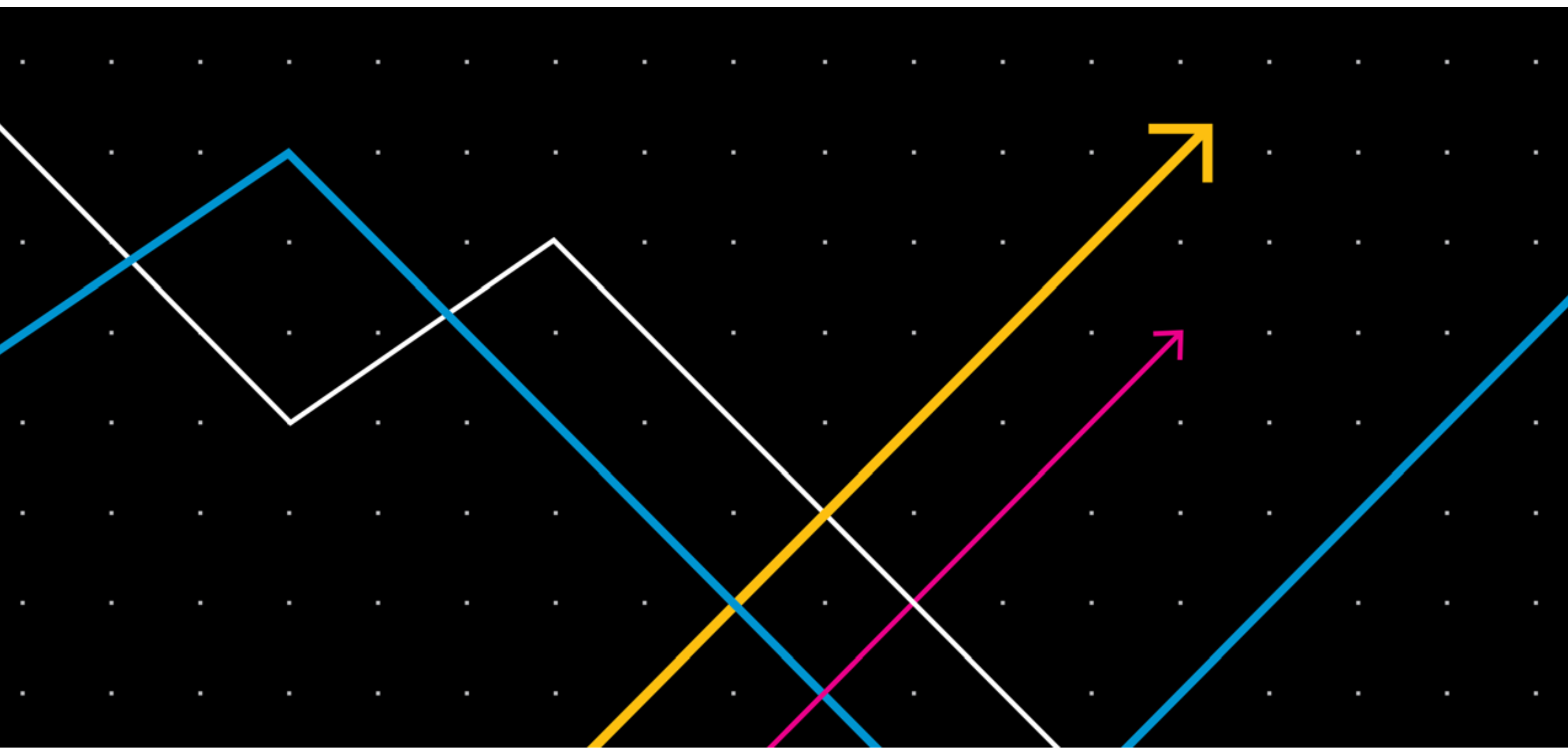

RESEARCH REPORT

What Will It Take to Meet Substance Use and Social Service Needs in Communities of Color?

Lessons from 27 Programs and Priorities for Future Policy

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June 2021

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Acknowledgments

This report was funded by the US Department of Health and Human Services' Office of Minority Health and Office of the Assistant Secretary for Planning and Evaluation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors thank Genevieve M. Kenney for helpful comments and suggestions.

Executive Summary

Communities of color—American Indian and Alaska Native, Asian American and Pacific Islander, and Black, and Hispanic/Latinx populations—continue to experience inequities related to substance use, as the Biden administration recently acknowledged.[1] Research shows people of color who use substances have inadequate access to substance use disorder treatment (Pinedo 2019), experience worse outcomes when they access treatment (Mennis and Stahler 2016), and have high social service needs, and these patterns are driven by systemic racism and community disinvestment (Farahmand, Arshed, and Bradley 2020). Yet, relatively little research and policy attention have been given to identifying models of culturally and linguistically effective care that address unhealthy substance use and social service needs among communities of color, which are highly diverse.

To fill this knowledge gap, we interviewed substance use service providers from 27 programs across the country to learn about care and services that engage and support people of color with unhealthy substance use in treatment and recovery and to create policy recommendations to better support high-quality care and services. We selected programs that employ evidence-informed and culturally effective approaches to substance use and address social service needs. The substance use programs in our study commonly

- center and reflect the community in leadership and staff, services, and pathways to treatment;
- offer comprehensive, holistic care addressing substance use and health and social needs;
- use person-centered and harm-reduction approaches; and,
- incorporate culture, including culturally and linguistically effective services, into their organizational structures and treatment models.

Such programs span culturally or linguistically specific services, harm reduction, strength-based care approaches, and clinically recommended treatment options. Our study sample criteria also required programs to be geographically diverse and serve American Indian and Alaska Native, Asian American and Pacific Islander, Black, or Hispanic/Latinx populations.

Participants described a wide variety of challenges and limitations, including structural barriers that limit their abilities to address social needs, challenges training and maintaining staff, and program

funding issues, including a lack of adequate funding, complexities related to combining multiple funding streams, and limited funds for program evaluation. We find that leaders of the study programs have been creative and resourceful in advocating for funding, but doing so was time intensive. And program leaders still reported facing structural hurdles to fully funding the community-driven, harm-reducing, holistic, and culturally effective care they strive to provide. Program staff frequently cited the following as barriers to effectively serving their patients:

- historic racism and other structural barriers that limit resources available to address social needs
- challenges maintaining staff with language and cultural skills and program values
- a strong need for fundraising and heavy reliance on multiple funding streams
- a lack of adequate federal and state government and philanthropic funding
- numerous funding gaps for specific services and populations
- a lack of program evaluation data demonstrating effectiveness in ways that could expand funding opportunities

Participants in this study also described several research gaps related to caring for people with substance use in communities of color. They therefore suggested various policy and program changes and community resources needed to effectively address the needs of people of color with substance use issues. The study participants' eight recommendations (ordered from broad to narrow below) focused on guiding government policy and funding to ensure a culturally effective approach to meeting substance use and social service needs:

1. Transform the government's approach to substance use; end the War on Drugs and promote culturally effective policies.
2. Involve communities in decisionmaking to change substance use policy.
3. Increase funding and reimbursement opportunities for culturally and linguistically effective care in public and private insurance.
4. Increase funding for harm reduction and other social services that respond to community needs.
5. Increase flexibility in grant funding that supports care for the uninsured and in reimbursement rules related to the health care workforce and billing in public and private insurance.

6. Provide technical assistance to community-based clinics and organizations on applying for federal grants, collecting data, reporting on performance metrics, conducting program evaluations, and building other capacities.
7. Engage the community in substance use research by partnering with community members to codesign initiatives that invest in the community and by funding researchers who live in the community.
8. Enforce and reassess community-centered policies already in place (e.g., culturally and linguistically appropriate services, or CLAS, standards.

What Will It Take to Meet Substance Use and Social Service Needs in Communities of Color?

Communities of color—American Indian and Alaska Native, Asian American and Pacific Islander, and Black, and Hispanic/Latinx populations[*]—continue to experience inequities related to substance use, as the Biden administration's Office of National Drug Control Policy recently acknowledged.[2] Research shows communities of color have more unmet needs for substance use disorder (SUD) services and experience worse outcomes when they access such services than do white people (Acevedo et al. 2012; Arndt, Acion, and White 2013; Dickerson et al. 2010; Evans et al. 2012; Garrison et al. 2019; Guerrero, Khachikian, et al. 2013; Guerrero, Marsh, et al. 2013; Lewis et al. 2018; Mancini, Salas-Wright, and Vaughn 2015; Mennis and Stahler 2016; Mulvaney-Day et al. 2012; Pinedo 2019; Ramos et al., forthcoming; SAMHSA 2020; Yu and Warner 2013).[3] The structural racism that has permeated all aspects of life in the United States drives these disparities, including the inequitable ways in which substance use policies and treatment resources are designed and delivered (GAO 2017; Ramos et al., forthcoming; US Commission on Civil Rights 2019). In particular, long-standing criminalization of substance use has disproportionately affected communities of color (Fellner 2009; Meng 2015; Provine 2008)[4] and resulted in a treatment system inadequately equipped to address the health and social needs people of color are more likely to experience, such as the fallout from criminal justice involvement (Ramos et al., forthcoming).

The literature examining the barriers and facilitators to providing effective substance use services across different communities of color in the United States is limited, particularly for Asian Americans and Pacific Islanders and those who identify as two or more races. Further, we know little about how

[*] As noted, "communities of color" refers to American Indian and Alaska Native, Asian American and Pacific Islander, and Black, and Hispanic/Latinx populations and the diverse subgroups and cultures within them. We recognize, however, that these terms do not resonate with all people in these groups, and we remain committed to using respectful, inclusive language.

integrating human services with substance use care and treatment affects engagement and outcomes for people of color (Allen, Ramos, et al., forthcoming).

A growing body of research documents the effects of systemic racism on both people of color who use substances and their communities (Alegría et al. 2021; Bailey, Feldman, and Bassett 2020; Farahmand, Arshed, and Bradley 2020; Hansen, Jordan, and Tookes 2021; Hardeman and Karbeah 2020). On the Biden administration's first day in office, the President signed an executive order directing federal agencies to advance racial equity and support underserved communities.[5] Additionally, the administration's year-one priorities for substance use policy prioritize advancing racial equity in the federal government's approaches to substance use.[6] By centering racial equity, the new administration is poised to enact policy reforms to help root out structural racism in federal substance use policy and improve care and well-being for communities who have been harmed.

The findings in this report draw on interviews with staff at 27 substance use service programs serving people of color across diverse populations in the United States. We seek to fill some of the gaps in current knowledge and provide a greater understanding of promising models and strategies to substance use care that respond to the diverse needs of communities of color. Below, we describe the interview methodology used to collect data. We next provide key findings describing the practices, strategies, and challenges substance use programs experience when serving communities of color and share research gaps identified by the programs. We conclude with interviewees' eight policy priorities for both federal and state governments and a discussion of the study's implications for policy and practice.

Methods

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 used the provision of such services as a key criterion for selecting programs and models for this study. As noted, we also focused on programs serving the following racial and ethnic groups: American Indian and Alaska Native, Asian American and Pacific Islander, Black, and Hispanic/Latinx 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.) We

also required that study programs address clients' social needs. After a 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 representative's and project team's 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 and Pacific Islander, Black, and Hispanic/Latinx populations because of the 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 both clients' and communities' needs and clinical evidence; they likely do not represent programs from these communities. Appendix A includes brief descriptions of the programs included, and appendix B shows the demographic characteristics of the clients served by the programs. Staff from almost all of the study programs reported that their programs served more than one racial or ethnic group; 9 programs serve American Indian and Alaska Native populations, 10 serve Asian American and Pacific Islander populations, 12 serve white populations, 16 serve Black populations, and 20 serve Hispanic/Latinx populations. We also found that the populations served by the programs in our study often intersect with other marginalized groups, such as people identifying as LGBTQIA+, immigrants, people experiencing homelessness, and people involved in the criminal justice system.

