Acculturation and Latinx Presence in New York State Substance Use Disorder Treatment

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Abstract

Facilitating Latinx help-seeking access to substance use disorder (SUD) treatment is essential and challenging. This mixed-methods study by a not-for-profit group in New York State attempts to give voice to the treatment provider presence and to describe their experiences concerning the successful development of resources that increase access and encourage involvement of Latino/a clients in SUD treatment in New York State. Findings were that provider acculturation level was significantly related to the presence of Latinx clients in SUD treatment. Clinicians' comments illuminate trends and highlight creative ways in which clinics can enhance Latino/a SUD treatment access and involvement.

Keywords: Latinx, Substance Use Disorder, Acculturation

As a result of many factors including stress, drug use deaths for Hispanics have been rising faster than average in the U.S. according to the Centers for Disease Control and Prevention (Bebinger, 2018). Latinx fatalities increased at a rate of over 50% between 2014 and 2016, compared to less than 50% for whites. Drug use particularly affects the youth and young adults in Hispanic communities. More than 74.5%of all deaths among Latinx ages 15 – 24 y.o. are attributed to accidents, assaults/homicides, intentional harm/suicide, HIV/Aids and chronic lower respiratory disease, all of which have been associated with drug use (Prado et al., 2016). The greatest recent increase in drug overdose deaths for Latinx have been due to heroin, as well as natural/semisynthetic opioids, benzodiazepines, synthetic opioids, and psychostimulants (Shiels, Freedman, Thomas, & Berrington de Gonzalez, 2018). New York is one of the states with the highest number of Latinx as well as problematic drug and alcohol use by the Latinx community in the state (New York State Department of Health, 2020).

Understanding of the driving forces behind the rise in overdose deaths in the Latinx communities is lacking (Bebinger, 2018) and important to establish. The organization which initiated the trainings and the research is a small not-for-profit organization in New York State with a commitment to substance use disorder training and research. We have a ten year history of offering free and low cost courses to New York State addiction counselors. We understand that the Latinx community has a history of under-utilization of substance use disorder treatment resources (Rodriguez & Smith, 2020), and asked for addiction counselors in New York State to participate with us in exploring barriers and facilitators to Latinx participation in treatment. In this release of preliminary results from an ongoing study, we are investigating the individual (microsystem) and perceived organizational (mesosystem) factors which are associated with Latinx presence in substance use disorder treatment in New York counties.

Implications for facilitation of Latinx help-seeking for alcohol and drug use disorder issues are discussed.

Influences on Latinx Help-seeking

A framework which rests on the Social Ecology Model (Bronfenbrenner, 1979) informs the investigation of systemic factors which influence access to substance use disorder (SUD) treatment for Latinx. The Social Ecology Model suggests that individuals are nested in contexts which require broadening definitions (family, community, institutions and society). Each broader level of context influences and is influenced by the ones within which it nests. In the basic framework of the Social Ecology Model, these contextual levels are grouped into individual (microsystem), organizational (mesosystem) and systemic (macrosystem) categories. Investigation of interactions between levels yields promotional and inhibiting factors which can help understand access to another level. This model has often been applied to yield information about systems' and systemic components' behavior in studies of health and mental health.

Individual Influences

Individual factors that are immediate to the question include the micro-effects of two cultures coming into contact for purposes of helping. Latinx come from a collectivist culture which prioritizes group values, as contrasted with an American individualistic culture which prioritizes freedom of action for individuals. Delgado (2017) eloquently addresses cultural barriers to services, when he states that in order to increase service accessibility, "providers must be knowledgeable and able to respond to consumers' history and cultural heritage.. . .respect is manifested through the structuring of services in a manner that increases access by minimizing barriers" (p.171).

Latinx help-seeking. A definition of Latinx can be obtained from the U.S. Census Bureau; i.e., Latinx are individuals of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race (U.S. Census Bureau, 2020, April 21). In this definition, "Hispanic" and Latinx are equivalent. Other sources are less clear about whether Brazilians are categorized as Hispanic (National Advisory Committee on Racial, Ethnic, and Other Populations, 2020). Personal issues of acculturation stress, economic strain and immigration issues (Grigsby, Forster, Soto, Baizconde-Garbanati, & Unger, 2014; Rodriguez & Smith, 2020) as well as psychological distress (Grigsby et al., 2014) affect the physical and mental health of individuals within the Latinx community and are related to problematic substance use. Ruiz and Strain (2014) mention individual factors such as the lack of appropriate educational levels and excessive poverty as deficits which affect individuals in Latinx communities. Other individual factors which may hinder access to appropriate health care for substance use disorder issues may include the mental state of the Latinx individual, his or her

resilience, social support from family or friends, financial status, healthcare status, language capability, healthcare access, and legal status.

Counselor insights and training. Most substance use disorder treatment in the U.S. is provided in addiction specialty care centers by addiction counselors. Addiction counselors as a group have generally been trained using an apprenticeship model. They may have a wide range of academic and experiential backgrounds, and the group "often includes individuals who enter the addiction workforce due to life experiences rather than academic and professional training" (Ruiz & Strain, 2014). Though the counseling staff of the addiction centers is professionalizing, research suggests addiction counselors have historically been para-professionals who relied heavily on their personal experiences (Brigham, Slesnik & Schroeder, 2011).

The counselors/providers in any facility which offers mental health and substance use disorder care in New York State may have unique insights into help-seeking behavior of the people they serve because they hear stories of help-seeking firsthand. Spanish- speaking counselors may have unique insights into Latinx help-seeking behavior because of their cultural background and understanding. In our experience with training these counselors, they are often passionate and dedicated. They have often struggled to "give back" to clients who are disadvantaged and leading stressful life paths, which have included substance use.

