MINNESOTA SUBSTANCE USE DISORDER COMMUNITY OF PRACTICE

CULTURALLY SPECIFIC AND RESPONSIVE MODELS OF CARE

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EXECUTIVE SUMMARY

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines substance use disorder (SUD) as the recurrent use of alcohol and/or drugs that "causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." Furthermore, SUD continues to be an underlying factor for drug overdoses. Exacerbated by the pandemic and changes in the formulation of widely available substances, overdose continues to be the leading cause of injury-related deaths in the United States.[1,2] In Minnesota, the rate of drug overdose deaths increased by 3% between 2020 and 2021, with a disproportionate impact on communities of color.[3]

Following Minnesota's enactment of legislation to address this issue (Minnesota Statutes 2021, Chapter 254B.151), the Minnesota Department of Human Services (DHS) sponsored the creation of the Minnesota Substance Use Disorder (SUD) Community of Practice (CoP), facilitated by Health Management Associates (HMA). The MN SUD CoP is composed of individuals who engage in SUD treatment and prevention in any capacity, including people with lived experience, providers, family members, researchers, recovery peers, state and local government representatives and advocates. The MN SUD CoP seeks to bring individuals from across the Minnesota SUD treatment continuum together to engage in information sharing, competence development, rich discussion, and mentoring.

Amongst other topics of interest, the CoP works to identify methods for improving culturally specific and responsive care in Minnesota, which has been identified as a gap in the SUD care continuum.[4]

The following report describes MN SUD CoP participants' input on the state of culturally specific and responsive care in Minnesota, current efforts by Minnesota organizations to improve culturally specific and responsive treatment, and recommendations for how Minnesota can continue to improve care. These include information on partnering with community-based organizations to develop a robust network of culturally responsive care organizations, standardized training on culturally specific care evidence-based practices and providing adequate family-based care. Implementation of these strategies and best practices are provided with the goal of improving comprehensive access to culturally competent and gender-specific care across Minnesota and improving outcomes for Minnesotans.

[1] CDC. Understanding Drug Overdoses and Deaths. 2023. Available at: https://www.cdc.gov/drugoverdose/epidemic/index.html. Accessed December 29, 2023.
[2] National Institute on Drug Abuse. Drug Overdose Death Rates. 2023. Available at: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates. Accessed December 29, 2023.
[3] MN Dept. of Health. (n.d.). Drug Overdose Dashboard. MN Dept. of Health. https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html
[4] MN SUD CoP Treatment Outcome Gaps Summary, Strategies, & Recommendations Report

BACKGROUND

While Minnesota is considered one of the healthiest states in the nation, it is also home to some of the most significant health disparities between different racial groups.[5] In 2020, the state's demographic composition comprised 61.6% White, 12.4% African American, 18.7% Hispanic, 6% Asian, 1.1% American Indian and Alaska Native, 0.2% Native Hawaiian and Other Pacific Islander, 8.4% categorized as "Other" race, and 10.2% as Two or More Races.[6] Notably, non-White residents exhibit a disproportionate prevalence of poverty and lack of health insurance, leading to adverse health outcomes. For instance, in 2022, poverty rates among American Indian, Hispanic, and African American residents were 30.1%, 16.8%, and 24.7%, respectively, in contrast to 7.2% among White residents. Moreover, health insurance coverage for Minnesota's American Indian, Hispanic, and African American residents under 65 years old was notably lower compared to their White counterparts, with uninsured rates of 15.2%, 16.7%, and 7.3%, respectively, against 3.9% for White residents.

Racial disparities are also noticeable when examining overall SUD drug overdose mortality rate, both nationally and in Minnesota. For example, American Indian/Alaska Natives report more substance use; Black women are less likely to drink, but those who do are more likely to develop & sustain alcohol use disorder (AUD); and US-born Hispanic men & women have greater AUD risk than White individuals while non-US-born Hispanics do not. There are also more instances of substance use in sexual & gender minorities (LGBTQIA+) and increased rates of substance use among those with physical and mental disabilities.[7,8,9,10,11]

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[5] MN Health Care Disparities by Relc. Available at: https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2020%20Disparities%20by%20RELC%20Chartbook%20-%20FINAL.pdf. Accessed April 26, 2024.

[6] Census. Minnesota: 2020 Census. 2023. Available at: https://urldefense.com/v3/__https:/www.census.gov/library/stories/state-by-state/minnesota-population-change-between-census-decade.html__;!!NwMct28-Ww!OOkQNGa7frGQn8yASOdn9c5uvzysSCo4FknpQSd5T9vlPDePnINpKewYYa1MKGyH1pBUuGHNtsk4eNqzOYvc59E$. Accessed April 26, 2024.

[7] Schuler, M. S., Prince, D. M., & Collins, R. L. (2021). Disparities in Social and Economic Determinants of Health by Sexual Identity, Gender, and Age: Results from the 2015-2018 National Survey on Drug Use and Health. LGBT health, 8(5), 330–339. https://doi.org/10.1089/lgbt.2020.0390

[8] Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. JAMA Netw Open. 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

[9] Grant, J. D., Vergés, A., Jackson, K. M., Trull, T. J., Sher, K. J., & Bucholz, K. K. (2012). Age and ethnic differences in the onset, persistence and recurrence of alcohol use disorder. Addiction (Abingdon, England), 107(4), 756–765. https://doi.org/10.1111/j.1360-0443.2011.03721.x

[10] Mereish EH. Curr Opin Psychol. 2019

[11] Roux, A. M., Tao, S., Marcus, S., Lushin, V., & Shea, L. L. (2022). A national profile of substance use disorder among Medicaid enrollees on the autism spectrum or with intellectual disability. Disability and health journal, 15(2S), 101289. https://doi.org/10.1016/j.dhjo.2022.101289

Although Minnesota ranks relatively low in overall drug overdose mortality rates compared to other states, it exhibits some of the most significant racial disparities in drug overdose deaths in the nation. In Minnesota, the African American and American Indian populations face disproportionate rates of drug overdose deaths and American Indian Minnesotans were ten times as likely to die from a drug overdose in 2021. There has been an overall increase in drug overdose mortality rates across all racial groups, and from 2018 to 2021, these racial disparities have worsened. The age distribution of overdose deaths varies among racial groups, with Whites primarily affected in the 25-54 age group, American Indians in the 25-34 age group, and African Americans in the 45-54 age group. While opioids remain the leading cause of overdose deaths for all racial groups, there have been significant increases in deaths involving other substances such as benzodiazepines, psychostimulants, heroin, and synthetic opioids over the past 19 years.[12]

African American and American Indian drug overdose deaths are more likely to involve multiple substances compared to those among Whites, highlighting complex challenges in addressing addiction and overdose risk within these communities. For additional information on SUD and overdose rates in Minnesota, including breakdowns by racial and ethnic groups, view the MN DHS Drug Overdose Dashboard.

