Workforce Diversity and Ethnoracial Disparities in Substance Use Disorder Treatment in the United States

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- Individuals self-identified as racial and ethnic minority groups are more likely than White individuals to experience difficulty entering and staying in outpatient substance use disorder (SUD) treatment (1–3).

- The addiction health services system in the United States has limited capacity to deliver culturally and linguistically appropriate services (CLAS) (4).

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Workforce diversity in outpatient substance abuse treatment: The role of leaders' characteristics

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ABSTRACT

Although the outpatient substance abuse treatment field has seen an increase in referrals of African American and Latino clients, there have been limited changes in the diversity of the workforce. This discordance may exacerbate treatment disparities experienced by these clients. Program leaders have significant influence to leverage resources to develop staff diversity. Analysis of panel data from 1995 to 2005 showed that the most significant predictors of diversity were the characteristics of leaders. In particular, programs with managers with racially and ethnically concordant backgrounds and their education level were positively related to the percentage of Latino and African American staff. A high percentage of African American staff was positively associated with managers' tenure, but inversely related to licensed directors. Diversification of the field has increased, yet efforts have not matched increases in client diversity. Implications for health care reform legislation seeking to improve cultural competence through diversification of the workforce are discussed.

1. Introduction

The outpatient substance abuse treatment (OSAT) field has seen a rapid increase in referrals of clients of color. In particular, the percentage of African American and Latino clients entering substance abuse treatment has been steadily increasing during the last 10 years (Arndt, 2010; Office of Applied Studies, 2009, 2010). Although several studies have documented increased diversity in the client population, only a few have explored the extent to which the racial and ethnic composition of the OSAT workforce matches this client diversity (Howard, 2003a, 2003b; Mulvey, Hubbard, & Hayashi, 2003). As health care reform, through the Patient Protection and Affordable Care Act, seeks to increase national standards on culturally and linguistically appropriate care for minorities to reduce existing health disparities, diversification of the workforce has become one of the chief strategies (Andrulis, Siddiqui, Purtle, & Duchon, 2010; Office of Minority Health, 2012). Upper managers have the authority to pursue such strategies, yet little is known about the extent to which these leaders play a significant role in the diversification of their workforce. Using nationally representative data from1995 to 2005, this study seeks to understand the role that key organizational factors, particularly leaders' characteristics, play in developing a racial and ethnic diverse workforce in the OSAT field over time.

The importance of diversifying the workforce in OSAT stems from disparate research that suggests that the discordance between the racial and the ethnic diversity of clients and treatment staff may contribute to service and health disparities (Bhadury, Mighty, & Damar, 2000; Broderick, 2007; Howard, 2003a; McGuire & Miranda, 2008; Pitts, 2009). Specifically, congruence between the cultural and the linguistic backgrounds of staff and clients is thought to elevate the competencies of health care providers and improve client treatment adherence via the use of racial/ethnic history and cultural norms, as well as the reliance on client's native language or dialect during health interventions (Grumbach & Mendoza, 2008; Herring, 2009; Howard, 2003a; Lok, Christian, & Chapman, 2009; McGuire & Miranda, 2008). Furthermore, having a diverse workforce may create a conducive climate for implementing culturally and linguistic responsive services (e.g., family support groups in Spanish) (Guerrero, 2010; Prince Inniss, Nesman, Mowery, Callejas, & Hernandez, 2009) and addressing treatment outcome disparities among minorities (Center for Substance Abuse Treatment [CSAT], 1993, 2006; Howard, 2003a; Quist & Law, 2006).

Although limited, existing statistics of the racial and ethnic composition of the substance abuse treatment workforce suggest that more than 70% of providers are White, female, and older than the largely African American and Latino young male client population (Broderick, 2007; Mulvey et al., 2003). Other national samples of the workforce show less staff diversity, with 86% of counselors identifying as White, 8% as African American, and 3% as Latino (Knudsen, Johnson, & Roman, 2003). This low level of diversity poses a challenge for program leaders who seek to recruit, retain, and develop program

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- Workforce diversity is a key strategy to engage individuals identified as members of racial/ethnic minority groups (12,13).
- Defined as the demographic and cultural representation of health workers and managers that reflect inclusion of backgrounds that are representative of the client population (14).
- Limited progress in diversifying the workforce of the addiction health services system (5).