Systemic Influences

The Latinx community is stressed by racial and ethnic discrimination (Okamoto, Ritt-Olson, Soto, Baezconde-Garbanati, & Unger, 2009; Ruiz & Strain, 2014) and poverty (Delgado, 2017, p. 52). For the Hispanic American community, "socioeconomic status, social class, gender-related issues, and ethnic and racial factors all relate to potential disparities in the health and mental health care systems" (Ruiz & Strain, 2014). Administrative healthcare policy or immigration policy decisions have had major repercussions for the Latinx community. Over 20% of Hispanics live below the poverty line (Delgado, 2017, p. 52). Lack of parity between medical and addiction care and lack of universal access to health care are systemic issues stemming from policy decisions and have resulted in lack of insurance coverage for many individuals in the Latinx community. Large numbers of Latinx addicts do not receive appropriate treatment for health and mental health issues, and large numbers drop out prematurely.

The Affordable Care Act did not address some issues that are important to the Latinx community; insurance coverage was not extended to those without documentation, for instance. At the same time, because of the growing Latinx population, systems of care are stressed, and there are few Latinx medical care personnel (Delgado, 2017, p. 99; Ortega, Rodriguez, & Bustamante, 2015).

The Social Ecology model suggests that the reduced availability of services for many in the Latinx communities is linked to poorer individual outcomes; one of those poor outcomes is the higher percentage of overdose deaths for Latinx. Faced with recent rising opiate deaths, New York State has made heroic efforts to make a comprehensive plan to decrease use,

prevent overdose, and decrease the overall risk to the population (New York State Department of Health, 2019). However, the effect has not been felt so strongly in the Latinx community. For instance, in New York State in 2018, hospital discharges for opioid use for reasons including overdose, abuse, dependence, and unspecified use was highest among Latinx individuals (New York State Department of Health, 2019). In New York City, the rate of substance overdose deaths among Hispanics increased by 5 percent overall in 2018 (NYC Health, 2020b), rising specifically in the Bronx and Manhattan (NYC Health, 2020a; NYC Health, 2020c).

Exploring Access to Healthcare

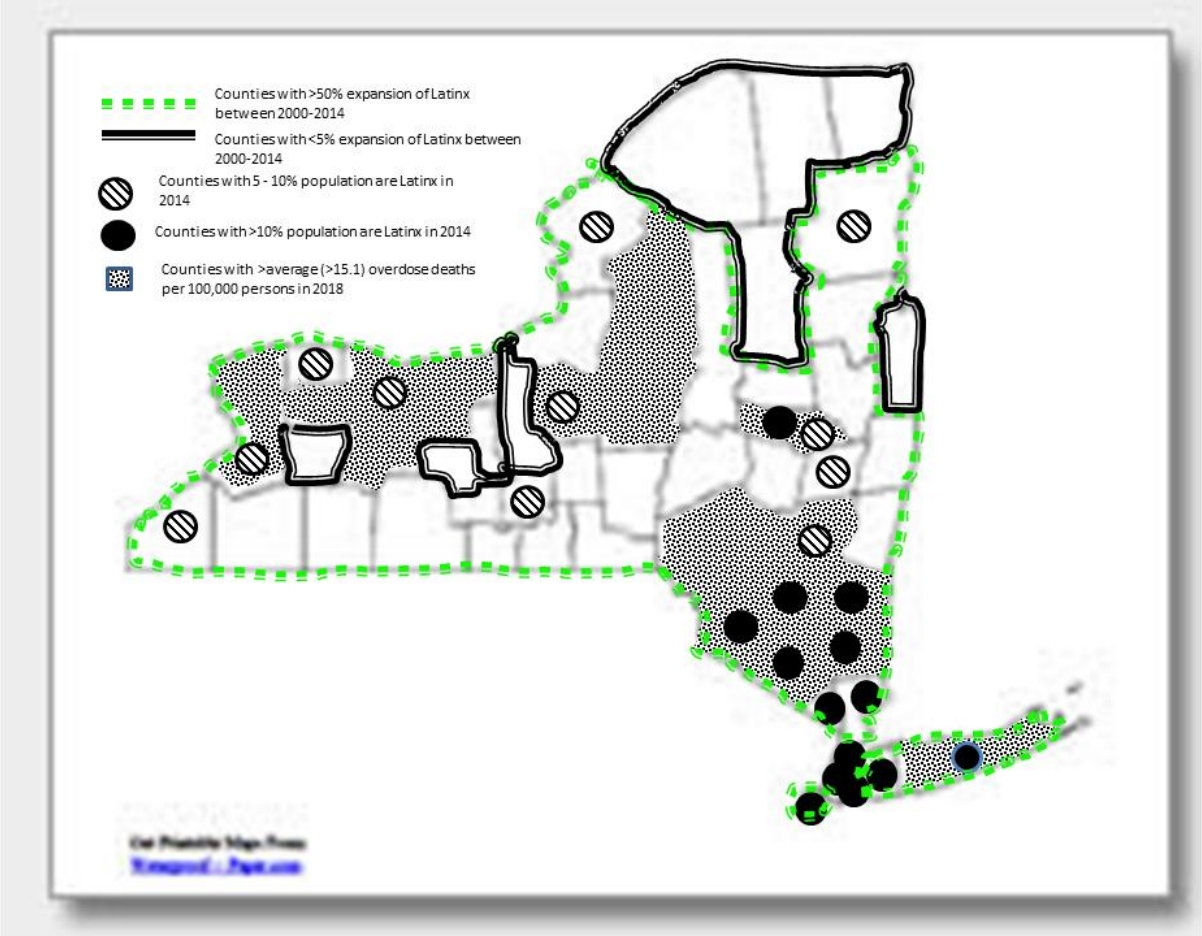
It is important to understand the paths of help-seeking of individuals in various Latinx communities in order to address their needs more effectively. For Latinx individuals who embrace a collectivist value system (Delgado, 2017, p. 99), help-seeking from an American individualistic culture meets barriers that hinder the help-seeking behavior beginning at the initial contact. The lack of literature on Latinx help-seeking for mental health or substance use disorder problems in the current administrative era might suggest the usefulness of a qualitative approach to information-gathering. A qualitative approach, typically useful when little is known about a topic (Padgett, 2017) can be used to explore Latinx help-seeking pathways. Literature that describes barriers to healthcare access focuses on conceptualizing access in ways that include the cultural differences between the Latinx and the dominant culture. The use of the phrases "culturally competent" care and "marginalized groups" helps the research understand that extra effort and care needs to be taken to facilitate Latinx access to healthcare. The mesosystem characteristics which inhibit or facilitate access to mental health or substance use disorder treatment for Latinx, as perceived by addictions counselors who are embedded in the facilities offering treatment, are focal characteristics for this study.

