# WEBINAR VIDEO TRANSCRIPT

Minority Fellowship Program

## Culturally Responsive Substance Use Disorder Treatment

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ASYA LOUIS: Good afternoon, everyone. My name is Asya Louis. And I'd like to welcome you to the Culturally Responsive Substance Use Disorder Treatment webinar. This webinar is brought to you by the SAMHSA Minority Fellowship Program Coordinating Center. We'd like to draw your attention to the disclaimer.

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the US Department of Health and Human Services. I'd now like to introduce today's speaker. Gabriela Zapata-Alma.

Gabriela is the Director of Policy and Practice on Domestic Violence and Substance Use at the National Center on Domestic Violence, Trauma, and Mental Health, as well as faculty at the University of Chicago where they coordinate the advanced alcohol and other drug counselor certification program at the School of Social Service Administration.

Gabriela brings over 15 years of experience supporting people impacted by trauma, violence, mental health conditions, substance use disorders, housing instability, and HIV/AIDS, providing bilingual and bicultural counseling, training, advocacy, and policy consultation, and leading programs using trauma informed approaches, motivational interviewing, harm reduction, gender responsive care, housing first and third wave behavioral interventions.

Gabriela has been recognized with numerous awards, including Health and Medicine Policy Research Group's 2018 Health Award and the 2017 Rising Star Award from the Illinois Chapter of the National Association for Addiction Professionals. Gabriela provides consultation in trauma informed policy to advance racial equity at the national level, as well as training and technical assistance related to serving marginalized communities impacted by trauma and other social determinants of health, nationally and internationally.

Gabriela, the floor is yours.

GABRIELA ZAPATA-ALMA: Great. Thanks so much. Thanks so much for that lovely introduction. And thanks so much for having me today. And to everyone who is on, thanks so much for joining and for taking the time to take in this information. I know that everyone is really busy. And so I take it really seriously whenever I am taking away time from direct practice or, you know, I really want to make sure that we're getting the most out of our time together.

In that vein, I really want to welcome folks to be sure to use the questions, to submit questions, and to share comments, thoughts, ideas, experiences, et cetera. So here today we'll be talking about culturally responsive substance use disorder treatment. OK. And that's me. You already found me. You already heard about me.

And then a little bit about the center where I'm from, so I'm a Senior Lecturer at the University of Chicago. And I oversee our addictions program there, as well as trauma informed care certification programs. I help plan and administer a lot of those seminars, as well as teach evidence-based practice and spirituality and social work there.

But I actually full time work at a national resource center, the National Center on Domestic Violence, Trauma, and Mental Health. And so we are a special issue resource center. That-- and we offer a comprehensive array of training and technical assistance services and resources. We conduct research and evaluation, policy development and analysis. And we also engage in public awareness efforts.

We're the only national resource center dedicated to addressing the intersection of domestic violence, trauma, substance use, and mental health. And then here's my government disclaimer. The things I say don't necessarily represent the official positions or policies of the US Department of Health and Human Services.

And so at the national center, this interpretive framework informs everything that we do. So everything that we do is really rooted within and filtered through this integrated framework, which is rooted within survivor defined approaches. That people are the experts in their own lives. That people's realities are exceptionally complex.

And that they are the ones who know best, what is safest for them, what's possible for them, how they define their needs and their problems and any potential resources and activities that might help them move towards self-defined goals. And that our services really need to be rooted within physical and emotional safety and rooted within relationship and connection, thereby fostering hope and resilience.

From this place, we are able to operate from then a trauma informed approach, an approach that is based in domestic violence and sexual violence advocacy, which is an empowerment framework. A framework that really centers human rights and social justice and has an awareness of our responsiveness to cultural, historical, and community context.

Four objectives for the next 90-ish minutes, we're going to look at, what are some of the unique risk factors and barriers that people of color face? We're going to contextualize symptoms of substance use disorders as coping responses that aid in self-protection and survival for individuals impacted by structural and interpersonal violence. And then we're also going to talk about strategies on how to culturally adapt evidence-based interventions.

So our first part here, contextualizing substance use disorders for people of color, unique risks and barriers and understanding symptoms as threat responses. But first I want to introduce this concept of recovery capital. So recovery capital is everything that-- all the internal and external resources that aid in the journey of recovery.

I want to take a moment and also acknowledge that the concept of recovery is not a concept. It's not how people understand or describe their experience necessarily across cultures. So I remember, I was giving a training. And someone in the audience participant shared his experience. And he said, you know, recovery is really not something that I connect to. For me, it's about healing.

Other folks may connect to ideas about getting healthy versus recovery. So understanding that even the term recovery can absolutely be culturally specific and not necessarily resonate across cultures. So thinking about recovery capital, there's four main categories, the human, which is our skills, our education, both attainment and access, our self-efficacy, hopefulness, our personal values.

Social capital, our family, intimate relationships, experiences and relationships of kinship, and our social supports. There's the physical quadrant, both our health as well as our basic needs, including safe housing, insurance coverage, access to financial resources, and overall economic stability. And then the aspect of community, where we exist is there-- is it an anti-stigma community?

Are there recovery role models? Are there peer-based supports, including peer-led support groups? And a lot of times here we're also talking about the availability of recovery support services. So I want folks to think about, as we're going through this first part, how do structural and interpersonal violence impact these areas of recovery capital for people of color?

And where do you see culturally specific sources of resilience connection and healing represented in this idea of recovery capital? Is there anything that's potentially culturally specific or salient that is missing from this framework that you would add in order to have it be more responsive to your own community, one of your social identities or cultures? Really approaching culture as an ecosystem of social identity.

And so thinking about this framework and how people can access recovery capital, what their access looks like within both intersectionality and their positionality, as we talk about some of the risks and barriers that disproportionately and uniquely impact people of color. So looking at first experiences of collective trauma and minority trauma.