White clients 52% - White workforce 64%

Black/AA clients 33% - Black/AA workforce 22%

Latino/Hispanic clients 12% - Latin/Hispanics workforce 8%

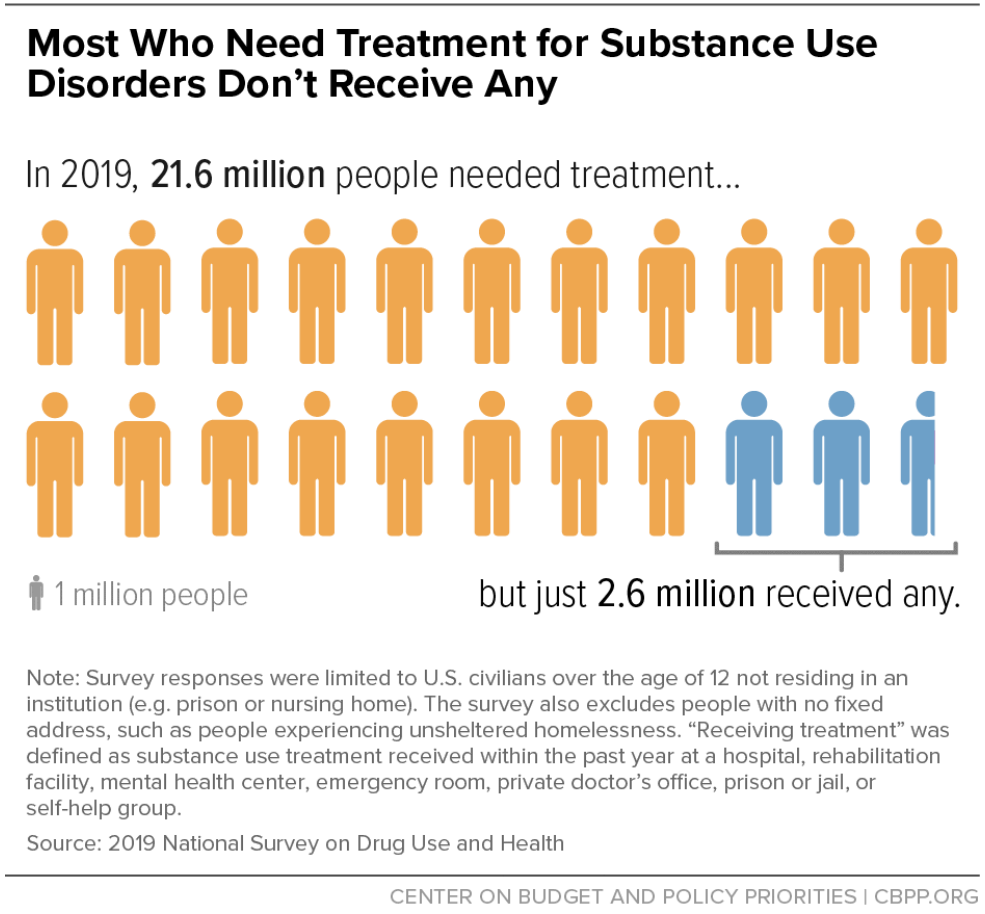
Asian clients 3% - Asian workforce 6%

- National priority to enhance access to care, particularly to engage ethnoracial minorities.
- Abate the effect of the covid and opioid syndemic.
- Culturally responsive interventions have an effect on treatment engagement and outcomes (4, 6-8),

    Translated material (9)

    Cultural adaptations (10)

    Client-Counselor matching (racial/language) (11)

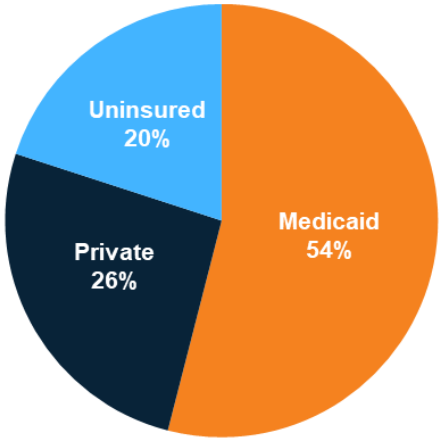


- Because only about 10% of people who need treatment enter care, access (wait time to treatment) and retention (duration) in treatment are critical process measures to abate disparities in SUD treatment (4).

- This study addresses the impact of workforce diversity on wait time and retention for individuals self-identified as Black/African American (hereafter African American) or Hispanic/Latino (hereafter Latino).

Figure 5

Nonelderly Adults with Opioid Use Disorder Who Received Any Treatment in Past Year, by Insurance Status, 2017



Total Nonelderly Adults with OUD Who Received Treatment: 617,000

NOTE: Nonelderly adults are 18 to 64 years. Any treatment includes receiving drug and/or alcohol treatment at any of the following in the past year: inpatient hospital, residential rehabilitation, outpatient rehabilitation, mental health center, and private doctors' office. Excludes those in the other insurance category due to statistical unreliability.
SOURCE: KFF analysis of 2017 National Survey on Drug Use and Health (NSDUH).