Mesosystem influences. "Mesosystem" describes the environment which is closest to the individuals who are the study participants. For this study, the mesosystem environment includes the laws and organizational infrastructure in which New York State (NYS) addictions counselors are "nested." New York State has been a haven for immigrants for hundreds of years, and is one of the five states in which Latinx are the largest minority (Stepler & Lopez, 2016). Currently, the density of Latinx people in NYS is 19.2% of the population (U.S. Census Bureau, 2020, April 9). By 2014, Latinx had dispersed across the sixty-two NYS counties, with differential densities in every county, ranging from 1% in Cattaraugus County in western New York State to 55% in Queens County, in the heart of New York City (Pew Research Center, 2014).

As in the rest of the U.S., in New York State there is a disparity between income levels for whites and Latinx. For example, only 9.1% of whites in NYS experience poverty level income, while 21.3% of Latinx experience that level of poverty (U.S. Census Bureau, 2018). Even more indicative of a disparity is the comparison of those who have health insurance versus those who

do not in New York State. Overall, 65.9% of whites in New York State have health insurance, while 19.2% of Latinx have health insurance (Krogstad & Lopez, 2014), and the Latinx who are undocumented immigrants are more than twice as likely to be uninsured as U.S. –born Latinx persons. This disparity influences access to treatment for substance use or mental health disorders.

As seen in Figure 1, a mapping of the expansion of the Latino population across the counties of New York State demonstrates that most counties, with some exceptions noted on the map, have seen over 50% expansion of Latinx between 2000 and 2014. This is demonstrated by a dashed outline of New York State areas which have seen such expansion in Figure 1, and a solid line outlining counties which did not see such expansion. All data which is represented in Figure 1 can be found in the Table 1 at the end of the paper. Though most counties have seen expansion of the Latinx population of over 50%, the density of the Latinx population in most counties is under 5%. The counties that are close to urban areas of Buffalo, Rochester, Syracuse, Utica, Schenectady, and Albany have a Latinx population between 5 – 10%, indicated with hashed black & white circles in Figure 1. NYC and the surrounding counties have >10% Latinx population density. In Figure 1, the map of NY state shows the density of Latinx in NYC and the surrounding counties as indicated by a black circle, indicating >10% Latinx population. A quick sketch of the 26 NY state counties that had higher than average drug overdose deaths in 2018 (> 15.1/100,000) (National Institute of Health, 2020) has been overlaid on the county map to show where drug problems have been the highest. Areas with higher-than-average drug overdose deaths in 2018 are marked as gray. Expansion of the Latinx population in New York State and rising drug use as described above would indicate that facilitation of Latinx access to addiction services is crucial.


Counties with >50% expansion of Latinx between 2000-2014
Counties with <5% expansion of Latinx between 2000-2014
Counties with 5 - 10% population are Latinx in 2014
Counties with >10% population are Latinx in 2014
Counties with >average (>15.1) overdose deaths per 100,000 persons in 2018

Barriers to Healthcare Access

Barriers can be defined as factors that hinder access to services for Latinx. Literature on the health or mental health help-seeking of Latinx individuals mentions perceived barriers of Latinx individuals that impact utilization of health or mental health services (Moitinho, Garzon, Freyre & Davila, 2015; Ruiz & Strain, 2014; Szapocznik, Prado, Burlew, Williams, & Santisteban, 2007). According to a longitudinal study done by Balcazar, Grineski and Collins (2015), it takes 3-4 generations for the Latinx families to overcome the barriers to healthcare. That study found that, even when access to health insurance is available, it doesn't guarantee access to treatment due to continued financial, transportation, continuity of care, and language barriers, among others. Some literature has mentioned, specifically, barriers of geography, language, cultural differences, and legal issues (Moitinho et al., 2012; Ruiz, 2011; Szapocznik et al., 2007) that prevent Hispanics/Latinx from accessing mental health or substance use disorder care.

Structural barriers. Latinx men and women from low socioeconomic (SES) backgrounds may encounter a number of challenges in obtaining access to and utilizing services for mental health or substance use disorders. Latino men, who are often the primary bread-winners for a family with no other means of support, may have to take time off work to attend SUD treatment (Valdez, Garcia, Ruiz, Oren, & Carvajal, 2018), which may bring difficulties to Latinx families. Affordability of quality services can also be problematic (Ruiz & Strain, 2014; Valdez et al., 2018). As mentioned earlier, over 20% of NYS Latinx families live below the poverty level, and 80% of NY Latinx families do not have health insurance. Services may also be at a distance and/or may be expensive to access because of transportation limitations of families (Balcazar, Grineski & Collins, 2015; Ruiz & Strain, 2014; Valdez et al., 2018).

Language barriers. Although the number of Latinx who speak English proficiently is growing by the year (Krogstad, Stepler & Lopez, 2015), the last available figures put the percentage who did not speak English proficiently at 32% in the U.S. in 2013 (U.S. Census Bureau, 2014). Lack of the ability to speak English well may provide a barrier to accessing and participating in treatment for Latinx (Balcazar, Grineski & Collins, 2015; Pippins, Alegria & Haas, 2007; Rastogi, Massey-Hastings, & Weiling, 2012; Valdez et al., 2018). In his interviews of Hispanic males who are trying to access treatment for alcohol use disorders, Valdez et al. (2018) finds their comments instructive, i.e., "participants reported difficulties finding services that were available in Spanish, adding that 'when help is offered in Spanish there are often long waits and not enough linguistically competent staff to meet their needs'" (p. 1952).

