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Response to culturally competent drug treatment among homeless persons with different living arrangements

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ABSTRACT

This study investigated the association between program cultural competence and homeless individuals' drug use after treatment in Los Angeles County, California. Los Angeles County has the largest and most diverse population of homeless individuals in the nation. We randomly selected for analysis 52 drug-treatment programs and 2158 participants who identified as homeless in the Los Angeles County Participant Reporting System in 2011. We included their living arrangements (indoors and stable, indoors and unstable, and outdoors) and individual and program characteristics (particularly whether their programs used six culturally competent practices) in multilevel regression analyses. The outcome was days of primary drug use at discharge.Results showed that higher levels of staff personal involvement in minority communities (IRR = 0.437; 95% CI = 0.222, 0.861) and outreach to minority communities (IRR = 0.406; 95% CI = 0.213, 0.771) were associated with fewer days of drug use at discharge. Homeless individuals living outdoors used their primary drug more often than any other group. Yet, compared to individuals with other living arrangements, when outdoor homeless individuals were treated by programs with the highest community resources and linkages (IRR = 0.364; 95% CI = 0.157, 0.844), they reported the fewest days of drug use. We discuss implications for program evaluation and community engagement policies and practices.

1. Introduction

Substance use is one of the most commonly observed health risks among people experiencing homelessness (Johnson, Freels, Parsons, & Vangeest, 1997; National Coalition for the Homeless, 2009; Substance Abuse and Mental Health Services Administration, 2013). Homeless persons are considered individuals without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42U.S.C., 254b). Some studies reporting that most homeless persons experience substance use disorders (SUDs; Baumohl & Huebner, 1991; Folsom et al., 2005). Substance use among individuals who are homeless is associated with increased morbidity of physical and mental health conditions (Burt, 2001; McCarty, Argeriou, Huebner, & Lubran, 1991; Rhoades et al., 2011; Substance Abuse and Mental Health Services Administration, 2013) and early mortality (Henwood, Byrne, & Scriber, 2015; O'Connell, 2005; Zivanovic et al., 2015). Due to the scope of the problem, there have been continuous efforts to deliver effective SUD treatment to homeless populations (Drake, O'Neal, & Wallach, 2008; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005; Milby et al., 1996). Yet, there is a dearth of research on the most effective approaches to SUD treatment for homeless individuals.

Experts have suggested considering homeless individuals' racial and ethnic culture when tailoring services, given that minorities disproportionately experience chronic homelessness (Padgett, Gulcur, & Tsemberis, 2006; Padgett, Stanhope, Henwood, & Stefancic, 2011). Hence, the delivery of evidence-informed culturally competent SUD treatment may be key to improving substance-use outcomes for homeless individuals (Amodeo, Chassler, Oettinger, Labiosa, & Lundgren, 2008; Amodeo et al., 2011). Cultural competence has been generally defined as a series of policies, practices and attitudes that allow providers and programs to effectively respond to the cultural services needs of individuals (Cross, Bazron, Dennis, & Isaacs, 1989). SUD treatment programs with culturally competent practices and

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policies, such as matching providers and clients based on their cultural and linguistic background have shown greater retention for African American and Latino clients (Guerrero & Andrews, 2011; Guerrero, 2013). Yet, there has been limited research on the role of culturally responsive practices in SUD treatment for homeless populations.

In the state of California, Los Angeles County seeks to reduce homelessness by funding, regulating, and supporting health and human services (County of Los Angeles Homeless Initiative, 2016), including SUD treatment. This study assesses whether culturally responsive practices of treatment programs can reduce drug use among homeless persons. We investigated substance use outcomes for 2158 individuals who received SUD treatment in 2011 from programs funded by the Los Angeles County Department of Public Health. Los Angeles County has the largest unsheltered homeless population in the United States, with an estimated 57,794 people experiencing homelessness on any given day (Los Angeles Homeless Services Authority, 2017). This number represents nearly 10 percent of the homeless population in the United States any given night in 2016 (National Alliance to End Homelessness, 2016. Although the overall U.S. homeless population has decreased in recent years, that in Los Angeles County increased (Los Angeles Homeless Services Authority, 2017). Because residential instability can compromise the effectiveness of SUD treatment (Robertson, Zlotnick, & Westerfelt, 1993), we investigated whether the type of homelessness—i.e., living with friends or family (indoors and stable), in a shelter (indoors and unstable), or on the streets (outdoors)—affects the relationship between culturally responsive practices and substance use outcomes. This relationship has been rarely considered in the literature (Kashner, Rosenheck, Campinell, Surís, & the CWT Study Team, 2002; Slesnick & Erdem, 2013; Slesnick, Kang, Bonomi, & Prestopnik, 2008).