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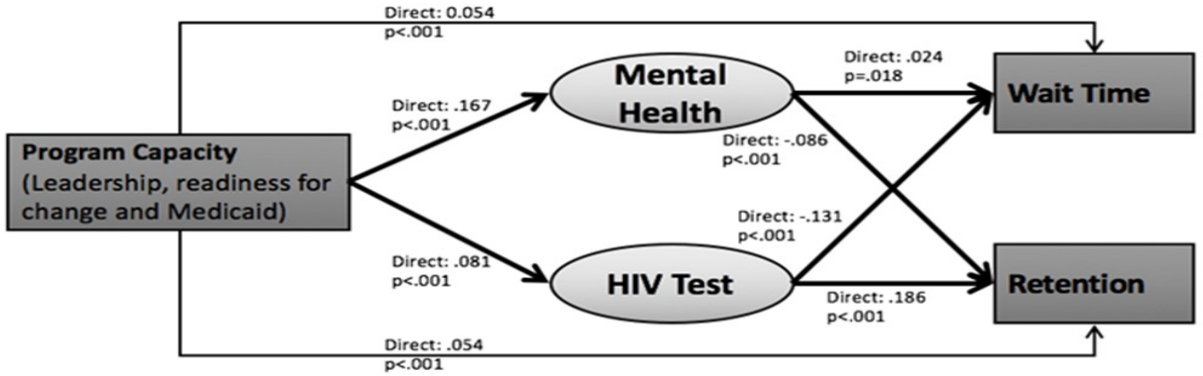
- Medicaid expansion also increases regulation on quality of care and improves implementation or, that includes provision of culturally responsive and evidence-based SUD treatment (5).

- Medicaid expansion may play a significant role in the delivery of culturally responsive care, as well as in wait time and retention.

Study 1: Findings on Medicaid Expansion in L.A. County – Outpatient SUD treatment services

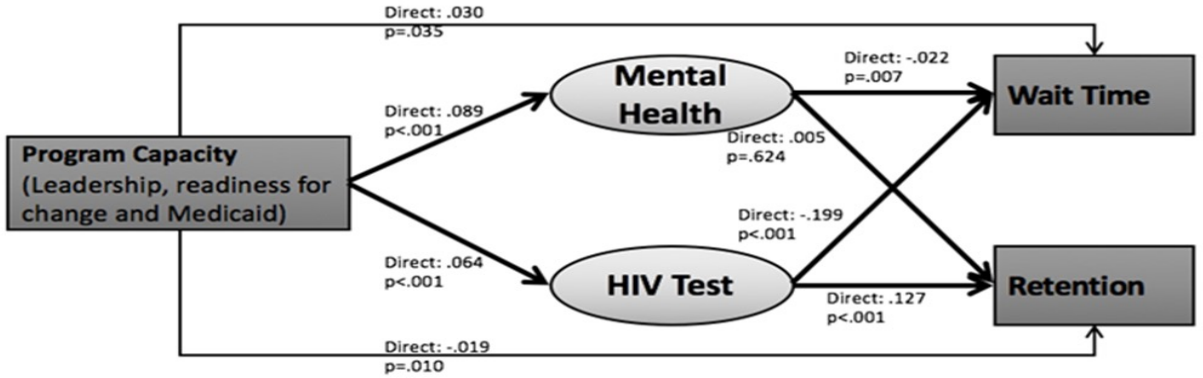
Prior ACA (2011-2013). Higher wait time, higher retention, higher completion rate when programs w/ Medicaid

Post ACA (2015-2017). Lower wait time, but through MH and HIV services. Higher retention, but through HIV testing services



Prior ACA

Indirect effect of path (**Capacity -> MH -> Wait Time**): .004, p=.018; Indirect effect of path (**Capacity -> MH -> Retention**): -.014, p<.001;
Indirect effect of path (**Capacity -> HIV -> Wait Time**): -.011, p<.001; Indirect effect of path (**Capacity -> HIV -> Retention**): .015, p<.001