So understanding collective trauma as the cultural, historical, political, and economic trauma that impacts individuals and communities across generations. You know, historical trauma is not something that just happened in the past, and it's over now. But it's something that continues to unfold on a daily basis, as we continue to contend with the legacies of genocide and slavery and many other kinds of historical trauma.

Racial trauma, so evidence is clear that discrimination is a salient risk factor for substance use disorders, as is chaotic neighborhood disorganization, right. Which we know that many times neighborhoods that have been systematically cut off from resources and phenomenon and structural violence, such as redlining, then it really keeps people trapped in these kinds of environments.

And then-- which then lead to social determinants of health, right, where the zip code is a stronger predictor of health than genetic factors. And part of this is-- a lot of research has shown the significance of allostatic load. That allostatic load is associated with a variety of health conditions, cardiovascular, metabolic, inflammatory and has been found to be higher amongst racial and ethnic minorities, so people of color, who experience discrimination.

And that this contributes to higher risks for health conditions, which in turn also can increase risk for substance use disorders or complications due to substance use in that, you know, for example, heightened risk for overdose. Somebody may be at risk for accidental fatal overdose, regardless of whether or not they meet criteria for a substance use disorder.

And having underlying health conditions increases one's risk for accidental fatal overdose. So keeping in mind how this plays a role not only in the increased risk for developing a substance use disorder but also just complications due to substance use in general, including fatal overdose. So then this calls to mind the question of, well, what do we do about it, right?

And this first segment I'm talking more about kind of the unique risk factors and barriers and talking more in the second half around what are some pieces we can do. But I want to make sure to name right here that this reality calls all of us as helping professionals, as health care professionals really calls us to center dismantling racism and all other kinds of oppression to be central to our health care, to the services that we provide.

That it is not something that is extra, it is not something that is-- that it's something that's really central to the work that's needed and the work that we do. So in addition to dismantling systemic racism, additional insight into mediators and moderators of the effects of racial trauma are needed. So some evidence of just that parent child attachment and supportive parenting can moderate the impact of discrimination as a risk factor for substance use disorders.

So really looking at the importance of parent child attachment, of supporting family, of supporting parents as well as dismantling racism within family regulation systems that disproportionately impact people of color and interrupt that attachment and that safety within families. There are some tools for assessing racial trauma that have been developed and tested.

That said, more research is needed to see how these tools can be best used to improve clinical outcomes. So a couple tools that are available. There is by Williams and others a 2018 study. The article is called "Assessing Racial Trauma with a Trauma Symptoms of Discrimination Scale." And the article is in the Psychology of Violence.

Then Williams again with others from 2018, the "Assessing Racial Trauma within the DSM-5 Framework, The University of Connecticut Racial and Ethnic Stress and Trauma Survey." And that was from the Practice in Innovations Journal. So just a couple of resources there to look into.

And then with migration trauma, something that is so pervasive but is not nearly recognized enough or talked about enough in our services and in our educational systems, to be honest. And so here, really looking at the different ways that there's trauma potential within experiences of migration, both pre-migration. We often think about the push and pull factors that lead to someone migrating, then during migration, during transit and that initial arrival, and then further on with settlement.

And that many times within that settlement piece, there's also a disillusionment with what the expectation was versus what the reality is. And now the new kind of home country or the host country, including experiences of discrimination and systemic oppression that may be very different than the person's experience in their country of origin. And we also know, research has indicated that acculturation has been correlated with increased substance use concerns.

So here really makes us think about, again, what are those mediating and moderating factors? And how has access to protective factors, such as economic resources, access to health services, social support, social networks, social capital, parent child attachment, cultural traditions, and sources of support and healing, how have those been interrupted by the migration experience?

And that we know that all of these increase trauma risk factors. That the factors-- so really all of us at one point or another are exposed to a potentially traumatizing situation or scenario. But there are certain risk factors that increase the likelihood for a person going from that initial exposure to a potentially traumatic situation to developing a trauma-related disorder.

And research has shown that some of those are health disparities, heavy stress, social isolation, generational history of trauma, and being blamed for hardship. And we see those phenomenon all showing up. We see those risk factors really all present within these collective experiences of trauma, as well as minority and migration forms of trauma.

And then looking at the experiences of adverse childhood experiences, so I trust that folks have been exposed to this information. This study that was done in and released in the mid to late '90s. That there's a collection of adverse childhood experiences that were studied. So experiences within the home happening before age 18 that were found to be correlated with different kinds of health conditions, social problems, and, tragically, early death, shortened life expectancy.

So specifically around substance use, the original ACEs study looked at 10 childhood experiences of adversity. And experiencing four of these was correlated with a seven times higher rate of alcohol use disorder and a 10 times higher rate of intravenous drug use. And then

specifically for cis gender men, six of these were correlated-- so six ACEs were correlated with a 46 times higher rate of intravenous drug use.

So here are some things to keep in mind about adverse childhood experiences. The original ACE study focused on adverse experiences within a household and was tested with nearly 80% white sample. The expanded ACEs, which was developed and tested in Philadelphia with a racially diverse sample, included the 10 conventional ACEs and added community-based adverse experiences, including witnessing violence, living in an unsafe neighborhood, being bullied, and living in foster care.

So the findings of the expanded ACE study with the racially diverse sample found a slightly higher rate of the conventional ACEs. So it was-- in the original study, it was 2/3 of respondents, so roughly 67%. Whereas in the expanded ACEs study, it was found that 70% of respondents, so slightly higher. But there were higher rates of ACEs when including both conventional and expanded.