1.1. Conceptual framework

Most organizational cultural competence frameworks outline a diverse set of practices, attitudes, and services for enhancing the sensitivity and responsiveness of health care organizations (Brach & Fraser, 2000; Harper et al., 2009; Lewin Group, 2001; Prince Inniss, Nessman, Mowery, Callejas, & Hernandez, 2009; Weech-Maldonado, 2002). There are several health care practices for effectively responding to the service needs of racial and ethnic minority clients (Brach & Fraser, 2000; Guerrero & Kim, 2013; Mason, 1995). The most common practices reported in the literature are, a) having providers with knowledge of community needs in racial and ethnic minority communities, b) personal involvement in racial and ethnic minority communities, c)development of resources and linkages to serve racial and ethnic minorities, d)hiring and retention of staff members with racial and ethnic minority backgrounds, e) reaching out to racial and ethnic minority communities, and f) developing policies and health service practices (e.g., bilingual treatment).

Preliminary studies have shown a strong relationship between staff cultural sensitivity and knowledge of minority communities and shorter wait time with greater retention among Latinos and African American clients (Guerrero & Andrews, 2011; Guerrero, 2013). Spanish-language translation of treatment materials was associated with higher odds of treatment completion among Latinos in California (Guerrero, Campos, Urada, & Yang, 2012). When interpreters or bilingual providers are not available, clients may wait longer to commence treatment (González, Vega, & Tarraf, 2010; Office of Minority Health, 2001). To date, however, there is limited evidence of the impact of culturally sensitive practices on treatment outcomes (i.e., post treatment drug use) among homeless individuals.

Poor response to SUD treatment among homeless clients may be due to programs' limited knowledge and understanding of and response to community context and individual service needs (Padgett et al., 2006; Padgett et al., 2011). Culturally competent treatment include practices, such as delivering services in a bilingual, culturally diverse, and inclusive setting, are associated with minority clients experiencing effective communication, more accurate diagnosis, a positive therapeutic alliance, and greater satisfaction with treatment (Brach & Fraser, 2000; González et al., 2010; Saha et al., 1999; Saha, Taggart, Komaromy, & Bindman, 2000; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Wells, Klap, Koike, & Sherbourne, 2001).

This suggests that by (a) understanding and investing in the minority communities SUD treatment programs serve homeless individuals and (b) integrating hiring, training, and service practices and policies that are most responsive to client service needs in local communities (Guerrero & Kim, 2013), SUD treatment organizations may be more likely to reduce substance use among homeless individuals. SUD treatment effectiveness may vary by exactly where the homeless live (Padgett et al., 2006; Padgett et al., 2011). Hence, program personnel must understand and respond to the unique service needs of individuals with different living conditions and service needs. This work considers three hypotheses about homelessness and SUD treatment.

Hypothesis 1. Homeless individuals living outdoors will report more days of drug use at discharge than those living in stable indoor settings.

Hypothesis 2. Among all homeless individuals, higher degree of implementation of the six culturally competent program practices identified above will be associated with fewer days of primary drug use at discharge.

Hypothesis 3. Living arrangements (outdoors, indoors and unstable, or indoors and stable) will moderate the relationship between the degree of implementation for culturally competent program practices and days of primary drug use at discharge.

2. Methods

2.1. Sampling frame and data collection

The data were collected by accessing a fully concatenated program and client dataset involving all 408 nonprofit SUD treatment programs funded by the Los Angeles County Department of Public Health. Through the Los Angeles County Participant Reporting System, researchers can access all data entered by each provider on every client served on an ongoing basis. These data capture the treatment experiences, substance use, and individual characteristics of 15,100 individuals who participated in treatment from July 1, 2010 to December 30, 2011. Ethical and human protection practices were followed in data collection based on the Institutional Review Board of the Los Angeles County Department of Public Health and the based research institution. The dataset features 141 items, more than half of which are standardized scales following the guidelines of the California Outcomes Measurement System and the federal Treatment Episode Data Set system.

2.2. Analytic sample

To access program-level information, we obtained a random sample of 147 publicly funded and nonprofit programs from among 350 programs located in communities at least 40 percent Latino or African American. Of these 147 programs, 95 did not provide services to homeless individuals and were excluded from analysis. The final analytic sample included 52 programs serving 2158 individuals self-identified as homeless at admission.

2.3. Individual-level independent variables

We analyzed three types of homelessness, identifying clients by whether they were staying indoors in a stable setting with family or friends (coded as 0), living indoors but in an unstable setting (staying in a shelter, hotel, motel, car, or van; coded as 1), or living outdoors

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