Data collection and analysis. We conducted interviews virtually via Zoom between May and December 2020 using a semistructured interview guide. Researcher demographics are shown in appendix B, and the interview protocol is in appendix C. The discussion topics included programs' approaches to serving people of color, their outreach to the 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 we conducted interviews 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 paper (Allen, Winiski, et al., forthcoming). 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 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 (4 out of the 13 programs contacted participated), programs serving American Indian and Alaska Native communities (1 out of 14 participated), and programs in the South (0 out of 4 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.

Findings

Below we describe key themes that emerged from discussions with staff from the study programs. We first summarize characteristics the study programs have in common. We then discuss the constraints and challenges limiting programs' impacts, research gaps described by study participants, and participants' policy priorities to more effectively support programs in addressing the needs of people of color with substance use issues.

Characteristics Study Programs Have in Common

Program staff indicated that collaborative leadership structures that reflect the community in their staffing and decisionmaking greatly facilitated a program culture and service design that respond to community needs. As noted and discussed in greater detail below, substance use programs in our study commonly

- center and reflect the community in leadership and staff, services, and pathways to treatment;
- offer comprehensive, holistic care addressing substance use and health and social needs;
- use person-centered and harm-reduction approaches; and
- incorporate culture, including culturally and linguistically effective services, into their organizational structures and treatment models.

CENTER AND REFLECT THE COMMUNITY IN LEADERSHIP AND STAFF, SERVICES, AND PATHWAYS TO TREATMENT

Staff from each program described being rooted in and driven by the communities they serve. Staff centered community needs by hiring from the community and continually seeking community members' input. Interviewees agreed being community centered is essential to effectively engaging and meeting the needs of clients of color.

Leadership and staffing that reflect the community. Program staff indicated collaborative leadership structures that reflect the community in their staffing and decisionmaking greatly facilitated a program culture and service design that respond to community needs. We repeatedly heard the importance of employing staff who reflect the community, including with their language skills and culture. Interviewees said it is important to have diverse staff at every level; as one said, "People sometimes say that, 'I go and I see the secretary looks like me, it's not the directors and the managers or clinician.' So, sometimes you have to make sure that all the layers are diverse, not one layer."

However, program leaders also shared that they didn't just want to "check the box" with diversity and highly valued lived experience. Some interviewees had found employing peers was the most effective way to reach and engage clients with substance use issues. Interviewees also described how they invest significant time to finding staff who are a good fit for the organization. For example, one shared, "We need a specific kind of person—a person that's not intimidated to go into the home, or transport clients in their car, or just engage with our families…who can put on jeans and go out to the home and sit at a cookout."

Given that staff often have lived experience, program leaders recognized that such employees' growth in their jobs is also a continuation of their long-term recovery. Many of the program leaders had lived experience, reflected their community in other ways, and had started in the organization as an intern or counselor. We also frequently heard that organizations had staff who had come through their programs. As one interviewee shared, their organization was always "looking for more people in recovery to serve as peer recovery coaches or mentors…even preparing them to become director someday."

Services driven by community input and client demographics and needs. We consistently heard how programs sought to be versatile and responsive to their clients' and communities' needs. Some programs approached this through a nonhierarchical organizational structure, where leaders obtain continual input and share opportunities to lead with their staff. In addition to hiring staff from the community, program staff mentioned seeking community input from clients through surveys, focus groups, or community advisory groups as their primary strategy for identifying community needs and developing practices and policies accordingly. This means programs rarely serve a narrow demographic group and are constantly adapting, expanding, or modifying services to meet their clients' needs.

Respondents recounted how feedback from clients led their organizations to create new services. At one program, staff learned that clients who experience homelessness faced discrimination or may not qualify for assistance because they carry syringes or take medications for opioid use disorder. In response, the program developed its own shelter and transitional housing. Several other informants described how demographic shifts in their client populations required them to develop new capacities and partnerships, such as adding staff with linguistically and culturally effective skills or developing programming for adolescents and youth, LGBTQIA+ clients, or new immigrants and refugees. One respondent aptly captured the importance of community input and responsiveness, saying:

> "Our model works for our demographic. Sometimes when people develop programs, they think that they can just take and implement, whereas we get feedback from our families and listen to our community. So, our program works really well because it was made specifically for our demographic, in our community and the things that we saw culturally in our community. You may take this and put it somewhere else and it may fail, because it's not meant for that community, it's meant for this one."

Offering multiple pathways and reducing barriers to treatment. Programs also centered community in how they engage clients in treatment and conduct outreach. Many study programs take a "no wrong door" approach, meaning they create multiple pathways to substance use treatment services; clients can access treatment through internal or external referrals, community outreach teams, or by walking in. Several programs also strive to remove or minimize barriers to treatment, for example, by not requiring

health insurance or a picture ID and by going out into clients' communities. Some programs use mobile clinics and community health workers to reach out to potential clients and provide basic health care, inductions into medication treatment, or maintenance of medication treatment.

Though word of mouth seems to be one main way clients learn about and access services, many programs in our study also receive referrals from other community-based organizations, social service agencies, and the legal system. Several programs collaborate on diversion and reentry programs or work with clients who have been referred to treatment after driving under the influence.

OFFER COMPREHENSIVE, HOLISTIC CARE ADDRESSING SUBSTANCE USE AND HEALTH AND SOCIAL NEEDS

Many informants strongly emphasized the need to address the whole person, including their health, social, and emotional needs, for those struggling with unhealthy substance use; doing so can support their well-being in treatment and recovery or even (or especially) while they are still using substances. (See the below discussion of harm-reduction philosophies embraced by several study programs.) As one informant explained, "Just providing treatment is not going to help people change their lives and improve the quality of their life for long-term periods." That informant added that substance use treatment providers need to understand "how to move people that are largely underserved and disenfranchised in our community from a place of degradation to dignity."

Addressing the full continuum of care for substance use. The programs we studied were designed to respond to the treatment needs of their clients based on prevalent substance use trends in their communities. Many programs also incorporate a continuum of substance use services, from harm reduction and early intervention to treatment and recovery services. This continuum includes a 12-step program, medications for opioid use disorder, outpatient and residential treatment, individual and group therapy, and recovery support services. Most programs, however, partner with other providers in the community to deliver the full continuum of substance use care. Many programs incorporate family members in treatment, and several offer residential programming for parents with children and do not limit the number or age of children parents can bring with them to programming. Many programs also build in opportunities for positive social interactions, recreational activities, and new experiences, such as taking clients to the beach or fine dining. As described below, participants also indicated that providing a continuum of care for SUD will require systems change and additional funding. As one respondent said:

> "It's not like you just have to get more MAT [medication assisted treatment for opioid use disorder] into the clinic. You also have to change the funding streams, you have to change the

> way the courts sentence, you have to change the way the jail operates, and the way the police and the guards are trained, and the way they do business."

Addressing physical and mental health care needs. Many programs also address clients' emotional, physical, and mental health needs. As one interviewee explained, integrated primary, behavioral, and mental health care takes on a new meaning for programs that serve clients who (1) may lack health insurance or the ability to navigate complex systems of care and/or (2) have comorbidities and chronic physical and mental health conditions but may distrust health care providers or have been traumatized by discrimination in health care settings. As such, many programs in our study take a "one-stop shop" approach, providing substance use, physical and mental health services, and sometimes dental care in one location, ensuring clients can access needed care in a setting where they feel safe and comfortable. Programs also commonly use multidisciplinary teams and team-based care to ensure clients' needs are identified and addressed and needed services are coordinated.

Addressing social needs as inseparable from substance use treatment. Nearly all study programs provide some direct social services and offered assistance or navigation to help clients apply for public benefits and access needed social services and supports in the community.

Several informants said they saw social services and supports as inseparable from treatment and the core of their mission. Often, these organizations may be one of the few providers or the only provider of services for people of color in the community and thus play many different roles. As one informant expressed:

> "We're helping organizations. That's it. That's the core of any ethnic service, ethnic community–facing organization. We become masters of everything. It makes me chuckle these days because the term of the last decade has been integrated care. What is there to integrate? We've been doing everything from the very beginning."

During the intake process, programs often screen clients about their health and social needs to determine the services or supports they may need. Routinely, programs help clients enroll in Medicaid; obtain Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and Supplemental Security Income benefits; navigate public housing assistance; or obtain picture IDs, voter registrations, and green cards.

Clients' needs often inform the direct social services and supports that programs offer in house. For example, programs that primarily serve people experiencing homelessness operate shelters or provide permanent supportive housing. Programs that specialize in providing reentry services work to address a range of social needs, from legal assistance, to job skills training, to housing; they also often incorporate support and education in basic life skills, such as parenting, financial literacy, cooking and nutritional

guidance, or even civics. Programs primarily focusing on women might include interpersonal violence services and transitional housing for survivors of domestic violence. Many programs have food pantries on site and offer child care and transportation assistance, and some help clients pay utility bills and educate them on tenants' rights.

Working with many partners to address social needs. Programs partner with a wide range of service agencies and community-based social service providers to fill the gaps in services they may not offer in house. Case managers and care coordinators are typically responsible for helping clients find and access needed services.

Several programs collaborate or coordinate with multiple public systems. A few work with local school districts, where they provide youth behavioral health prevention and intervention services. Other programs work with local police departments, courts, probation agencies, and correctional facilities on diversion and reentry programs. They may also coordinate with child welfare agencies. Several informants described productive relationships with these agencies that help their programs keep clients out of the legal system (or stay in touch if a client goes to jail) and facilitate community-based access to services and treatments.

One informant noted their particularly trusting relationship with a local child welfare agency helps them keep families together or facilitate speedier reunification. On the other hand, some informants characterized their relationship with the public safety system as adversarial or neutral at best, noting the politics and personal beliefs of the people in charge of public safety services often dictate such services' coordination with the study programs. One informant said that "meeting people where they are" should not only apply to clients but to partners from law enforcement and human service agencies. This suggests building collaborative relationships across all systems that serve a community requires the same approach as building trust with clients.

Staff at the study programs also worked to help their partners more effectively serve their clients. One program teaches doctors and clinicians about harm reduction. Another interviewee said their program has been working to train school counselors and psychologists to work with populations who have experienced significant trauma and face poverty and discrimination.

Organizational capacity and a skilled workforce for providing holistic care. Interviewees emphasized that providing holistic care is resource intensive and requires significant organizational capacity, such as writing and coordinating grant applications to cover a range of services, navigating regulations and certification requirements, coordinating and maintaining multiple funding streams, and communicating with state policymakers or lobbying them about needed policy and regulatory changes.

To connect clients with the social services they need, staff must be skilled in "navigating the social services system and human services system, which is complex and difficult, even for people who aren't experiencing language and transportation barriers," according to one participant. That participant added:

> "We've worked hard to get more case management services into our programs, but it's never enough. The process of trying to get identification and a birth certificate is a good example, because you need identification to get a birth certificate and a birth certificate to get identification. You feel like you're going around in circles. Even our well-educated, literate case managers want to pull their hair out."

USE PERSON-CENTERED AND HARM-REDUCTION APPROACHES

Participants reported that their clients face considerable stigma in seeking help for substance use and mental health conditions, which also negatively affects many aspects of their lives, such as their abilities to find housing and employment. This can be particularly acute for transgender clients and clients involved in the legal system. Interviewees described the importance of using a harm-reduction framing to help program participants overcome the stigma associated with seeking help.

Prioritizing harm-reduction and client-focused approaches. Embracing a harm-reduction approach to care was a strong and consistent theme in our interviews. Informants most commonly described this approach as meeting people where they are in their substance use treatment journey and supporting people who use substances so they can stay as safe and healthy as possible. For example, a mobile outreach team may offer water, snacks, or clothing to someone preferring not to come to a clinic for treatment or other services. One informant explained that their initial conversation with a client may not even cover substance use or mental health treatment, but small gestures like giving someone a bottle of water or asking about their day can help grow trust and eventually facilitate entry into treatment.

