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Anti-racism and substance use treatment: Addiction does not discriminate, but do we?

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ABSTRACT

Contemporary racism in the United States contributes to health, mental health, and substance use disorder (SUD) disparities among People of Color (POC) compared with White individuals. Despite entering into substance use treatment with a greater severity of SUD and related consequences, POC experience more barriers to treatment engagement, completion, and satisfaction than their White counterparts. As substance use treatment counselors are socialized within institutions of systemic racism, it is important to examine their positioning on racism in relation to their capacity for culturally competent care. This article articulates a need to implement an antiracist framework for substance use treatment.

KEYWORDS

Antiracism; counselor; racism; substance misuse; substance use treatment

Demographers allege that by 2050, 14.6% of U.S. citizens will be Black, 8% will be Asian, and 24.4% will be Latinx (Passel & Cohn, 2008). Despite the rapid growth of non-White populations, the United States maintains a consolidated system that creates opportunities for White Americans while creating impediments for people of color (POC) (Hall, 2015). Health care is one system where racial inequities persist, including within substance use treatment (Feagin & Bennefield, 2014; Kressin, Raymond, & Manze, 2008; Paradies, 2006; Sabin, Nosek, Greenwald, & Rivara, 2008; Smedley, Stith, & Nelson, 2003; Truong, Paradies, & Priest, 2014; Williams & Mohammed, 2009).

Substance use disorder (SUD), involving the presence of clinically significant impairment and distress caused by the recurrent use of alcohol and/or drugs (American Psychiatric Association, 2013), remains a growing public health crisis in the United States (Substance Abuse and Mental Health Services Administration, 2014). Compared to White individuals, POC are disproportionately vulnerable to negative consequences associated with substance misuse, such as involvement with the criminal justice system, greater morbidity and mortality, and violence (Amaro, Arevalo, Gonzalez,

Szapocznik, & Iguchi, 2006; Boyd, Phillips, & Dorsey, 2003; Iguchi, Bell, Ramchand, & Fain, 2005; Mennis & Stahler, 2016; Smedley et al., 2003). Despite these accentuated consequences, Black and Latinx individuals, in particular, are found to have greater barriers to accessing, completing, and having satisfactory experiences within substance use treatment than White individuals (Marsh, Cao, Guerrero, & Shin, 2009; Mennis & Stahler, 2016). For example, Latinx individuals using heroin were only 75% as likely as White Americans to complete a treatment episode (Mennis & Stahler, 2016). Similarly, Black Americans were 69% as likely as White Americans to complete substance use treatment across all types of substances (Mennis & Stahler, 2016).

With the growing racial diversity in the United States and evidence of the association between racial discrimination and substance misuse among POC (Borrell et al., 2010; Hurd, Varner, Caldwell, & Zimmerman, 2014; Pro, Sahker & Marzell, 2017; Yoo, Gee, Lowthrop, & Robertson, 2010), there is a need for providers to adopt an antiracist substance use treatment approach to working with POC. There is presently a dearth of literature on the role of providers in addressing how racism impacts substance use treatment processes. This article addresses this gap by articulating a need for the implementation of an antiracist framework for substance use treatment. Specifically, we aim to (a) highlight antiracism as a necessary complement to cultural competence models of clinical practice; (b) define and discuss the modern sociocultural, economic, and institutional salience of racism to substance misuse and substance use treatment; (c) share the results of a literature review specific to the associations among racism, substance misuse, and substance use treatment; and (d) provide counselors and providers with recommendations for the implementation of an antiracist framework for substance use treatment.

Key definitions

Race is a social construct assigned to groups based on their perceived phenotypic characteristics within categorical organizations (Helms, Jernigan, & Mascher, 2005). We acknowledge racial categorizations as having no biological basis (Smedley & Smedley, 2005) and as foundational to the persistence of racism. For example, *whiteness*, as a construct, delivers unearned privilege to individuals whose race is assigned as *White* (Saperstein, Penner, & Light, 2013). Accordingly, we have chosen to capitalize the words that refer to People of Color (POC), Black, Latinx, Asian, Native American, and other racial identifications to acknowledge the equal importance of the shared cultural identities and contexts experienced within those groups, while recognizing in-group variations. We use *Latinx*

as a gender-neutral term compared to *Latino/Latina*, which denote masculine/feminine gender identities.