So for the number of respondents, or the percentage of respondents who experienced any kind of ACE, whether it was the what's in the home, conventional, or the expanded community level, that jumped to 83% had experienced at least one of those ACEs. 50% of respondents had experienced both. Expanded aces were also common. So 63% experienced at least one. And some, a hand-- so 13% had only experienced expanded ACEs and hadn't experienced any of the conventional ACEs within the home.

And so something to keep in mind, again, when working with diverse populations is that there may be other kinds of adverse childhood experiences that may be more common or more salient in their experience. Expanded ACEs were correlated with increased risk of substance use disorder, as well as sexually transmitted infections and were moderated by socioeconomic status.

So that having economic stability was found to be a salient protective factor in moderating the risks within the substance use disorder and the STIs. So again here, really looking at how poverty is violence, right. And this is why we talk about structural poverties.

So additionally, there are limited studies that look at the prevalence of ACEs and health disparities in culturally specific groups. But the ones that do exist point to disproportionate impact and burden on racial and ethnic minorities. So in one study of Alaska Native and Native American children, it was found that they were two times more likely to have experienced two or more ACEs, compared to non-Latin American, white children. And that this was correlated with increased health disparity.

And that race-based differences were largely accounted for by structural violence, including social and economic disenfranchisement. So a lot to consider here and really pull apart when it comes to the unique realities and threats and barriers faced by persons of color in communities.

So more on structural violence, again here looking at some of the data that exists. It's been found that people of color tend to have a higher recognition of needing services, specifically substance use disorder services. So Wells found that Black and Latinx individuals were more likely to endorse structural barriers to treatment, as opposed to their white counterparts, who are more likely to endorse, you know, not needing treatment, and what's often cited in research as lower problem recognition.

Results indicated that there was a high level of, quote, problem recognition but low levels of access, as well as-- this was compounded by histories of bad experience with providers, so decreased satisfaction with services, experiences of discrimination and maltreatment by treatment staff. And studies have also found that people of color are more likely to access mutual aid, so peer-based support rather than formal treatment.

Yet even with mutual aid, there are still barriers to affiliation, to engagement, to connecting with relevant sources of support. Studies have found that there were lower rates of affiliation with mutual aid. And that affiliation is the core mechanism by which mutual aid contributes to positive recovery outcomes.

And I realize I'm getting a little jargon-y. So when I say mutual aid, I'm talking about peer-based support, community recovery groups, such as 12 Step, Smart Recovery, Women for Sobriety, et cetera. And then the realities of economic disenfranchisement, obviously not all people of color live in poverty.

And we also know that poverty disproportionately impacts persons of color, communities of color. And that there are a lot of systemic pieces that perpetuate this form of violence. So we know that there are increased barriers to employment and reduced income access, reduced insurance coverage, as well as even when insurance status has controlled, there are still disproportionate impacts of barriers.

So one national study found that uninsured white individuals access specialty substance use disorder treatment three times more than uninsured people of color. And the reality of treatment deserts, which also tend to be food deserts, pharmacy deserts, as well as areas that lack educational and economic opportunities.

Another study found that counties with higher proportions of Black residents and residents who were uninsured were also found to have less treatment programs that accepted public insurance or were publicly funded. So really a mismatch of resources that are meant to create access for people who either do not have access to insurance or are underinsured.

Interestingly, while Black individuals who were found to experience more severe employment problems, they had less severe alcohol, legal, family social, or psychiatric difficulties than their white counterparts in the study by Petry. So this indicated that culturally specific treatment needs that are responsive to structural violence and economic disenfranchisement and marginalization are particularly important.

That, you know, this study really demonstrates that integrating, for example, educational and vocational services with substance use disorder treatment for this population could be a very important adaptation to kind of traditional substance use disorder treatment. Given all the barriers that exist to treatment access, how do people of color typically access specialty substance use disorder care?

And the unfortunate reality here is that people are often driven to treatment-- people of color often access, are able to access treatment through criminal legal systems. And that this actually then drives further health disparities. So a disproportionate criminal legal system involvement contributes to health disparities of people of color.

And looking at this large scale study of Black and Latinx youth, as compared to white counterparts, it was found that Black and Latinx youth were much more likely to be referred to treatment through the criminal legal system, were more likely to be mandated to treatment, and at the same time were more likely to use cannabis and not use drugs intravenously, and were more likely to be released from treatment with a, quote, unsatisfactory status, which we know can have a huge ripple effect in a young person's life and anyone's life if they are being mandated through some kind of regulatory body, especially a legal system.

In addition to reduced access to any treatment, much less culturally responsive treatment, people of color are much more likely to be met with punitive responses that involve legal systems rather than having proactive access to health and recovery resources. And legal system involvement has been found to contribute to health disparities, including accidental fatal overdose and HIV.

One study I want to cite here. Chasnoff and colleagues in 1990, they examined the rates of compulsory treatment referral among pregnant women in Florida. And so toxicology testing found no racial or ethnic difference in the actual use of alcohol or other drugs amongst these pregnant women. Nonetheless, Black women were 10 times more likely than white women to be reported to the authorities for court intervention and compulsory treatment.

So really keeping in mind the systemic pieces that continue to drive health disparities and risk for substance use disorders, as well as create barriers to resource, that recovery capital, right, all of those resources that aid in the journey of recovery. So this brings me to this framework that many people use to contextualize substance abuse as a threat response.

This can also be used for mental health symptoms. And this actually emerged from the work of psychologists, psychiatrists, and people with lived experience who found that the DSM kind of diagnostic classes, they found that people share a lot more in common across diagnoses. And we know that there's not zones of rarity within diagnoses. There's a lot more overlap and hence the importance of differential diagnosis.