Another informant described their program's approach as primarily delivering interventions in the community, where potential clients feel most comfortable. Their program helps clients recognize their strengths and weaknesses and educates them about the importance of self-care through informal conversations and relationships. The program thereby empowers people to seek services that improve their health, which, in turn, often leads to clients seeking treatment later, when they are ready.

The programs in our study provide clients with harm-reduction services including wound care, syringe exchange services, overdose reversal training and medications, and testing and treatment for infectious diseases such as HIV, hepatitis C, and sexually transmitted diseases. One informant described their program's harm-reduction approach as listening to clients and respecting, supporting, and

addressing their needs and goals, even those unrelated to substance use. Respondents said these practices can also help cultivate trust that can eventually help clients enter treatment. Another informant explained that treating clients with respect is especially important because clients may otherwise not be respected in their community because of stigma and discrimination related to their substance use and other intersecting characteristics, such as their race and ethnicity, gender identity, disability status, or socioeconomic status.

The same informant went on to say that "helping our clients to feel safe, to feel appreciated, respected is really a key component of the treatment process." Therefore, several informants rejected abstinence-only approaches, recognizing abstinence may not be a realistic goal, and clients should not be penalized for recurrence of use. Indeed, several programs allow clients to reenter treatment or receive other services if they terminate treatment. In addition, interviewees described the importance of preparing all staff to engage with clients; as one leader explained, "I actually want our front desk staff to go through…basic MI [motivational interviewing] training because it's the first person you see. If the front desk is able to do some basic MI and engagement, it's more likely that you stick around."

Using healing-centered and trauma-informed approaches to care. Many informants also described their approaches to care as healing centered and trauma informed, recognizing that people from marginalized communities who have unhealthy substance use often have faced or are facing traumatic experiences. These experiences include abuse, domestic and neighborhood violence, foster care, criminal justice involvement, racism and discrimination, and intergenerational trauma. Interviewees also recognized that many of their staff members may have had traumatic experiences and may be retraumatized through their work, and therefore these program leaders take a trauma-informed approach to engaging with staff, too.

Study respondents asserted that addressing underlying trauma is essential to successfully engaging clients in treatment and supporting long-term recovery. Most participants described incorporating various asset-focused, strength-based, and trauma-informed approaches to care to address clients' experiences of stigma and discrimination. Respondents also noted that supporting clients requires pairing evidence-based therapies (e.g., cognitive behavioral therapy) with deep empathy and kindness. As one of our informants suggested, trusting relationships between counselors and clients can support healing. Another informant shared the following:

> "We don't just believe in trauma-informed practices, we live trauma-informed practices. We treat everybody with extreme welcoming and friendliness and understanding and empathy...When they walk in our doors, they feel treated like a human being, sometimes for the first time."

INCORPORATE CULTURE, INCLUDING CULTURALLY AND LINGUISTICALLY EFFECTIVE SERVICES, INTO ORGANIZATIONAL STRUCTURES AND TREATMENT MODELS

Interviewees shared that many prevalent treatment models and substance use programs deemed evidence based in the United States were designed for white patients. Thus, understanding of how well these models meet the needs of people of color is limited. In response to community and patient needs, program staff modified multiple aspects of their care, including the program's organizational structure, the treatments and services it offers, and how those services account for intersectionality and multiple cultural identities. Program staff members also described addressing historical trauma as part of their culturally effective care. Further, program leaders we spoke with had often developed their own models of care. One described cultural effectiveness as part of caring for the whole person and of customizing care for each individual, by "understanding who [patients] are, how they identify, their religious beliefs or nonreligious beliefs, and trying to understand their culture."

Interviewees shared that an organization must be intentionally built to provide culturally effective care, from the staffing to the policies and organizational culture. Program leaders described offering trainings aimed at continually equipping their staff to serve clients from diverse cultures and communities (e.g., providing trainings on pronouns and cultural preferences) and in a trauma-informed way.

Though they viewed training as important, interviewees were concerned about the general perception that cultural competency can be achieved through a training alone. One leader shared, "Dealing with issues of disparities and equity is not just about training the individual. It's also about organizational transformation. It's about policies and procedures that then help the individual implement what they learned in training and sustain it over time."

Several interviewees talked about setting an expectation of cultural humility among their staff, whereby staff observe how clients respond to them and adjust if they are not connecting or if the client seems offended. One leader shared that this model requires continual coaching, but it also allows conflict among staff as they work through issues to ensure someone does not inadvertently offend a client. It also promotes continual personal growth. That leader shared the following example:

> "I think some words that she was using were offensive to the South American Spanish speakers. And so I reminded her about this, and it's been almost a year now and it's been interesting to actually see how much she's evolved. But it is…sometimes, like, having the conversation with the staff person to let them know, like, 'Hey, this will be an expectation that you meet the needs of a client.'"

Incorporating culture into treatment and recovery services. Interviewees spoke about considering race, ethnicity, and language when matching program participants with providers and incorporating cultural preferences in their care. This often meant understanding clients' spiritual or religious beliefs, particularly to address how someone's culture may conceptualize mental illness and substance use. For example, some clients may want to incorporate therapies and medicines from their culture into their treatment plans. Interviewees also talked about understanding that the stigma associated with substance use varies by culture. As one interviewee said, "Different cultures have different perspectives about what addiction is. A lot of times it makes the patient feel blame or not know that addiction is a disease and that there's help for it. When patients come to our facility, they understand that there's nothing to be ashamed about, and they learn about addiction and getting help."

Many study programs incorporated culturally significant activities; one program primarily serving an Asian American and Pacific Islander population incorporated embroidery, and another program implemented community and agricultural work for some Hispanic/Latinx and American Indian and Alaska Native participants with a historic connection to the land. Another program that serves both Hispanic/Latinx and American Indian and Alaska Native populations incorporates sweat lodges, traditional healing groups, drum circles, yoga, Bible studies, and a 12-step program developed for Native populations. As one interviewee put it, their organization aims to provide a range of options to have "space for [clients] so that they can start to heal in different ways." Relatedly, one program leader also shared that their program is cautious not to segment their community while upholding cultural identities and preferences:

> "We work with a lot of people that are coming out of incarceration, and those settings are so segregated…You're either white, Hispanic, African American, or other, and you are in that group and immersed in a culture that you have to survive in. People have to buy into some of the things that they may not believe in in any other setting, but in prisons you have to do that. It's important that we don't reinforce that. We do not want to replicate institutional settings. We want to make sure that it's a diverse community."

Some interviewees shared that a deeper understanding of how an individual views themselves with respect to their culture is critical. One program leader shared that their staff must consider questions like, "What is that individual's connection to culture? Does their opioid use disorder or behavioral health diagnoses have anything to do with their disassociation or nonconnection to their culture?" Another interviewee said, "A lot of our therapists utilize the addressing model, which is a model that speaks about identities and which identities are important for each individual. That gives an opportunity for the client and potentially the therapist to talk about shared identities and which ones are important or not important and then address those in the overall treatment."

Considering intersectionality when customizing care. Program leaders emphasized that multiple intersectional cultural identities must often be considered when customizing a person's care. Clients have often been structurally disadvantaged in multiple ways, and informants frequently mentioned encountering generational differences within cultures and gender differences. One interviewee shared the following:

> "If we constrain our clients as Latinos, then we have a problem when it's a gender, class, or race issue. So Latino is not enough. In that definition, we also have to differentiate between those who are immigrants or born in the US, those who are Afro-Latinos, or those who have moved around and are European, and those who have an immigration status that allows them to work or bars them from services. We have to take into account differences for women, the LGTBQ community, etc."

Noting the damaging effects of facing multiple structural disadvantages, one interviewee described keeping the following in mind when interacting with clients: "People have had so little choice and have been so systematically disenfranchised that even in the conversation around what they desire, they have no frame of reference for that."

In addition, clients with identities involving "intersecting systems of oppression," as one informant put it, can be subject to more stigma and discrimination. Intersecting identities can involve race or ethnicity, income, sexual orientation, gender identity, nationality and citizenship, as well as systemic oppressions and discrimination based on these characteristics, like colorism (López and Gadsden 2016). One interviewee said:

> "There are oppressions in our society with respect to race, ethnicity, language, and gender that obviously impact our client populations, but we find that the stigma around addiction can be one of the most impactful. Often, we're one of the few programs, facilities, people who reach out to our clients from a place of respect and appreciation for who they are as a whole person. Clients say, 'This is the only time that I've been treated with respect when I go to medical facilities, when I go out into the community, people are unkind.' So, we feel that helping our clients to feel safe, appreciated, and respected is a key component of the treatment process."

Addressing historical trauma as part of culturally effective care. Interviewees also described needing to understand the traumas people from different cultures have faced. One interviewee shared that the Hispanic/Latinx immigrants their program serves often need mental health services for the trauma they have encountered. That interviewee described their trauma as "not just only the trauma that they go through in their own countries, but also the journey from Honduras, El Salvador, and Guatemala, and also the trauma when they arrive to a new society that sometimes may not be that welcoming." Another program leader described the additional trauma among immigrants from the LGBTQIA+ population:

> "They not only have to deal with the journey, but they come here with terrible histories of rejection and violence in their countries, and then they have to deal with discrimination, social

determinants of health, and their inability to find jobs. It's very hard to reach out. For the last two years, we have had a grant from [the Substance Abuse and Mental Health Services Administration] in which we focus on the LGBTQ population and create a space just for them and provide an intervention…We developed a social media campaign last year where the slogan was basically that it is okay to ask for help when you have a problem with substance use or when you have a story that you don't want to tell anyone."

The historical context of substance use in a person's culture also plays a role in their treatment, according to interviewees. For many, that historical context is rooted in disenfranchisement and trauma. Drug use preferences can differ by culture, often because of underlying differences in access to health care and health insurance and, according to one program leader, "the health care system's disposition toward people of color." Multiple interviewees spoke of the historic trauma faced by American Indian and Alaska Native populations, specifically, and its connection to their substance use and implications for their care. As one shared:

> "Our Native American communities are [dealing with] intergenerational trauma. Looking at the person holistically and all of their needs, [you] recognize that just about all of the barriers and obstacles that one can encounter are frequently experienced by our clients. It really highlights how important it is to provide connections and case management services to address issues around poverty and transportation."

Another program leader shared, "We, as treatment providers, have to understand that a lot of people are ending up in addiction because of other underlying community conditions, and we have to be mindful of what those other conditions are, both family dynamics and community dynamics."

Addressing tension between evidence-based and culturally effective care. Several program leaders highlighted how the current evidence base and standard treatment models were not developed for communities of color or tested with them. Therefore, they are "not reflective of the men and women that we serve," as one leader said. A program leader similarly shared the following:

> "I firmly believe that culturally responsive work is different than evidence-based work. And I have done the evidence-based work, and I believe in evidence-based practices. What I do not believe in is that you take the curriculum and you translate it, and you make some adjustments, and you give it to that community of color, and you expect them to do what they do."

One interviewee shared that working with people from different cultures requires an openness to practices that may not be in the evidence base or aligned with one's beliefs. This person noted they had heard about some faith-based institutions where people do not believe in addiction as a disease and therefore do not consider themselves in recovery; rather, they view their addiction as being gone. This interviewee added, "What I have come to understand is that we need to support the multiple [treatment] pathways, regardless of our beliefs in our own pathway and what our evidence and data says."