Race is distinguished from *ethnicity*, which refers to the shared beliefs, customs, language, and heritage of a group commonly based on regional affiliation (Helms, 1994). We specifically focus on the term *race*, rather than *ethnicity*, to explore the manifestation of *racism* within substance use treatment. As Bonds and Inwood (2016) articulated, it is necessary to name racism in order to address its problematic impact. *Racism* has been described as a system of oppression manifested within internalized, interpersonal, and institutional levels based on racial categorizations that privilege Whites as the dominant group. *Interpersonal racism* can be described as perceived or direct experiences with racial discrimination, harassment, or violence as perpetrated by individuals or a group. *Systemic racism* involves the maintenance of racial privilege and subjugation within institutional structures.

Antiracism and cultural competence

Antiracism

Antiracism interrogates racism as part of the social order, recognizing that contemporary institutional structures and dominant sociocultural discourses in the United States were founded on a racist historical context that privileges people who are not of color (Dei, 2000; Sinclair, 2011). Antiracist practices include building awareness about one's social positioning within a historical and social context of power and oppression, assessing norms and values pertaining to race and related social constructs (e.g., gender, class), and challenging policies and practices that maintain the oppression of POC (Sinclair, 2011). Practitioners who embrace antiracism seek to challenge policies, practices, and mores that marginalize POC—both interpersonally and systemically—while recognizing their own race-based social positioning. There is a need for research investigating the effectiveness of using antiracism ideology in clinical practice, including within substance use treatment with POC (Horevitz, Lawson, & Chow, 2013).

Cultural competence

Sue, Arredondo, and McDavis (1992) introduced the model of *cultural competence*, which focuses on counselors building awareness of their own cultural perspectives, counselors understanding a cultural variance in worldviews, and the development of culturally appropriate interventions (Chao, Okazaki, & Hong, 2011; Dei, 2000). Substance Abuse and Mental

Health Services Administration (SAMHSA) calls for the cultural competence of practitioners and organizations to understand the cultural context of their target communities (SAMHSA, 2016). There is evidence that the use of cultural competence (e.g., bilingual materials, understanding of cultural perspective) in substance use treatment contributes to enhanced client engagement and treatment retention outcomes (Gainsbury, 2017). Cultural competence is distinguished from antiracism in that the former relates to the ability to effectively engage with people from diverse cultural backgrounds, not exclusive to race, whereas the latter involves an ideology and practice aimed at addressing the systemic causes and ameliorating the negative effects of interpersonal racism (Montalvo, 2009; Spinney et al., 2016). Therefore, antiracism is recommended as a complement to cultural competence models of clinical practice to address the influences of racism on POC seeking care for their substance misuse issues.

Racism, substance misuse, and substance use treatment

A literature review was conducted to understand the state of evidence within peer-reviewed academic journals (2000–2018) specific to the associations among racism, substance misuse, and substance use treatment outcomes. Two databases were used (MEDLINE, SocINDEX) by searching for the terms “racism OR racial discrimination OR racial prejudice OR racial bias” AND “substance use OR substance misuse OR substance abuse OR alcohol abuse OR drug abuse.” The literature review findings highlight evidence of an association between interpersonal racism and substance misuse among POC, substance use treatment as an industry inseparable from the influences of systemic racism, evidence of common racial factors within substance misuse, inconsistent findings pertaining to racial differences in substance use treatment outcomes, and evidence of racial disparities in substance use treatment retention rates.

Interpersonal racism and substance misuse

Racism is an enduring persistent source of stress for POC in the United States such that coping with race-based stigma and discrimination becomes a normative experience (Beatty, Kamarck, Matthews, & Shiffman, 2011; Kuo, 2011; Turner & Avison, 2003). There is growing evidence of the associations between racial discrimination and substance misuse among Black Americans (Bennett, Wolin, Robinson, Fowler, & Edwards, 2005; Borrell et al., 2010; Brody, Kogan, & Chen, 2012; Hunte & Barry, 2012; Hurd et al., 2014; Paradies, 2006; Pro et al., 2017; Purnell et al., 2012; Terrell, Miller, Foster, & Watkins, 2006), Asian Americans (Chae et al. 2008, Yoo et al., 2010), and Latinx Americans (Borrell et al., 2010; Otiniano

Verissimo, Gee, Ford, & Iguchi, 2014). For example, Otiniano and colleagues (2014) found that the experience of racial discrimination was significantly associated with increased risk of alcohol use for women and increased risk of drug use for men among Latinx individuals.