Legal barriers. Latinx may have concern for their residency documentation in the U.S. The fear associated with legal status and fear of deportation both may deter help-seeking for

treatment issues (Rastogi, Massey-Hasings, & Wieling, 2012). Other legal barriers concern whether insurance may be available for the Latinx client seeking services, mentioned in structural barriers above.

Cultural barriers. Generally, cultural considerations have been identified as deterrents for Latinx seeking treatment (Delgado, 2017). The collectivist nature of Latinx cultures and the individualist nature of American culture are identifiably different from the first contact, according to Delgado. Medical decisions are family decisions, not individual decisions, in the Latinx family. The need for family services, underscoring the cultural value of familismo (Moitinho, Garzon, Freyre & Davila, 2015) have been noted in some studies (Rastogi, Massey-Hastings, & Wieling, 2012).

Perceived stigma associated with mental health or substance use disorders has been a barrier to the utilization of services (Rastogi, Massey-Hasings, & Wieling, 2012; Valdez, Dvorscek, Budge, & Esmond, 2011). Lack of cultural sensitivity or competence on the part of SUD counselors might miss the stigma that accrues to consequences of alcohol use to "*machismo*," the idea that drinking is associated with valued Latino toughness (Valdez et al., 2018). A quote from the men who were interviewed in Valdez et al.'s (2018) qualitative study is enlightening, i.e., "men are often too proud to admit they need help even when their health is at risk and their lives are falling apart" (p.1953).

Delgado (2017) mentions other culturally important ideas. *Respeto*, or respect, for the culture is an important part of building trust with a provider. *Respeto* may be evidenced by, for example, knowing to use the full name of a client when a client is called from the waiting room. Including both the family of origin name and the nuclear family name instead of using only first and last names as is the American custom would indicate respect for the Latinx person and the culture.

Geographical barriers. The transportation infrastructure that serves Downstate New York is unparalleled; Upstate New York transportation resources are fewer because of a lower infrastructure investment. Availability of transportation, distance to providers, and cost of transportation (Sayed, Gerber & Sharp, 2013) are factors that delay healthcare differentially by urban or rural locations. According to a national study (Wallace, Hughes-Cromwick, Mull & Khasnabis, 2005), these differences are more likely to affect healthcare access for those who are older, less wealthy, less educated, female and from an ethnic minority group.

Methodology

One of the process hypotheses of the study was that Latinx clients might gravitate toward those who might be able to have a better cultural understanding of their situation and understand better how to help. Specific to problems concerning substance use, the investigators hypothesized that the cultural similarity of provider and client would be attractive to Latinx clients seeking help for substance use problems. The relationship between provider

and client, underscored as crucial to client motivation toward positive change, was assumed to be enhanced by cultural similarity. This study used the Short Acculturation Scale for Hispanics to measure acculturation. As mentioned in the Measures section, higher acculturation scores meant greater respondent similarity to the mainstream (speaking English-only) culture, while lower acculturation scores for providers indicated greater likelihood of Spanish-speaking cultural influence. The major hypothesis of the study was that acculturation level of providers would be negatively correlated with the percentage of Latinx clients that were on providers' caseloads.

Sample

The sampling frame for this study was the list of email addresses of active clinicians who held a certificate provided by the New York State Office of Addiction Support and Services (NYSOASAS) that certified them to offer substance use disorder treatment services in New York State. The number of clinicians who held the Certificate for Alcohol and Substance Abuse Counselor (CASAC) was 6562 at the time of the initiation of the study planning (M. McKeown, personal communication, July 3, 2018), although "the number changes daily."

This study collected data from clinicians as part of a free training opportunity offered in English and Spanish with the use of a convenience sampling plan. Email invitations were sent to the entire group to participate in the research study, which made Cognitive Behavioral Therapy (CBT) trainings in both English and Spanish available free of charge. Special notices were placed on the NYSOASAS website concerning the free trainings for CASACs. Phone contact with each of the directors of NYSOASAS facilities was made or attempted in order to alert clinic directors that there were online CBT trainings available in both Spanish and English which gave continuing education credit for CASAC counselors. Those registering signed an informed consent, indicating they understood that they were participating in an online training which was part of a research study. All clinicians over 21 years of age who held a CASAC in NYS were included in the study. The method resulted in the collection of 381 completed surveys which documented demographic, acculturation and caseload data. Because the open-ended and closed-ended questions concerning organizational resources were collected as a posttest to the training, the study collected only 219 responses by the time the data were harvested in July of 2020.

Design and Procedure

This was a cross-sectional design intended to ascertain the relationship between acculturation level and percentage of caseload of Latinx clients for provider respondents. It also was designed to elicit a description of organizational resources which providers identified as facilitating Latinx involvement in SUD treatment.

Data collection instruments were surveys, administered electronically via Surveymonkey.

The surveys were taken as pretests and posttests to an online clinical training in cognitive behavioral therapy (CBT) use with substance use disorders made available free of charge to clinicians. Certified Alcohol and Substance Abuse Counselors (CASACs) received certificates for 6 CEUs when they passed a posttest on the knowledge portion of the CBT training with a 75% score. If they didn't pass on the first try, they were given a second try with access to the training materials.

The surveys collected information about the clinicians' caseload level of Latinx clients, their ethnicity, and acculturation level as well as sociodemographic and practice information A mix of open and closed-ended questions were used to elicit information about perceived barriers and facilitators of treatment for Latinx clients. Organizational components which were explored were: language resources, e.g., Spanish-speaking clinicians; legal resources, e.g., instructions in Spanish to help Latinx get access to services; cultural resources, e.g., a list of phone numbers for Neighborhood resources to welcome Latinx clients, such as a Community Outreach team; and geographical resources, e.g., late clinic hours for working clients.