Constraints Limiting Program Impact

Participants described various challenges and limitations, including structural barriers limiting their abilities to address social needs, challenges training and maintaining staff, and program funding issues, such as a lack of adequate funding, complexities related to combining multiple funding streams, and limited funds for program evaluation. We find that study program leaders have been creative and resourceful in advocating for funds, but doing so was time intensive. Leaders reportedly faced structural hurdles to fully funding the community-driven, harm-reducing, holistic, and culturally effective care they strive to provide. Interviewees frequently cited the following barriers to effectively serving patients:

- historic racism and other structural forces that limit resources available to address social needs
- challenges maintaining staff with language and cultural skills and program values
- a strong need for fundraising and heavy reliance on multiple funding streams
- a lack of adequate federal and state government and philanthropic funding
- numerous funding gaps for specific services and populations
- a lack of program evaluation data demonstrating effectiveness in ways that could expand funding opportunities

HISTORIC RACISM AND OTHER STRUCTURAL BARRIERS THAT LIMIT RESOURCES AVAILABLE TO ADDRESS SOCIAL NEEDS

Participants reported that resources to address social needs are limited and that both historic racism and a lack of investment in communities of color added to their clients' social needs *and* limited community resources to address their needs. Informants commonly described the lack of public transportation systems in communities of color as a challenge for people in early recovery. Other common needs include housing, child care, transportation, and literacy. Many program staff members noted that securing the full range of services their clients need is challenging, primarily because of the limited supply of certain resources and the stigma around people who use substances. Interviewees also reported a lack of culturally and linguistically effective community organizations to refer clients to. Some program leaders spoke of the importance of referring clients only to places that share their values. As one interviewee put it, "We're very selective, so if they don't treat our participants like human beings, we don't mess with them." Another interviewee shared their organization will not work with organizations that will not hire people who have been incarcerated.

Almost all interviewees mentioned housing as a significant challenge. The shortage of affordable housing is a national problem, but housing is particularly challenging to obtain for people who have a history of substance use and involvement in the legal system or who are in medication-assisted treatment. Our informants indicated that unsafe or unstable housing is a barrier to treatment and recovery for people who struggle with substance use. One informant shared the following:

> "I think that housing is the biggest factor and will always be the biggest hole, because it affects everything. You can't successfully treat someone for anything if they're homeless, because there's just so many factors that are beyond their control that will affect their treatment."

Study participants cited Housing First programming as critical to improving access to treatment and treatment outcomes for disadvantage populations affected by substance use. But only a couple of study programs offered Housing First units, and even then, the demand for housing far outpaced the supply.

CHALLENGES MAINTAINING STAFF WITH LANGUAGE AND CULTURAL SKILLS AND PROGRAM VALUES

Program leaders frequently reported that the way they hire, treat, and invest in their staff reflects their program values. However, interviewees described hiring, training, and retaining staff that reflect their communities as one of their biggest challenges. Almost all participants noted the lack of funding for training staff with the skills they need to provide holistic care. One participant explained:

> "We cannot do workforce development with clients who have been marginalized and treated badly without attending to the need to train our staff. For example, people in recovery who come to our training program to be a substance use counselor and have a history of incarceration—we can't just say we're here to provide you with substance use disorder training. We need to help them figure out how to seal a criminal record. We need to help them figure out how they're going to answer questions in an interview process. We need to figure out if they're struggling with housing. Our grant pays for us to do specific training with clients, but our team has a different orientation and does much more. It took a lot of work to find the staff who have that type of orientation and, more importantly, that level of commitment."

Challenges maintaining competitive staff salaries. Interviewees' most common workforce challenge was their inabilities to offer salaries competitive with those offered in the for-profit sector, particularly for retaining bilingual and multilingual staff. One participant reported that the behavioral health workforce shortage "where credentialing and certification and licensure is highly valued means that [practitioners with] culturally relevant and linguistically appropriate services are a very competitive market." Another said, "For not-for-profit organizations, one of the biggest issues is the ability to retain staff. Our staff members grow and develop [at our organization] and become important to our clients, but we [lose staff] simply because we can't compete with the for-profit organizations."

Limited availability of workers with appropriate language and cultural skills. Interviewees most commonly cited language skills as their biggest challenge to providing high-quality care. As one shared, "Most substance use programs don't have Spanish-speaking counselors, even [in Los Angeles], but 80 percent of our staff speak Spanish." Participants noted that the lack of linguistically effective care or Spanish-speaking populations is a significant barrier; as one participant said, "The lack of providers of color…[creates] a disconnect between providers and clients." According to participants, Spanish-speaking providers were especially needed for residential treatment programs.

Participants also described workforce challenges related to providing culturally and linguistically effective care for specific client populations. One participant described the need to partner with a transgender-focused organization to train their staff in providing care to this population. One participant serving an Asian American and Pacific Islander client population with numerous languages and cultures explained, "The whole health care system has a workforce retention and shortage issue when it comes to bilingual, bicultural licensed staff. I always call them unicorns, because they're almost nonexistent."

One participant said no services to help Hispanic/Latinx and LGBTQIA+ populations with substance use and mental health issues exist in their area. Others noted that Hispanic/Latinx and American Indian and Alaska Native clients who need medication treatment for opioid use disorder face nearly unsurmountable provider shortages. As one interviewee shared, "For a Suboxone patient [in New Mexico] that doesn't live in the Santa Fe County area, trying to find a Suboxone provider can mean that they might have to drive three to four hours for care."

Filling workforce shortages by growing program staff. Some interviewees reportedly tried to fill workforce shortages by providing training to specific populations underrepresented among their staff. One organization created a training institute leadership program to recruit young professionals who are LGBTQIA+ and preferably from communities of color to pursue behavioral health licensure and counseling. Another organization provides training programs inside prisons and in the community to try to increase the availability of licensed drug and alcohol counselors with lived experience. Several interviewees also rely on short-term staff, such as interns or AmeriCorps workers, when they face limited resources or other shortages. Whereas one interviewee saw this as an opportunity to build a potential future workforce for their field, another shared it was challenging to work with people who are not from their community and lack long-term commitment to their program's mission.

Addressing workforce shortages through policy change. Several study participants worked with state legislators and representatives to expand the number and type of staff who can bill for services to

thereby increase the workforce with cultural and linguistic skills who can bill for services. These efforts are numerous and varied and include making clinician licensing and certification rules more flexible, creating career pathways for community health workers, and allowing experience to substitute for educational credentialing. One interviewee shared the following:

> "In the Chinese community, there aren't many individuals with the specific required credentials to provide [reimbursable] care…Peer support individuals are critical to care teams and need to be recognized in terms of billing, because people with cultural and language skills and years of experience working in a care team with an organization should be recognized, as far as eligibility for credentialing and reimbursement."

A STRONG NEED FOR FUNDRAISING AND HEAVY RELIANCE ON MULTIPLE FUNDING STREAMS

Respondents reported needing to constantly fundraise from various sources, which takes time away from clients and services. Programs' patchwork of funding sources often hampered the creation and maintenance of fully integrated clinical and social services and the provision of high-quality services and supports, according to respondents. One program representative expressed a wish "to establish one program so that everybody has access to the same services, regardless of who refers them or who is paying for a particular case manager."

Participants reported managing between 24 and 40 funding sources and described challenges blending and braiding funding. One participant said, "We have 24 different funding sources that make everything a nightmare to manage, and each funding source has something they'll pay for that the others won't." Participants also described how handling multiple funding streams complicates advocacy with state and federal legislators and decisionmakers. One interviewee put it as follows:

> "We have 37 different layers of contracting and funding streams, and as an organization, so that's a long list. I layer the funding and figure out how to extend it, fill the gaps, and advocate for what is needed in the community."

Cost savings due to Medicaid funding. Most respondents reported that Medicaid reimbursed a large share of services for clients with SUD, including intensive case management services in some states. Respondents from nearly all programs reported assisting clients in applying for Medicaid if they were not already enrolled. As one respondent shared:

> "[Due to] intensive case management services that…[are] Medicaid billable services, we are really able to decrease the law enforcement budget, and…divert those funds right into other state budget needs. We need to [fund] affordable housing and other kinds of social services, including legal help…Overall, you save money because you don't need all this money in criminal justice anymore. In theory, you're not putting people in jail anymore…and you can put that money into your community, wherever it is needed."

Other funding sources. Respondents reported that some of their funding comes from Medicare. They also specified that the Substance Abuse and Mental Health Services Administration provided funding for services for underresourced client populations (e.g., those who are LGBTQIA+), the US Department of Housing and Urban Development provided funding for housing and some social services, and various private foundations funded additional needed services. One respondent also shared that, through a public-private partnership, a group of large foundations provided their organization with funding it could distribute to smaller providers in the community to provide essential services like housing assistance, transportation, direct assistance, connection with health care and substance use treatment, and employment support. Self-pay clients were a small but important source of funding. They paid, for example, from $2 to $25 for a substance use counseling session.

The harms of short-term funding. Short-term funding can perpetuate distrust in health care and other systems among communities of color. Many participants communicated that a culturally sensitive approach to providing services and supports to the community involves being careful with funding. As one respondent said:

> "We only go after funding that matches our model and our vision. We'd rather struggle than go after funding [that is not] in line with our model. We also don't want to go after short-term funding that's just going to come into the community for a year to do research and then leave the community high and dry. The [community] already [has] a distrust with systems, and if we provide [short-term help], we're just perpetuating that pattern of distrust."

A LACK OF ADEQUATE FEDERAL AND STATE GOVERNMENT AND PHILANTHROPIC FUNDING

Some participants viewed the lack of federal and state government funding to address both behavioral health and social service needs as part of historical racism and structural oppression. They also noted the lack of acknowledgment of past harms to communities of color by state and federal governments. One respondent shared the following:

> "Federal and state policymakers must stop with the government neglect. The inattention to communities of color and their leaders leads to missed opportunities for economic development…The structural oppression that exists isn't allowing for more good work to happen in communities of color. Government neglect means that the tax dollars being put into federal and state budgets doesn't return enough dollars into community organizations that serve people of color.

One respondent urged state and federal officials to shape funding priorities for people of color with SUDs around the organizations with the most experience in providing equitable care:

> "In terms of all these billions of dollars of funding to address substance use disorder, it's important to analyze who's getting that money. It's criminal justice settings, including police departments and sheriff's departments, drug courts—that sort of thing. Health care centers and

hospitals are other places where that money's going. The third bucket is community-based organizations. Of those three buckets, who has the most experience? Community-based organizations."

Respondents from many organizations described advocating for funding to support community needs as time consuming. On respondent said, "It's a continued process to give feedback on funding to legislators and decisionmakers." Most respondents reportedly had these funding negotiations with state legislatures and local advocates, not with federal legislators or policymakers. One interviewee shared the following:

"I'm in a process of connecting with over 20 state legislators for a meeting on mental health in communities of color. The only way I am finding success in meeting with the legislators is by being in relationship with former legislators who are now community advocates."

One participant mobilized community members to lobby the state legislature for SUD funding for their Hispanic/Latinx and American Indian and Alaska Native communities: "I organized a group of mothers who had lost children, and we showed up to everything. We had candlelight vigils at the state legislature...That went on for about five or six years [before] funding came in."

Shortages of treatment providers due to inadequate funding. Participants also commonly mentioned the shortage of clinics in areas where the population is covered mostly by Medicaid. Respondents with American Indian and Alaska Native, rural, and Hispanic/Latinx clients most commonly mentioned this limitation. One participant noted that treating American Indian and Alaska Native clients is "potentially an incentive for providers because, as opposed to all of the other Medicaid claims, Medicaid claims for Native people are completely reimbursed to the state by the federal government." Despite those incentives, Medicaid-funded clinics are extremely sparse in majority–Native regions. According to one interviewee, "In most places the provider is the Indian Health System, and there's only one clinic within an hour or more."

Limited philanthropic funding for substance use services. One participant noted that limited government funding for substance use treatment is exacerbated by the fact that "the philanthropic community takes the position that SUD is a responsibility of county and state governments, as opposed to philanthropic organizations." Consequently, philanthropic organizations have focused on economic and community development and education, and "have not incorporated behavioral health into their overall giving mission," according to one participant. Another participant said foundations must understand that "it doesn't matter what kind of education system you developed, what your community development is, or your economic development is if you have a population that has addiction and other behavioral health issues."

