

RAPID REVIEW

Race-based Equity in Substance Use Services

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Key Findings

- The number of studies focusing on evaluated substance use services (treatment or harm reduction) for racialized communities were limited; the majority of the literature focused on documenting inequities, discussing barriers and facilitators in accessing services, or offered general recommendations without action.
- Findings pointed to a few imbalances in the literature: a focus on treatment and limited discussion on harm reduction; frequent reference to culturally-informed practices/skills development and limited reference to explicit anti-racist approaches; as well as a primary focus on service or practice development and a secondary focus on staff development.
- The main equity components in substance use services described in included documents were:
 - Integrating culturally-informed approaches in planning and delivery services, representing four main themes:
 - Holistic care that includes the individual, kinship/family, and community; representation in staff/services; spirituality or religiosity; and language.
 - Leveraging community strengths.
 - Building or strengthening staff capacity and skills (a secondary but emerging focus).

Scope

- This rapid review addressed the following question: What are the characteristics of services that apply a racial equity lens in the provision of substance use services?
 - What are the reported impacts of those services?
- The purpose of this review was to summarize evidence on integrating a race-based equity lens in two substance service areas: treatment and harm reduction services. Harm reduction services are based on the principle of “meeting people where they are” and centring the perspectives of people who use drugs in creating solutions that meet their needs.¹ There is also robust evidence on the effectiveness of harm reduction strategies in mitigating substance use harms, such as naloxone distribution/availability in reducing overdoses.²

- To meet eligibility criteria, services needed to demonstrated intentional and explicit adaptation or design for racialized populations. This included outlining the equity adaptation/design elements of any treatment or harm reduction service.
- This review focused on articles published between 2011 and 2021 and written in English. It also specifically included services in Canada and the US to increase applicability and comparability with an Ontario context.
- We used the following exclusion criteria:
 - Articles or reports that offered critical reflections or theoretical discussions without data or evidence of implementation and evaluation (i.e., proposals, theoretical frameworks, editorials, commentaries).
 - Articles or reports that described services without reporting on consequent outcomes, impacts, or results.
 - Services related to alcohol, tobacco, cannabis.
- The scope of the search included literature and reports with an Indigenous lens. However, those findings will be shared in a dedicated report with the aim of drawing on Indigenous-informed knowledge-sharing and centring Indigenous experiences.

Background

‘Structural racism’ refers to the ways that systems, institutions and policies perpetuate marginalization and lead to differential access to power, privilege, and other resources for racialized groups.³ The resulting inequities and conditions include limited economic opportunities, eroded social capital, and discrimination in social, political and economic spheres; these conditions are also central to the overdose crisis.⁴

Data from the US indicates that although substance use rates are similar among different racial groups, and in some cases highest among white populations, racialized communities bear significantly higher burdens with substance use.⁵ These burdens span a range of critical areas with significant impact on their lives including health and mortality,^{6,7} policing and criminalization,⁶ employment,⁵ and substance-use care outcomes.^{8,9} While opioid use harms have been rising more steeply in racialized communities, the research on evidence-based approaches for substance use services remains largely focused on white participants.¹⁰ This raises serious questions about the effectiveness and ethics of a ‘universal approach’ given the continued exclusion of marginalized populations’ needs from both practice and research.^{5,11}

Despite the disproportionate burdens of substance use, racialized communities also face greater barriers in accessing treatment and harm reduction services. For example, Black patients are less likely to be referred to treatment⁵ and racialized patients are less likely to be provided naloxone¹² or evidence-based medications.¹³ Racialized community members have more adverse experiences within service and programs,^{14,15} lower treatment completion rates,^{16,17} lower-quality services,¹⁸ and worse health outcomes.¹⁰

Increased demands for taking anti-racist and anti-colonial approaches in substance use are supported by growing evidence on the importance of integrating the impact of lived experiences of racism into services and developing culturally-informed practices.¹⁹ The integration of a culturally-informed lens is

also viewed as a key element in meeting the needs of diverse populations, as well as a foundational component of improving service uptake and retention.²⁰

Despite some debates and variation on what designates a program or intervention as ‘culturally-informed’, most have common threads around grounding supports and services in the practices, beliefs, world views, and languages of communities being supported.²¹ Culturally-informed adaptations also integrate a historical lens and localize health within individual, familial, and community levels.²² ‘Cultural safety’ and ‘cultural humility’ have also been used to refer to similar principles. While these terms originated in discussions on Indigenous wellness and health, they are now also used in discussions on planning and implementing safe and meaningful programs for racialized populations. For example, Jones and Branco outlined a guide to applying cultural humility when working with racialized communities.²³

Anti-racism approaches are an equally important but distinct component for action on racial inequities. They refer to strategies or actions aiming to actively confront power imbalances and the structures that maintain them,²⁴ which is distinct but complementary to designing and implementing services based on a culturally-informed lens. Combining both approaches acknowledges the systemic structures underlying racism while recognizing the heterogeneity of communities, their needs, and their wellness.