Criminal and legal consequences of substance use also disproportionately affect minority populations, with arrest, prosecution, conviction, sentencing, and incarceration among Black individuals (six times as likely to be incarcerated as adults and more than four times as likely as youth) and Hispanic individuals (three times as likely to be incarcerated as adults and one and a half times as likely as youth).[13] Among misdemeanor drug- and alcohol-related arrests, American Indian/Alaska Native (AI/AN), Latino, and Black persons were more likely than White persons to be booked into jail as opposed to cited and released. AI/AN, Latino, and Black persons also were more likely than White persons to be convicted and serve time for their misdemeanor charges. Results were similar for felony drug- and alcohol-related arrests aggregated and stratified.[14] In addition, pregnant people with SUD face prosecution, given state laws that specifically criminalize drug use during pregnancy.[6-8] Pregnant AI individuals are disproportionately affected by these laws due not only to their race and gender, but also their lower socioeconomic status and the compounded government surveillance under federal, state and tribal laws.[15]

Background Terminology

To address SUD among these populations, it is important to identify population-specific challenges and reduce barriers for treatment. To better understand barriers to and strategies for implementing recommendations for improving culturally specific and responsive care, it is first critical to understand and agree on terms, described in Table 1.

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[12] MN Dept. of Health. (2024, May 14). Drug Overdose Dashboard. MN Dept. of Health. https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html#:~:text=In%202021%2C%20American%20Indian%20Minnesotans,drug%20overdose%20than%20white%20Minnesotans

[13] Report of The Sentencing Project to the United Nations Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia, and Related Intolerance Regarding Racial Disparities in the United States Criminal Justice System

[14] Camplain R, Camplain C, Trotter RT 2nd, Pro G, Sabo S, Eaves E, Peoples M, Baldwin JA. Racial/Ethnic Differences in Drug- and Alcohol-Related Arrest Outcomes in a Southwest County From 2009 to 2018. Am J Public Health. 2020 Jan;110(S1):S85-S92. doi: 10.2105/AJPH.2019.305409. PMID: 31967892; PMCID: PMC6987943.

[15] Simon, R., Giroux, J., & Chor, J. (2020). Effects of substance use disorder criminalization on American Indian pregnant individuals. AMA J Ethics, 22(10), E862-867. doi:10.1001/amajethics.2020.862

Table 1. Introductory Terminology[16,17]

Term	Definition
Equality	Each individual or group is given the same resources or opportunities.
Equity	Mandates customized solutions to meet the unique requirements of specific communities or population(s); tries to correct imbalance by creating more opportunities for people who have historically had less access.
Culturally Specific and Responsive Care	Care in which individuals work from a culturally humble stance to provide services that are culturally focused and responsive, consider sociocultural factors, and allow for engaging the individual in collaborative decision-making. Culturally specific and responsive care acknowledges that distinct cultures view and interact with the world in a manner influenced by unique historical and social experiences and perspectives. In Minnesota, a culturally specific or culturally responsive program is defined under 254B.01, Subd. 4a. as an SUD treatment service program or subprogram that is culturally responsive or culturally specific when the program attests that it: (1) improves service quality to and outcomes of a specific community that shares a common language, racial, ethnic, or social background by advancing health equity to help eliminate health disparities; (2) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to an individual within a specific community's values, beliefs and practices, health literacy, preferred language, and other communication needs; and (3) is compliant with the national standards for culturally and linguistically appropriate services or other equivalent standards, as determined by the commissioner.

Additional terms related to racial terms and differences are available through the National Institute for Health webpage and the 254B.01 Minnesota Statutes.

Benefits of Culturally Specific and Responsive Care

A 2003 Institute on Medicine report showed unequal treatment in health care with pervasive racial and ethnic disparities leads to poor health outcomes. Because evidence-based practices are traditionally normed to White individuals, standard practices may not be sufficient to improve treatment outcomes in minoritized populations. Additionally, cultures influence how individuals and their families or social supports perceive and understand SUD and the need for treatment, which can in turn impact an individual's ability or willingness to access care.[18]

[16] Dunn, L. (2020, November 6). What is Diversity, Equity & Inclusion (DEI)?. InclusionHub. https://www.inclusionhub.com/articles/what-is-dei

[17] Mcleod, J. (2021, March 11). Understanding Racial Terms and Differences. National Institutes of Health. https://www.edi.nih.gov/blog/communities/understanding-racial-terms-and-differences

[18] Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Alan R. (2003). Unequal treatment : confronting racial and ethnic disparities in health care. National Academy Press.

For example, the Imani Breakthrough Project is a faith-based individual and group wellness intervention taking place in the community within Latinx and Black churches in Connecticut. It includes two facilitators with lived experience and one member of the respective church who provided individualized coaching, mutual support, and recovery education classes to members of their community. At 12 weeks, the intervention had 42% retention (as compared to studies which have shown as high as approximately 75% to 80% of treatment seekers disengaging at one of the multiple stages of the enrollment and treatment process).[19,20]

Some studies have shown that behavioral health interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds. Furthermore, services conducted in clients' native language were more effective than those conducted in English only.[21] Positive SUD treatment outcomes are contingent upon the treatment provider's ability to deliver information in a way that and individual can understand and internalize.

MINNESOTA PROGRAMS

The Minnesota DHS recognizes the critical role that culturally specific SUD programs play in recovery and has dedicated resources to expand culturally specific care services. One of those efforts is the Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program, which provides funding to culturally specific behavioral health services. Recipients of these grants include:

SUD Only

- Hmong American Partnership
- Life House
- MIPRTC/Mash-Ka-Wisen
- Turning Point

Integrated Mental Health & SUD

- American Indian Family Center
- Avivo
- Brakins Consulting & Psychological Services, LLC
- CLUES
- JustUs Health
- Minnesota Indian Women's Resource Center
- Pact 4 Families Collaborative
- Vietnamese Social Services
- White Earth Tribal Nation
- Zumbro Valley

While this may not include all culturally specific programs as defined by Minnesota 254B.01, it provides an overview of those currently dedicated to the work. Additional information on ongoing DHS efforts is available below.

In the MN SUD CoP, participants noted they often assess the efficacy of their culturally specific and responsive services through holistic measures such as continued participation, ongoing recovery, and willingness to share stories and serving as a mentor to others, which they often perceive as higher importance when tailoring services to the needs, languages, and cultural practices of the community. However, panelists noted that staffing and funding shortages limit their ability to collect sufficient outcome data on all participants who receive culturally specific treatment and services.

[19] Bellamy, C. D., Costa, M., Wyatt, J., Mathis, M., Sloan, A., Budge, M., Blackman, K., Ocasio, L., Reis, G., Guy, K., Anderson, R. R., Stewart Copes, M., & Jordan, A. (2021). A collaborative culturally-centered and community-driven faith-based opioid recovery initiative: the Imani Breakthrough project. Social Work in Mental Health, 19(6), 558–567. https://doi.org/10.1080/15332985.2021.1930329

[20] Loveland, D., & Driscoll, H. (2014). Examining attrition rates at one specialty addiction treatment provider in the United States: a case study using a retrospective chart review. Substance abuse treatment, prevention, and policy, 9, 41. https://doi.org/10.1186/1747-597X-9-41

[21] Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training, 43(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

While there is a limited evidence base with minimal rigorous studies on the topic of outcomes in relation to culturally specific and responsive care, the available evidence demonstrates positive results, with decreased frequency of substance use, higher rates of abstinence, decreased cravings, and reduction in mental health symptoms and should therefore be prioritized in state SUD efforts.[22,23]

DATA COLLECTION METHODS

To identify challenges within the Minnesota SUD treatment system and develop recommendations aimed at improving culturally specific and responsive care, HMA aggregated findings from publicly available resources with those collected during the MN SUD CoPs and workgroups, as described below.