Measures

Acculturation was an important factor in the study and research of appropriate measures for acculturation was undertaken by the investigators involved in designing the study. The Short Acculturation Scale for Hispanics (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987) was chosen because it avoided some errors of other scales, e.g, it had no sociodemographic items in the scale itself, and because the countries of origin of the Hispanic population with which it was developed were mixed (Mexican, Puerto Rican, Cuban, Central American) and similar to the countries of origin of New York State Latinos (Puerto Rican, Dominican, Mexican, and Central and South American). It had been psychometrically evaluated, found to be valid and reliable and has a Chronbach's alpha of .92, indicating internal consistency. It had been validated with a population of Puerto Rican patients in New York City and found to adequately represent that population (Ellison, Jandorf, & Duhamel, 2011).

Emerging themes of clinical resources were clustered into two categories of population density of Latinx in New York counties: 1), population density of Latinx people = less than or equal to 10%, and 2) population density of Latinx people = greater than 10%.

Initial barrier/facilitator themes, suggested in counselor surveys, were: language, legal, cultural, geographical and other. Those themes were represented with closed-ended and open-ended questions in the surveys. Copies of the survey instruments can be obtained by request from the authors of this article. Provider comments concerning barriers/facilitators enriched the quantitative information concerning barriers/facilitators in the NY State areas.

Other sociodemographic measures were formulated as research standards suggested.

Statistical Analysis Plan

Descriptive analyses using the study sample were conducted to describe demographics of the clinicians, and to describe the prevalence of the organizational resources. Bivariate analyses compared Upstate vs Downstate clinician demographics and organizational resources. The bivariate analysis explored relationships of demographics and acculturation level to percentage caseload of Latinx clients.

The answers that clinicians made to open ended questions were included with the results of the bivariate comparisons.

Results

Description of the Sample Clinician Population

Demographic characteristics of the surveyed clinicians are listed in Table 2. Sampled clinicians in direct practice were female (70.2%), Caucasian (54.1%), had an average age of 51.4 years (*SD* = 11.9), had an education level of Master's or above (49.3%), were certified to practice substance use disorder treatment with a CASAC (89.5%), and were generally English-only speaking and highly acculturated to the mainstream culture (*M* = 19.1; *SD* = 2.3). Of the 377 clinicians who declared the county in which they worked, 38.2% (*n*=144) worked in Upstate locations and 61.8% (*n* = 233) worked in Downstate locations. Upstate clinicians were younger (*M* = 48.6 years; *SD* = 12.5) than Downstate clinicians [*M*=53.2 years; *SD* = 11.2; *t*(374)=3.67; *p*<.001] and more Upstate clinicians were English-only speakers with higher acculturation scores (*M* = 19.7; *SD* = 1.2) compared to Downstate clinicians [*M* = 18.7; *SD* =2.8; *t*(334.8)=4.74; *p*<.001]. There was a significant difference between Upstate clinicians ethnicity vs the ethnicity of Downstate clinicians [*F*(3, 360)=48.36; *p*<.001]. There was a higher proportion of White clinicians (77.1%) in the Upstate counties, while the Downstate counties had a higher proportion of Black and Hispanic clinicians (30% and 20.9%, respectively). In both Upstate and Downstate regions, there was a wide range of educational attainment; approximately 20% of surveyed clinicians had not completed a Bachelor's degree, and almost 50% had completed a Master's degree or above.

Table 2. Demographic Characteristics of Surveyed CASACs in Direct Practice and Upstate/Downstate Comparison (n = 381)

	All NYS CASACs		Upstate CASACs		Down-state CASACs			test
	n	M (SD)	n	M (SD)	n	M(SD)	n	
Age	379	51.4 (11.9)	144	48.6 (12.5)	231	53.2 (11.2)	375	t=-3.67***
Acculturation	370	19.1 (2.3)	141	19.7 (1.2)	225	18.7 (2.8)	366	t=4.74***
	n	%	n	%	n	%	n	X2
Gender	376						371	.033
male	111	29.5	42	37.8	69	62.2		
female	264	70.2	101	38.8	159	61.2		
other	1		0	0.0	1	100		
Ethnicity	364						360	48.36***
Black	87	23.9	18	21.4	66	78.6		
Hispanic	54	14.8	8	14.8	46	85.2		
Caucasian	197	54.1	108	55.1	88	44.9		
Other	26	0.07	6	23.1	20	76.9		
Education	371						367	2.66
Below Bachelors	92	24.8	30	32.6	62	67.4		
Bachelors	96	25.9	42	44.2	53	55.8		
Masters or above	183	49.3	70	38.9	110	61.1		
CASAC	373						369	2.47
no	32	8.4	16	51.6	15	48.4		
yes	341	89.5	126	37.3	212	62.7		

*****p<.001**

Description of General Practice Characteristics

The practice characteristics of the surveyed clinicians are presented in Table 3. Surveyed clinicians noted that they generally worked in an outpatient setting (41.9%), offered SUD treatment (79.5%), and had an average of 22.7 % Latinx on their caseload. A comparison of Upstate vs Downstate practice characteristics yielded no significant differences in practice characteristics.