In addition, the literature reveals that racial discrimination is associated with psychological distress among POC (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Paone, Malott, & Barr, 2015; Paradies, 2006; Pieterse, Carter, & Ray, 2013; Seaton, Caldwell, Sellers, & Jackson, 2010; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Watkins, Hudson, Caldwell, Siefert, & Jackson, 2011). In turn, studies show that psychological distress among POC is linked to substance misuse (Green, Zebrak, Robertson, Fothergill, & Ensminger, 2012; Mason, Mennis, & Schmidt, 2010). Sanders-Phillips et al. (2014) pointed to a pathway whereby perceived racial discrimination is associated with increased depressive symptoms, which, in turn, were associated with greater substance misuse issues.

The U.S. society has shifted so that while explicit forms of racial discrimination are generally no longer accepted, aversive racism (Dovidio & Gaertner, 1998), or implicit beliefs framing White identities as the norm and superior, have persisted in contemporary society (Paone et al., 2015; Ratts, 2017; Shield, 2008). This is supported by research estimating that up to 76% of White individuals possess an implicit bias toward POC and a preference toward White identities (Nosek, Smyth, & Hansen, 2007). Aversive racism can be enacted through racial microaggressions, defined as “brief, everyday exchanges that send denigrating messages to POC because they belong to a racial minority group” (p. 273) (Sue, Bucceri, Lin, Nadal, & Torino, 2007). The subtle forms of racism relating to microaggressions or color-blind perspectives have been shown to be damaging to POC with evidence that POC report feeling they cannot present their true selves within institutions that privilege White identities (Wingfield & Alston, 2014).

Systemic racism and substance use treatment

Feagin’s (2000) concept of systemic racism is useful in understanding the institutional causes of racial disparities over centuries of subjugation. Systemic racism involves maintaining the privilege of White groups through the domination of institutional positions of power and maintenance of discourses illustrating White culture as superior and normative. SUD and substance use treatment operate within the systemic context of institutions with historical racist practices, such as the health care system, education system, employment system, media, and criminal justice system. Specifically, substance use treatment providers collaborate with health care

providers, criminal justice entities, and employee assistance programs for referral processes, as well as health insurance organizations to negotiate coverage for the costs of treatment. Most substance use treatment organizations recruit employees who have been educated and socialized within institutions of higher education. Therefore, in alignment with antiracist practice, the substance use treatment industry, as embedded within institutions of historical racism, must interrogate its own positioning on the subject of racism.

Health care, employment, education

Evidence indicates that there are race-based disparities in the quality of health care delivery (Feagin & Bennefield, 2014; Smedley et al., 2003) as well as access to health insurance (Barnett & Vornovitsky, 2016). Educational attainment and employment status influence pathways toward accessing health insurance and medical leave, which are critical to receiving substance use treatment. The higher rates of unemployment among POC, particularly Black and Latinx individuals, may correspond with lack of access to employer-based private health insurance (Barnett & Vornovitsky, 2016); U.S. Bureau of Labor Statistics, 2018). POC without private health insurance or the ability to self-pay may not gain access to private substance use treatment programs, which are found to have more expansive evidence-based service offerings compared to public substance use treatment programs (Roman, Ducharme, & Knudsen, 2006).

Media

Media is another institution that influences the racialized understandings of substance misuse within the United States. Netherland and Hanson (2016) pointed out that racialized distinctions in U.S. media coverage of substance misuse among White individuals compared with Black and Latinx individuals trace back to the early 20th century. For example, portrayals of crack cocaine use have been racially distinguished from cocaine use, whereby crack cocaine use has been socially constructed as an issue of POC compared to cocaine use, which has been constructed as an issue of White individuals (Netherland & Hanson, 2016). Media depictions around substance misuse by race have promulgated stereotypes of POC as developing SUD based on personal deficits (e.g., morality, criminality), compared to White individuals as developing SUD based on contextual influences (e.g., social and environmental factors).

Such stereotypes may influence substance use counselors in applying stigmatizing morality-based approaches to substance use treatment for POC (i.e., substance misuse as caused by internal deficits) while the treatment of

White individuals focuses on coping with external factors that contribute to substance misuse. For example, the use of nonmedical stimulants (e.g., Adderall) by White middle/upper-class individuals has been portrayed in the media as a means of career and/or academic advancement (Hanson et al., 2013). The negative impact based on these biases is evidenced by the harsher criminal punishments for crack cocaine possession compared to cocaine possession (Kerrison, 2017; Netherland & Hanson, 2016).