Discussions on inequities can unintentionally promote a deficit-focused framing about experiences and realities of racialized communities.²⁵ The result is harmful narratives that divert away from the role of systems in determining health, and overlook the role that racialized communities have played in advancing equity and wellness in their communities. For example, Black identity has been shown to be a significant protective factor and predictor of meeting treatment goals, particularly when compared to the role of racial identity in other groups.¹⁸ Therefore learning about and adopting anti-racist or culturally-informed approaches should be accompanied by reflection on the narratives surrounding this topic.

Statement on Positionality

The Public Health Ontario team acknowledges the power imbalance between us and the communities with lived experiences of the research we are sharing, and that those imbalances can only be mitigated. We are committed to holding ourselves accountable, listening, and investing in building meaningful relationships and collaborations. Our team includes representation from people of colour who come from diverse cultural and ethnic backgrounds, but we recognize that we continue to benefit from privileged social locations. We acknowledge that we are not experts in the lived reality of people who use drugs, particularly those in racialized and under-resourced communities. We also appreciate the labour and insights of community members whose work we have learned from and who have generously reviewed this work to provide insights and feedback.

Methods

- A rapid review was chosen as a method that facilitates responsiveness and feasibility, and aligned with the scope of our question. Rapid reviews are a type of knowledge synthesis whereby certain steps of the systematic review process are simplified in order to be timely.²⁶
- Library services at Public Health Ontario (PHO) supported the development of specific search terms as well as search strategies for both academic and grey literature based on the review’s scope and goals. The search strategies, including details search terms, can be shared upon request.
- On December 12, 2021, PHO conducted an academic literature search in five databases: MEDLINE, CINAHL, PsycINFO, SocINDEX, and Scopus.

- Academic literature includes materials that go through peer-reviewers and editors with scientific audience in mind,²⁷ such as peer-reviewed ('journal') articles
- On February 1st, 2021, PHO conducted grey literature searches in WorldCat (theses repositories), Google (general web search), and two custom search engines: Ontario's Public Health Units and Canadian Health Departments and Agencies. Based on recommendations by Library Services, the first 50 results were reviewed (per search) given that relevancy drops after the first few pages.
 - Grey literature covers content produced from governments, academics, and community organizations. It includes reports, magazines, websites, and policy documents. It is an important element in knowledge syntheses and critical for filling knowledge gaps.²⁷
- The record selection process was completed by three reviewers. One reviewer screened titles and abstracts. Full-text screening was divided into two sets, with each set screened by separate reviewers. The full-text list of relevant records was reviewed by a third reviewer to determine the final inclusion.
- Data from included records was synthesized and charted to include record characteristics (e.g., year of publication, study design, geographic location, and population), aims, equity considerations, and impacts. A thematic analysis was also used to summarize race-based equity strategies in the records.
- Due to time constraints, critical appraisal of the methodological quality of the included records was not performed.

Results

- Seven studies were included in the final analysis based on the scope defined above. The initial list of screened articles reduced significantly once we limited the search to studies that both presented a service that has already been implemented and included information about impacts or outcomes. See Appendix A for a breakdown of the screening and inclusion strategies (adapted from the PRISMA 2020 guidelines²⁸).
- All included studies were based in the US (n= 7); no records were based in a Canadian context.
- Three studies used qualitative data analysis (e.g., extracting themes from individual interviews or focus groups), two adopted quantitative data analysis (e.g., regression models), and one used a mixed quantitative/qualitative model. Characteristics such as study design, location, community focus, and others have been summarized in a table in [Appendix B](#).
- The included studies focused on Black and Latinx communities; no records were found on additional racialized groups. Our use of 'Black' is intended to include the two groups in these studies: 'Black' and 'African American', recognizing that the term 'African, Caribbean, and Black' is a preferred term in more general contexts because it captures the heterogeneity of Black communities in Canada and elsewhere.²⁹ In this review, the term 'racialized' encompasses 'Latinx'; while Latinx is framed as an ethnicity in the US literature, it has been used as a racial group in Canada,^{30,31} has been closely tied to experiences of racialization,³² and will facilitate the discussion of the findings.

- Six records focused on outpatient treatment services.^{14,19,21,33,34,5} We used an existing list of treatment categories³⁵ to identify the following treatment areas: psychological and social care,^{5,14,19,20,33,34} a trauma-informed lens,^{5,14,19,33} access to treatment,^{19,20,34} recovery program or supports,^{5,14,19} screening and referral for treatment,^{19,20,34} provider education or training,^{5,19} family centred treatment,³³ and services for youth.³³
- Focus on harm reduction was limited. The Bmore POWER was the sole project to focus on harm reduction through the distribution of educational information, naloxone kits, fentanyl strips, and other services.¹ Additionally, the Imani Breakthrough project included elements of harm reduction education.¹⁴
- All studies grounded their introduction and literature review in the lived realities of racism,^{1,5,14,19,20,33,34} and primarily adopted culturally-informed approaches in service planning and delivery.^{5,14,19,20,33,34}
- Reflecting the wide diversity of projects discussed in the studies, the range of equity adaptations also varied by scope, approach, and population focus. The main themes are summarized below and [Appendix C](#) provides more detailed description of the equity adaptation per adaptation.
- The focus on including studies with impacts or results was a practical strategy intended to keep the search manageable and limited to services that have reflected on progress with their communities. It was not a statement on the value of the work based on whether or not an evaluation was included. In fact, the way evaluations are used to determine ‘value’ can be viewed as a colonial approach to research.³⁶ We recognize that equally or more important and impactful work is not being evaluated.

