Lack of Community Voice in Substance Use Interventions

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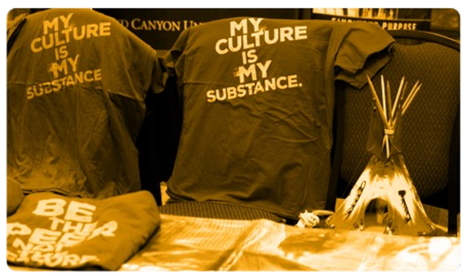
INTRODUCTION

The National Institute on Drug Abuse (NIDA) and Substance Abuse and Mental Health Services Administration (SAMHSA) define substance use disorders (SUD) as recurring alcohol and/or drug use that significantly impairs health, responsibilities, and functioning. However, these disorders are often prevalent in American Indian and Alaska Native (AI/AN), Black, and other marginalized communities due to factors such as poverty, trauma, violence, sexual abuse, loss of cultural and spiritual identity, and increased substance use.[1,3] These issues are interconnected and deeply rooted in historical contexts like colonization.[2,6] The impact of substance use disorders goes beyond physical health, affecting social determinants of health through racism, discrimination, and inequitable access to services.[5,6,7]

Unfortunately, SAMHSA's nationally implemented initiatives may not adequately address the unique challenges faced by AI/AN, Black, and other culturally oppressed communities. To achieve health equity, it is crucial to consider cultural practices and incorporate the voices of these communities, as the current Westernized approaches to SUD treatment may leave a significant population without the necessary care they deserve.[1,2,5] By integrating community perspectives and acknowledging the historical experiences of AI/AN, Black, and other marginalized populations, the effectiveness of interventions for substance use disorders can be maximized.

HOW DOES THIS AFFECT MARGINALIZED COMMUNITIES

Although the prevalence of substance use disorders (SUDs) is similar among White, Latinx, and Black populations in the U.S., minority communities face more negative consequences and decreased access to evidence-based treatment and harm reduction services.[8] For example, despite similar rates of opioid misuse, Black people have experienced the greatest increase in fatal opioid-related incidents.[8] Additionally, discomfort with Western approaches to mental health care and distrust of the healthcare system pose significant barriers to receiving appropriate treatment within minority communities.[2]



RACIAL MISCLASSIFICATION

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2 X In counties with more income inequality, overdose death rates for Black people were more than two times as high as in counties with less income inequality in 2020.

7 X Overdose death rates in older Black men were nearly seven times as high as those in older White men in 2020.

2 X Overdose death rates for younger American Indian and Alaska Native (AI/AN) women were nearly two times those of younger White women in 2020.

RACISM AND SUBSTANCE USE

Racism plays a significant role in perpetuating substance use and health inequities.[5,7] The creation, enforcement, and propagation of drug laws have disproportionately targeted minority communities, leading to higher rates of incarceration for drug offenses.[5] Although Black, Latinx, and Indigenous individuals are not more likely than Whites to use illicit drugs, they are significantly overrepresented in the criminal justice system.[5] Furthermore, access to high-quality and stigma-free services for persons who use drugs is limited for minority communities.[5,7] Representation of AI/AN, Black, and other culturally oppressed groups as both investigators and participants in substance use and addiction research is also lacking, which perpetuates the exclusion and underrepresentation of these communities in shaping policies and interventions.[1,5,7]

DISCUSSION

A clear concern when evaluating rates of SUD and the effectiveness of its treatment in AI/AN and other marginalized communities is that of racial misclassification. Oftentimes, race and ethnicity are misrepresented in data reporting due to the nature of classification in American society. This could lead to underestimates, especially in AI/AN communities, and overestimates in certain categories. Despite this, however, current evidence-based treatments are implemented and subsequently evaluated with the assumption that they accurately represent all populations. There is a strikingly low number of interventions that are community or culture-specific and very little effort to include these perspectives in accepted evidence-based interventions.[6]

INCORPORATING COMMUNITY VOICE AS A SOLUTION

To address these issues, interventions should consider the influence of historical trauma on minority communities and adopt a community-based participatory research (CBPR) approach.[2] By involving the community in all aspects of the research process, this approach ensures equity and recognizes existing strengths within the community. Interventions should focus on integrating individual, familial, and community wellness and aim to address the underlying forces that promote substance use disorders.[1,2,4] Creating opportunities for disconnected individuals to reengage with healing forces within their communities is important.

Additionally, adjustments should be made in research practices to include minority populations in efficacy trials of behavioral and pharmacological treatments for SUDs.[2,7] By incorporating community voice and addressing the holistic view of health, which encompasses physical, mental, emotional, and spiritual well-being, future interventions can promote greater health equity and better outcomes for minority communities.

CITATIONS & ACKNOWLEDGEMENTS