Criminal justice

Emerging attention has been devoted to examining the criminalization of substance misuse among POC compared to White populations (Amaro, Larson, Gampel, Richardson, Savage, & Wagler, 2005; Netherland & Hanson, 2016; Thompson, Newell, & Carlson, 2016). Despite evidence indicating similarities in rates of SUD among Black, Latinx, and White individuals, POC are routinely disproportionately criminalized for substance misuse or related behaviors (Acevedo, Garnick, Ritter, Horgan, & Lundgren, 2015). For example, Blacks represent 80% of individuals sentenced under federal crack cocaine laws (U.S. Bureau of Justice Statistics, 2015), despite comparable rates of illicit drug use among Black and White individuals (SAMHSA, 2014). Such racialized distinctions can be understood as extensions of mechanisms that permit the mass incarceration of POC related to substance misuse without providing them with equal access to quality treatment services, while White Americans with substance misuse issues are referred to substance use treatment (Fosados, Evans, & Hser, 2007; Thompson et al., 2016). This phenomenon dates back to the Nixon Administration and the War on Drugs (Alexander, 2010) and is presently exemplified within empathic media depictions of White middle-class heroin users as victims of “The Opioid Epidemic” rather than criminals (Tiger, 2017).

Racial factors in substance misuse

The literature indicates common factors associated with substance misuse across POC, including related to racial identity (Amaro et al., 2005; Caldwell, Sellers, Bernat, & Zimmerman, 2004; Choi, Rankin, Stewart, & Oka, 2008; Corneille & Belgrave, 2007; Markus & Kitayama, 2010; Pugh & Bry, 2007; Schmidt, Ye, Greenfield, & Bond, 2007; Sellers & Shelton, 2003), acculturation (Choi et al., 2008; Unger, 2012), and the negative consequences of substance misuse (Amaro et al., 2005; Boyd et al., 2003; French, Finkbiner, & Duhamel, 2002; Galea et al., 2003; Iguchi, et al., 2005; Schmidt et al., 2007; Shore, Beals, Orton, & Buchwald, 2006).

Racial identity development

Racial identity can be defined as a component of self-concept that is based on identification with one's racial group membership(s) (Tajfel, 1981). Pride in one's racial identity is found to be associated with increased psychological well-being (Sellers et al., 2003). This is critical based on evidence that exposures to racial discrimination can lead to issues with substance misuse and psychological distress among POC (Pachter & Coll, 2009; Sanders-Phillips, Settles-Reaves, Walker, & Brownlow, 2009). High levels of racial identity development are found to reduce the risk of substance misuse among adolescents and young adults of color based on the negative perceptions of substance misuse within their racial groups (Caldwell et al., 2004; Corneille & Belgrave, 2007; Pugh & Bry, 2007; Sellers & Shelton, 2003). In addition, high levels of racial identity development are found to protect against the negative effects of race-based stigma and discrimination, including as relates to mental health and substance misuse issues, by promoting social connectivity, social support, and group affiliation (Caldwell et al., 2004; Stock, Gibbons, Walsh, & Gerrard, 2011).

Acculturation

Acculturation can be defined as the extent to which members of a stigmatized and/or marginalized cultural group adopt the values, attitudes, and behaviors of the dominating culture (Berry, Trimble, & Olmedo, 1986). Acculturation is found to be associated with an increased risk of substance misuse among POC in the United States (Choi et al., 2008; Unger, 2012). Exposure to race-based stigma and discrimination is linked with levels of acculturation whereby those who are more acculturated tend to have greater exposure to the dominant White culture (Choi et al., 2008; Thai, Connell, & Kraemer Tebes, 2010) and are, in turn, more vulnerable to racial discrimination (Hahm, Lahiff, & Guterman, 2004; Hussey et al., 2007). For example, despite having lower rates of SUD compared with all other racial groups (SAMHSA, 2014), Asian Americans who are more acculturated are found to have higher rates of SUD compared with those with lower levels of acculturation (Hahm et al., 2004; Hussey et al., 2007). These findings highlight a need for substance use treatment providers to consider the implications of race and acculturation factors on substance misuse patterns. This includes assessing for the extent to which the client is acculturated within the United States, examining how this increases their exposure to racial discrimination as a risk factor for substance misuse, and supporting the client in building coping skills to manage their race-based triggers.