But what they did find was a commonality that they felt with underrepresented in the current diagnostic system were experiences of trauma, and not just individual trauma or acute trauma,

which many times is what the DSM-5 is really reflecting, but much more so collective trauma, the community level trauma, historical trauma in addition to individual trauma.

So in the power threat meaning framework, I'm going to walk us through it. And then I'll provide an example. So we look at the impact of power, all different kinds of power that interact in a person's life, the life of their family, the life of their community. So here we can think about, what's happened? All right.

Both the impact of history as well as modern day forms of how power moves in our society and really reflect on how is power operating in this person's life. From there, moving in to the core threats, so all the different ways that the impact of power can present threats to a person's well-being, the well-being both their bodily well-being, the well-being of their community, economic well-being, relational well-being, et cetera.

Here really reflecting on what kinds of threats has the power posed, right? So how has power been operating in this person's life and what kinds of threats does it pose? Then the kind of last part of this initial framework is the meaning piece, so both the ideological meaning, the social discourse meaning. So what does society tell us, right? What's the stigma? What's the social narrative, right? Are people blamed for their problems?

So what's the kind of social discourse around these experiences, as well as the personal discourse. And here, we're often reflecting on what sense do they make of their experience. What's the meaning of these experiences for them? As we know that traumas have a really big impact on our cognitions, really interrupt sources of meaning and connection, as well as have a big impact on our identity, our sense of self, and our connection with others.

From here, of course, we understand that there are different risks and protective factors and mediating biological processes. And then from there, within all of this framework, right, after we've considered all of this, then we get to the final reflection question. Which is, what has helped them to survive? Or in other words, what kinds of threat responses are they using? And what's the function of those threat responses?

So understanding any symptoms related to substance use and mental health as a threat response that has a function. That maybe that function is also getting in the way of some of their other goals or their other pursuits or their other domains of functioning. But starting from a place of understanding that resilience and our capacity for adaptation to extremely averse circumstances is how we see symptoms evolve, right?

That they don't just poof out of nowhere. But that they evolve-- they evolve from a context of power, threat, and meaning. So I'll walk us through an example. I was overseeing a housing program. And we had a funder who, through the funding, we were able to provide emergency food resources, so emergency food vouchers. And a funder, this particular funder was-- would require us to have receipts on file.

Now if we were purchasing food vouchers ourselves, or if we'd had a say in it, we would not keep receipts on file. Because it's very invasive. But this funder was requiring that and so we were doing our best to comply with that requirement. And there was a resident in our program who was unable to provide the receipt.

And staff had been able to cultivate a trustworthy relationship, where this person felt supported enough and felt that they could really talk about what was going on with this staff member without fear of judgment or punishment. And so shared with a staff member, I don't have a receipt for this because I traded it for drugs. And so staff was unsure of how to proceed and sought supervision.

Which supervision is really the cornerstone of sound services, you know. Sound supervision is the cornerstone of sound and effective services. In supervision we were able to talk through, OK, what are the options? And how can we support the person? And how can we move forward? There was somebody who said, well, you know, is this person still eligible for emergency food vouchers if they traded it for drugs?

And it was a really important conversation to be able to have. Because we were able to discuss, as a group, that first of all, lack of food access or threatened food access does not produce recovery. So we know that food is a really important part of recovery. And that food insecurity, food instability actually is a driver of substance use and substance use disorder.

And so, you know, cutting off access to emergency food resources is not going to help anyone and is actually going to be more of a punitive response if anything else. So we were able to talk about, OK, well, how can we approach the conversation? She's let us know what happened to the food voucher. But we don't really know anything beyond that.

Because we need to come from a place where we need to understand that people are doing the best they can with what they have in that moment. And that if she would have been able to choose having access to food and also procuring those substances, that's probably the choice she would have made.

So what was going on in her situation that she felt like her best option, or potentially the only viable option, was to trade a food voucher, trade her food resource for drugs in that moment? And so being able to approach it from this perspective and then approach the conversation from this perspective where we're joining with her, we were able to come to learn she felt safe enough to share with us that she was experiencing intimate partner violence in her relationship.

That the person who she was in a relationship with was forcing her to procure drugs. And that the violence was much more, was much worse, was much more dangerous when she wasn't able to supply drugs. And that she also was experiencing some sexual coercion and having to engage in transactional sex in the procurement of drugs, which was not something that she wanted to be engaged in.

And so here, being able to understand the context, all the different forces at play, and how that then is resulting in what was really her threat response and her best attempt at coping with her situation, then we were able to offer support that was truly relevant to her situation. We were able to then offer safety planning supports.

We were able to offer other kinds of resources that would be relevant to her situation, so that we could really expand the choices that she had access to. And in addition, understanding that her context, understanding that this person happened to also be a woman, so experiences of sexism within society, misogyny within society. She also is Black, so understanding the compounding intersectionality. And then she also is transgender.

So, again, understanding how because of structural violence, the difficulty of being able to access all of those resources that aid in recovery as well-- and just overall stability and safety, and so understanding substance abuse from kind of this holistic framework. That it's not-- we have to kind of go beyond, you know, certainly moral models. But we also have to be able to go beyond kind of medical models as well.

Along that theme of intersectionality, a systematic review looked at treatment barriers as experienced and reported by Black women. And the themes that emerged from this systematic review were themes of economic disenfranchisement. That economic disenfranchisement, which is violence, structural violence, impacted the ability to access treatment and the inability to pay for treatment, through insurance or income, the inability to access transportation, child care, as well as experiencing long wait times.

And that this was compounded by living in an area that had little access to treatment and recovery resources. Looking at family support and family responsibilities found that the family played a central role in having access to treatment and other recovery resources. So whether or not the family's supportive in engaging in treatment and other kinds of recovery resources was found to be a salient factor, as well as the responsibilities of being a mother and a wife and the overall role within the family.