NUMEROUS FUNDING GAPS FOR SPECIFIC SERVICES AND POPULATIONS

Participants described facing limited flexibility to fund nontraditional services and supports, including linguistically and culturally effective care; gaps in funding for longer-term recovery (e.g., beyond 28 days); and gaps in funding for coverage for people released from incarceration but not yet enrolled in Medicaid coverage, for the uninsured, and for immigrants who lack documentation. We describe these funding limitations below. We also describe strategies participants use to bridge these funding gaps and support program staff and participants.

Lack of funding for culturally and linguistically appropriate care, nontraditional services and supports, and life necessities. Medicaid does not cover the full range of health services clients need, including many elements of culturally and linguistically effective care described above (e.g., community health workers and culturally specific services, like sweat lodges, traditional healing groups, and drum circles). In addition, respondents indicated that care and counseling that address historical racism and trauma are needed but not reimbursed;[7] one participant said, "Many of our clients with substance use disorders have experienced trauma throughout their lifetime or even intergenerational trauma, so that is definitely something that we do focus on—but we're not funded for it." Program staff also reported difficulties providing clients with basic life necessities. One participant described having little funding to cover "the donation unit that sends out donations to the families" during the pandemic. That participant described the unit, saying, "It drops off little packages every week to our families, including underwear, socks, deodorant, and other basic hygiene items our families need because they're starting over or were transient." Participants therefore suggested payment reforms that specifically build in payment for culturally and linguistically appropriate care. One participant asked for "support at the federal level for recognition of the language and cultural skills…and a federal funding mechanism [such as] an enhanced rate structure that could support those skills and overall workforce development." Another participant observed the following:

> "A lot of value-based payment conversation is focused on how to get to the most efficient care with the limited resources to deliver care. But it misses a really fundamental piece around delivering culturally competent care and the costs and resource intensity associated with delivering that high-quality care."

Lack of funding to support recovery and long-term client well-being. Respondents described a lack of funding to support recovery beyond the first 30 to 90 days[8] and funding opportunities that seldom support what clients need. One participant shared the following:

> "Thirty days of treatment or even 90 days of treatment is not adequate for the population that we're serving. We need more time to build relationships and really get somebody back to a place of being whole. Current rehabilitation service funding assumes that the client was once in a good place of living and they are going to return to that place, but the men and women we serve don't

> have that reference point. [So] we've learned how to extend the runway. We've figured out creative ways to get a year, by 6 months plus another 6 months of supportive services and a different level of housing, because some things are nonnegotiable. We can't work miracles in 14 or 28 days."

If funding were expanded for recovery services, many participants felt their programs could better serve clients and help improve their long-term well-being. One participant said:

> "We do not focus on a lot of the aftercare because we haven't been able to establish a [funding] structure for that yet. Our natural next step is to develop our own sober housing structure and continue aftercare through outpatient services and more direct coordination with organizations that provide vocational training and other necessary employment development services. That's a big thing about this industry—we're able to successfully bring someone through 30 days, but 30 days isn't a whole lot of time. If they're in an outpatient program in nice sober housing, we could keep them for another 3 to 6 months."

Interviewees said they could not accept certain funding that would not support the comprehensive recovery treatment and services their programs provide. Some reported being selective in pursuing funding opportunities, because funders' goals and requirements seldom aligned with longer-term program goals for client recovery. Funding for housing is especially hard to secure and has major impacts on client well-being. As one participant reported:

> "We want to do more, but funders think [client support] costs less than it does, especially when it comes to housing and transitioning into housing. If I'm an adult and I need to provide for myself and I don't have a job, I'm going to go make money the way I can. That's where you'll see some of the recidivism happen with our population…Even though [they] know it's wrong, it's about surviving."

Funding gaps related to incarceration. All programs participating in this study were in states that expanded Medicaid eligibility under the Affordable Care Act. Program staff reported that most clients were eligible for Medicaid, particularly through the Affordable Care Act expansion of the program. However, despite efforts to minimize coverage gaps in some states, some program staff reported that clients recently released from incarceration often face long waiting periods before Medicaid coverage begins. (Many or most of these clients would be ineligible for Medicaid in states that have not expanded the program.) Thus, non-Medicaid funding is important because, as one respondent noted, a "person who is just released from jail is going to have three months of gaps with no Medicaid." Though most counties lack such a mechanism, one participant's program had a sales tax–based funding source for health care for clients not enrolled in Medicaid. According to the participant, the funding is used for "behavioral health services for those who are criminal justice involved, those who are not necessarily eligible for Medicaid or do not have other resources to address behavioral health needs."

In addition, one participant reported that federal government regulations, which may intersect with state and local regulations, prohibit serving clients during an incarceration of 30 or fewer days, even when the client is still enrolled in Medicaid. That participant described working with state policymakers to address this:

> "Most of our inmates are only in jail for 30 days, and they are there because of substance use. They're not kicked off of their Medicaid for 30 days, but we cannot treat them because we cannot bill Medicaid on the jail premises. There are some regulations that have to be changed to use the county building right next to the jail for treatment. I'm trying to work out a new state Medicaid waiver so that we can bill Medicaid next door to the jail and just walk them over. The reason we can't is because there are only two insurers of jails in the state and neither of them will allow you to take the prisoners off premises. So, we have to work with the insurance commissioner or another state policymaker to get that rule changed."

Limited funding to provide services to uninsured clients. Many participants reportedly had very limited funding to cover uninsured clients, including inadequate funding from Substance Abuse and Mental Health Services Administration block grants designed for this purpose. One participant said, "Medication assisted treatment with Suboxone can cost upwards of $700 a month. There really isn't safety net funding that can maintain an uninsured patient for any significant length of time. Safety net funding doesn't meet all the needs that clients have, and the gap is not specific to medication treatment." Other participants reported that they had some state and local funding for substance use and medical services for immigrants without documentation, but such funds often did not match the need.

Limited access to care for immigrants without documentation. Providers serving Hispanic/Latinx and Asian American and Pacific Islander clients commonly described undocumented immigrants' access to care as a significant problem. They reportedly encountered problems referring undocumented people for medication assisted treatment, such as methadone treatment at an opioid treatment program, which requires clients to provide identification to initiate and maintain treatment at highly regulated clinics. Participants generally did not know of inpatient treatment programs that would accept undocumented clients, except faith-based programs that participants felt were unlikely to offer evidence-informed care.

Restricted funds for harm-reduction services. Program staff noted restricted federal funding for their programs' harm-reduction services, including syringes, wound care, syringe exchange services, overdose reversal training and medications, and testing and treatment for infectious diseases such as HIV, hepatitis C virus, and sexually transmitted diseases. They also described inadequate funding for social services, such as housing, for their clients who carry syringes or take medications for opioid use disorder. Funding is available at some health clinics, such as federally qualified health centers, for some

harm-reduction services, like wound care related to injection drug use and treatment for HIV and hepatitis C virus. However, program staff generally could not obtain funding for comprehensive harm-reduction services (e.g., hepatitis C virus and HIV prevention services, like syringe services) because they are not reimbursable through Medicaid or other federal funding. However, reimbursement for these more comprehensive services may potentially expand because of allocated funding for such services under the American Rescue Plan Act, the Biden administration's Office of National Drug Control Policy priorities,[9] and the trend toward more integrated systems of care.

Funding needed to care for staff exposed to trauma. Many participants also expressed needing to devote more time and funds to support and care for their own workforce. One participant said:

> "It'd be nice to have access to programs for self-care for our therapists. Self-care is something that we talk about a lot because we work with a lot of trauma. We don't make a lot of money, so it's challenging to pay for yoga classes or meditation classes or something else for the staff. I don't want to sound self-centered, but our funding doesn't include money [to care] for the staff."

A LACK OF PROGRAM EVALUATION DATA DEMONSTRATING EFFECTIVENESS IN WAYS THAT COULD EXPAND FUNDING OPPORTUNITIES

Participants reported having limited resources, bandwidth, and expertise to track metrics and evaluate program effectiveness. They were interested in tracking client experiences and well-being in addition to traditional outcome metrics (e.g., recurrence of use, overdose, cost of care) to create a feedback loop to improve services and use program results to build a business case for further funding. Program staff also wanted to demonstrate effectiveness in ways that facilitate and expand funding and reimbursement from mainstream payers. Though some participants reported their programs are monitored by a state quality assurance department, few had been able to conduct robust formal evaluations that could be used to support program fundraising. Many participants were interested in community-engaged and community-led research.

Research Gaps Described by Participants

Participants called for more research on caring for people with substance use in communities of color, including the following topics:

- the impact of programs developed by communities of color and culturally responsive organizations (Curry-Stevens and Reyes 2014)

- the availability and impact of culturally and linguistically effective care integrated with social services and delivered by respectful counselors and staff who reflect the culture and demographics of the client population
- the impact of societal determinants of health and inequitable resources on substance use and social services needs in communities of color
- differences in the availability and quality of culturally and linguistically effective substance use and social services among communities of color in urban, rural, frontier, and border areas
- the effect of low Medicaid payments on outcomes and provider participation in Medicaid in communities of color
- the availability of substance use and social services in settings where patients of color want to receive care (e.g., churches, schools, parks, residences)
- cultural considerations when addressing substance use in communities of color, including culturally appropriate substance use screening methods
- the affordability of the health care and social services necessary for supporting the well-being of people of color who use substances
- the impact of culturally and linguistically effective substance use and social services on the use of law enforcement and the legal system

Participants' Policy Priorities

Participants from our study programs suggested various policy and program changes and community resources for more effectively addressing the needs of people of color with substance use issues. Their eight recommendations (listed below from broad to narrow) focus on guiding government policy and funding to ensure a culturally effective approach to meeting substance use and social service needs in communities of color:

1. **Transform the government's approach to substance use by ending the War on Drugs and promoting culturally effective policies.**
    a. End the federal government's criminalization of substance use disorder, which several participants described as making the most recent opioid epidemic more deadly and dangerous.

b. Focus on community assets, strengths, and successes and stimulate aspirational thinking; too often policymakers and researchers focus on communities' deficits related to substance use, which can lead policymakers to implicitly or explicitly limit discussions about and goals for change.
c. Revise and enforce culturally effective substance use policies within US Department of Health and Human Services (HHS) agencies and offices and other governments. This would involve engaging community stakeholders to provide feedback and removing current harmful policies.
d. Facilitate a reckoning with and awareness of the harms of substance use policy to communities of color that (1) involves looking "upstream" from substance use to the systemic racism and other barriers that shape social determinants and (2) considers reparations critical to policy solutions.

2. **Involve communities in decisionmaking to change substance use policy.**
   a. Recognize and address the fact that HHS has a reputation for not listening and responding to community needs. This could be done by requiring that substance use research conducted in communities of color use frameworks that value community members' perspectives and include a theory of change for addressing inequities. HHS should collaboratively develop this framework with representatives who reflect the community's diversity of races, ethnicities, sexual orientations, gender identities, abilities, citizenship and immigration statuses, and more.
   b. Involve more community members and organizations in shaping substance use policy and share decisionmaking power with them. Provide funding for community councils that bring together state and federal policymakers and community leaders of color to design policies and remove harmful policies. Provide funding to local organizations and researchers to allow community stakeholders to express concerns and develop policies in a nonjudgmental and safe environment.
   c. Provide funding to community organizations that provide substance use care to conduct community needs assessments, including social service needs, in partnership with researchers; use this to fund investments and define research needs.
   d. Let community members identify the relevant subgroups to be considered for both substance use policy and research purposes; fund community-research partnerships to provide the community with disaggregated data needed to understand the population's service needs.