MN SUD CoP Meetings and Workgroups

During the 2023-2024 MN SUD CoPs, participants and guest speakers were asked to share their experiences related to obtaining or delivering culturally specific care in Minnesota. The gaps identified during those meetings were first summarized in the MN SUD CoP Treatment Outcome Gaps Summary, Strategies, & Recommendations Report and are described in the section below.

Following the identification of gaps in this area, the primary agenda items for the February and May 2024 CoP meetings were dedicated to the discussion of strategies for delivering culturally specific care. A summary of the meeting content from each of these meetings is available for review on the MN SUD CoP webpage. A series of workgroups were also held in March and April 2024 to offer additional opportunities for facilitated discussion on the recommendations for improving culturally specific care in Minnesota, available in the MN SUD CoP Treatment Outcome Gaps Summary, Strategies, & Recommendations Report and the Recommendations section below.

Culturally Specific Care Obstacles Identified by MN SUD CoP Participants

- Lack of culturally specific and sensitive care (particularly in rural areas) for youth and adults. Currently, only 22 programs are indicated as having culturally specific/culturally responsive services under the state's SUD licensed treatment database.[24]
- Extended program wait times (particularly for culturally responsive and specific programs).
- Lack of gender-specific care for youth and adults.
    - One participant noted she was unable to seek treatment as she had children who were not permitted in the treatment facility. Another noted that her family did not allow her to attend a treatment program that included members of the opposite gender as it was not permitted by her cultural practices.

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[22] Steinka-Fry, K. T., Tanner-Smith, E. E., Dakof, G. A., & Henderson, C. (2017). Culturally sensitive substance use treatment for racial/ethnic minority youth: A meta-analytic review. Journal of substance abuse treatment, 75, 22–37. https://doi.org/10.1016/j.jsat.2017.01.006

[23] Venner, K. L., Greenfield, B. L., Hagler, K. J., Simmons, J., Lupee, D., Homer, E., Yamutewa, Y., & Smith, J. E. (2016). Pilot Outcome Results of Culturally Adapted Evidence-Based Substance Use Disorder Treatment with a Southwest Tribe. Addictive behaviors reports, 3, 21–27. https://doi.org/10.1016/j.abrep.2015.11.002

[24] MN Dept. of Human Services. (n.d.). DHS Licensing Information Lookup. MN Dept. of Human Services. https://licensinglookup.dhs.state.mn.us/

- Lack of tribal representation, LGBTQIA+ representation, services for veterans and seniors, and other cultural or racial groups.
- Lack of funding for culturally responsive programs, delayed funding, or increased competition for single funding sources. This may also include difficulty applying for grants or obtaining state supported funding opportunities.
    - One participant noted that culturally specific programs may not have access to staffing bandwidth, expertise, or technology to compete effectively for grant opportunities directed at them.
- Highlighted instances of stigma and discrimination, particularly towards Native American culture, as well as other religious practices, race, and gender.
    - For example, one participant noted they felt stigma and discrimination when partaking in Native American cultural practices such as smudging.
    - Another participant also recalled traumatic experiences of being asked to remove cultural and religious coverings in the presence of men and a lack of facilities to accommodate prayer and other religious services during their time at treatment centers.
- Disingenuous efforts toward culturally responsive care.
    - For example, though many of the individuals in SUD treatment and recovery programs are individuals of color, treatment professionals and decision-makers are often White. This presents a challenge for individuals in treatment, as it requires individuals to adapt to White frameworks and communication styles, which increases an already heavy burden on those in recovery.
    - Additionally, individuals noted an ongoing lack of action following continued, often years-long discussions around improvement of culturally specific and responsive care. Many MN SUD CoP participants expressed frustration at the slow progress in the space and expressed desires for actionable steps and lasting change.
- Insufficient representation and advocacy for women with SUD. Traditional culture and gender norms often mean it is challenging for women to admit to substance use and they are less encouraged to seek professional help. For many women, formal treatment is not sought until life threatening instances, such as overdose, occur.
- The SUD prevention, treatment, and recovery landscape does not adequately incorporate viewpoints from individuals of color into discussions and decisions to combat systemic racism and improve cultural responsiveness in the SUD field. (Of note, participants emphasized that while this is prevalent in the SUD treatment field, these changes are essential through all aspects of the system including schools, housing, etc.)
- SUD counselors or treatment providers, particularly White providers, face challenges in connecting with clients due to a lack of shared experiences and systemic injustices.
- Aftercare for the Native American community is limited and/or lacks inclusion for those who are reentering the community after incarceration.

Current Minnesota Efforts

Significant funding has been dedicated to culturally responsive and gender-specific care recently in Minnesota. Some examples of recent state efforts to address the cultural gaps in SUD care include:

- **Community-based participatory research for pregnant and parenting persons:** The aim of this project is to expand family-centered behavioral health program services through the Women's Culturally Responsive Recovery Services.[25] A toolkit is being developed with this information to disseminate to providers and the public. The Amherst H. Wilder Foundation serves as an evaluator for the Women's Recovery Services (WRS) grant aimed at collecting data around women's SUD recovery services in Minnesota. The aggregate report will be available at the end of the WRS grant in 2026.[26] Additionally, Minnesota currently has eight grantees throughout the state that provide outpatient, residential, and community-based services to women and children. Funding was also awarded to three grantees to provide prevention and community engagement initiatives to women and children. An example of grantee work is provided at https://www.rseden.org/family-recovery-project.
- **Family Residential Grant:** DHS proposed to the legislature to expand family residential services for women's substance use disorders. DHS was awarded $10 million for this effort which includes allowance for structural expansion. This is important and it has been highlighted as a barrier for many providers. This RFP is anticipated in the next couple of months.
- **Opioid Response Dashboard:** The Opioid Epidemic Response Spending Dashboard describes 1) awards by the Opioid Epidemic Response Advisory Council and 2) cities and counties that received funding from the statewide opioid epidemic settlement agreement, including information on which cultural/racial groups are receiving funding.[27]
- **American Indian Section Initiatives:** The American Indian Team Strategic Plan is working on or has completed the following: 1) The American Indian Summit, held in August 2023[28], 2) The American Indian Team Strategic Plan, which will focus on what MN will provide to Tribes and American Indian urban areas for both Mental Health and SUD, and 3) A Medical Assistance Behavioral Health System Transformation Study to evaluate traditional healing under the medical assistance program.[29] Additionally, MN has dedicated about two million dollars per year in general fund dollars for traditional healing services.
- **New MN DHS Funding and Staff Positions:** Minnesota is allocating up to four million dollars in funding and hiring additional staff to assist organizations with navigating systems, including a position dedicated to providing technical assistance to culturally specific organizations.
- **Rate Enhancement Eligibility:** Per Minnesota legislation 254B.01, subd 4a, programs that meet these culturally specific or responsive care guidelines are eligible for a reimbursement rate enhancement.[30]

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[25] Minnesota Management Analysis and Development. (n.d.-a). MN Families. https://www.mnfamilies.org/

[26] Wilder Foundation. (2024, March 20). https://www.wilder.org/

[27] Minnesota Department of Health and Human Services. (n.d.). Opioid Epidemic Response Spending Dashboard. https://mn.gov/mmb/impact-evaluation/projects/opioid-epidemic-response/spending-dashboard/