Table 3. ***Practice Characteristics of Surveyed NYS Clinicians in Direct Practice (n = 381)***

	All NYS CASACs		Up-state CASACs		Down State CASACs		test	
	n	M(SD)	n	M(SD)	n	M(SD)	n	t
Caseload % of Latinos	253	22.7 (24.5)	96	21.3 (25.8)	155	23.4 (23.6)	251	t=-0.64
	n	%	n	%	n	%	n	X^2
Practice Type	363							
Private/Outpt	152	41.9	61	40.7	89	59.3	359	.670
Intensive Outpt/Inpt/Res	116	32.0	44	37.9	72	62.1		
Other	95	26.2	33	35.5	60	64.5		
Offering SUD ass't or treatmt	371							
no	76	20.5	35	46.1	41	53.9	371	2.2
yes	295	79.5	109	36.9	186	67.6		

Relationship of Acculturation Level and Percentage Caseload of Latinx Clients

The results of the analysis supported the hypothesized inverse relationship between clinicians' acculturation level and their caseload level of Latino clients. Acculturation, as measured by the SASH scale (*n*=370; *M*=19.1; *SD*=2.3) was significantly and inversely correlated (*n* = 244; *r*= -.18; *p* <.005) with clinicians' percentage caseload of Latinx clients (*n*=253; *M*=22.7%, *SD*=24.5). The percentage caseload of Latinx clients was also positively related to provider ethnicity. Those CASACs who identified as Hispanic had an average percentage of 33.2% Latinx clients on their caseloads compared to the mean caseload percentage of Latinx clients for all clinicians = 22.7% [*F*(3, 237) =3.35; *p*=.02)].

Organizational Resources

The surveyed clinicians' reports of organizational resources of their clinics are summarized in Table 4 – 6 below. After each of the four closed-ended questions concerning language, legal resources, cultural and geographical resources, respondents were invited to comment further on their perceptions of their clinic's resources. The fifth question was open-ended.

Language facilitation. Language resources and a comparison of Upstate and Downstate responses are presented in Table 4. Approximately 80% of surveyed NYS clinicians said their clinics had language resources that would facilitate Latinx client involvement in treatment. The Upstate and Downstate clinicians noted a significant difference in how their clinics used language resources to facilitate Latinx engagement. Upstate clinicians, more often English-only speaking, tended to rely on translators to meet the needs of those Latinx clients who did not speak English well [X^2(1, 219)=13.19, p<.001]. "Translators who could speak Spanish" was the most commonly mentioned resource by Upstate clinicians (58.9%). Much more often, Downstate clinics tended to hire Spanish-speaking clinicians [X^2(1, 219)=15.94, *p*<.001] . "Clinicians who spoke Spanish" was the most commonly mentioned resource by Downstate clinicians (65.1%).

In response to the open-ended questions, clinicians commented on clinic language resources that facilitated Latinx client involvement. A bilingual Latina who is an administrator in a New York County clinic, remarked:

> "As an agent of a SUD treatment-prevention-recovery regulating agency . . . . Language is one item of special importance for which I . . . provide strong TA [technical assistance]. Latinos face the language barriers coupled with social-migratory limitations and un-insurability intensify the suffering and perpetuates addiction and its concomitant stigma."

Those providers who have enough Spanish speaking clinicians to meet the need of their Spanish-speaking clientele may match clients with Spanish-speaking clinicians. An administrator in Brooklyn comments,

> "There is matching in the assignment of Spanish patients to Spanish counselors so that they are relaxed in their engagement with providers, i.e., culturally."

Those providers who have more Spanish-speaking clients than their clinics can serve easily use strategies which increase the client to provider ratio; they may refer them to "resources that can assist them in their language," run groups in Spanish, or use technical assistance. An administrator in Brooklyn comments,

> "Counselors use CYRACOM for engaging patients with Spanish as primary language."

Facilitation of continuity of treatment in the language of choice is important. Even if the main treatment facility has Spanish-speaking clinicians, aftercare and care for the mental health disorders that accompany 60% of SUDs may not be available in Spanish, which can diminish good treatment outcomes.

Of the providers who commented, a Latina who provides SUD services in Brooklyn commented on the language barriers to aftercare treatment for Latinx:

> "There isn't enough treatment for Spanish speaking only clients. When making referrals for Spanish speaking clients, the distance is too great. This is a set back for continuum of treatment for Spanish speaking clients."

And a provider who understands the issue, and has Spanish-speaking aftercare availability, mentions,

> "We refer our Spanish-speaking to aftercare facilities that have Spanish speaking counselors/staff."

Understanding that mental health issues often co-occur with substance use disorders, one provider mentions the need for:

"Spanish translation services of psychiatrists."

Providers from the Upstate region were more likely to mention personal translation from family members or adjunct staff, for instance:

"We have a bi-lingual staff person as a receptionist." [Genesee and Monroe Counties]
"We have non clinical staff [who are] Latino." [Albany and Columbia Counties]
"Interpreter or family member who interprets for [those who do not speak English well.][Albany and Columbia Counties]

Providers from the Upstate region were more likely to mention language resources that depended on technology, for example:

"over the phone translation"[Erie and Niagara Counties]
"we have translator lines for people who speak other languages besides English."[Albany and Columbia Counties]
"use of an automatic translator."[Genesee and Monroe Counties]

Providers from the Upstate region also use community or groups to supplement deficits in language resources, for example:

[we] "link [Spanish-speaking clients] with clinics or community services that can assist them"[Erie and Niagara Counties]
"groups in Spanish" [Erie and Niagara Counties]

Table 4
Perceived Language Resources of NYS clinics (n=221): Comparison of Upstate vs Downstate Resources

	All NYS CASACs		Up-state CASACs		Down State CASACs			test
	n	%	n	%	n	%	n	X^2
Language	219	100.0						
Translator	98	44.7	54	58.9	44	34.1	99	13.19***
Clinicians who speak Spanish	118	53.9	34	37.8	84	65.1	118	15.94***
Signage in Spanish	65	29.7	28	31.1	37	28.7	65	.150
None of the above	43	19.6	19	21.1	24	18.6	35	.21

*****p<.001**

Legal facilitation. Legal resources and a comparison of Upstate and Downstate responses are presented in Table 5. Approximately 71% of surveyed NYS clinicians declared that their clinics facilitated Latinx client involvement in treatment by providing legal or financial resources. In the Downstate region, over 73% of the respondents described clinic resources which addressed the legal or financial needs of Latinx help-seekers. The most common resource reported by Downstate clinicians was a list of instructions in Spanish to help Latino clients get access to coverage for services (42.6%). In the Upstate region, the most common resource was a list of phone numbers in Spanish to help Latinx clients get legal help (31.1%). The difference in the provision of service coverage access instructions between Upstate and Downstate clinicians approached significance [$X^2(1, 219)=3.61$; $p=.06$]