3. **Increase funding and reimbursement opportunities for culturally and linguistically effective care in public and private insurance.**
    a. Implement payment reforms in Medicaid, Medicare, and private insurance, including both Marketplace and employer-sponsored insurance, that specifically build in payment for culturally and linguistically appropriate care. These could include enhanced rates or value-based payments that also reward progress toward more equitable outcomes across groups.
    b. Address (1) provider shortages and coverage gaps, particularly provider shortages for effective substance use treatment (e.g., methadone and buprenorphine treatment), among American Indian and Alaska Native populations; (2) gaps in funding for recovery services, including access to linguistic services in residential care; and (3) gaps in funding for social services, such as housing, transportation, and legal services, that support clients' long-term well-being and recovery.
4. **Increase funding for harm-reduction and social services that respond to community needs.**
    a. Provide funding for social supports, such as housing, transportation, child care, and legal services, to help clients obtain official, legal identification, which would start to address long-standing structural underinvestments in communities of color.
    b. Address the lack of adequate funding for the full continuum of harm-reduction services (e.g., safe injection supplies, overdose education, and contingency management treatment services).
5. **Increase flexibility in grant funding that supports care for the uninsured and in reimbursement rules related to the health care workforce and billing in public and private insurance.**
    a. Change state and federal regulations to allow for greater flexibility in clinician licensing and certification to support reimbursement for culturally and linguistically effective care. This can include establishing a career pathway for community health care workers, counselors, and peers who have experience rather than educational credentials to become recognized billing providers in public and private insurance and under grant funding that supports care for the uninsured (e.g., Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration grants).
6. **Provide technical assistance to community-based clinics and organizations on applying for federal grants, collecting data, reporting on performance metrics, conducting program evaluations, and building other capacities.**

a. Provide community-based organizations with the technical assistance and workforce development needed to apply for, win, and successfully complete federal grants. Community-based organizations also need technical assistance to qualify for and submit for reimbursement from public and private health insurers. This training is "critical to opening more doors for other funding opportunities through the federal government," said one respondent. Provide ongoing support to organizations so they can successfully navigate the funding awarded.
b. Focus special attention on smaller community-based groups, which often have limited operational budgets, for investment and support.
c. Provide technical assistance on capacities needed for program evaluation and business development.

7. **Partner with community members to codesign substance use initiatives that invest in the community and fund researchers who live in the community.**

a. Involve the community and community organizations in everything from the research questions that drive government solicitations for substance-use-related funding (e.g., What barriers does your organization face in promoting well-being for your clients?) to community outreach and materials translation (e.g., How can we support your organization to create your own culturally specific and linguistically appropriate materials?).
b. Codesign research initiatives that invest in communities. Researchers can ask the community what they can do to provide more resources to them, connect them with resources, and help them grow alongside the research.
c. Facilitate shared learning between community leaders and researchers by capturing and disseminating findings about successful substance use programs and approaches, including social services and other supports.
d. Increase funding for researchers who live and/or work in communities to improve understanding of the diverse needs of communities of color, including those with intersectional identities, and build partnerships between researchers and community stakeholders. Program participants agreed that researchers, like program staff, can study needs and evaluate solutions more effectively when they reflect the community they are studying.
e. Connect HHS and key stakeholders through regular meetings to discuss, better understand, and respond to situations faced by communities of color.

f. Pilot community-engaged research to study the impact of community engagement on project-specific outcomes. Such pilots would include funding for capacity building within community organizations.

8. **Enforce and reassess existing community-centered policies.**

   a. Fund community-research partnerships to evaluate the extent to which existing policies support delivery of culturally effective care.

   b. Evaluate the extent to which substance use treatment providers meet established culturally and linguistically appropriate services, or CLAS, standards, which "intend to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services."[10] Participants reported that though they try to adhere to these standards in their programming, such standards do not appear to be operational in much of the available substance use care, especially in residential care.

Discussion

Through this study of 27 substance use programs serving communities of color in 10 states and the District of Columbia, we aimed to provide information about existing care models and strategies to address social service needs and unhealthy substance use among communities of color across the United States. We also sought to offer policy priorities and recommendations, particularly to the federal government. Our findings surface strengths of the programs and the communities they serve, as well as needs and challenges. First, participants were intentional in and committed to demonstrating program values through their staffing, partnerships, and service delivery and in the funding they pursued. Second, they described providing culturally and linguistically effective care that is comprehensive and addresses both substance use and social needs using a holistic, harm-reduction approach. The care and services they provide included a medical model of effective SUD care (e.g., medication treatment for opioid use disorder), but programs also offered far more comprehensive care. For example, by taking a healing-centered, holistic care approach, program staff reportedly addressed clients' strengths and traumatic experiences in addition to their physical, behavioral, and social service needs. Participants described providing care that identifies and draws on client and community strengths and is informed by and acknowledges intergenerational and historic trauma.

Informants from our study programs indicated that addressing clients' social needs is inseparable from engaging them in substance use treatment, and nearly all programs provide some direct social services. Though participants acknowledged the need to address structural determinants of health (Bailey et al. 2017), most said integrating social care into service provision was challenging. Their responses echoed many of the recommendations recently issued by the National Academies of Sciences, Engineering, and Medicine on this challenge. These recommendations related to tailoring services to support positive and resolve negative social needs, strengthening social supports and redesigning health services to meet the needs of the communities where care is provided, and the role of advocacy in supporting these efforts (NASEM 2019).

Participants had challenges maintaining staff with language and cultural skills and program values. They also noted provider shortages for all types of culturally and linguistically effective services (e.g., services in the numerous languages spoken in diverse Asian communities and services designed for LGBTQIA+ people of color). Culturally skilled staff are needed for programs and services to respond to clients' traumatic experiences in culturally effective ways; they can also help address the relationship between a client's substance use and traumatic experiences, including intergenerational trauma related to historic racist policies. Participants also noted a lack of provider options for medications for opioid use disorder (i.e., methadone or buprenorphine treatment), particularly for American Indian and Alaska Native communities.

Participants faced funding issues related to multiple funding streams, funding gaps, and an inability to conduct program evaluations that could lead to additional funding opportunities. They also identified numerous research gaps related to substance use policies and practices in communities of color, including a lack of research on the impacts of culturally responsive organizations and of programs developed by communities of color.

Program participants reinforced the need for research on substance use to meaningfully engage communities, by partnering with community members to codesign initiatives that invest in the community and by funding researchers living in the community. They also expressed an urgent need for federal policymakers to engage with and respond to the perspectives and experiences of people who use substances.[11]

Yet study participants were universally eager to address and overcome these challenges through collective action. One said, "[There is] power in multiethnic coalition building…When communities of color come together, they make things happen." Participants therefore enthusiastically offered the eight policy priorities described above.

The information provided by our study participants aligns with President Biden's 2021 executive order directing federal agencies to advance racial equity and support underserved communities.[12] It also aligns with many of the Biden administration's year-one priorities for substance use policy, including prioritizing advancing racial equity while expanding treatment and harm-reduction approaches to substance use.[13] As discussed, program participants suggested eight policy recommendations for more effectively supporting programs in addressing the needs of people of color with substance use issues. Their recommendations revolve around community engagement and call for the federal government to break from its historic pattern of neglect toward communities of color and instead listen and respond effectively to such communities' needs and preferences, particularly regarding substance-use-related needs. The federal government is poised to address historic injustices in how substance use has been used to discriminate against and criminalize communities of color. The more the federal government can support a comprehensive, holistic system of prevention, harm reduction, treatment, and recovery services for substance use in communities of color—and address social service needs and redress harms—the more likely those community members can thrive in their recovery. Such action would benefit families and communities as well as those served directly.

Appendix A. Program Descriptions

Amity Foundation (California). Amity Foundation is a nonprofit that provides comprehensive and inclusive care to empower its community members. It provides substance use services, including medications to treat opioid use disorder, behavioral health services, employment services, and housing support. Its Returning Home Well program is a public-private partnership to provide these services to people in California returning home after involvement in the criminal justice system. Additionally, their Just in Reach diversion program helps people get behavioral health and substance use services, stable housing, and medical care. Amity strives to create learning communities, where staff and participants learn from and teach one another about cultural, social, economic, and environmental issues.

Asian Counseling and Referral Service, or ACRS (Washington State). ACRS is a nationally recognized nonprofit organization working for social justice and offering an array of behavioral health programs, human services, and civic engagement activities for Asian Americans, Pacific Islanders, and other communities in and beyond King County. ACRS promotes social justice and the well-being and empowerment of such communities—including those who are immigrants, refugees, and American born—by developing, providing, and advocating for innovative community-based multilingual and multicultural services.

Bienvenido Community Solutions LLC (Indiana). Bienvenido Community Solutions is an educational health consulting organization that provides substance use and mental health services to the Hispanic/Latinx community. The program trains people in the community to facilitate outreach and support groups. It has been implemented in 13 cities across Indiana and is available in 14 states across the US. Bienvenido Community Solutions also serves as a consultant to universities that conduct health disparities research for mental health and health promotion. It emphasizes the importance of relationship cultivation among community members and connecting clients to local resources to address behavioral health and general concerns.

Central City Concern, or CCC (Oregon). Since the 1980s, CCC, a federally qualified health center, has been providing mental health and substance use treatment and affordable housing support to its community. Through Old Town Clinic and the Blackburn Center, CCC provides clinical care, including medications for the treatment of opioid use disorder. Additionally, CCC's Puentes program provides culturally and linguistically responsive care, both intensive outpatient and outpatient care, to the Hispanic/Latinx community. Some of these programs are designed specifically for women and for young people ages 13 to 21. CCC's community-based and trauma-informed approach allows it to create a

welcoming environment, and its commitment to providing other social services, such as housing, employment, and peer support services, help it best serve its clients.

Clínica Monseñor Oscar A. Romero. More information is available at https://clinicaromero.com/.

Community Family Life Services, or CFLS (Washington, DC). CFLS has been providing services to families in the Washington, DC, area for more than 50 years. It provides both short-term crisis assistance and services such as housing, employment, financial literacy, and mentoring to help individuals and families achieve long-term independence. Specifically, CFLS helps women overcome their specific challenges transitioning home after incarceration. It provides trauma-informed and gender-specific care, using clients' input to guide and improve programs and services.

Crisis Assistance Helping Out on the Streets, or CAHOOTS (Oregon). A part of White Bird Clinic, a federally qualified health center that has served Eugene, Oregon, for more than 50 years, CAHOOTS is a mobile crisis-intervention van that responds to noncriminal situations with a team of medical and crisis workers trained in deescalation. They are dispatched through the Eugene police-fire-ambulance communications center and offer services including stabilization for those having a behavioral health crisis and connections and referrals to other services. CAHOOTS is dedicated to offering accessible, compassionate, and client-centered care.

Entre Familia (Massachusetts). For more than 25 years, Entre Familia has provided bilingual and bicultural residential treatment programs for pregnant and postpartum people and their children in Boston. It offers substance use treatment services, primary care for pregnant and postpartum residents, referrals to mental health services, harm-reduction services, and medications for SUDs. Entre Familia intentionally hires staff with lived experience to help shape its care model and provide more responsive and effective care.

Family and Medical Counseling Service Inc., or FMCS (Washington, DC). Since 1976, FMCS has been providing holistic emotional and physical health care to Washington, DC–area residents. It provides comprehensive services, including primary medical care, mental health and substance use services, medications to treat SUDs, and needle exchange services. Additionally, FMCS helps participants access social services, like Medicaid and WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children), provides transportation assistance, and operates a food bank. FMCS is committed to providing culturally responsive treatment and does so in part by hiring staff from the community with lived experience and creating an accessible and welcoming environment.

HIPS (Washington, DC). Since 1993, HIPS has advanced the health, rights, and dignity of people and communities affected by sex work and substance use in Washington, DC. HIPS uses a community-based approach to provide harm-reduction services and advocacy. Drawing on the lived experience and expertise of community members, it offers comprehensive services, including a syringe exchange, medications for treating SUDs, and an overdose education and reversal program. Additionally, HIPS helps clients enroll in Medicaid and other support services as needed.

Hispanic Urban Minority Alcoholism Drug Abuse Outreach Program, or HUMADAOP (Ohio). Since 1989, HUMADAOP has existed to empower Hispanic/Latinx and other communities in Cuyahoga County and reduce the negative impacts of substance use on such communities. With community partners, the organization offers evidence-based, bilingual, culturally responsive, and gender-specific prevention education, youth development, and adult residential treatment programming. HUMADAOP is certified by the Ohio Department of Mental Health and Addiction Services and is a service provider member of the Alcohol, Drug Addiction, and Mental Health Services Board of Cuyahoga County.