[28] https://www.eventbrite.com/e/moving-our-relatives-forward-in-a-good-way-american-indian-sud-summit-tickets-667771912767

[29] Sec. 23. MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY. Minnesota Session Laws - 2023, Regular Session. (2023). https://www.revisor.mn.gov/laws/

[30] 2023 Minnesota Statutes: Sec. 254B.01 MN Statutes. Minnesota Legislature. (n.d.). https://www.revisor.mn.gov/statutes/cite/254B.01

- **Culturally Specific Mental Health and Substance Use Disorder Services Grants:** The purpose of the Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program is to provide and expand culturally specific, trauma-informed mental health and SUD services for African, African American, American Indian, Hispanic, Latino, Asian, Immigrants, Refugees, and Lesbian Gay Bi-sexual Transgender Queer (LGBTQ+) populations. A list of current CEMIG providers is available here: https://mn.gov/dhs/partners-and-providers/policies-procedures/behavioral-health/cemig/.
- In addition to the cultural and ethnic population of focus, the Department of Human Services recognizes the importance of providing access to not only our urban areas, but greater Minnesota and rural areas which are rapidly growing with a diverse population of ethnic and cultural minorities. The goal is to ensure SUD and mental health services in the state are culturally responsive and meet the cultural needs of the target communities served.[31]

RECOMMENDATIONS, STRATEGIES, AND ACTIONS

The MN SUD CoP Treatment Outcomes Gaps, Summary, Strategies, and Recommendations Report (Gaps Report) included 16 recommendations for improving SUD care in Minnesota. Four recommendations from the Gaps Report are related to culturally- and gender-specific care. Two of the recommendations have been combined for the purposes of this report. The recommendations, strategies, and action steps are described in the narrative on pages 10-24, followed by a graphic summary in **Figures 3a-3c**. Based on the information gathered from MN CoP meetings, workgroups, and other publicly available information, HMA has developed the following strategies and actions Minnesota can implement to build a statewide, sustainable infrastructure that ensures culturally and gender responsive care centered around these three recommendations.

A foundational element to building a sustainable, statewide infrastructure for culturally responsive and gender specific care is a statewide evaluation framework that includes data collection, outcome measurement, and collection of demographic data to look for potential disparities across race, ethnicity, gender, sexual orientation, and other areas to be determined by partners. To inform the evaluation framework, a landscape analysis of culturally responsive and gender-specific care in Minnesota must be conducted to understand current capacity and identify barriers to sustainability and expansion. The landscape analysis should include formal identification of culturally responsive organizations that provide substance use disorder-related services as defined in 254B.01, as well as programs that identify as providing gender-specific SUD services.[32] Once programs are identified, data gathering, and program engagement is needed to determine current capacity and barriers to sustainability and expansion. The framework, along with the landscape analysis, would offer insight into strengths, gaps, and challenges within the continuum of care allowing for strategic resource investments.

[31] MN Dept. of Human Services. (2024, January 17). Culturally Specific Mental Health and Substance Use Disorder Services. MN Dept. of Human Services. https://mn.gov/dhs/partners-and-providers/policies-procedures/behavioral-health/cemig/
[32] MN Dept. of Human Services. (n.d.). DHS Licensing Information Lookup. MN Dept. of Human Services. https://licensinglookup.dhs.state.mn.us/

Recommendation

Enhance culturally responsive and specific care by contracting with community-based agencies that are successfully providing expert care to these populations and train existing providers on evidence-based practices for delivering culturally specific care. Additionally, using the Collective Impact approach, fund backbone agencies that may apply for and manage grants, bill Medicaid, and track and monitor outcomes for small agencies with limited capacity.

Minnesota could improve cultural responsivity by **making it easier for small, culturally competent agencies to apply for grants, contract with DHS and the Minnesota Department of Health (MDH) and obtain Medicaid reimbursement.** The CoP members shared support for a robust network of small, community-based, culturally responsive and gender-specific providers meeting the treatment and recovery needs of culturally diverse populations. This approach would increase access and utilization of SUD services and supports within communities with the highest disparities. While MN DHS has spearheaded initiatives to support culturally responsive and gender specific organizations to increase services access and program sustainability, as well as increase staffing for supporting these organizations, many participants were unaware of current initiatives or service offerings in these areas or expressed challenges with bandwidth or funding to dedicate to applying for grant opportunities. Minnesota may consider **expanding and enhancing these initiatives to accelerate access and more broadly share learnings, tools, and resources from these initiatives to the community**.[33]

Also, using the Collective Impact approach as outlined in the MN SUD CoP Community Advocacy and Capacity-Building Strategy Report, Minnesota should **consider funding backbone agencies that may apply for and manage grants, bill Medicaid, and track and monitor outcomes for small agencies with limited capacity**. This strategy would provide culturally specific community-based organizations (CBOs) or tribal governments and organizations with a sustainable path to leading culturally specific and responsive care efforts while they continue to support people and families.

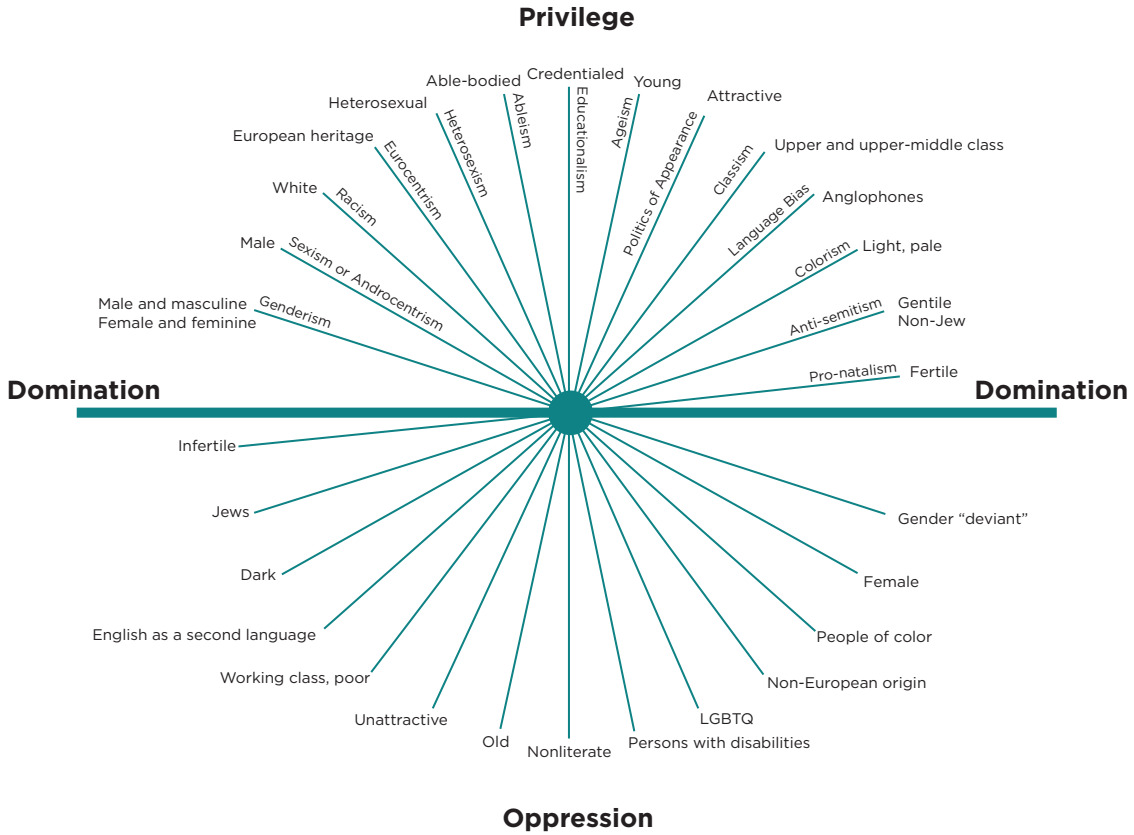
In addition to expanding and enhancing small, community-based provider capabilities, all providers across the Minnesota SUD continuum must work to improve efforts to provide culturally responsive care. This responsibility includes ensuring providers receive adequate training to implement culturally responsive services and supports. **All SUD providers should have access to training and implement the following key concepts and practices to ensure culturally responsive care**. Providers who are recognized as providing culturally responsive care, particularly to those populations most effected by SUD, should also be provided with reimbursement models to offset culturally specific services and trainings, including adoption of rates established through the most recent rate study conducted on behalf of the Department of Human Services.[34] Where possible, free trainings and incentivizing the adoption of these practices should be explored and adopted. Examples of culturally specific practices are provided below.

