphetamine use disorder during our study period. Meanwhile, Black/African American adults had a higher rate of cocaine use disorder compared to the median. The rate of overdose deaths linked to psychostimulants, including methamphetamine and cocaine, increased 28% between 2018 and 2019 and has increased more than threefold over the past five years, with a substantial share involving more than one substance (e.g., including fentanyl) (CDC, 2021; National Institute on Drug Abuse, 2020). Yet guidance related to stimulant overdose prevention and treatment (e.g., SAMHSA, 2020b) is limited compared with the vast research and guidance related to opioid overdose. For the treatment of stimulant use disorders, evidence supports the efficacy of contingency management, a psychosocial intervention that involves reinforcing recovery-oriented behaviors (e.g., abstinence, treatment session attendance, medication adherence) with items of value (Glass et al., 2020). However, various policy barriers impede its availability, including limited health insurance coverage and restrictions on incentive values in certain federal programs. Culturally informed guidance on addressing stimulant use and overdose prevention is needed, especially for disproportionately affected communities of color. Further, though people who use a substance may not have a substance use *disorder*, they may benefit from receiving culturally informed prevention and early-intervention services.

The findings that substance use and SUD rates were often at the median or below median for Black/African American and Hispanic/Latino adults contrasts with the racialized and criminalized history of substance use policy in the United States, which has resulted in disproportionate criminal justice involvement for drug offenses among people of color. More effective and equitable outcomes may be achieved through an approach to measuring and treating substance use that uses a more intersectional lens, is culturally and linguistically competent, and more consistently relies on evidence-informed care. Paying more careful attention to differences within groups in future research, both related to smaller racial and ethnic groups and to other, intersecting sociodemographic identities (e.g., age, sex, gender identity, sexual orientation), can improve understanding of how the need for substance use services intersects with the needs of historically and systematically disadvantaged populations, such as communities of color, women, and LGBTQ+ communities, but not always in expected ways.

CONCLUSION

To address the varied needs of different communities of color, additional guidance and research is needed to support clinicians in providing evidence-informed, culturally effective SUD prevention and treatment services. More support is also needed for communities of color to lead the development, evaluation, and implementation of effective models that provide care for people who have unhealthy substance use in their communities. The HHS Overdose Prevention Strategy outlines policy initiatives and strategies to increase the availability of culturally competent care, to address underlying social determinants of health that increase risk of substance use and SUDs within communities of color, and to provide evidence-based SUD treatment to heavily impacted communities. Policy and research attention to differences in and accessibility of the types of care that are culturally and clinically effective for different racial and ethnic groups is critical. These approaches would both help address the specific needs described in this analysis and promote equitable health care access and outcomes for all people regardless of race or ethnicity.

ENDNOTES

1. NSDUH survey language uses the word doctor, but other providers could prescribe these substances, depending on state scope-of-practice laws.

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