Hoy Recovery Program Inc. (New Mexico). Hoy Recovery is a nonprofit organization started in the Española, New Mexico, valley in 1974 to provide residential treatment for alcoholism to community members 18 years and older in Rio Arriba County and northern Santa Fe County. Hoy Recovery has since evolved to provide substance use and mental health treatment services in both residential and outpatient settings; it offers clients residential, outpatient, and intensive outpatient services. These services combine trauma-informed care, evidence-based best practices, and cultural healing to form a holistic treatment program. Hoy Recovery's mission is to enhance and strengthen individuals, families, and the community by providing culturally relevant substance use services in a safe and clinically and trauma-informed environment.

Korean Community Services Health Center (California). More information is available at https://www.kcshealthcenter.org/.

Koreatown Youth and Community Center, or KYCC (California). KYCC was established in 1975 to support a growing population of disadvantaged youth in Los Angeles. Today, it is the leading multiservice organization in Koreatown supporting children and their families in education, health, housing, and finances. KYCC is committed to making Koreatown a safe and beautiful place to live and work, and its mission is to serve the evolving needs of the Korean American population in the greater Los Angeles area and the multiethnic Koreatown community. Its programs and services are directed toward recently immigrated, economically disadvantaged youth and families and promote community socioeconomic empowerment.

La Clínica del Pueblo (Washington, DC). For more than 35 years, La Clínica del Pueblo, a federally qualified health center, has provided culturally and linguistically specific integrated primary care, mental health, and substance use treatment services to the Hispanic/Latinx community in the Washington, DC, area. Its comprehensive services and programs include care management and coordination, health insurance enrollment assistance, virtual mental health services, school-based mental health, medical interpretation and language access advocacy, community health education and promotion, and social services navigation (e.g., employment and housing). Its Volviendo a Vivir program is the only bilingual substance use program serving the Hispanic/Latinx population in DC and Maryland. The organization also has a long history of advocacy to increase inclusion and health equity for Hispanic/Latinx individuals and families, including immigrants, unaccompanied minors, women, the LGBTQIA+ population, and people with HIV/AIDS.

Latino Addiction Counselor Education (LACE) program (Massachusetts). The LACE program provides affordable training to Hispanic/Latinx people to help them become licensed alcohol and drug counselors and certified alcohol and drug counselors. The program includes 300 hours of classroom instruction that incorporates theoretical frameworks on social justice and Latino critical race theory. Participants also gain work experience by completing an internship. Additionally, LACE provides technical assistance and consulting services to help equip organizations, including those funded by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services, to provide culturally and linguistically responsive care.

Law Enforcement Assisted Diversion (LEAD) program (New Mexico). LEAD is a public safety program in which police officers exercise discretionary authority to divert individuals suspected of low-level, nonviolent crime driven by unmet behavioral health needs to community-based health services instead of arrest, jail, and prosecution. LEAD takes a harm-reduction approach to all service provision. It does not require abstinence, and clients cannot be sanctioned for substance use or recurrence of substance use. LEAD recognizes that unhealthy substance use is a complex problem, and people need to be reached where they are. The program's goals incorporate health, employment, and overall well-being.

National Asian Pacific American Families Against Substance Abuse, or NAPAFASA (California). NAPAFASA is a national organization that prevents and reduces SUDs in Asian American, Native Hawaiian, and other Pacific Islander families and communities through research, advocacy, education, and capacity building. A private, nonprofit membership organization, NAPAFASA is dedicated to addressing alcohol, tobacco, and other substance issues of Asian American and Pacific Islander populations in the continental US, Hawaii, the six Pacific Island jurisdictions, and elsewhere. Founded in

1988, NAPAFASA involves service providers, families, and youth in efforts to reach communities to promote health and social justice and reduce behavioral health issues.

National Latino Behavioral Health Association, or NLBHA (New Mexico). NLBHA was established to fill a need for a unified national voice for Latino populations in the behavioral health arena and to bring attention to the great disparities they face to access, utilization, practice-based research, and adequately trained personnel. NLBHA's mission is to influence national behavioral health policy, eliminate disparities in funding and access to services, and improve the quality of services and treatment outcomes for Hispanic/Latinx populations.

Northwest Portland Area Indian Health Board (Oregon). More information is available at https://www.npaihb.org/.

Pathways to Housing (Pennsylvania). Since 2008, Pathways to Housing has deployed a housing-first model to help end chronic homelessness for people with disabilities in Philadelphia. Specifically, it has three assertive community treatment teams that provide case management to people living with SUDs. Additionally, Pathways operates the only non-hospital-based Center of Excellence for Opioid Use Disorder in the state. Pathways pairs housing, substance use treatment, case management, and mental health services to provide wraparound support to its program participants. In addition to recognizing that participants are experts in their own experience, Pathways uses a team-based approach, trauma-informed care, and harm-reduction strategies to support participants with their self-determined goals.

Pilsen Wellness Center, or PWC (Illinois). PWC has been serving Chicago's Hispanic/Latinx community for more than 40 years. It provides a comprehensive suite of services, including medications for treating opioid use disorder, mental health services, a doula program, and education services. It provides culturally and linguistically responsive care by employing bilingual and bicultural staff and by recognizing both the unique characteristics of their participants and the common experiences within their communities. Additionally, PWC offers holistic care that includes assistance with food security, Medicaid and health insurance enrollment, transportation, and other services.

Prevention Point Philadelphia, or PPP (Pennsylvania). PPP is a community-based public health organization providing harm-reduction and substance use treatment services to approximately 15,000 low-income Philadelphians. It offers services including syringe exchange, medical care, case management, medications for treating opioid use disorder, housing, food assistance, and legal aid. Its approach to care is centered on low-barrier entry and harm-reduction principles and guided by community input to address the needs and preferences of its participants in culturally and linguistically effective ways. In addition to partnering with health and social service agencies to bring needed services

to its clients, PPP collaborates with the city of Philadelphia on a police-assisted diversion program and provides overdose prevention education and training to the community.

Rio Arriba County Health and Human Services Department (New Mexico). The Rio Arriba County Health and Human Services Department at the Health Commons is an innovative, state-of-the art, one-stop shop designed to meet all of a person's health care needs in one place. The building is divided into one medical, one behavioral health, and one maternal child health wing. The department shares the space with El Centro Family Health, a primary care clinic, and the Espanola Public Health Office, which serves mothers and infants. The Rio Arriba County Department of Health and Human Services works to ensure Rio Arriba residents can access the services they need and deserve.

Santa Fe Recovery Center, SFRC (New Mexico). The SFRC is a nonprofit SUD program based in Santa Fe, New Mexico. It works with individuals to sustain lasting recovery from substance use and related mental health disorders by providing culturally relevant, evidence-based treatment and education in partnership with other community organizations.

Servicios de la Raza (Colorado). Servicios de la Raza provides culturally and linguistically responsive mental health and substance use services to people in the Denver area. Its team uses person-centered and trauma-informed care to discuss and address the systemic barriers their clients experience before, during, and after treatment. In service to this commitment, Servicios can help clients access emergency services, housing, employment, health insurance, and more. Further, it is committed to social justice and empowering its clients to become their own advocates.

SHIELDS for Families (California). Since the 1990s, SHIELDS for Families has been providing culturally responsive, comprehensive behavioral health and social services to the South Los Angeles community. Guided by its goal to empower participants and their families, SHIELDS for Families uses the family-centered treatment model, which allows participants to bring their entire families to treatment. SHIELDS provides perinatal, youth, outpatient, and residential substance use treatment services, as well as mental health services for participants of all ages. It also offers numerous social services, including child care, transportation, employment services, dental and medical care, and educational services. By using family-centered and trauma-informed treatment models and regularly elevating its participants' voices to shape programming, SHIELDS provides effective care that fosters the independence and success of its participants and families.

Appendix B. Demographic Information

The tables in this appendix provide demographic information on the populations served by our study programs (table B.1), the program staff we interviewed (table B.2), and the research team (table B.3).

TABLE B.1

Race and Ethnicity of the Populations Served by the Study Programs

Racial/ethnic group	Percent
American Indian or Alaska Native	33.3
Asian American and Pacific Islander	37.1
Black	59.3
Hispanic/Latinx	77.8
White	48.1

Source: Authors' calculations of estimates provided by study interviewees and publicly available information.

Notes: *N* = 27 programs. Totals do not add up to 100 percent because each program reported serving multiple racial and ethnic groups.

TABLE B.2

Demographic Characteristics of the Program Staff Interviewed

Demographic characteristics	Percent
Ethnicity	
Hispanic, Latinx, or Spanish origin	37.0
Race	
American Indian or Alaska Native	3.8
Asian[a]	15.4
Black or African American	23.1
Native Hawaiian or other Pacific Islander[b]	0.0
White	34.6
Other	3.8
Multiple races	
Black or African American, American Indian or Alaska Native, and white	3.8
Black or African American and white	3.8
White and American Indian or Alaska Native	11.5
Language spoken at home	
English	53.8
Spanish	34.6
Other	11.5

Source: Authors' calculation of survey responses administered to study interviewees.

Notes: Twenty-six of the 32 staff members interviewed responded to this question. The survey response rate was 81.3 percent. Some program interviews included multiple staff members. Respondents could select more than one race.

[a] The answer option on the survey instrument read "Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian."

[b] The answer option on the survey instrument read "Native Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islander."

TABLE B.3

Demographic Characteristics of Researchers

Demographic characteristics	Percent
Ethnicity	
Hispanic, Latinx, or Spanish origin	22.0
Race	
American Indian or Alaska Native	0.0
Asian[a]	22.2
Black or African American	22.2
Native Hawaiian or other Pacific Islander[b]	0.0
White	22.2
Other	22.2
Multiple races	
Black or African American and American Indian or Alaska Native	11.1
Language spoken at home	
English	77.8
Spanish	11.1
Other	11.1

Source: Authors' calculation of survey responses administered to study interviewees.

Notes: *N* = 9 researchers. The survey response rate was 100 percent. Respondents could select more than one race.

[a] The answer option on the survey instrument read "Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian."

[b] The answer option on the survey instrument read "Native Hawaiian, Guamanian or Chamorro, Samoan, or other Pacific Islander."

Appendix C. Interview Protocol and Discussion Guide

[This discussion guide is to be customized based on stakeholder type being interviewed and their preference in language used to refer to communities of color (the language they use when answering Q2).]

Introduction

Thank you so much for speaking to us during this challenging time. How are you holding up with all that is going on?

Before we begin the study, there is some information we are required to share with you about the study and how we will protect your confidentiality, so please bear with me as it will take a minute or so.

- The Urban Institute is being contracted by the US Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Office of Minority Health (OMH) to conduct a study on promising models for integrating SUD treatment with human services in a culturally effective way for communities of color.
- Participation in the study is completely voluntary and you may skip any question you want to or stop the interview at any time.
- The information that we collect as part of this study will be analyzed and shared in a summary report for ASPE and OMH. The report will not identify you by name or specific job title but will summarize all the information we learned.

Do you have any questions for me about the study before we get started?

Do you consent to allow us to record the discussion to help confirm the accuracy of our notes?

1. Can you please tell us about your position and role with [program name]?
2. Can you tell us about the demographics of the population you serve?
3. Please tell us about [effective or promising model] and how you serve communities of color.
4. How do individuals of color with unhealthy substance use typically enter your program?
5. Are there ways you have tailored your program to provide culturally effective care to the communities you serve (including cultural traditions, language, etc.)?

6. How are human services integrated with substance use treatment?
7. To what extent are the human services needs of your clients being met?
8. How is your [program/policy] funded?
9. What strategies or aspects of [effective or promising model] do you see as most successful in addressing the needs of individuals of color who use substances?
10. In your opinion, what are the primary challenges to, or missing pieces in, your work with communities of color?
11. What additional policies or resources would be most helpful to you in working with communities of color?
12. Is there anything we haven't discussed today about your experience providing substance use or human services to communities of color that you think we should know?