Post ACA

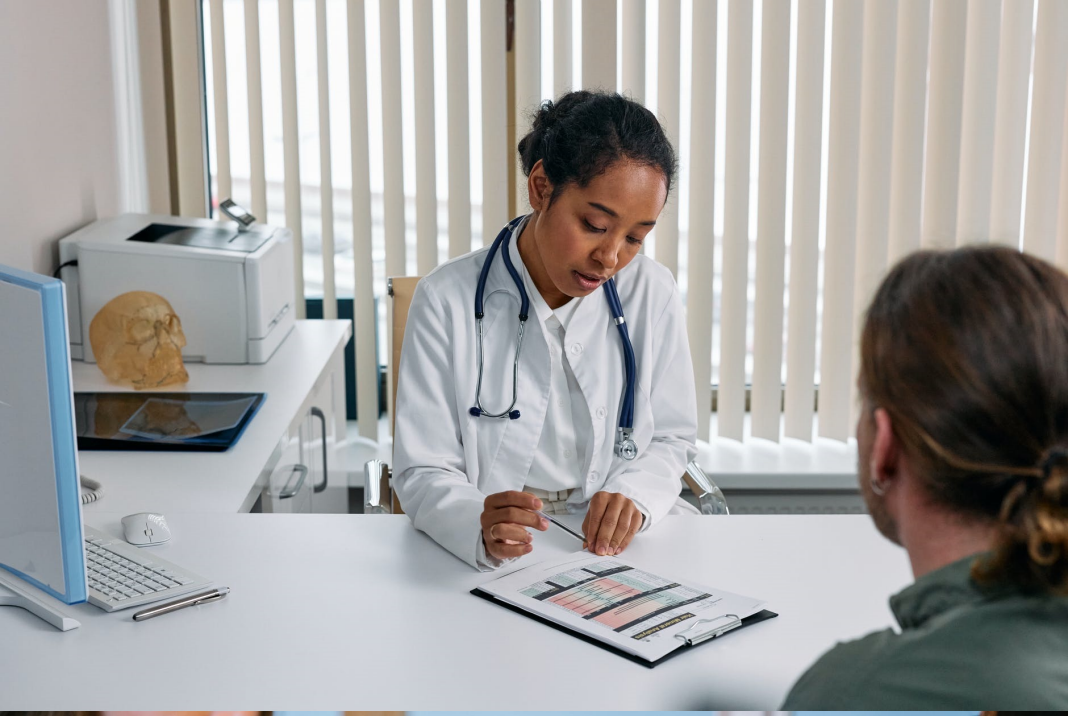
Indirect effect of path (**Capacity -> MH -> Wait Time**): -.002, p=.008; Indirect effect of path (**Capacity -> MH -> Retention**): .000, p=.624;
Indirect effect of path (**Capacity -> HIV -> Wait Time**): -.013, p<.001; Indirect effect of path (**Capacity -> HIV -> Retention**): .008, p<.001

Study 2: Workforce Diversity and Wait time and Retention in the United States

- Main hypothesis: High workforce diversity will be associated with (a) lower wait time and (b) higher retention in well-resourced opioid treatment programs.

- Subsample of opioid treatment programs (OTPs) from four waves of the National Drug Abuse Treatment System Survey (NDATSS)(2000- 2017).

- Comparative and predictive analysis of sample of programs pre- Medicaid expansion (162 in 2000, 173 in 2005) and post- expansion (282 in 2014, 300 in 2017).



FINDINGS

High staff/client diversity – lower access

- Programs with higher proportion of African American staff and higher proportion of African American clients were associated with **higher average wait times** compared with programs with lower proportion of African American clients and staff.

High staff/client diversity – lower retention

- Programs with both a higher percentage of Latino staff and a higher percentage of Latino clients were associated with lower rates of treatment retention beyond three months.

FINDINGS

High staff diversity in public programs – higher access

- Public programs with higher percent of African American staff were associated with lower wait time, compared with private programs with lower percent of African American staff.

High staff diversity in non-private programs – higher access and higher retention

- Non-profit programs with higher percent of Latino staff were related to higher retention, compared with private programs with lower percent of Latino staff.

CONCLUSIONS

- Findings expand understanding of the complex role of workforce diversity in enhancing access and retention in opioid treatment.
- High workforce and client diversity associated with lower resources and poor outcomes.
- Workforce Diversity improves client outcomes WHEN other resources (Medicaid) are in place and in specific settings (public, non-profit).
- It is critical to further examine workforce diversity within the resource and capacity needs of treatment programs serving minority communities.

- Bias related to program managers over-reporting positive features, such as lower wait times and greater retention may exist.
- Findings only represent a subsample of NDATSS opioid treatment programs.
- Findings might be affected by nonrandom attrition of programs from the sample over time and unaccounted unobserved program characteristics affecting our outcomes. But we control for these factors.

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