And then of course here as well, the very real fear of negative interactions with the child protective systems and then experiences of discrimination and maltreatment by staff. And unsurprisingly, it was found that Black women preferred a Black woman therapist whenever possible. And here the authors also highlighted how many of the-- many of these barriers impact women of all races and ethnicity.

But for Black women there was the added barrier of structural violence resulting from economic disenfranchisement, reduced social capital, and increased scrutiny by systems such as CPS, and increased racial trauma, which then manifest in increased experiences of discrimination by service providers, as well as not having access to trustworthy staff and service.

And we've been talking so much about how trauma, both individual and collective forms of trauma, are risk factors for substance use and substance use disorders. And then on the flipside of that is the lack of access to trustworthy staff, to trustworthy services that then are going to be potentially retraumatizing and, frankly, inaccessible for people who are experiencing the effects of trauma.

And additionally, here we see the intersection more plainly laid out with interpersonal violence as well. That while women living with substance use disorders are highly impacted by intimate partner violence and sexual violence, women of color often experience reduced access to resources that aid with safety, stability, and healing from intimate partner violence and sexual violence.

And going one step further, than looking at when people don't have access to the resources meant to aid in experiences of both individual, interpersonal, and structural violence, then what are the systems that don't turn people away, emergency rooms and criminal legal systems? Our county state attorney here, she's an amazing advocate. And I'm going to quote her for a moment. Her name is Kim Fox.

And she said, you know, jail is at the-- is at the end of a road of failed systems, right. And this is particularly true when we see the gender based violence to prison pipeline, the sexual abuse to prison pipeline. So there was this landmark report, a recent report 2015. So we know that girls are the fastest growing population under correctional control, women and girls.

And that this disproportionately impacts girls of color. And we see here in this bar graph, right, disproportionately impacts Native American and African American girls, followed by Latin American girls. And that the reason, the drivers to this criminal legal system is largely due to the effects of trauma, including substance use.

So there's no evidence of increases in crime rate or in violent crimes. But there is evidence of aggressive enforcement of minor offenses and technical violations that are rooted in surviving gender based and family based violence and abuse. And that girl's common reactions to trauma are criminalized and then exacerbated by juvenile legal systems.

And that this becomes apparent when we look at the ACEs, the prevalence of ACEs in girls in juvenile legal systems. That 45% of girls in juvenile legal systems have five or more ACEs. That is astronomical. That's just absolutely astronomical. And then keep in mind, right, that these are conventional ACEs. These aren't measuring expanded ACEs, which we know are also salient risk factors.

And that just four ACEs result-- was correlated with a 10 times higher rate of intravenous drug use. And we're talking about nearly half of these girls have experienced five or more ACEs. So here we're really seeing the intersection of the common experiences of high levels of surveillance and scrutiny by systems and low access to meaningful resources and support.

And then looking at the substance use and mental health effects of intimate partner violence. So that we know, the evidence is clear that victimization by an intimate partner increases a person's risk for depression, PTSD, substance use, and suicidality. And that there are higher rates of DV amongst women accessing substance use disorder treatment.

And that that's not to say that substance use disorder treatment systems are cross-trained in intimate partner violence or are prepared to meet the needs of people who have a history of intimate partner violence or are currently experiencing this kind of ongoing targeting and abuse and assault. So on top of this, there's also been data to show that substance abuse in and of itself can be used as a tactic of abuse.

And this is a phenomenon that is known as substance use coercion. So that intimate partner violence is often targeted towards abusing somebody using substances, or using their substance use disorder, including blocking them from accessing resources meant to help them with their substance use disorder. So this was a survey style study that we did with the National Domestic Violence Hotline.

And this was just five questions. People were not prescreened for identifying as having a substance use disorder or using substances. They just were not in crisis at the time of their call and agreed to be a part of this survey. 26% of callers had used substances to reduce the pain of domestic violence. 27% had been pressured or forced to use substances or made to use more than they wanted.

24% were afraid to call police, because their partner said they would be arrested or not believed. And that this really went through the roof, you know, this really increased particularly when the person was a person of color. And then 38% said that their partner had threatened to report their substance use to authorities to prevent them from getting something they wanted or needed, such as a protection order, custody of their children, job, you know, things like that.

And then of those who had tried to get some kind of help for their substance use, 60% said that the partner or ex-partner had tried to prevent or discourage them from getting help. And Native American and Alaska Natives were the most likely to have experienced all three major forms of substance use coercion.

And so here we see now just the complexity of the interpersonal violence with the structural violence. So while trauma increases the risk of developing a substance use disorder and a substance use disorder increases a person's risk of being targeted by an abusive partner. And so stigma associated with substance use contributes to the effectiveness of these abusive tactics and the pervasiveness of these abusive tactics.

And that they further create barriers for survivors when they seek help. And that this is, of course, further amplified in the context of structural violence. So here we just have a visualization of how interpersonal and structural violence really hook into one another, feed

into one another in order to create really complex barriers for people of color, particularly survivors of color.

And so the interplay and the effects of structural and interpersonal violence plays out along all intersections of targeted social identities and marginalization, including LGBTQ communities, who also experience increased risk, substance use disorder, and barriers to affirming and effective care. So we cannot hope to end interpersonal violence until we can truly end structural violence.

So how-- so all of this points to the need, of course, for trauma-informed services. And beyond trauma-informed services to be accessible, culturally responsive, and trauma-informed services. So here we have a picture of a manual that's free on our website that is an organizational reflection tool kit on becoming accessible, culturally responsive, and trauma-informed organizations.

And some ways that this can help, so integrating accessibility as a fundamental goal, normalizing human responses to individual and collective trauma, so really that feeds into the anti-stigma approaches, and understanding symptoms as survival strategies. It offers a more holistic approach and really creates opportunities to cultivate safety and healing and nurturing those empathic connections.