Main Themes

CULTURALLY-INFORMED APPROACHES

The use of a culturally-informed lens was mentioned in six records,^{5,14,19,20,33,34} making it the predominant equity approach in adapting existing services or creating new ones. The studies demonstrated a wide variation in settings, participants, and service delivery, but a common vision of centring communities’ unique needs in their programs and services. Another commonality was the focus on outpatient treatment services. Culturally-informed approaches were seen as key for building trust and meaningful relationships,^{14,19,20,34} addressing inequities in access to services,^{20,34} increasing retention rates,^{5,20,34} maximizing cultural fit between experiences and service,^{19,33} and supporting participants in meeting their own goals.¹⁴

These studies also pointed to a number of common culturally-informed dimensions, which are presented in [Table 1](#) alongside their translation to practice and examples from articles. This table is not comprehensive of culturally-informed dimensions, but rather those that emerged from the six records being reviewed.

Table 1. Common dimensions of culturally-informed approaches

Dimension	Translation to practice	Examples from articles
<p>Holistic care within individual, kinship/familial, community levels^{5,14,19,33,34}</p>	<p>Draw from world views, identities, and practices of communities served</p>	<ul style="list-style-type: none"> • Integrated community wellness as a component of client wellness. Participants linked improvements in their sense of wellbeing to the improvements they saw in their community (as a result of available education and support)¹⁹ • Provided safe spaces where people can share experiences and build connections with other community members¹⁴ • Adapted therapy approach to include option of closer connection to family for (youth) clients³³
<p>Representation in staff and organization^{5,14,19,33}</p>	<p>Ensure representation and capacity to match service providers with clients based on shared lived experiences (racialization, drug use, ...)</p>	<ul style="list-style-type: none"> • Group therapy facilitators were members of the church community and had lived experience in substance use and mental health conditions¹⁴ • Participants emphasized the importance of being supported by people with shared Black identity and experiences⁵ • Representation in substance use services was identified as a critical strategy for mitigating power imbalances, where having all-white staff can bring up past/ongoing experiences of being controlled and monitored¹⁹
<p>Spirituality or religiosity^{5,14,19,20}</p>	<p>Program builds on high cultural importance of spirituality by integrating spiritual elements and/or collaborating with faith-based groups</p>	<ul style="list-style-type: none"> • Worked with church staff to train and mentor facilitators on working with people who use drugs while promoting choice, trust, and autonomy¹⁴ • Church-based health advisors approached their work as part of ‘ministry’ commitment to communities rather than a traditional ‘treatment’⁵ • The Amistad Village Project held ‘Gospel Fests’ in collaboration with places of worship and included entertainment, dinner and the opportunity to share poetry and stories¹⁹
<p>Language^{20,33,34}</p>	<p>Services delivered in a the native language of the communities served</p>	<ul style="list-style-type: none"> • Recruiting bilingual therapists (e.g., English/Spanish) is important not only for therapy, but also to enable connection with client’s family³³ • Cultural adaptation includes matching language as well as dialects for Latinx and Black communities²⁰ • Providing services in Spanish for Latinx communities is considered a quality of care indicator³⁴

LEVERAGING COMMUNITY STRENGTHS

The majority of included studies pointed to the link between culturally-informed approaches and strengths-based perspectives, which reflects themes in the literature.³⁷

In adapting cognitive behavioural therapy to Latinx communities, Burrow-Sánchez et al. added a new module on ‘ethnic identity and adjustment’ to leverage the strengths in relation to a Latinx identity. Results showed that Latinx adolescents who had strong Latinx identification responded to the adapted treatment more strongly than those in the ‘traditional’ treatment group.³³

In another study, participants talked about the importance of the Black church in providing a strong sense of Black pride, shared heritage, and a common sense of experience. The presence of those elements provided a motivation to join their treatment program and develop a sense of a safe space.⁵

Achara et al used the term ‘recovery capital’ to refer to the combination of interpersonal, intrapersonal, and community resources that can be leveraged to strengthen a holistic approach to health and wellness for Black-identified individuals seeking treatment services. This was rooted in integrating activities that strengthen social bonds, provide a role in community progress, opportunities to engage in spiritual settings, and others. This approach drew from the premise that every community has strengths that can be leveraged to support wellness and recovery, and that this approach can facilitate moving away from symptom-management and into a community care approach to health.¹⁹

BUILDING STAFF CAPACITY AND SKILLS

The majority of the articles focused on the integration of culturally-informed lens in service planning, implementation, and evaluation, and most discussions focused on the clients of substance use services. Although discussions on the role of staff (e.g., counsellors, facilitators, managers, etc.) was often secondary or tangential, they still provided some insights and direction on the importance of building internal people capacity in the path to culturally-informed care.

In one study of 147 outpatient treatment programs, higher manager culturally sensitivity was a significant predictor of shorter wait times for treatment and longer program retention. However, organizational scores on culturally competent practices weren’t similarly predictive of improvement in outcomes.³⁴ So while most of the included studies focused on practices alone, this may be only part of the story on the impacts of culturally-informed approaches.