Negative consequences

POC are found to experience an increased severity of consequences as a result of substance misuse compared to White individuals, despite evidence indicating relatively comparable rates of SUD among Black, Latinx, and White individuals (SAMHSA, 2014). Compared to their White counterparts, POC are more likely to experience higher substance use mortality rates, greater severity of SUD, and increased vulnerability for criminal justice system involvement (Amaro et al., 2005; Boyd et al., 2003; French et al., 2002; Galea et al., 2003; Iguchi et al., 2005; Schmidt et al., 2007; Shore et al., 2006). There is a need for substance use treatment providers to be prepared to serve the unique issues that their clients of color face related to the causes and consequences of SUD (Schmidt, Greenfield, & Mulia, 2006).

Racial factors in substance use treatment access

While there is no evidence of increased rates of substance misuse among POC compared to White individuals, there is evidence that POC enter into substance use treatment with a greater severity of substance misuse issues than White individuals (Lowman & LeFauve, 2003). This phenomenon is believed to result from a tendency to delay seeking health care services (Schmidt et al., 2007) because of economic barriers (Griffith, Ober Allen, & Gunter, 2011; Schmidt et al., 2007; Shavers, Klein, & Fagan, 2012). In a study examining utilization of substance use treatment among Black, Hispanic, and White individuals, Schmidt et al. (2007) found that at higher levels of alcohol use severity, Black and Latinx clients were less likely than White clients to have used substance use treatment services due to economic barriers.

The literature discusses these economic barriers as relating to access to private health insurance, which corresponds with access to quality substance use treatment services. For example, lower employment rates among Black and Latinx individuals compared to White individuals (Ali, McWhirter, & Chronister, 2005; Diemer & Blustein, 2007) impact their access to employer-based private health insurance, which restricts their access to quality substance use treatment services (Jacobson, Robinson, Bluthenthal, 2007; Saloner & Cook, 2013). There are documented racial differences in client characteristics between private and public substance use treatment facilities, with private substance use treatment centers more likely than public substance use treatment centers to have non-Hispanic White clients (O'Grady, Suratt, Kurtz, & Levi-Minzi, 2014; Roman et al., 2006). Furthermore, McCaul, Svikis, and Moore (2001) emphasized that POC with lower socioeconomic status (SES) may experience chronic issues with

poverty and environmental violence that may further impede their ability to engage in substance use treatment and lead to treatment retention issues.

Racial factors within substance use treatment outcomes

There is inconsistent evidence related to whether race influences substance use treatment outcomes specific to a reduction in substance misuse. Some studies have found that Black and Latinx clients experience worse treatment outcomes than White clients (Acevedo et al., 2015; McCaul et al., 2001; Saloner & Cook, 2013; Tonigan, 2003; Wells, Klap, Koike, & Sherbourne, 2001). For example, the literature indicates that Black and Latinx individuals are more likely than White individuals to report unfavorable substance use treatment experiences (McCaul et al., 2001; Tonigan, 2003; Wells et al., 2001). However, other scholars have found no significant differences in treatment outcomes based on race, noting that these differences may be accounted for by client and treatment program factors rather than race alone. (Brower & Carey, 2003; Melnick et al., 2011). In addition, there is inadequate evidence related to treatment outcomes for Asian Americans, Native Americans, and Mixed-Race Americans.

Treatment retention

One of the means of measuring treatment outcomes in substance use treatment is treatment retention, with evidence indicating a correlation between length of stay and a reduction or cessation in substance misuse (Greenfield et al., 2007; Mertens & Weisner, 2000; National Institute on Drug Abuse, 2009). *Treatment retention* has been defined as “the number of days spent in treatment from the date of admittance to the last date of service” (Roberts & Nishimoto, 2006). Literature points to racial disparities in rates of treatment retention (Bluthenthal, Jacobson, & Robinson, 2007; Brady & Ashley, 2005; Brower & Carey, 2003; Campbell, Weisner, & Sterling, 2006; Evans, Spear, Huang, & Hser, 2006; Hser, Joshi, Maglione, Chou, & Anglin, 2001; Jacobson et al., 2007; Milligan, Nich, & Carroll, 2004), with Black individuals having lower treatment retention rates compared with White individuals (Campbell et al., 2006; Davis & Ancis, 2012; Jacobson et al., 2007; King & Canada, 2004; Longshore & Teruya, 2006; McCaul et al., 2001; Milligan et al., 2004; Siqueland et al., 2002; Wolf, Sowards, & Wolf, 2003). Treatment retention is found to be influenced by client factors (Davis & Ancis, 2012), including the level of acculturation (Guerrero, Marsh, Khachikian, Amaro, & Vega, 2013; Vega & Lopez, 2001) and employment status (Davis & Ancis, 2012).