Understanding that safety is not-- there's no universal definition for safety and the importance of individualization and collaborative approaches in building safety. This framework also acknowledges both the importance, as well as the challenges, of interpersonal connections, while also optimizing self-determination, optimizing control for the person over their own decisions and their choices.

Also fosters an understanding of our own responses. So how we are also impacted when we are truly open and present to the experiences of others and our self-awareness and self-improvement that is critical for trauma stewardship, as well as anti-oppressive practices. And that within this framework, we can then also recognize the role of culture, social context, structural violence.

We can work to address the social conditions that perpetuate abuse, and discrimination, and disparities, as well as recognize and incorporate sources of healing, resilience, and community. What's fascinating is that despite all of these complex risks and barriers, there's evidence that suggests that people of color experience similar recovery outcomes at follow-up.

And so this indicates the presence of culturally specific sources of resilience and healing that are not included in formal treatment. So a major reason for cultural adaptation of evidence-based practices is both to address the unique risks and barriers, as well as to strengthen long-term recovery outcomes through mobilizing cultural strengths and resources.

So what are some of the important steps in ensuring that we are including culturally specific sources of healing, but including them in a way that doesn't become a form of cultural appropriation? So now we're going to review some models, with the 30 minutes we have left, and I'll be sure to leave time for questions as well. So models for developing culturally specific and culturally adaptive practices that can mitigate the risks of appropriation and other forms of cultural destructiveness.

All right. So moving into EBP. So first of all, there's a whole lot of barriers to research evidence. There's not much diversity in the sample-- in the samples. There's a history of abuse and exploitation of people of color in research. So there's not only exclusion of people of color in research, but then also a hesitance to engage and participate in the research because of the history of abuse and exploitation.

And that there's also a lot of the exclusionary criteria for research, you know, so there was-- OK. So let me cite this research here. There was Humphreys and Weisner, their 2000 article, their article from the year 2000. They analyzed exclusionary criteria. And they identified an overall pattern that resulted in the disproportionate exclusion of Black individuals, low income individuals, and people with more severe substance use disorders and psychiatric conditions.

Also people who are experiencing or have experienced intimate partner violence have also been historically excluded from research. Even when there are diverse samples, outcomes are rarely reported by racial or ethnic identity. And then there's also problems with the broad categories that are used when racial and ethnic identities are reported out.

So there is a high risk of homogenization. And there's also assumptions about what are the salient experiences or identity. So for example, Black and Latinx urban youth may have more shared salient experiences than Latinx youth in rural versus urban settings. So looking at, what is actually the salient experiences and social identities that are-- need to be taken into account in research?

And so all of this points to the need for the expansion of participatory research, especially because many times experimental research design methods may conflict with the values and priorities of culturally specific groups. Now looking at EBPs that have been tested with diverse samples.

So Seeking Safety, Helping Women Recover and Beyond Trauma, and then many kinds of cognitive behavioral therapies, including relapse prevention therapy and specifically within relapse prevention therapy, mindfulness-based relapse prevention, what's found to be more effective with women of color than traditional relapse prevention.

The Brief Marijuana Dependence Counseling, which is a hybridization of cognitive therapy and motivational enhancement therapy. And then the Matrix Model, which is a combination of CBT and family support. Then looking specifically at motivational interviewing and motivational enhancement therapy, that there is-- there's a lot of research done both just on, you know,

traditional motivational interviewing and MET that had diverse samples both within the US and outside the US.

And then there's also cultural adaptations of motivational interviewing and motivational enhancement therapy. So there's cultural adaptations that have been developed and tested with Latinx communities, with Native American tribal nations in the Southwest, as well as Native American youth in urban settings. This has been done also to a smaller degree for Black Americans.

There may be deeper adaptation needs for Asian-American individuals. And there has been some developing, but not much testing, for adaptations of Asian American and South Asian American individuals. And then looking at youth, so here these are the EBPs that have been most tested with diverse samples of youth, so Adolescent Community Reinforcement Approach, Functional Family Therapy, combined MET and CBT, multi-dimensional family therapy, multi-systemic family therapy, and teen marijuana check-up.

The multi-systemic family therapy is also recommended evidence-based practice for Black adults who've been found to have more intact family relations and extended networks of support when compared to their white counterparts. And then for culturally specific interventions, a meta-analysis done by Steinka and Fry, specifically looking at youth interventions.

So it was found that culturally sensitive interventions yielded statistically significant decreases in substance use. The majority used group or individual and family formats. And here are the different interventions that were found to be evidence supported that were culturally adapted or culturally specific. All incorporated language accessibility. And clinicians generally trained in cultural responsiveness.

Some matched clinicians racially or ethnically to the adolescent and family. All incorporated culturally responsiveness to salient experiences, including attention to cultural strengths and resources, as well as experiences of discrimination, acculturation stress, and migration trauma.

And then looking at adults, culturally specific interventions for adults, so generally, culturally adapted EBPs have been found to be more effective when compared to unadapted EBP. Still more research is needed. So here's a list of promising interventions. But again, there's still more research needed.

So now looking at methods in evidence-based and evidence-informed adaptations. There are many models that exist around cultural adaptation. And they have many common elements, many which you see displayed in this infographic from the National Latina Network. So we'll review just a couple of the models here.

So the main reasons for cultural adaptation are first ineffective clinical engagement. So I was delivering a webinar a couple weeks ago, or maybe last week, I forget. And there was a really

great question around what do we do if, you know, somebody is having trouble attending appointments because of the violence that they're experiencing in their life? But then at the evidence-based model, you know, in order to practice with fidelity, we're supposed to not allow them to continue in the intervention.

