Substance Abuse and Mental Health Services Administration
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Speaking out for Addiction Recovery (SOAR)
Establishing a Peer-Driven Statewide Network of Recovery Community Organizations
Disparity Impact Statement (Working Draft)

Existing Subpopulations Vulnerable to Disparities

Massachusetts is not homogenous, and it is important to understand the differences in race, ethnicity, and poverty within our cities and towns and how this can influence substance use trends and the need for culturally-supportive addiction solutions. For instance, there are 434,398 Black residents within the Commonwealth and more than half (238,138) live in our biggest cities: Boston, Chelsea, Lawrence, Lynn, Springfield, and Worcester (U.S. Census, 2010). The total number of Hispanic or Latino residents in these same six cities is 350,021, which is also more than half the total Commonwealth population (U.S. Census, 2010). Differences in demographics among cities are also apparent. As demonstrated in the chart below comparing three of our major cities (representing the eastern, central, and western parts of the Commonwealth), there are more Black residents living in Boston and Springfield than Worcester; more residents from an "other single race" in Worcester and Springfield than Boston; and far more Hispanic residents living in Springfield than in either of the other two cities. Educational differences are apparent as well. While Boston's admissions are primarily people with less than a high school education, this is untrue for Worcester and Springfield.

Characteristics of Admissions FY 2012								
	Male	**Female**	**White**	**Black**	**Other Single Race**	**Hispanic**	**Less than HS Education**	**Homeless**
Boston	73%	27%	58%	22%	17%	17%	89%	39%
Worcester	73%	27%	67%	7%	23%	27%	29%	26%
Springfield	78%	22%	54%	17%	26%	42%	34%	22%
Massachusetts	69%	31%	81%	7%	10%	11%	80%	19%
Source: Bureau of Substance Abuse Services, Substance Abuse Fact Sheet – FY 2012								

Geographical differences also are apparent in the reason for treatment admissions. For example, Worcester has fewer admissions for alcohol, but some of the highest admissions for heroin (alongside Boston). Even so, Worcester's admissions for "other opiates" are twice as high as Boston's (and Boston's admission rate for "other opiates" is actually less than the state average).

Admissions to Treatment FY 2012						
	Alcohol	**Cocaine**	**Crack**	**Heroin**	**Marijuana**	**Other Opiates**
Boston	33%	2%	3%	52%	3%	2%
Worcester	26%	3%	3%	51%	3%	6%
Springfield	38%	4%	5%	40%	5%	3%
Massachusetts	35%	2%	2%	43%	3%	5%
Source: Bureau of Substance Abuse Services, Substance Abuse Fact Sheet – FY 2012						

Massachusetts experiences differences in youth drug and alcohol use based on racial and ethnic lines, at least in the earlier years. According to a 2012 report, White students were only half as likely as Hispanic or Multiracial students to report any lifetime drug us (MA DPH, 2012). When the same question was asked of high school students, differences were insignificant. In regards to alcohol use, Hispanic and Multiracial middle school students were more likely than White students to have used alcohol in their life time (MA DPH, 2012). Clear racial implications exist in incarcerations as well with a disproportionate number of incarcerations of Black persons (5.6 times more) and Hispanic persons (1.8 times more) when compared to White persons (Mauer & King, 2007).

Planned Grant Activities/ Quality Improvement Plan to Decrease the Differences in Access, Use, and Outcomes Associated with our Infrastructure Activities

The Massachusetts Organization for Addiction Recovery (MOAR) values "effective, equitable, understandable, and respectful quality care and services" for individuals struggling with substance abuse, and as a result, our grant activities need to be "responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (Office of Minority Health, DHHS). MOAR, through its ongoing strategic planning process, has reflected on the importance of diversity and the importance of cultural humility (a deep awareness of our environment and the barriers to meaningful inclusiveness). We understand that peer-driven services are not, in actuality, peer driven unless they are fully accessible, regardless of an individuals' culture, race, ethnicity, language, sexual orientation, or other characteristics. Our *Speaking out for Addiction Recovery (SOAR)'s* grant objectives provide us with a wide range of opportunities to understand existing behavioral health disparities and minimize them. We describe our key activities below.

Organizational Commitment

MOAR will outreach to diverse communities to seek SOAR leadership that is inclusive of people who experience minority statuses (race, sexual orientation, disabilities, and others). Also, we will work to ensure our guiding principles for the development of committees, outreach efforts, and products promote CLAS and health equity.

SOAR Diversity Committee (linked to Objective 2B)

Our SOAR statewide network cannot effectively represent the larger recovery community voice without understanding the needs of communities experiencing tremendous disparities in substance abuse outcomes. We will establish a SOAR Diversity Committee to ensure we adopt a climate of "cultural humility." The Diversity Committee will include representation from groups

that face disparities, including peers, RCOs, treatment providers, and local officials. The Diversity Committee, in direct partnership with local leaders, will plan a series of SOAR Diversity meetings (e.g., in Boston, Worcester, and Springfield) to understand community demographics and disparities that exist. These meetings will allow SOAR and our local partners to strategize on ways to address existing disparities in recovery-based care. Our Diversity Committee will document themes that surface and communicate these themes to recovery stakeholders, including our SOAR statewide network; local, state, and federal officials; treatment providers; and academic institutions. Our SOAR Diversity Committee will assume a lead role in the ongoing refinement of our Health Disparities Impact Statement.

Partnerships and Local Community Forums

Our local partners will be engaged in the planning of all of our events, and we will ensure targeted outreach to recovery minority communities, including communities of color. Our local forums also provide us with numerous opportunities to conduct informal community needs assessment as well, and our findings will inform our work as a SOAR statewide network and the work of the Diversity Committee. We will dedicate resources to ensuring our outreach methods and materials are accessible to individuals who have limited English proficiency and/or other communication needs. We will work with our local partners to develop methods and materials in various languages and ensuring our materials read at an 8th grade reading level or less.

Proposed Number of Individuals to be Engaged by Subpopulations

The numbers in the chart below reflect the proposed number of individuals to be engaged through statewide meetings, local meetings, forums, workgroups, etc. during the grant period.

	Total	FY1	FY2	FY3
Infrastructure Services: Number to be Engaged				
By Race/Ethnicity				
African American	15	5	5	5
American/Indian/Alaska Native	9	3	3	3
Asian	9	3	3	3
Caucasian	24	8	8	8
Non-White Hispanic	15	5	5	5
Native Hawaiian/Other Pacific Islander	9	3	3	3
Two or more Races	9	3	3	3
By Gender				
Female	45	15	15	15
Male	45	15	15	15
By LGBT Status	15	5	5	5

Plan to Align Efforts with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

We will ensure, as we address each of our objectives, we are asking how the National Standards for CLAS can be applied. Our survey (Objective 1B) will include questions specific to CLAS National Standards, and we will report out on these findings. Also, we will monitor our progress with CLAS by developing CLAS-specific measures as part of our data collection and performance measurement process. We will monitor our progress no less than quarterly and report our successes and shortcomings (as well as strategies to address shortcomings) during our leadership meetings.