In another study, offering computer-based training on cognitive behavioural therapy for church-based health advisors was identified as a foundational piece in integrating services in the Black church setting.⁵ This training resource (CBT4CBT) has been validated and was designed to include videos and storylines with Black characters. It also demonstrated the feasibility of skills and capacity building activities with diverse partners who have built trust with racialized communities.

A review of the Amistad Village Project examined the strengths of building racialized staff who include lived experience of drug use and its demonstrated impact on improving the experiences of people seeking those services. Given the negative experiences of racialized communities with ‘traditional’ services, this component was seen as a facilitator of stronger relationships and valuable perspectives for the project. In addition, staff with lived experience were offered leadership development opportunities with the goal of investing in their skills and strengthening engagement.¹⁹

EVALUATION AND IMPACT

All studies reported either fully or partially demonstrating the impacts or effects they had intended. However, only three included comparison groups or data sets and could point to statistical significance of impacts.^{20,33,34} For the remaining four studies, feedback on impact was collected either through interviews,^{1,14,19} or through pre- and post- service measures of substance use rates.⁵ The table below provides a high level summary of intended impacts/evaluation outcomes and related findings.

Table 2. A summary of intended impacts/evaluation outcomes of included studies

Name or descriptor	Study design	Impacts
Amistad Village (2012) ¹⁹	Qualitative thematic analysis: Focus group interviews	<ul style="list-style-type: none"> Feelings of empowerment, strengthened community bonds, strong social bonds, reduction in stigma, higher engagement post-treatment.
Imani Breakthrough (2021) ¹⁴	Qualitative thematic analysis: Participant interviews	<ul style="list-style-type: none"> Empowerment in decision making Enriched relationships and self-respect Perceived respect for autonomy and freedom Connection with spirituality and belief Strengthened trust Engagement and increased options
Culturally Accommodated Cognitive Behavioural Treatment (A-CBT) (2015) ³³	Quantitative data analysis: Randomized control trial	<ul style="list-style-type: none"> No difference in substance use decrease between traditional and A-CBT treatment programs A-CBT treatment was significantly more effective for Latinx clients who reported higher ethnic identification and familism.
Outpatient treatment programs and organizational cultural competence (2011) ²⁰	Quantitative data analysis: Regression modelling	<ul style="list-style-type: none"> Integration of culturally component practices was not related to referral wait times or retention Increased managers' culturally sensitive beliefs associated with shorter wait times and higher retention
Substance use treatment therapists with Spanish proficiency (2018) ³⁴	Quantitative data analysis: Regression modelling	<ul style="list-style-type: none"> Counselor Spanish language-proficiency linked to shorter wait times and higher retention rates.

Name or descriptor	Study design	Impacts
CBT4CBT (2021) ⁵	Mixed methods: Qualitative thematic analysis of focus group interviews; Quantitative data analysis: Change in substance use	<ul style="list-style-type: none"> 78% of participants completed all seven sessions 55% of participants reported feeling better 33% of participants reported this being the first treatment program they attend Significant reduction in cocaine use
Bmore POWER (2020) ¹	Qualitative thematic analysis: Natural observation of program events and in-depth interviews	<ul style="list-style-type: none"> Program has been in high demand in community events, churches, media appearances, and health fairs Participants note positive de-stigmatising impact of conversations on substance use Program still being held across parts of Baltimore with highest need and includes negotiating roles with various community partners

NOTE ON MEANINGFUL ENGAGEMENT AND COLLABORATION

It is important to highlight the ways that communities contributed to shaping and leading substance use services, particularly given the importance of “nothing about us without us” principles in equity and substance use work. None of the studies identified community co-design as an equity-based strategy, but several integrated community feedback and collaboration into their processes.^{1,5,14,33}

In the case of the Imani Breakthrough project, community participants played a central role in developing service components, including strategies on how to integrate the social determinants of health into the treatment. Their contributions formed the foundation of culturally-responsive approaches to engagement.¹⁴ The CBT4CBT project took a similar approach where participants were engaged through surveys, focus groups, and interviews on their perception of what a substance use treatment service could look like in a collaboration with a church in their communities. Conversations also focused on potential barriers to those partnerships and how to mitigate them. The collaboration was heavily practice-focused and seen as a critical component of people’s positive experiences in the program.⁵

Bmore POWER is a peer-based, grassroots harm reduction organization made up of people with living or lived experience of drug use who are dedicated to working with racialized communities and marginalized neighbourhoods experiencing high rates of overdoses. Their community focus was positioned as an alternative to ‘traditional’ models of health that often exacerbate ongoing experiences of stigma, discrimination, and criminalization. Reflecting the focus on meeting communities where they are at, their work significantly focused on community-driven outreach events that include education on harm reduction, distribution of naloxone kits, and anti-stigma campaigns. Feedback about their work in highly racialized and under-resourced communities has pointed to meaningful relationship building, increase in demand for their services, and opening up conversations on stigma and substance use.¹

When community members were not directly engaged in the adaptation of a treatment model, one paper used an existing framework that provides guidelines for adapting and evaluating evidence-based substance use services. This framework was developed in collaboration with Latinx community members and has been validated in a number of studies.³³