And so here, that's a really important reason for adaptation. That if, for whatever reason, someone has-- doesn't have access or whatever barriers they're experiencing to their engagement, that this is a really important reason for adaptation of any evidence-based practice. So ineffective clinical engagement, the presence of unique risk or resilience factors, the presence of unique symptoms of a common disorder, or non-significant intervention efficacy for a particular group.

So here's a heuristic model from Castro's article, which the last slide was also from Castro's article. And so here I've highlighted the kind of often the reasons, or the drivers of cultural adaptation and adaptation in general. So an ineffective clinical engagement, we can look at outreach. Does the community recognize the provider as a potential source of assistance?

We can look at access. Are there organizational barriers, such as language or procedures or environment? So what kinds of organizational barriers are there that are really culturally insensitive, not responsive, or culturally destructive to accessing services? So it's not enough to be able to once you're already in services find out that there's interpretation services, right.

That that needs to be communicated somehow on the front end. Otherwise, it's not very useful. Engagement, so if the person is able to make initial contact, do they then engage with the program and with the provider? Problem and goal definition, here looking at, can the person and the provider-- can they arrive at a mutually resonant, acceptable definition of problem and goals?

How is that discussed? How is that-- how is the provider really adapting their communication to be culturally relevant and responsive for the person? Or is the provider's culture being kind of projected onto the person? And only when they adopt that kind of problem formulation and treatment formulation can they access the services that are offered.

Then the acceptability of the intervention, so once the goals or the need have been negotiated, and they're responsive and acceptable, are the services that are being offered relevant and acceptable? Then from there, looking at participation in those services. So often we talk about as adherence, as well as the completion of those services, or what we often talk about as retention.

Does the person stay long enough in the service to get an adequate dose of the intervention? And then looking at unique risk and resilience factors, do certain groups exhibit different ideological processes that influence the occurrence of the condition or the course of the condition? And if so, do we need to add some intervention components to address those factors or modify or delete existing components?

Are there unique protective or resilience factors that can be included in the services being offered? And then looking at the unique symptoms of a common disorder, identifying unique symptom features from the epidemiological research, this is especially important to screen and attend to physical symptoms for potential somatization.

And we can also look at the literature on culturally bound syndromes, as well as SAMHSA's TIP 59 for common beliefs and traditions surrounding substance use. Now of course, always guarding against not making assumptions or engaging stereotype bias. And then lastly, looking at non-significant intervention efficacy, does the client respond to the intervention when the intervention is delivered at its optimum dose?

So this, of course, there is an assumption that the client has been exposed to the evidence-based practice and that their outcomes are sufficiently tracked. And many times, this is not the case. So here really highlighting, of course, the importance of evidence-based practice as not only a noun but also a verb, the ongoing measurement and evaluation of client outcomes and progress or lack of progress in order to inform clinical decision making.

Now there are a couple different ways generally to look at cultural adaptation. There's top-down, which is that we take an existing evidence-based practice and we just change a couple things about it and then deliver it with a different group. And there's a lot of reasons why that isn't enough, right.

It assumes that, you know, something that has been effective for white people will be effective for people of color with just a couple of tweaks. Kind of reinforces this idea that white people are the neutral. Or that whiteness is like a base culture that people of color culture can just kind of be sprinkled on top of.

There's also an assumption that implicit bias can be detected or removed from interventions. Or that interventions are somehow bias free. And that EBPs developed from a euro-centric culture can continue to replicate existing oppression, oppressive structures. These are all things to keep in mind if we are using top-down approaches to cultural adaptation.

A bottom-up approach to culturally specific programs is a practice or intervention that's developed within the perspective, values, history, traditions, and realities of our group's specific cultural context. And here we have an example from SAMSHA's TIP 59. Ho'oponopono is a form of group therapy used by Native Hawaiians that involves family members and is facilitated by a Kupuna, an elder. It was found to be highly effective with pregnant and postpartum women with substance use disorders, primarily methamphetamine use.

Then looking at surface versus deep adaptations, so surface adaptations are really just those small changes of materials and activities that are just small changes in observable aspects of culture, like language, music, foods, clothing, changing role play examples name from John to Juan, right. So really surface level changes to more deep structure adaptations.

So these are changes based on deeper cultural, social, historical, environmental, and psychological factors that influence health behaviors in a population. So for example, an example of a deep structure adaptation the international recovery coaching principles excluded the principle of empowerment and self-determination, which are in the US recovery coaching principles.

Because there was no consensus internationally that empowerment or self-determination were defining aspects of recovery in the global context. So seeing that that's-- was being more responsive to those deeper cultural and psychological factors present in other cultures.

Then I also wanted to highlight this second model from Burrow-Sanchez and all. So cultural accommodation model for substance abuse treatment, and here you see that there's state one, all these different sources of information. Stage two, that information is integrated. And there's adaptations made both in the content of the treatment as well as the delivery of the treatment.

And then, of course, with any other process, there is a piloting, and then from there, a rolling out, and, in their case, efficacy testing. And here is an example taken from the table in their article of one of the major themes that they found, the theme of family. And this was specifically with Latinx individuals and communities.

And so finding the theme of family being very central and the different sub-themes that came up from those different information sources. And then in the content, they infused role plays that included relevant family situations. And then in the delivery, the changes that they made with a increased contact with parents and adolescents through phone calls, mailings, as well as holding an initial parent meeting.

And then here, enhancing effectiveness for survivors of intimate partner violence. Based on our systematic review, these five following steps can enhance existing evidence-based practices. So psychoeducation around the causes and consequences of IPV and their traumatic effects, awareness of mental health coercion and substance use coercion, and the sabotaging of recovery efforts, attention to ongoing safety, cognitive and emotional coping skill development to address trauma-related symptoms and support goals, and a focus on survivors' strengths as well as cultural strengths on which they can draw.