[33] See Current Minnesota Efforts Section – Women's Culturally Responsive Recovery Services and Culturally Specific Mental Health and Substance Use Disorder Services Grants

[34] Minnesota Health Care Program Outpatient Services Rates Study. MN Dept. of Human Services. (2024a, February 26). https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/behavioral-health/mhcp-outpatient-services-rates-study/

- **Acknowledge intersectionality:** Every individual brings with them a collection of different sociocultural identities, some of which are marginalized and others that are privileged. The additional identity of being a person with SUD brings its own stigma and marginalization. These identities intersect to shape individuals' perspectives, experiences, opportunities, and outcomes. **Figure 1** below illustrates how individuals can identify across the spectrum.[35]

Figure 1. Intersectionality Diagram



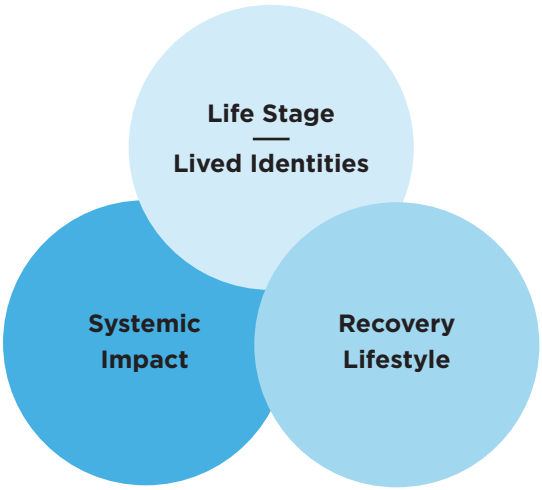
- **Develop cultural humility:** In contras to cultural competency, which implies attainment of a concrete set of skills, cultural humility has no endpoint. Cultural humility requires openness, respect, and lack of superiority when interacting with others with different identities, culture, and world view. It also requires a continual process of self-reflection and critique, mutual learning, acknowledgement of power differentials and implicit biases.[36]

[35] AWIS. (n.d.). Intersectionality: A Critical Framework for STEM Equity. AWIS. https://awis.org/wp-content/uploads/AWIS_FactSheet_Intersectionalityv4.pdf

[36] Jones and Branco, Advances in Addiction & Recovery. 2021; Ranjbar, Erb, Mohammad, Moreno. Focus. 2020; Prasad, et. al., Med Educ Online. 2016.

- **Understand your priority populations:** It is critical that organizations and individuals interested in serving specific priority populations understand what may contribute to their ability to seek and respond to SUD, including their life stage, lived identity, systemic impact, and recovery lifestyle as illustrated in **Figure 2**.[37]

Figure 2. Impacts on Seeking SUD Treatment



    - For example, historically, Black individuals in America are Americans of African Ancestry descended from Africans who were stolen from Africa and forced into slavery. This history contributes to a history of generational trauma and proceeds through systems of institutionalized racism. Black Americans have been exposed to generations of discrimination, racism, race-based segregation, and the resulting poverty. They are also consistently subjected to daily microaggressions. A history of atrocities against Black Americans contributes to ongoing suspicion and paranoia regarding physical and mental health services and may lead to a hesitance to obtain SUD services. Black Americans who do seek SUD treatment are forced to enter treatment with the knowledge that treatment will look like the society that has caused most of his/her social trauma, yet they have no other option. Organizations and individuals interested in providing services to Black Americans must therefore establish respect by understanding how this history may impact treatment strategies and outcomes.[38]
    - Strategies which may help build trust include: the Minnesota Department of Corrections
        - Encourage open-ended questions at any time during sessions, including questions about family and community histories
        - Establish confidentiality and security with no judgement
        - Assess verbal, written, and social skills and obtain past experiences with group activities or discussions – recognize that language/expression is not a measure of intelligence
        - Actively listen and validate the individuals' experiences and emotions – challenge excuses—not the individual—when meeting with resistance
        - Speak WITH, not AT or DOWN TO your client.
        - Trust that the individual can do the work necessary to recover.

[37] Culturally Responsive Substance Use Treatment A Guide for Practitioners, Students, and Organizations By Gabrielle Jones https://www.taylorfrancis.com/books/mono/10.4324/9781032708829/culturally-responsive-substance-use-treatment-gabrielle-jones

[38] Lewis, G. (n.d.). Bami Soro Cultural Diversity Training for Professionals. Motivational Consulting Inc. https://www.motivationalconsultinginc.com/bami-soro

- **Understand how the Stages of Change Model can help staff/organizations to deliver culturally specific and responsive care:** The National Association of Addiction Treatment Providers (NAATP) outlines how diversity, equity, and inclusion practices can be implemented at organizations and are dependent on the stage of change at which the individual or organization currently resides. This includes staff/organizations at the precontemplation, contemplation, preparation, action, and maintenance stages.[39] Provider organizations should assess organizational policies and practices and their impact on the promotion of diversity, equity, and inclusion.
- **Train treatment providers on the best practices for providing culturally responsive and specific care:** Ideally, this training would begin during education and continue with existing treatment providers. SAMHSA has developed a Treatment Improvement Protocol that provides evidence-based strategies for improving culturally responsive care. Tips for training culturally responsive treatment counselors include teaching counselors to[40]:
    - Frame issues in culturally relevant ways
    - Allow for complexity of issues based on cultural context
    - Make allowances for variations in the use of personal space
    - Be respectful of culturally specific meanings of touch (e.g., hugging)
    - Explore culturally based experiences of power and powerlessness
    - Adjust communication styles to the client's culture
    - Interpret emotional expressions considering the client's culture
    - Expand roles and practices as needed

  Additional information is available via the SAMHSA Treatment Improvement Protocol: Improving Cultural Competence (Chapter 3).
- **Establish culturally and linguistically service standards (CLAS):** US Department of Health and Human Services Office of Minority Health provides 15 action steps for improving health and healthcare quality, culturally and linguistically appropriate services (CLAS).[41]
    1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
    2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
    3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
    4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

[39] Diversity, Equity, Inclusion & Belonging (DEIB) Best Practices in Addiction Treatment: STAGES OF CHANGE MODEL AND ORGANIZATIONAL ASSESSMENT TOOL. National Association of Addiction Treatment Providers. (2022). https://www.naatp.org/sites/naatp.org/files/NAATP's Stages of Change Model and Organizational Assessment Tool.pdf

[40] Substance Abuse and Mental Health Services Administration. A Treatment Improvement Protocol: Improving Cultural Competence. 2014. Available at: https://store.samhsa.gov/sites/default/files/sma14-4849.pdf. Accessed December 28, 2023.