Discussion and Conclusion

The aim of this rapid review was to summarize and share evidence on the integration of race-based equity lens in substance use services, recognizing that there remain many examples of ongoing and impactful work that has not been documented. It is important to emphasize that there is a large body of work on the topic of anti-racism and culturally-informed approaches in substance use services, but we found that it largely focuses on background, evidence of inequities, policy analyses, facilitators and barriers, or general proposals and recommendations (see [Appendix A](#) for detail). These discussions are critical and foundational for the field, but this rapid review focused on the much narrower lens of ‘so what?’ question by using the following criteria:

- An explicit anti-racist and culturally-informed adaptation (e.g., we excluded papers or reports that used ‘traditional’ services as a benchmark for working with racialized populations)
- Evidence of implementation (e.g. outlining steps and challenges/facilitators)
- Findings on impacts (e.g. community-reported impacts, measures of effectiveness in meeting goals)

Stigma, complex pathways to care, mistrust of the medical system based on historical and ongoing experiences, loss of social capital, and the absence of culturally informed service options have all been identified as key factors underlying race-based health inequities in substance use.⁵ The studies in this review offered us an opportunity to see how community members, researchers, and practitioners have acted on those complicated connections. They spanned a wide range of the health journey: access to care, service design, service implementation, and retention/participation in services. Solutions and interventions to address those inequities highlighted innovative, community-driven, and feasible options.

The most common strategies for integrating equity into substance use services were included in the ‘culturally-informed approach’ theme: a focus on holistic individual/familial/community care, reflection of communities being served in staff and supports, integration of spirituality and faith, and availability of therapy and supports in a language other than English.

For example, the Imani Breakthrough project was able to take a structural approach by putting the social determinants of health at the centre of their work. In practice, this meant framing the impact of determinants as ‘modifiable’ and planning support around treatment needs to include emotional (e.g. therapy), occupational (e.g. employment support), physical (e.g. activity), social (e.g. group facilitation), and spiritual (e.g. church support) components.¹⁴

While similar themes underlay the work on culturally-informed approaches, the demonstrated variations highlighted the need for a practice-based framework for integrating such a lens. This is in line with reviews in the literature demonstrating the need for additional consensus on principles and evaluation metrics around culturally-informed approaches (and related concepts).³⁸

All studies emphasized the historical and ongoing impacts of racism and related trauma but none explicitly adopted an anti-racism approach. The grey literature search pointed to a few organization-based reports from Ontario that focused on anti-racism action but were not included due to lack of information on implementation or impact. While they didn't fit the inclusion criteria, it might be beneficial to mention that their explicit focus on anti-racism recognized the importance of two components for ensuring success: patients/services, staff/organization.^{39,40} This aligns with what we found in the included studies, although the focus on staff seemed weaker. However, the reports still provided some points of reflection for organizations and groups looking at ways to integrate anti-racism into their work. They highlight the importance of focusing on both practices as well as the people who are leading the implementation of those practices and missing from those roles.

While this review has focused on racialization, it is important to acknowledge that our multiple identities mean that racism often operates and is compounded by other forms of discrimination. Efforts to look at those combined factors is known as an 'intersectional' lens and can include gender, housing, poverty, incarceration, and others.⁴¹ For example, adding a gender layer tells us that Black women have lower retention rates in treatment compared to Black men and women in other racial groups⁴² (note: research on trans, non-binary, or gender queer folks did not come up in our search). Other factors that intersect with racialization to exacerbate inequities include geography,⁴³ incarceration,⁴⁴ and homelessness.⁴⁵ Adopting an intersectional lens provides a more accurate reflection of lived realities and acknowledges the diverse experiences of racialized communities and their unique needs.

Limitations and Questions

It was outside the scope of this review to evaluate the quality or validity of the evidence shared in the literature, but three of the seven articles provided the capacity to directly compare service impacts between 'traditional' and a 'culturally-informed' lens.^{14,20,34} The studies also used a range of designs, which aligns with the recommendation for the use of both qualitative and quantitative analyses in work around anti-racism.⁴⁶ One limitation was that the majority of qualitative studies discussed impacts in open-ended or unstructured interviews that did not follow specific themes, adding some challenges to the extraction of information. While qualitative data is critical for deepening a race analysis lens, the literature would benefit from adding some structure in the questions and using thematic analyses.

Only seven studies fell within this rapid review's scope, highlighting the inroads that still need to be made around building a body of evidence on impactful substance use services for racialized communities. More importantly, additional work is needed in Canadian settings to provide some foundational work in this area. It is particularly unsettling to see the limited scope of this work given the large body of work emphasizing inequities and the acute need for developing race-based and culturally-informed substance use services.

The small number of articles limited the range of common themes that could be extracted, particularly given the variation in study designs, sample sizes, and communities. It also meant that some key areas were less explored such as:

- Ways that harm reduction services can be adapted and re-visited to increase fit with the needs and perspectives of racialized communities, although research in an Ontario context suggests that racialized communities' needs around harm reduction⁴⁶ align with the summary in this review.
- Experiences of racialization beyond Black and Latinx communities (reminder: literature on Indigenous communities is not covered in this review).