Respondents commented about legal or financial facilitation for Latinx clients:

> "information concerning contacting the Legal Aide Office is made available." [Brooklyn MAT clinic]
>
> " I believe we offer client advocacy (including legal, housing, case management, health care) in Spanish!"[Manhattan]

Table 5
Perceived Legal Resources of NYS clinics (n=201): Comparison of Upstate vs Downstate Resources

	All NYS CASACs		Up-state CASACs		Down State CASACs			test
	n	%	n	%	n	%	n	X^2
Legal	219	100.0						
Legal help ph nos.	78	35.6	28	31.1	50	38.8	78	1.35
Info re undoc. rights	55	25.1	19	21.1	36	27.9	55	1.30
Info re svc coverage	82	37.4	27	30.0	55	42.6	82	3.61(see note)
None of the above	64	29.2	30	33.3	34	26.4	64	1.25

Note: difference between Upstate and Downstate approaches significance p = .06

Cultural facilitation. Cultural resources and a comparison of Upstate and Downstate responses are presented in Table 6. Cultural resources are part of the way that many clinics accommodate Latinx clients and attempt to outreach to "collaborate with other providers in the community" and pave access for Latinx clients to come to SUD and mental health treatment. Both Upstate (43%) and Downstate (38%) clinicians cited a list of phone numbers for neighborhood resources which would be welcoming to Latinx clients as the most commonly provided clinic cultural resource. Upstate and Downstate regions differed in reported clinic outreach to the community. The outreach, measured by the response to the question "do you have clinic outreach to local churches that Latinos might attend, was significantly different in the two regions [Upstate =14.4% vs Downstate = 25.6%, $X^2(1, 219)=3.96$, p=.05].

Respondents commented on creative cultural facilitation by clinics.

> "provides workshops in Spanish at community centers about their program." [Queens County]
>
> "hosts special events such as Hispanic Heritage Month." [Kings County]

Case management may be part of continuum of care and possibly outreach into the community. A Suffolk County based provider comments,

> "Extensive case management services are offered to provide education to this population." [Suffolk Co.]

Table 6
Perceived Cultural Resources of NYS clinics (n=202); Comparison of Upstate vs Downstate Resources

	All NYS CASACs		Up-state CASACs		Down State CASACs		test	
	n	%	n	%	n	%	n	X^2
Cultural	219	100.0						
Neighborhood resource ph nos	88	40.2	39	43.3	49	38.0	88	.63
Clinic outreach	46	21.0	13	14.4	33	25.6	46	3.96*
Childcare in Spanish	32	14.6	12	13.3	20	15.5	32	.20
None of the above	76	34.7	32	35.6	44	34.1	76	.05

** p = .05*

Geographical/ structural facilitation. Approximately 71% of surveyed NYS clinicians said that their clinics had geographical resources that would allow those who had no transportation to get treatment (pre-COVID). About 70% of the respondents in the Downstate region and 71% of the surveyed clinicians from the Upstate region declared their clinic had geographical resources which could facilitate Latinx involvement. The most common facilitation provided was late night hours for those clients who work (Downstate 41.9%; Upstate, 35.6%) and provision of transportation if the client had none (Downstate, 25%; Upstate, 33.3%). Telehealth resources were also available pre-pandemic (Downstate, 15.6%; Upstate 17.1%). No significant differences were noted in the perceived resources that surveyed clinicians reported for Downstate versus Upstate clinics.

One provider in a Manhattan clinic declared,

> "The clinic offers Transportation for those who have none and 2-way Metrocards for each of their appointments."[Manhattan]
> "We are open 24 hours and take people without insurance."[Albany and Columbia Counties]
> "We have mobile clinician services through the Greener Pathways program" [Albany and Columbia Counties]

When asked how else their clinic facilitated Latinx involvement, one provider in Manhattan says,

> " [We] support those who offer quality services and encourage and educate those in the process of understanding the importance of respecting and helping Latinos as much as other populations."

Discussion

An impersonal or "reductionist" ethical view (Campbell, T., 2020) obligates us to acknowledge that the nature of Latinx experiences matters ethically. It is important to understand that the experiences of many Latinx seeking treatment have been more difficult than those of others in the New York area. Language differences, immigrant status, undocumented status, and lack of insurance are generally obstacles for Latinx seeking treatment; this list captures only the most obvious roadblocks to treatment.

For treatment providers, a practical address of that inequity of access to treatment underscores the need for facilitation of substance use and mental health disorder treatment for

the Latinx community. The experiences of the counselors in New York State, where Latinx have found a foothold, can help us see what works and begin to replicate successes elsewhere.

The major hypothesis of the study, that acculturation is significantly related to the percentage of Latinx clients on counselor's caseloads, was born out by the results. This suggests that acculturation is a major factor that facilitates Latinx access to treatment. The importance of the finding is limited in its generalizability because of the convenience sampling, though the measure of acculturation, the SASH scale, was a satisfactory and reliable measure. A conclusion from the findings of the study is that facilitation of the access of Latinx to healthcare in general, and substance use disorder treatment in specific, can be enhanced with resources that have been mentioned by the surveyed clinicians in New York State.

The clearest commitment of NYS clinics to the facilitation of Latinx involvement is the accommodation of language needs. It is the most commonly embraced aspect of facilitation by clinics both Downstate (81% of respondents indicated their clinics had language resources) and Upstate (79% of respondents indicated their clinics had language resources). Strategies that enhance language resources for clinics attempting to facilitate Latinx involvement ranged from increasing the number of clinicians who are Spanish-speaking, to finding translators, to running groups for those who speak Spanish, to finding adjunct staff or relatives to translate, to relying on technology to facilitate translation. Downstate clinicians reported their clinics tended to favor the use of Spanish-speaking clinicians, (65% of Downstate clinicians reported their clinics retained Spanish-speaking clinicians) while the Upstate clinics favor the use of translators (59% of Upstate clinicians reported their clinics used translators).