[41] US Dept. of Health and Human Services Office of Minority Health. (n.d.). National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Think Cultural Health. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the public.

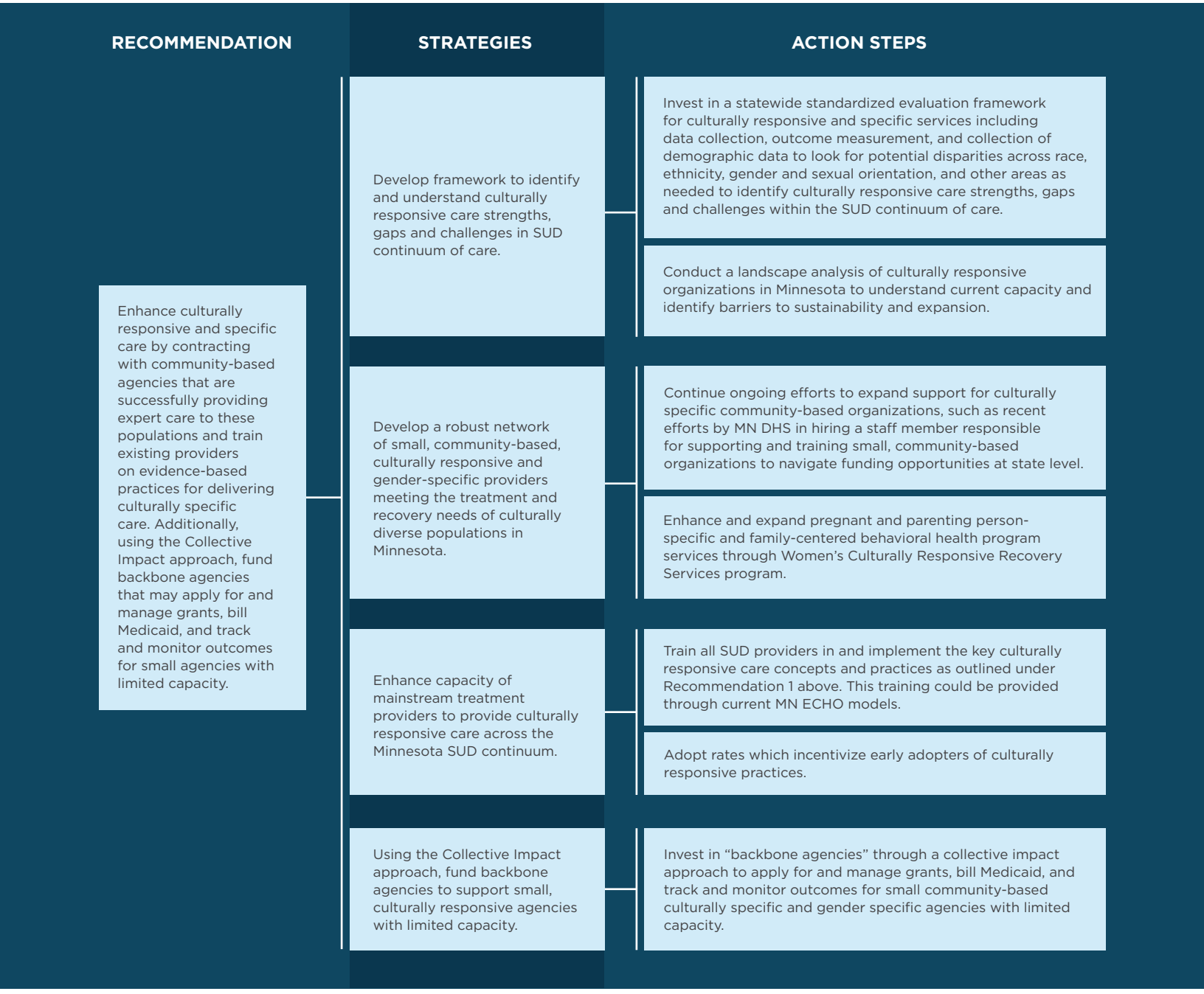
- **Adopt American Society of Addiction Medicine (ASAM) 4th Edition Criteria:** ASAM's 4th Edition provides guidelines for providing trauma-sensitive practices, culturally humble care, and addressing social determinants of health (SDOH).[42] This is the first time the ASAM Criteria have included a dedicated chapter with emphasis on culturally humble care. The chapter aims to empower stakeholders to:
    - "Engage in exploratory conversations that provide opportunities to safely identify and change biases, increase cultural humility, and expand skills"
    - "Create opportunities for deliberate conversations regarding how to better support a patient's values, cultural identities and healing from trauma"
    - "Identify opportunities for incremental program change to enhance trauma-sensitive and culturally humble practices…"
    - Ask "Why do we do things this way and how do these practices impact the people we serve"

Additional information on implementing the ASAM Criteria 4th Edition will be available in the MN SUD CoP ASAM Implementation Roadmap Report, available June 2025.

[42] American Society of Addiction Medicine. (n.d.). ASAM Criteria: 4th Edition. American Society of Addiction Medicine. https://www.asam.org/asam-criteria

Identifying key partners and experts, providing widespread training to and adequate reimbursement for culturally specific treatment practices, and communicating resources and opportunities efficiently are critical to improving recovery outcomes among Minnesotans.

Figure 3a. Recommendation, Strategies, and Action Steps Summary



Recommendation

Require treatment facilities to adopt national standards for delivering culturally responsive care, including trauma-informed training, to the American Indian/Native American community.

With the significant disparities with SUD access and outcomes, MN SUD CoP members expressed support for **requiring treatment facilities that serve American Indian/Alaskan Native (AI/AN) community adopt national standards for delivering culturally responsive care** to this community. National standards that should be considered include the National Institute of Health (NIH) objectives to improve culturally responsive SUD care among AI/AN (not specific to SUD care). Objectives include:

- Identify the unique cultural and historical factors that influence the healthcare experiences and outcomes of AI/AN patients.
- Screen for the prevalence of other chronic conditions, including diabetes, cardiovascular diseases, and mental health disorders, among AI/AN patients and understand their impact on health outcomes.
- Implement culturally responsive preventive measures, such as nutritionist referrals, blood glucose monitoring, and early screening for hypertension and cancer, to address specific health needs for AI/AN patients.
- Coordinate care with interdisciplinary healthcare teams, including traditional healers, to ensure holistic and culturally responsive care plans for AI/AN patients.