So I am at my summary slide. And at this point, I will go ahead and just open it up for questions. And here's a visual of transforming the conditions that perpetuate violence. And then we also have on our website a whole portion of our website dedicated to resources for mental health and substance use treatment and recovery support providers.

So I'll just kind of flip through these different resources we have. There's a comprehensive list of references and resources available, my contact information. And then I would love to open the floor.

ASYA LOUIS: Thanks so much Gabriela. We have just a few minutes for questions. And we had two submitted prior to the webinar that I'd like to start with. The first is, what do you think of 12 step programs as part of substance use disorder treatment?

GABRIELA ZAPATA-ALMA: I love that question. Thank you for asking me that question. Couple things, one, 12 Step is not treatment. And 12 Step doesn't purport to be treatment. And so I think it was best said by a member of 12 Step who said, don't pay for treatment for what you can get for free in the community. So 12 Step should not be the basis of treatment.

That said, 12 Step facilitation has been found to have-- to have good evidence. And 12 Step facilitation is a counseling that help somebody in early recovery both, you know, develop those different kinds of behavioral and cognitive coping, but then also facilitates their use of 12 Step, of all the different aspects of 12 Step, so the step work, the sponsorship, the fellowship, the service, et cetera.

Now in this context, particularly for persons of color, the majority of people in 12 Step it's been found that benefit from 12 Step and attend 12 Step are middle-aged white men who are married. That said, there has been evidence found that particularly people who identify as spiritual or identify with the Christian faith do have higher rates of affiliation with 12 Step.

And that this has been found for Black Americans. And so as a service provider, what's most important I would say is offering information on all the different options available, getting a sense of what resources there are in your community that have membership that are racially diverse, and providing unbiased information.

Not requiring attendance at 12 Step but also not keeping that resource from people. Because people who could benefit from it. You know, many people do benefit from it but particularly when they can feel a sense of commonality and affiliation with other members. And so knowing where and when racially diverse and women specific groups can-- and LGBTQ specific groups can be accessed.

ASYA LOUIS: Great. Thank you so much.

GABRIELA ZAPATA-ALMA: Let me say one more thing about that. There's also a 12 Step adaptation by Native communities that is based on an integration of the medicine wheel and traditional medicine and 12 Step and that a lot of people find that helpful, too.

ASYA LOUIS: Wow. That's so interesting. Thank you for sharing. Sort of as a follow-up actually, we have a question, how do you integrate the concept of cultural humility into your practice?

GABRIELA ZAPATA-ALMA: Yes. So hopefully people heard me saying things like attention to history, understanding the impact of history, understanding that we're ecosystems of culture and social identity and intersectionality. So all of this are part of the principles of cultural

humility. And that while it's important to know something about history, it's important to know something about cultural resources, cultural experiences, cultural strengths.

It's also really important to guard against stereotypes. And so what cultural humility has brought to our field is so incredibly important. Because it helped us move away from, you know, learning a list of supposed cultural attributes and instead moved us towards creating radically trustworthy, egalitarian relationships, where we bring an understanding of history and the impact of history and approach culture from the place of relativism, of humility, of understanding that we can only perceive other people through our own lens of culture.

And most importantly, that an institution must be held accountable to the very same principles. That we can only practice in culturally humble ways when we have institutions that are accountable and are practicing cultural humility. So yes, cultural humility, absolutely, it's a great framework, very important.

ASYA LOUIS: Our next question is, how do you integrate faith-based support into your services?

GABRIELA ZAPATA-ALMA: Yeah. Thank you for that question. So we need to approach faith and belief as another dimension of culture. And knowing that everyone has some kind of belief system. That atheism, humanism, agnosticism are also forms of belief the same way that what we more typically consider to be belief, organized religion also, that they're all forms of belief.

And so we need to be able to tap into people's belief systems as well as their communities of support. That for many people, for many people, whether it's kind of a church home or a faith community, or for somebody who may be more inclined towards humanistic ideals, than for many people who are inclined towards more a humanistic spirituality, their friends and family are really their faith community.

That those relationships are what they hold sacred. And so being able to detect and assess those spiritual strengths and resources are incredibly important. Because all of that is showing up in the therapy room. All of that is showing up in our services. And we do a disservice to people when we ignore it or when we gloss over it or when we're unprepared to be aware and responsive.

That said, there are also protective factors involved with faith and with spirituality and religion. There can also be risk factors involved with faith and spirituality and with religion. You know, for example, if someone feels like their substance use disorder is a manifestation of their spiritual wickedness. And we're not here to come in and say, no, you're wrong. Don't believe that, right.

Because that can be horrifically alienating and othering and invalidating. But to be aware of the different ways that faith, belief, and spirituality can show up, so that we are prepared to attend to those needs, to leverage strengths, as well as attend to those mean. And really understanding it as another dimension of culture that transcends racial ethnic identity.

But it's also very much rooted within racial ethnic identity and as such is subject to the phenomenon of acculturation as well. And I've probably said way too much for that. I've probably gone way too into detail for that question. But hopefully that answers that question.

ASYA LOUIS: No, we certainly appreciate how in-depth you go. You surely show how committed you are to the field.

GABRIELA ZAPATA-ALMA: Thank you.

ASYA LOUIS: And that concludes our question and answer period today. That's all the time we had. And in conclusion, we would like to thank you Gabriela as well as our participants for a really great question and answer period and for joining us on this webinar today. We hope that you've been able to utilize the information presented today to strengthen your work.

And in closing, we'd like your feedback on this webinar. After you close the webinar window, a new window will pop up that includes a brief survey. Thank you. And this concludes today's webinar.