There was a significant difference in the perception of Downstate vs Upstate counselors concerning their clinic facilitation of Latinx involvement by the use of legal or financial resources. About 74% of Downstate counselors perceive that their clinics have some sort of legal or financial resources for Latinx clients, while only 66% of Upstate counselors remark that their clinic has similar resources. This may reflect the richness and complexity of Downstate resources for Latinx, since the NYC counties actually have a population density of Latinx of 29.1% (Cordero-Guzman, 2019), and resources to address those complexities may have expanded to meet the need. The difference of the provision of service coverage information between the reports of Upstate (30%) and Downstate (42.6%) clinicians was the most striking difference between the regions. The most commonly reported legal resource by Upstate clinicians (31.1%) was the provision of a list of phone numbers for legal help. A comment was made by one Downstate clinician concerning client advocacy that cited help for Latinx clients that included "legal, housing, case management, and health care." The broad category of advocacy that this provider used suggests that the cue word "legal"used in the surveys may have limited the surveyed clinicians' responses to resources that pertained solely to legal matters. Possibly, a category of "advocacy" rather than "legal" would have captured a broader understanding of how clinics facilitate Latinx involvement via advocacy and case management..

Geographical resources were reported about equally by Upstate (71%) and Downstate (70.5%) clinicians. Clients of *all* ethnicities may not be able to get to treatment because of lack of transportation or conflict of the treatment timing with their working hours. In this case, Latinx clients benefit from structural interventions applied to serve all geographically challenged clients. With the arrival of the pandemic, the statistics for the telehealth resources have certainly changed even more. Though both Upstate and Downstate clinicians reported that telehealth was used by less than 20% of their clinics, the response to the pandemic may have deeply altered how treatment is delivered in New York State as a whole. The mobile clinic approach of Albany and Columbia counties is a creative way to overcome structural or geographical barriers.

The underutilization of services by the Latinx community is due, in part, to a cultural divide. Understanding that divide in order to bridge it is an ethical choice that we, as providers, make in every action that we implement. Approximately 65% of surveyed clinicians responded to say that their clinics had developed cultural resources, from providing a list of phone numbers in Spanish for neighborhood resources to providing Spanish-speaking childcare for clinic attendees. A significant difference between Upstate and Downstate clinics, according to surveyed clinicians, is the outreach into the neighborhood to local churches that Latinx might attend (14.4% vs 25.6%, $X^2(1, 219) = 3.96$; $p = .05$). Creative solutions to the need for outreach were found by Downstate clinics that provided, e.g., "workshops in Spanish at community centers about their program," or "hosted special events such as Hispanic Heritage Month."

Cultural outreach, according to Delgado (2017), could be one of the most powerful ways to build trust between the Latinx community and providers or facilities. The perceived stigma associated with substance use disorders is a barrier to treatment for Latinx (and others) which is difficult to overcome. Those clinics which demonstrate 'respeto' for the culture by extending themselves into the community can have a powerful impact. Many Downstate clinics have tapped into this idea. As the Latinx population grows and substance use disorders continue to devastate communities, families, and individual lives, it is important to recognize that we must work together toward the solution.

Table 1
NY Counties: Density and Growth of Latinx population (2000-2014) and Opioid Overdose (2018)

Name of county	Density 2014 Latinos	% Growth 2000-2014	Opioid O'dose deaths 2018 per 100,000
Albany	17629	83	15.0
Alleghany	740	67	2.1
Bronx	788575	22	41.5
Broome	7667	92	13.8
Cattaraugus	1534	94	5.1
Cayuga	2207	37	14.1
Chautauqua	9266	57	14.7
Chemung	2576	60	9.3
Chenango	1062	94	6.2
Clinton	2273	16	8.6
Columbia	2720	73	9.8
Cortland	1299	130	8.3
Delaware	1728	76	24.2
Dutchess	34365	90	28.2
Erie	47137	52	17.9
Essex	1193	40	5.2
Franklin	1710	-17	6.0
Fulton	1513	71	13.0
Genesee	1796	99	29.1
Greene	2628	27	25.3
Hamilton	66	16	0.0
Herkimer	1316	127	11.2
Jefferson	8705	86	8.8
Kings	512181	5	23.2
Lewis	468	172	18.6
Livingston	2215	52	24.9
Madison	1464	99	15.4
Monroe	60540	55	25.1
Montgomery	6267	83	18.3
Nassau	219324	65	11.0
New York County	423963	1	27.5
Niagara	5646	94	18.9
Oneida	12404	64	16.4
Onondaga	21495	92	16.7
Ontario	4752	171	12.7
Orange	73075	84	28.0
Orleans	1962	149	14.5

Oswego	2828	78	11.8
Otsego	2147	83	15.0
Putnam	12974	117	18.2
Queens	650576	17	13.7
Rensselaer	7144	122	12.5
Richmond	85663	60	66.0
Rockland	55498	90	9.8
St. Lawrence	2406	20	4.5
Saratoga	6629	134	11.0
Schenectady	16333	123	16.2
Schoharie	972	65	6.4
Schuyler	316	34	11.1
Seneca	1088	65	14.4
Steuben	1570	97	5.2
Suffolk	273623	83	21.6
Sullivan	11329	66	41.4
Tioga	839	67	14.4
Tompkins	4970	61	10.5
Ulster	17614	114	31.2
Warren	1421	28	6.2
Washington	1578	64	4.9
Wayne	3710	60	17.6
Westchester	230248	4	12.9
Wyoming	1325	141	14.7
Yates	549	94	12.0

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