- Impact of an equity approach on a wider range of outcomes such as: substance-use related harms and the disproportionately adverse impacts of substance use on racialized communities.
- Diverse faith-based settings or groups beyond churches. Data from a Canadian context points to greater religious diversity among racialized populations than among white populations,⁴⁷ which opens up questions about the role that spirituality and religion can play in culturally-informed models of substance use care.
- Illustrative information about the ‘how’, i.e. additional details on evidence-based guidelines and practices on working with racialized communities in substance use services. While authors are usually given limited space to share their work, this type of information would have been very beneficial to this specific topic and our understanding of the potential for adaptations in other settings or communities

Despite these limitations and open questions, the existing studies provide some foundational information and equally important, sheds light on gaps that need to be explored. The results provide a stepping stone to bigger questions on how substance use services can be adapted to support racialized communities (who are already been leading change), leveraging the strength of their communities, and looking at ways to link with ongoing calls to action (e.g. Toronto’s Action Plan to Confront Anti-Black Racism⁴⁸).

Implications for Practice

This review may prompt some thinking about the ‘scaling up’ of programs or interventions within other communities. A key strategy for practitioners would be to focus on the adaptation and replication of processes that were used to identify best-fit and design or adapt services, rather than directly copying activities and steps in the absence of critical reflection (i.e. focus common process instead of identical form).²⁸

In practice this reflection can mean learning from the studies’ strong and consistent emphasis on community engagement and collaboration, centring expertise and experiences racialized communities, and understanding what meaningful impact means to communities. For example while the literature has largely focused on services that focus on substance use itself, racialized communities may find it equally important to address inequities associated with the impacts of substance use.

Practitioners and researchers need to also anticipate potential barriers or facilitators for applying or adapting this knowledge. Delays in the translation of evidence to practice has been estimated at almost two decades and are particularly heightened for marginalized communities. This has been attributed to under-resourcing, poor alignment between research and applied settings, and the dominance of ‘majority culture’ approach to health care that doesn’t resonate with communities or align with their approaches.⁴⁹ One recommended approach to addressing those delays and applying a strengths-based approach would be to start with examining the feasibility of services based on resources, existing relationship with communities, scope, knowledge systems, etc. (e.g. National Institute of Health developed funding opportunities based on community research capacity, Indigenous approaches to knowledge, and other community-specific factors;⁵⁰ ‘Quality Improvement Framework’ outlined steps for translating evidence to practice at the community level⁵¹). This approach of evaluating the implementation of evidence and knowledge provides valuable lessons, can increase the success of full implementation, and provide opportunities to centre needs of communities.

While these studies use high level group labels in their discussions, authors also acknowledged the importance of within-community diversity. This within-group diversity has real impacts for health outcomes⁵² and can be explored through following similar strategies listed above, such as directly asking communities and exploring what has been already shared about it. Recognizing the diverse experiences and needs of racialized communities and the need to “just ask us” is a cornerstone strategy of anti-racism and culturally-informed work.⁵³ For example, the CBT4CBT project⁵ is run in collaboration with a church and has been positively viewed by the majority of participants. However, faith-based approaches will not be an appropriate or best-fit approach for everyone. In the same CBT4CBT research project, authors also learned that 21.8% respondents in a community survey would not participate in a treatment at church, and 22.4% indicated they were unsure.

When considering practice, the overall recommendations are to: ask and engage rather than assume, listen and learn from what has been shared but continue to adapt services, and apply a thoughtful and reflexive approach to feasibility planning and implementation.

A Note on Knowledge Sharing

The representation in this review is limited by the representation of the papers and reports that have been shared in the peer-reviewed and grey literature. Looking outside that literature, conversations with racialized communities demonstrate the impactful and meaningful work and progress that continues to take place,^{53,54} but which has not been shared through peer-review or formal report publications. The realities of publication and writing include: lack of representation on editorial panels;⁵⁵ racism and structural racism in research and knowledge sharing;⁵⁶ exclusion of research that names racism;⁵⁶ gaps in the representation of the language, viewpoints, values, and experiences of racialized communities;⁵⁴ asking communities for data but excluding them from authorship;⁵⁵ and significant institutional barriers for communities considering leadership roles in research and research collaborations.⁵⁸

Therefore, the limited number of articles should not be interpreted as the absence of impactful work. Rather, it is a reflection of the barriers, under-sourcing, and exclusion of racialized communities as well as grass-roots movements from the publication and peer-reviewed processes.^{53,54} While this review has focused on a particular sample of knowledge, it represents only a piece of what should be considered and reviewed in this area.