There is a need for research examining how therapeutic relationship factors may have an effect on race-based differences in treatment retention rates. The therapeutic relationship is found to have a more significant impact on treatment outcomes than any other factor (Lambert & Barley, 2002; Lewis, 2004). Working alliance (Lambert & Barley, 2002) involves the level of attachment and partnership between the client and counselor (Martin, Garske, & Davis, 2000) and is consistently found to predict treatment retention within substance use treatment facilities (Barber et al., 2001). An expansive body of literature indicates that the quality of a client-counselor working alliance is associated with the counselor's knowledge, skills, and beliefs as relate to the clients' cultural identifications (Abdou & Fingerhut, 2014; Castro & Garfinkle, 2003; Chung & Bemak, 2002; Constantine, Warren, & Miville, 2005; Ferguson & Candib, 2002). There is evidence that working alliances are negatively affected by the counselor's inability to address relevant cultural factors (Chung & Bemak, 2002; Constantine et al., 2005; Ferguson & Candib, 2002; Lewis, 2004), leading to issues with treatment retention (Castro & Garfinkle, 2003). Research points to a match in values and perspectives as being more associated with positive treatment outcomes (Gushue & Constantine, 2007; Zane & Yeah, 2002) than the matching of clients and counselors based on race (Zane & Yeah, 2002). For example, client perceptions that their counselor may not share similar views related to the ongoing existence of racism may dissuade them from discussing race-related issues and lead to premature treatment termination (Wallace & Constantine, 2005).

Antiracist framework for substance use treatment

Race and racism play a significant role in the development of substance misuse issues and in the process of substance use treatment for POC. This implicates a need for substance use treatment counselors to engage their clients in explicit explorations of how race and racism have influenced their substance misuse and recovery processes. Furthermore, counselors must investigate their own perspectives on racial identity and racism to potentially reconstruct their capacity for a racially conscious, non-color-blind approach to substance use treatment. We introduce an antiracist framework to substance use treatment that is intended to complement cultural competence models by more explicitly addressing the role of racial identity and racism within client experiences with substance misuse and substance use treatment.

The substance use treatment field and its constituent organizations are situated within a network of multiple institutions (e.g., health care, media, criminal justice) that maintain systemic racism in the United States

(Pieterse & Collins, 2007). Therefore, it is necessary to recognize that substance use treatment providers and counselors have been socialized within institutions of systemic racism. To build antiracist culturally competent practices, substance use counselors must examine their positioning with regard to race and racism (Pieterse, 2009; Spanierman, Poteat, Wang, & Oh, 2008), including the development of racial consciousness, a reduction in racial microaggressions, and the adoption of a non-color-blind approach.

Racial consciousness

The White racial consciousness model (Rowe, Bennett, & Atkinson, 1994) focuses on White individuals building internal processes of racial awareness, including how their racial attitudes affect POC. While this model specifically discusses the need for racial consciousness among White individuals because of their privileged status within institutional systems of racial oppression, it is important to distinguish that all individuals, across races, may possess racial biases. The antiracist practice of racial consciousness development involves building awareness of one's own racial identity within the context of racist sociocultural and institutional systems, as well as identifying, examining, and dismantling racist biases that can lead to discriminatory behaviors. Within a substance use treatment setting, the development of racial consciousness by a clinician would involve (a) having an awareness of one's own racial identity and how it may influence client-counselor dynamics, (b) building attunement to and working on one's own racial biases, (c) recognizing and dismantling the influences of one's socialization within racist institutions, (d) examining how interpersonal and systemic racism may have influenced the development of substance misuse issues within the client population, and (e) fostering an inclusive treatment environment for POC, such as not displaying only artwork and images that highlight White culture. These factors are imperative to providing antiracist client-centered care to POC with SUD, particularly considering research indicating that greater levels of racial consciousness and racial identity development are associated with higher levels of cultural competence (Ottavi, Pope-Davis, & Dings, 1994).