Thanks so much for taking the time to share with us about your very important work. This is completely optional, but we were wondering if you would allow us to include your program name in the list of study participants at the end of the report along with a brief program description, which we would give you the chance to approve ahead of time. We would love to be able to highlight the important work you are doing. Are you okay with including the name and brief description of your organization in the report?

Also, we will be emailing you an optional demographic information form that we would appreciate if you'd be willing to fill in and return. This information will be used to help us describe the diversity of our interviewees.

Notes

[1] "The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One," Executive Office of the President, Office of National Drug Control Policy, accessed May 25, 2021, https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf.

[2] "The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One," Executive Office of the President, Office of National Drug Control Policy.

[3] The most important exception is that Black and Hispanic/Latinx people generally have greater access to methadone treatment for opioid use disorder and less access to buprenorphine treatment than white people (Goedel et al. 2020; Hansen et al. 2013).

[4] German Lopez, "The War on Marijuana Is Racist. So Is the Rest of the War on Drugs," *Vox*, July 27, 2014, https://www.vox.com/2014/7/27/5940783/prohibition-marijuana-legalization-pot-weed-racism-new-york-times.

[5] "Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government," the White House, January 20, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

[6] "The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One," Executive Office of the President, Office of National Drug Control Policy.

[7] 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," National Council for Behavioral Health, accessed June 10, 2021, https://www.thenationalcouncil.org/wp-content/uploads/2019/11/Financing-Trauma-Informed-Primary-Care.pdf?daf=375ateTbd56.

[8] Funding for residential treatment also reportedly had limitations. For example, program staff in some states reported they can only bill for one service per day for residential treatment clients.

[9] "The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One," Executive Office of the President, Office of National Drug Control Policy.

[10] "Culturally and Linguistically Appropriate Services," US Department of Health and Human Services, Think Cultural Health, accessed May 25, 2021, https://thinkculturalhealth.hhs.gov/.

[11] This theme is powerfully explored by those who have faced substance use challenges in a report funded by the Patient-Centered Outcomes Research Institute (Community Catalyst 2020).

[12] "Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government," the White House.

[13] "The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One," Executive Office of the President, Office of National Drug Control Policy.

References

Acevedo, Andrea, Deborah W. Garnick, Margaret T. Lee, Constance M. Horgan, Grant Ritter, Lee Panas, Steve Davis, Tracy Leeper, Rebecca Moore, and Mark Reynolds. 2012. "Racial and Ethnic Differences in Substance Abuse Treatment Initiation and Engagement." *Journal of Ethnicity in Substance Abuse* 11 (1): 1–21. https://doi.org/10.1080/15332640.2012.652516.

Alegría, Margarita, Richard G. Frank, Helena B. Hansen, Joshua M. Sharfstein, Ruth S. Shim, and Matt Tierney. 2021. "Transforming Mental Health and Addiction Services." *Health Affairs*, January. https://doi.org/10.1377/hlthaff.2020.01472.

Allen, Eva H., Christal Ramos, Lisa Clemans-Cope, Kimá Joy Taylor, and Luis Basurto. Forthcoming. "Barriers, Facilitators, and the Role of Human Services in Addressing Substance Use in Communities of Color." Washington, DC: Urban Institute.

Allen, Eva H., Emma Winiski, Sarah Coquillat, and Lisa Clemans-Cope. Forthcoming. "COVID-19 Pandemic and Substance Use Service Programs: Findings from 27 Programs Serving Communities of Color, May to December 2020." Washington, DC: Urban Institute.

Arndt, Stephan, Laura Acion, and Kristin White. 2013. "How the States Stack Up: Disparities in Substance Abuse Outpatient Treatment Completion Rates for Minorities." *Drug and Alcohol Dependence* 132 (October): 547–54. https://doi.org/10.1016/j.drugalcdep.2013.03.015.

Bailey, Zinzi D., Justin M. Feldman, and Mary T. Bassett. 2020. "How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities." *New England Journal of Medicine* 384:768–73. https://doi.org/10.1056/NEJMms2025396.

Bailey, Zinzi D., Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, and Mary T Bassett. 2017. "Structural Racism and Health Inequities in the USA: Evidence and Interventions." *The Lancet* 389 (10077): 1453–63. https://doi.org/10.1016/S0140-6736(17)30569-X.

Community Catalyst. 2020. "Peers Speak Out! Improving Substance Use Treatment Outcomes during COVID-19." Boston: Community Catalyst.

Curry-Stevens, Ann, and Marie-Elena Reyes. 2014. "Protocol for Culturally Responsive Organizations." Portland, OR: Portland State University, Center to Advance Racial Equity.

Dickerson, Daniel L., Suzanne Spear, Patricia Marinelli-Casey, Richard Rawson, Libo Li, and Yih-Ing Hser. 2010. "American Indians/Alaska Natives and Substance Abuse Treatment Outcomes: Positive Signs and Continuing Challenges." *Journal of Addictive Diseases* 30 (1): 63–74. https://doi.org/10.1080/10550887.2010.531665.

Evans, Elizabeth, Jennifer Pierce, Libo Li, Richard Rawson, and Yih-Ing Hser. 2012. "More Alike Than Different: Health Needs, Services Utilization, and Outcomes of Asian American and Pacific Islander (AAPI) Populations Treated for Substance Use Disorders." *Journal of Ethnicity in Substance Abuse* 11 (4): 318. https://doi.org/10.1080/15332640.2012.735172.

Farahmand, Pantea, Arslaan Arshed, and Mark V. Bradley. 2020. "Systemic Racism and Substance Use Disorders." *Psychiatric Annals* 50 (11): 494–98. https://doi.org/10.3928/00485713-20201008-01.

Fellner, Jamie. 2009. "Race, Drugs, and Law Enforcement in the United States." *Stanford Law & Policy Review* 20 (2): 257–92.

Gallagher, John Robert, Elizabeth A. Wahler, and Elyse Lefebvre. 2019. "Further Evidence of Racial Disparities in Drug Court Outcomes: Enhancing Service-Delivery to Reduce Criminal Recidivism Rates for Non-White Participants." *Journal of Social Service Research* 0 (0): 1–10. https://doi.org/10.1080/01488376.2019.1575325.

GAO (US Government Accountability Office). 2017. *Nonviolent Drug Convictions: Stakeholders' Views on Potential Actions to Address Collateral Consequences*. No. GAO-17-691. Washington, DC: US Government Accountability Office.

Garrison, Yunkyoung Loh, Ethan Sahker, Chi W. Yeung, Soeun Park, and Stephan Arndt. 2019. "Asian American and Pacific Islander Substance Use Treatment Completion." *Psychological Services* 16 (4): 636–46. https://doi.org/10.1037/ser0000274.

Goedel, William C., Aaron Shapiro, Magdalena Cerdá, Jennifer W. Tsai, Scott E. Hadland, and Brandon D. L. Marshall. 2020. "Association of Racial/Ethnic Segregation with Treatment Capacity for Opioid Use Disorder in Counties in the United States." *JAMA Network Open* 3 (4): e203711. https://doi.org/10.1001/jamanetworkopen.2020.3711.

Guerrero, Erick G., Tenie Khachikian, Tina Kim, Yinfei Kong, and William A. Vega. 2013. "Spanish Language Proficiency among Providers and Latino Clients' Engagement in Substance Abuse Treatment." *Addictive Behaviors* 38 (12): 2893–97. https://doi.org/10.1016/j.addbeh.2013.08.022.

Guerrero, Erick G., Jeanne C. Marsh, Lei Duan, Christine Oh, Brian Perron, and Benedict Lee. 2013. "Disparities in Completion of Substance Abuse Treatment between and within Racial and Ethnic Groups." *Health Services Research* 48 (4): 1450–67. https://doi.org/10.1111/1475-6773.12031.

Hansen, Helena, Ayana Jordan, and Hansel Tookes. 2021. "Promoting Equity in Access to Opioid Use Disorder Treatment and Supports: A Focus on Black Communities." New York: Foundation for Opioid Response Efforts.

Hansen, Helena B., Carole E. Siegel, Brady G. Case, David N. Bertollo, Danae DiRocco, and Marc Galanter. 2013. "Variation in Use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City." *Journal of Behavioral Health Services & Research* 40, no. 3. https://doi.org/10.1007/s11414-013-9341-3.

Hardeman, Rachel R., and J'Mag Karbeah. 2020. "Examining Racism in Health Services Research: A Disciplinary Self-Critique." *Health Services Research* 55 (S2): 777–80. https://doi.org/10.1111/1475-6773.13558.

Lewis, Ben, Lauren Hoffman, Christian C. Garcia, and Sara Jo Nixon. 2018. "Race and Socioeconomic Status in Substance Use Progression and Treatment Entry." *Journal of Ethnicity in Substance Abuse* 17 (2): 150–66. https://doi.org/10.1080/15332640.2017.1336959.

López, Nancy, and Vivian L. Gadsden. 2016. "Health Inequities, Social Determinants, and Intersectionality." National Academy of Medicine Discussion Paper. Washington, DC: National Academy of Medicine. https://doi.org/10.31478/201612a.

Mancini, Michael A., Christopher P. Salas-Wright, and Michael G. Vaughn. 2015. "Drug Use and Service Utilization among Hispanics in the United States." *Social Psychiatry and Psychiatric Epidemiology* 50 (11): 1679–89. https://doi.org/10.1007/s00127-015-1111-5.

Meng, Grace. 2015. *A Price Too High: US Families Torn Apart by Deportations for Drug Offenses*. New York: Human Rights Watch.

Mennis, Jeremy, and Gerald J. Stahler. 2016. "Racial and Ethnic Disparities in Outpatient Substance Use Disorder Treatment Episode Completion for Different Substances." *Journal of Substance Abuse Treatment* 63 (April): 25–33. https://doi.org/10.1016/j.jsat.2015.12.007.

Mulvaney-Day, Norah, Darcie DeAngelo, Chih-nan Chen, Benjamin L. Cook, and Margarita Alegría. 2012. "Unmet Need for Treatment for Substance Use Disorders across Race and Ethnicity." *Drug and Alcohol Dependence* 125 (September): S44–50. https://doi.org/10.1016/j.drugalcdep.2012.05.005.

NASEM (National Academies of Sciences, Engineering, and Medicine). 2019. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: National Academies of Sciences, Engineering, and Medicine. https://doi.org/10.17226/25467.

Pinedo, Miguel. 2019. "A Current Re-examination of Racial/Ethnic Disparities in the Use of Substance Abuse Treatment: Do Disparities Persist?" *Drug and Alcohol Dependence* 202 (September): 162–67. https://doi.org/10.1016/j.drugalcdep.2019.05.017.

Provine, Doris Marie. 2008. *Unequal under Law: Race in the War on Drugs*. Chicago: University of Chicago Press.

Ramos, Christal, Kimá Joy Taylor, Eva H. Allen, Lisa Clemans-Cope, and Sarah Coquillat. Forthcoming. "Addressing the Harms to Communities of Color from a Punitive Approach to Substance Use." Washington, DC: Urban Institute.

SAMHSA (Substance Abuse and Mental Health Services Administration). 2020. *The Opioid Crisis and the Black/African American Population: An Urgent Issue*. Bethesda, MD: Substance Abuse and Mental Health Services Administration.

US Commission on Civil Rights. 2019. *Collateral Consequences: The Crossroads of Punishment, Redemption, and the Effects on Communities*. Washington, DC: US Commission on Civil Rights.

Yu, Jiang, and Lynn A. Warner. 2013. "Substance Abuse Treatment Readmission Patterns of Asian Americans: Comparisons with Other Ethnic Groups." *American Journal of Drug and Alcohol Abuse* 39 (1): 23–27. https://doi.org/10.3109/00952990.2012.694517.

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