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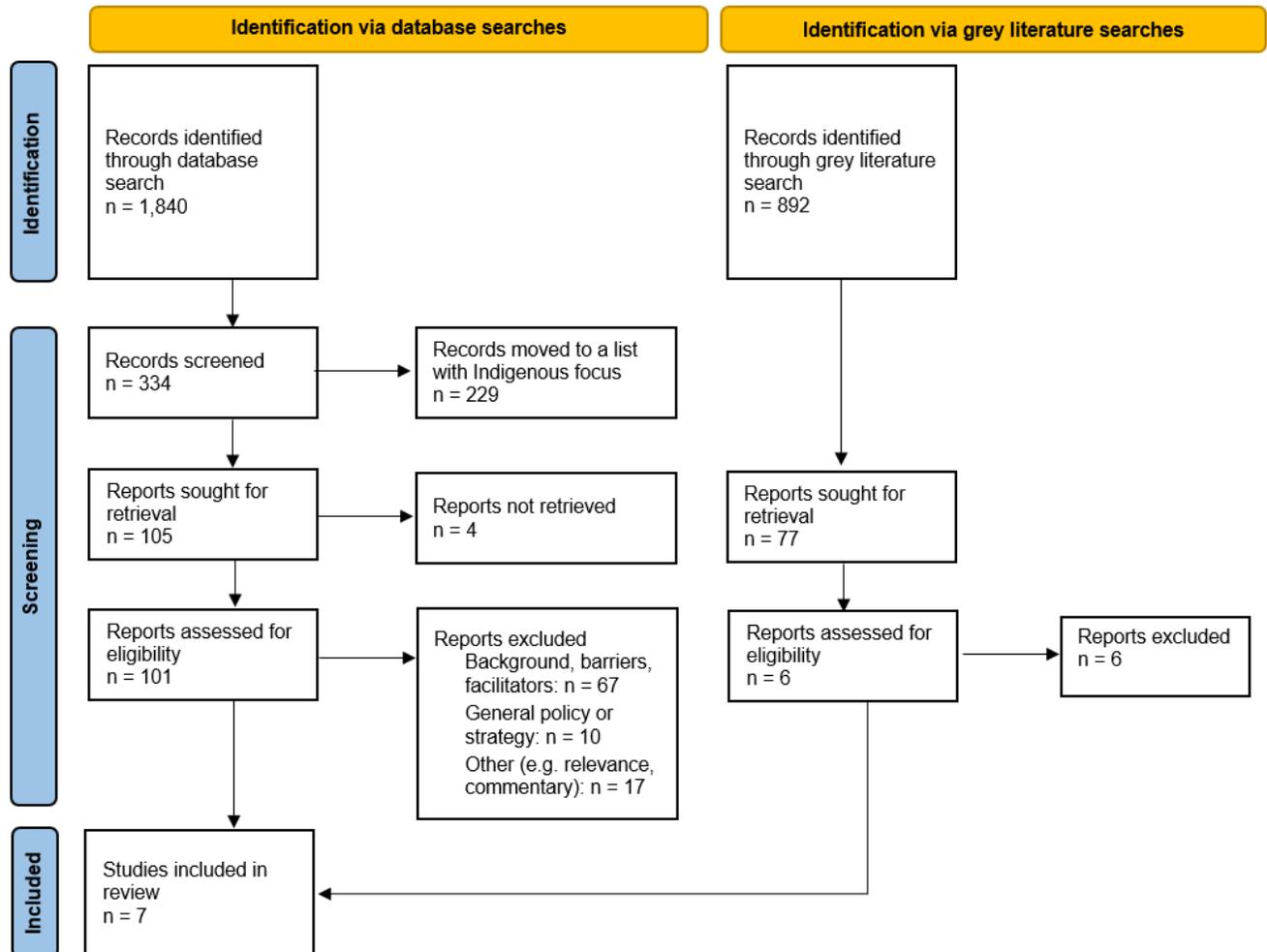
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Appendix A: Flowchart of Search and Screening Strategies

Figure 1. Flowchart of search and screening process



PRISMA Diagram

Adapted From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71.

For more information, visit: <http://www.prisma-statement.org/>

Appendix B: Record Characteristics

Table 1. Characteristics of Included Studies

Author(s)	Location	Study design	Sample description	Community focus	Project/Program intervention
I. Achara-Abrahams; A. C. Evans; J. Ortiz; D. Lopez Villegas; J. O'Dell; O. Ali; D. Hawkins (2012)	US - CT	Qualitative thematic analysis: Focus group interviews	12 focus groups & 31 key interviews	Black	Name (project): Amistad Village Project Outpatient treatment program for Black women
C. D. Bellamy; M. Costa; J. Wyatt; M. Mathis; A. Sloan; M. Budge; K. Blackman; L. Ocasio; G. Reis; K. Guy; R. R. Anderson; M. Stewart Copes; A. Jordan (2021)	US - CT	Qualitative thematic analysis: Participant interviews	20 participants enrolled in treatment program; 13 facilitators supporting treatment program	Black and Latinx	Name (project): Imani Breakthrough Outpatient treatment program hosted by church: 12-week education program that includes materials on trauma and racism; 10-week group and mutual support on topics such as harm reduction and employment; intensive wrap-around support and coaching to target SDOH factors.
J. J. Burrow-Sánchez; T. Minami; H. Hops (2015)	US	Quantitative data analysis: Randomized control trial	70 participants divided between two treatments	Latinx	Name (therapy): Culturally Accommodated Cognitive Behavioural Treatment (A-CBT) Culturally accommodated version of group-based cognitive-behavioural treatment.
E. Guerrero; C. M. Andrews (2011)	US - National	Quantitative data analysis: Regression modelling	363 outpatient treatment programs	Black and Latinx	Outpatient treatment programs with varying lens of organizational cultural competence (<i>culturally competent practices and managers' culturally sensitive beliefs</i>)