A non-color-blind approach

Racial color-blindness can be understood as not acknowledging the existence of White privilege, institutional racism, or the overall persistence of racism (Bonilla-Silva, 2001; Neville, Spanierman, & Doan, 2006). Color-blindness espouses a belief that minimizes (or denies) the role of racism in contemporary society, implying that all individuals, regardless of race, have

an equal opportunity to thrive (Neville, Lilly, Duran, Lee, & Browne, 2000). Counselor color-blindness has been found to be associated with lower multicultural competency (Chang & Berk, 2009; Neville et al., 2006; Spanierman et al., 2008), reduced empathy (Burkard & Knox, 2004), and reduced working alliances (Owen et al., 2014). A key concern with regard to a color-blind approach to counseling is that a counselor who denies or minimizes the role of race and racism within individual and group experience (Flores, Tschann, Dimas, Pasch, & de Groat, 2010; Harrell, Hall, & Taliaferro, 2003) may further marginalize the client, creating mistrust and disrupting the overall therapeutic process (Holcomb-McCoy, 2005; Holleran & Waller, 2003; Moodley & Palmer, 2006; Neville et al., 2006; Want, Parham, Baker, & Sherman, 2004). Furthermore, a lack of awareness of racist attitudes and beliefs in oneself and/or denial about the presence of contemporary racism can perpetuate oppressive racist dynamics within the therapeutic relationship, not only impeding the therapeutic process but also inflicting potential harm (Helms, 1994).

Protecting against microaggressions

Racial microaggressions enacted by counselors are found to weaken therapeutic alliances and decrease client treatment satisfaction (Constantine, 2007). Examples of racial microaggressions within a counseling context include pathologizing based on racial/ethnic attributes, failing to assess for the importance of race within the client's experiences, and minimizing the role of race and racism in the client's experiences (Chang & Berk, 2009; Gushue & Constantine, 2007; Sue et al., 2007). For example, a counselor with unconscious racist beliefs may misattribute substance misuse among Black and/or Latinx individuals as stemming from assumed personal or group traits (e.g., laziness, lack of intelligence, violence) without any acknowledgment of the role of systemic racism in the development of their SUD issues. In addition, a color-blind counselor may view microaggressions as unintended, thereby invalidating client reactions to racist commentary or behaviors (Gushue & Constantine, 2007). As an alternative, a counselor may seek to acknowledge, validate, and further explore the client's affective and behavioral responses to racist microaggressions, including as relate to the use of alcohol and drugs. In other words, treatment goals and tasks could focus on helping the client to identify and build coping skills to address triggers to relapse associated with microaggressions.

Implementation of an antiracist framework

The need for antiracist practices in substance use treatment stems from differences in rates of SUD, risk factors, and protective factors across racial

groups (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000). The use of antiracist practices involves customizing evidence-based interventions, programmatic practices, and policies to more affirmatively serve POC (Saloner & Cook, 2013). We provide recommendations for substance use treatment counselors and providers to implement an antiracist approach to serving the needs of POC.

Recommendations for counselors

We provide several focus areas for the implementation of antiracist practices with POC with SUD. First, substance use counselors should seek to build awareness of their beliefs and attitudes about race, related to both others and themselves, as part of a process of racial consciousness development. This includes recognition of their racial attitudes and biases as a barrier to building a healthy working alliance and a risk factor to enacting racial microaggressions. This can be accomplished by enhancing exposure to racially and socioeconomically diverse communities, engaging in an anti-racist training, and seeking supervisory guidance with a racially conscious individual. Second, counselors should pursue an understanding of how race and racism intersect with sociocultural, economic, political, and institutional factors to influence SUD and substance use treatment experiences among POC. Third, counselors should seek to customize assessment strategies that aim to illuminate the role of race and racism, among intersecting factors (e.g., SES, gender, education level, employment status), specific to their client's experiences with SUD. Finally, counselors should apply evidence-based interventions with their clients with mindfulness to their identified preferences, values, and needs.

Assessment

Clinical recommendations for counselors to implement an antiracist framework to clinical assessment with populations with SUD include assessing for (a) the client's beliefs, worldview, acculturation history, and other experiences related to racial identity; (b) the client's use of substances and related behaviors to cope with race-related stressors; (c) the dominant views and practices of the client's cultural group(s) related to substance use, mental health, and therapy; (d) the client's level of acculturation; (e) whether the client holds an individualistic or collectivist orientation; (f) potential risks and sources of support based on associations with family, institutions, and community; (f) additional intersecting social identifications that inform the client's experiences with SUD.

Intervention

Clinical recommendations for counselors to implement an antiracist framework to intervention with populations with SUD include (a) addressing any cultural barriers to embracing the use of coping skills that can reduce substance misuse (e.g., seeking help, 12-step involvement, using meditation/mindfulness); (b) developing coping skills to manage race-related triggers to substance misuse; (c) role-playing the use of communication and boundary-setting skills to manage any family- and/or community-level stressors; (d) acknowledging in-group differences within group counseling contexts; (e) connecting clients to resources (e.g., housing, employment, legal) that can address their outstanding service needs; (f) acknowledging and celebrating racial identity with clients, such as “Black is Beautiful” and the Chicano Movement; and (g) using the working alliance as a platform for healing.