In addition, the National Indian Council on Aging, Inc. (NCOA) has recommendations for improvement of healthcare among aging American Indians, which include:

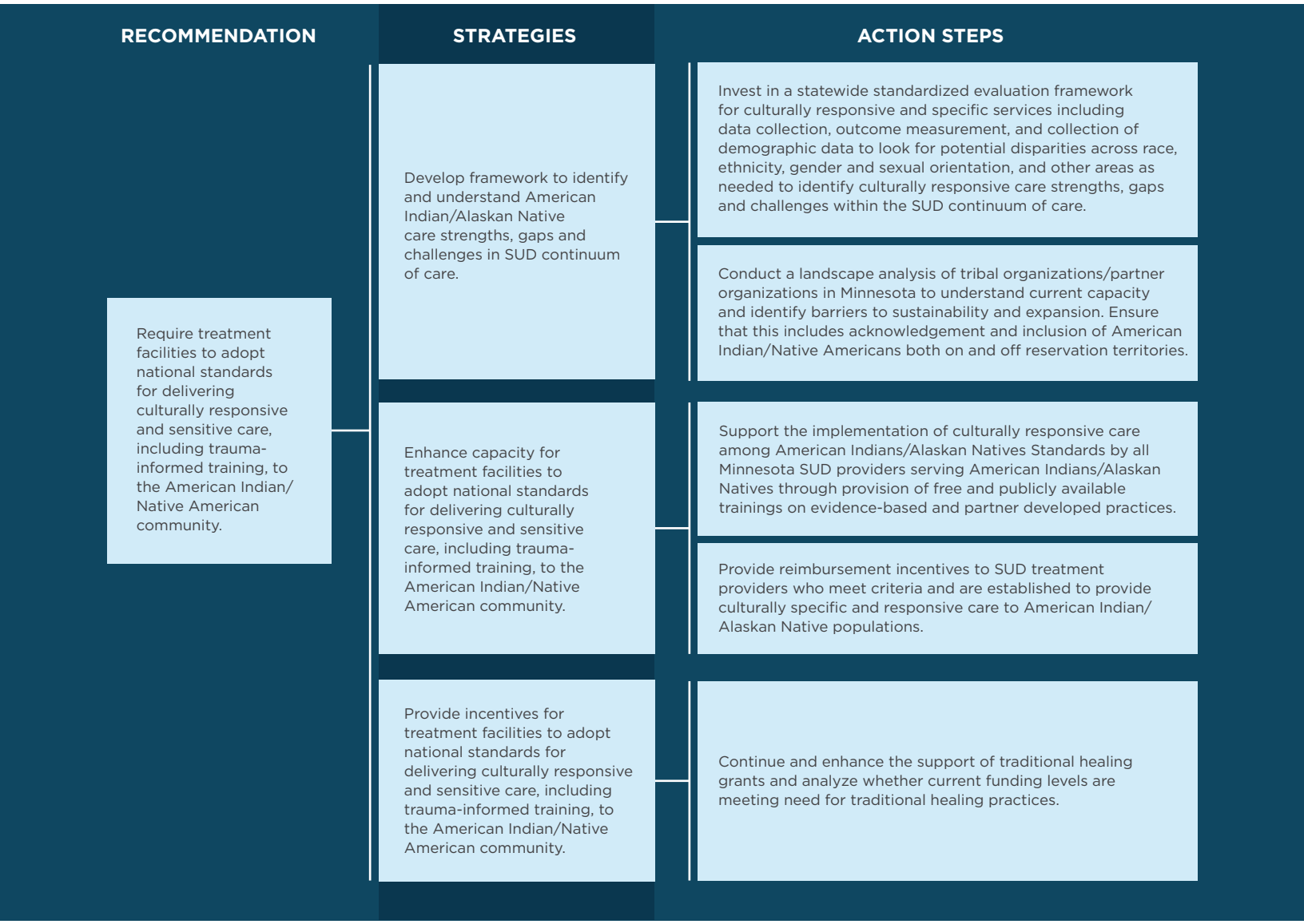
- **Create a Welcoming Facility for Elders:** AI/AN elders often are overlooked in efforts to improve culturally responsive care. Understanding the belief systems of natives, particularly elders, can help improve care outcomes.
- **Recognition:** SUD treatment systems must acknowledge the presence of Natives living both on and off tribal land. It is critical to recognize that the United States has hundreds of federally recognized tribes, all with differing beliefs and practices. Because an individual's identity is not always obvious or apparent, organizations need to be open and regularly practice culturally responsive care techniques.
- **Involvement:** It is critical that programs engage tribal members to understand their specific beliefs and care preferences. Native people may choose to look toward Western medicine to address the symptoms of an ailment while also pursuing spiritual guidance from traditional healers in their communities to recover from an imbalance between the mind, soul, and body. Non-native treatment providers will need to seek guidance and expertise from Native partners to ensure practices are managed with cultural sensitivity.
- **Taking Action:** AI/AN have experienced systemic racism and historical neglect for centuries, leading to trauma and mistrust of the healthcare system. Treatment centers need to listen to the American Indian community to design effective and culturally sensitive service delivery systems.
- **Storytelling Patient-Centered Native Healthcare:** Stories not only reflect knowledge of communities but also highlight core values that are important to tribal society. They offer tribes an auditory record of their traditional spirituality and history and can be a valuable tool for emphasizing health and wellness.

Similar to the strategy noted above, it is recommended that **free trainings** on these protocols are available to support the adoption, as well as **incentive programs for organizations** which adopt these protocols. MN DHS has supported several initiatives supporting access and higher quality SUD services and supports to the American Indian/Native American community. These efforts include the development of an American Indian strategic plan[43] and an evaluation of traditional healing services to determine if Medicaid reimbursable.[44] Additionally, Minnesota has dedicated about two million dollars per year in general fund dollars for traditional healing services. MN DHS should continue to enhance and support funding for the traditional healing grants and analyze whether current funding levels are meeting the need for traditional healing practices. Finally, it is recommended that Minnesota implement compliance and/or review processes to ensure that treatment facilities are following culturally specific and responsive care requirements as set forth.

[43] Under development according to American Indian Section of the Behavioral Health Division at Minnesota Department of Human Services

[44] Sec. 23. MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY. Minnesota Session Laws - 2023, Regular Session. (2023). https://www.revisor.mn.gov/laws/

Figure 3b. Recommendation, Strategies, and Action Steps Summary



Recommendation

Develop and fund more programs that allow parents to care for their children while receiving SUD care. Integrating parenting skills and family reunification strategies into SUD treatment has demonstrated promising outcomes and enhanced engagement.[45] Specific programming may include family-centered therapy, trauma-informed parenting skills training, and multisystemic family therapy.

According to Minnesota's Out-of-home Care and Permanency Report, 2021, "children enter out-of-home care for many reasons; in the last five years, Minnesota has seen a shift from neglect to caretaker drug abuse as the most common primary reason for removal for children across the age span; this remained true in 2021. **Nearly one-third of new placements were due to caretaker drug use.**"[46] Because of this, it is recommended that Minnesota consider co-creating and exploring funding options with child welfare to develop recovery programs that support parents and their children as parents seek treatment. Recent funding by the Minnesota legislature (as noted above) is a critical first step in achieving this goal and reducing existing barriers providers face in providing family-based treatment.