Author(s)	Location	Study design	Sample description	Community focus	Project/Program intervention
E. G. Guerrero; T. Khachikian; T. Kim; Y. Kong; W. A. Vega (2018)	US - CA	Quantitative data analysis: Regression modelling	147 outpatient treatment programs	Latinx	Counselors in outpatient treatment programs with varying levels of Spanish language proficiency
A. Jordan; T. Babuscio; C. Nich; K. M. Carroll (2021)	US - CT	Mixed methods: Qualitative thematic analysis Quantitative data analysis	40 participants in outpatient treatment program Three focus groups: 27 participants	Black	Name (project): CBT4CBT Outpatient treatment program in a Black church setting Church-based health advisors trained in computer-based training for cognitive behavioural therapy Seven part therapy sessions that incorporate spirituality elements
J. Owczarzak; N. Weicker; G. Urquhart; M. Morris; J. N. Park; S. G. Sherman (2020)	US - MA	Qualitative thematic analysis: Natural observation of program events and in-depth interviews	Eight program events 15 program members and coordinators	Black	Name (organization): Bmore POWER Peer and street based outreach and naloxone distribution program

Appendix C: Equity Focus

Table 1. Equity focus in included studies

Author(s)	Description of equity adaptation	Culturally-informed approaches: Holistic care	Culturally-informed approaches: Representation	Culturally-informed approaches: Spirituality	Culturally-informed approaches: Language	Community leadership or co-design	Leveraging community strengths	Staff skills or capacity building
I. Achara-Abrahams; A. C. Evans; J. Ortiz; D. Lopez Villegas; J. O'Dell; O. Ali; D. Hawkins (2012)	Analyzed the program's capacity to provide a culturally-informed and strength-based approach to holistic health and community partnerships	X	X	X		X	X	X
C. D. Bellamy; M. Costa; J. Wyatt; M. Mathis; A. Sloan; M. Budge; K. Blackman; L. Ocasio; G. Reis; K. Guy; R. R. Anderson; M. Stewart Copes; A. Jordan (2021)	<p>Built on high cultural importance of religion and spirituality</p> <p>Integrated the social determinants of health into treatment program</p> <p>Based in value of lived experience, culturally-responsive care, and tenants of choice, autonomy, and trust</p>	X	X	X		X		

Author(s)	Description of equity adaptation	Culturally-informed approaches: Holistic care	Culturally-informed approaches: Representation	Culturally-informed approaches: Spirituality	Culturally-informed approaches: Language	Community leadership or co-design	Leveraging community strengths	Staff skills or capacity building
J. J. Burrow-Sánchez; T. Minami; H. Hops (2015)	Adjusted aspects of treatment to increase cultural relevancy such as approaching Latinx identity as a point of strength, using Spanish names/terms, integrating experiences of racism, and larger involvement of parents		X	X		X		X

Author(s)	Description of equity adaptation	Culturally-informed approaches: Holistic care	Culturally-informed approaches: Representation	Culturally-informed approaches: Spirituality	Culturally-informed approaches: Language	Community leadership or co-design	Leveraging community strengths	Staff skills or capacity building
E. Guerrero; C. M. Andrews (2011)	<p>Developed measures to assess 2 dimensions of organizational cultural competence: 'Culturally component practices' and 'managers' culturally sensitive beliefs'</p> <p>Culturally competent practices include cultural training, language congruence, staff diversity, capacity for matching staff and client on racial identity, and group counselling.</p>			X	X			
E. G. Guerrero; T. Khachikian; T. Kim; Y. Kong; W. A. Vega (2018)	Focused on proficiency in Spanish language as a component of culturally-informed care for Latinx clients	X			X			X

Author(s)	Description of equity adaptation	Culturally-informed approaches: Holistic care	Culturally-informed approaches: Representation	Culturally-informed approaches: Spirituality	Culturally-informed approaches: Language	Community leadership or co-design	Leveraging community strengths	Staff skills or capacity building
A. Jordan; T. Babuscio; C. Nich; K. M. Carroll (2021)	Offering the Black church as an alternative treatment setting based its cultural significance in the community and its role in health promotion and social equity	X	X	X		X	X	X
J. Owczarzak; N. Weicker; G. Urquhart; M. Morris; J. N. Park; S. G. Sherman (2020)	Aim to work in communities of colour hardest hit by the drug poisoning crisis and living in structurally marginalized communities					X		

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Community Opioid/Overdose Capacity Building

Started in 2019, Community Opioid/Overdose Capacity Building (COM-CAP) is a four-year project funded by Health Canada's Substance Use and Addiction Program. The goal of COM-CAP is to support community-led responses to opioid/overdose-related harms in communities across Ontario. The supports focus on strengthening the knowledge, skills, and capacity of the key stakeholders involved.

- The Ontario College of Art & Design University (OCAD U) - Health Design Studio
- University of Toronto - Strategy Design and Evaluation Initiative
- Black Coalition for AIDS Prevention
- Chatham-Kent Public Health
- NorWest Community Health Centres
- Drug Strategy Network of Ontario
- The Ontario Network of People who Use Drugs

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