Advocacy

Counselors should seek to incorporate antiracist advocacy practices within their agencies, collegial networks, institutions, and communities. This includes seeking to advance antiracist education within their agencies and institutions, including potentially seeking and referring colleagues to involvement in local trainings by antiracist organizations. In addition, antiracist counselors can seek to model, for other providers, why and how to incorporate antiracist frameworks into clinical practice. Finally, counselors may also seek to advocate within their agencies and institutions policies that promote equitable hiring, promotion, and compensation practices, along with other policies that reduce cultural practices that permit microaggressions and other racist infractions.

Recommendations for providers

We provide three focus areas for substance use treatment providers to enhance racial consciousness within their organizations. First, providers should seek to provide antiracist trainings for all employees regardless of department or managerial status with consideration to racism manifesting not only at the level of client contact, but in institutional practices and policies. Research indicates that trainings have some effectiveness in promoting racial consciousness development (Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007; Heppner & O'Brien, 1994; Neville et al., 2000; Rothman, Malott, & Paone, 2012). While there is a need for more outcome-based research around the effectiveness of their trainings, the People's Institute for Survival and Beyond offers antiracist trainings to

individuals and organizations that seek to address the multi-systemic impact of racism (The People's Institute for Survival and Beyond, 2018).

A complication to the offering of trainings is that race and racism are emotionally uncomfortable topics, particularly among White trainees (Chick, Karis, & Kernahan, 2009; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Mio & Barker-Hackett, 2003; Pieterse, 2009; Spanierman & Poteat, 2005; Utsey, Gernat, & Hammar, 2005), including around their concern of appearing prejudiced (Richeson & Shelton, 2007; Spanierman et al., 2008). This complication can be addressed by providers seeking to create a judgment-free environment within trainings, where racism is normalized as something that all individuals, regardless of race, have internalized as a result of being socialized within a racist society. Critical race theory maintains that racism is an everyday occurrence, and as a result it has become normalized and ultimately invisible (Delgado & Stefancic, 2017).

Providers are also recommended to embrace an antiracist framework within their programmatic and policy practices. Gushue, Greenan and Brazaitis (2005) highlight how institutional racism can be exhibited within staff hiring practices. For example, clients may observe that staff working in reception, custodial, or other administrative positions are dominated by POC compared to counselors or managerial staff. This may lead to an implicit expectation of the clinic as embracing White cultural norms and not having the capacity to provide culturally competent services. Therefore, providers should revisit the extent to which their treatment models, policies, staffing decisions, office environment, marketing presence, and community relations practices are affirming of the perspectives and needs of POC (Acevedo et al., 2015).

Conclusion

This article illuminates the importance of substance use treatment providers and counselors embracing their responsibility to more effectively serve POC, with acknowledgment to the influences of contemporary racism on client experiences with SUD. There is enough emergent evidence to deduce that the public health crisis of SUD in the United States and the mechanisms through which individuals seek to gain health care-based recovery support is affected by racism in its varied manifestations. The application of an antiracist framework for substance use treatment can potentially enhance treatment outcomes among POC by more explicitly addressing the complex challenges of navigating recovery from SUD within a U.S. society where racism persists. Furthermore, an antiracist framework encourages substance use treatment counselors and providers to examine

and evolve their own states of racial consciousness, the effects of which may shape a more self-aware worldview that influences their overall capacity toward culturally competent work with clients within an increasingly diverse U.S. society.

The authors suggest research that investigates the effectiveness of incorporating antiracist practices within substance use treatment with POC specific to treatment outcomes (e.g., treatment retention, reduction in/elimination of substance misuse). In addition, it is critical to better understand the effects and mechanisms of race with other cultural variables (e.g., gender, class, sexuality) specific to substance use treatment entry and outcomes. The implications of this intersectional analysis point to a need for further investigations around how counselor biases specific to racism, along with other forms of oppressive ideologies (e.g., sexism, ageism, heterosexism), may affect the working alliance and client outcomes.

Finally, while addressing the impacts of racism within one's own practice or organization is essential, it is also necessary for counselors and providers to work at the macro level of society, advocating a change in policies that have a disproportionately negative effect on POC. This can be accomplished by working with elected officials and/or by raising awareness of racially unjust policies and practices. Counselors and providers can also advocate mental health parity, which ensures access to SUD treatment for POC who are low income.

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