Behavioral health professionals recognize **family-based residential treatment as having better outcomes for women and their children;** however, such programs often struggle to stay afloat because of staffing shortages and volatile funding. Consequently, families in rural areas are less likely to find such a residential treatment program in their communities. Only four family residential treatment programs are currently operating in the state. The National Center on Substance Abuse and Child Welfare (NCSACW) has developed a series of modules which provides information on implementing a family-centered approach to help communities move toward and maintain family-centered care.

These modules provide information on developing family-centered SUD services using six essential ingredients, including:

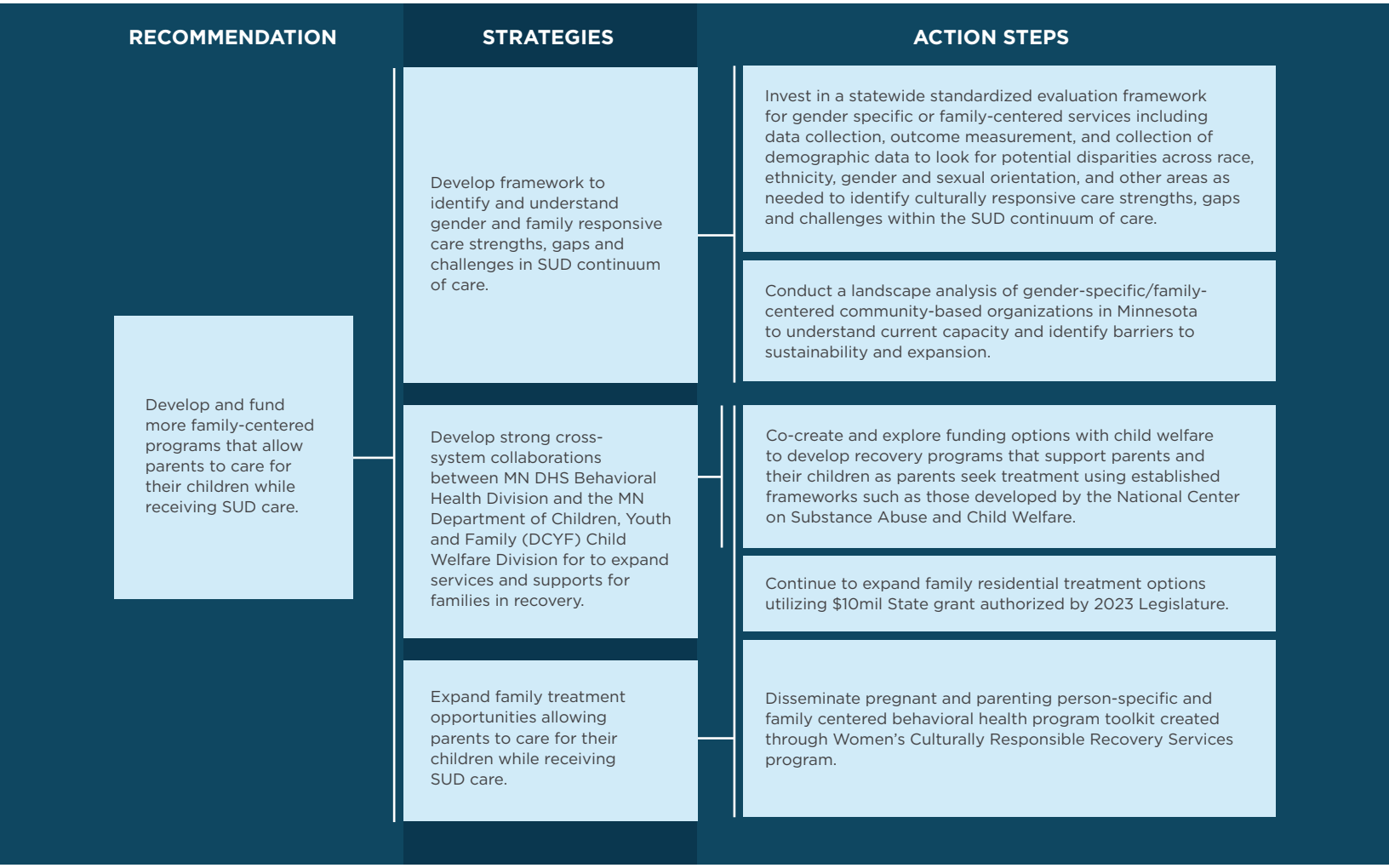
1. **Collaborative Partnerships:** Treatment providers are recommended to establish collaborative partnerships with "community services providers, county and staff administrators, and funders that can support the development of a comprehensive community-based, family-centered approach." These partnerships are also necessary to ensure the support and safety necessary for each member of the family.
2. **Adequate and Flexible Funding:** NCSACW acknowledges that innovative and flexible funding is required by state and county leaders to provide grants and other funding mechanisms for establishing family-centered care services adequate to meet the needs of the community.
3. **Performance Monitoring:** Effective family-centered care requires performance monitoring and quality improvement to ensure the support and safety of all involved in care. Partners must work together to identify and track metrics as appropriate.

[45] National Center on Substance Abuse and Child Welfare. Implementing a Family-Centered Approach (Companion Modules) Series. 2021. Available at: https://ncsacw.acf.hhs.gov/topics/family-centered-approach/fca-modules-series/. Accessed December 28, 2023.
[46] MN Dept. of Human Services. (2023, June). Minnesota's Out-of-home Care and Permanency Report, 2021. MN Dept. of Human Services. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5408Na-ENG

4. **Intensive and Coordinated Case Management:** Navigating SUD and family services can be complex. NCSACW notes that, "coordinated case management for families ensures that the SUD treatment provider and its collaborative partners are coordinating services, addressing barriers to access and engagement in services, and sharing information on families' progress against baseline data."
5. **High-Quality Substance Use Disorder Treatment:** Improved outcomes cannot occur without access to high quality SUD treatment, which is key to ensuring long-term results and family unity.
6. **Comprehensive Service Array:** In addition to SUD services, families will require access to additional services to support their recovery. These arrays of services are at the discretion of and dependent on the needs of their community.

As discussed in the foundational recommendation above, partners need to assess needs, assess resources, build partnerships, and identify services as the first steps to operationalizing family-centered services. Additional information and full modules are available at the NCSACW website.

Figure 3c. Recommendation, Strategies, and Action Steps Summary



DISCUSSION

The goal of each of these recommendations is to improve comprehensive access to culturally competent and gender-specific care across Minnesota. Notable disparities in substance use and substance use disorders by race, ethnicity, sexual and gender minority status, and ability exist within Minnesota and nationally. Inequities in substance use related consequences and treatment access also continue to exist. Those serving persons with SUD must develop and cultivate cultural humility and enhance efforts for providing culturally responsive care, which is an essential component in advancing health equity in SUD treatment. Though implementation of culturally and gender specific care varies depending on the population served, partners can begin to advance efforts by partnering with community-based organizations to develop a robust network of culturally responsive care organizations, standardized training on culturally specific care evidence-based practices and providing adequate family-based care.

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- researchers or members of the academic community who are SUD subject matter experts and who do not have financial relationships with treatment providers
- SUD treatment providers
- recovery community organizations
- the Minnesota Department of Human Services
- the Minnesota Department of Health
- the Minnesota Department of Corrections
- county social services agencies
- tribal nations or tribal social services providers
- managed care organizations
- individuals who have used SUD treatment services
- individuals from other communities that are disproportionately impacted by SUD

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Substance Use Disorder
Community of Practice