

SUBSTANCE USE AND SUBSTANCE USE DISORDERS BY RACE AND ETHNICITY, 2015-2019

KEY POINTS

- National survey data from 2015-2019 show that, across all reported racial/ethnic groups, more than half of adults aged 18 years or older reported any past-year alcohol use.
- The next most commonly used substance in the past year was marijuana, ranging from 7.5% for Asian adults to 25.6% for adults with more than one race, with a median of 15.9% for White adults.
- Rates of heavy alcohol use in the past month ranged from a low of 2.4% of Asian adults to a high of 7.7% for White adults, with a median of 5.1% for Hispanic adults.
- Past-year substance use disorder (SUD) rates were 4.3% for Asian adults, 7.3% for Native Hawaiian or other Pacific Islander adults, 7.5% for Hispanic or Latino adults, 7.6% for Black or African American Adults, 8.2% for White adults, 10.8% for adults identifying as more than one race, and 12.2% for American Indian or Alaska Native adults.
- Alcohol use disorder was the most prevalent SUD for every racial and ethnic group, in many cases at levels two or more times higher than those for all other SUDs combined.

INTRODUCTION

The drug overdose death crisis in the United States has expanded and worsened over time, and is estimated to account for nearly 841,000 deaths since 1999 (CDC, 2021; Mattson et al., 2021). Opioids have contributed to significant increases in overdose deaths, starting in 1999 with prescription opioids and followed by waves involving heroin and then synthetic opioids (CDC, n.d.). While synthetic opioids (primarily illicitly manufactured fentanyl) continue to play a major role in overdose deaths, recent years have seen a significant increase in deaths involving stimulants like methamphetamine and cocaine (Mattson et al., 2021). Data have also shown widening disparities in overdose deaths by race and ethnicity. For example, stimulant-involved overdose deaths have increased faster among Black/African American and American Indian and Alaska Native (AI/AN) populations compared to all other racial/ethnic groups (Kariisa et al., 2021). In addition, the opioid overdose death rate for Black/African American individuals increased by 38% from 2018 to 2019 in four U.S. states, while the rates for other racial/ethnic groups decreased or stayed the same in those same four states (Laroche et al., 2021).

The drivers of, and issues associated with, these alarming trends are complex. One factor contributing to disparities is systemic inequity rooted in policy. Substance use policies in the United States have been shaped in part by historic racism and have, in turn, driven disparities in health and well-being between people of color and White people (GAO, 2017; Commission on Civil Rights, 2019). For instance, the criminalization of substance use has led to disproportionate criminal justice involvement, particularly among Black/African American people who are disproportionately targeted, arrested, convicted, and incarcerated on drug charges

(Fellner, 2009; Lopez, 2014; Provine, 2008). The criminal justice approach has also negatively affected people of other race and ethnicity groups, including Hispanic/Latino and Asian people (Meng, 2015; Provine, 2008). In addition, studies suggest that the impact of family separation and historical trauma due to the Federal Government's forced assimilation of American Indian children in non-Native boarding schools and placement in non-Native homes has led to higher rates of alcohol and drug use and incarceration among this population (NARF, 2007; Zephier Olson & Dombrowski, 2020). Further, some suggest that the rise in prescription opioid-involved overdose deaths led to the opioid epidemic being framed as a problem of White, rural communities (Dasgupta et al., 2018). Approaches to address the drug overdose death crisis that are limited to prescription opioids may exclude the overdose experiences of some people of color, whose overdose mortality is often driven by substances other than opioids, such as cocaine (Shiels et al., 2018).

A vast body of research shows that communities of color have less access to substance use disorder (SUD) treatment than does the White population, and that barriers to accessing substance use care for people of color may contribute to racial and ethnic disparities (differences not attributable to clinical need, preferences, or both) in health care service use and outcomes (Acevedo et al., 2012; Arndt, Acion, & White, 2013; Dickerson et al., 2010; Evans et al., 2012; Garrison et al., 2019; Guerrero et al., 2013a; Guerrero et al., 2013b; Lewis et al., 2018; Mancini et al., 2015; Mennis & Stahler, 2016; Mulvaney-Day et al., 2012; Pinedo, 2019; Yu & Warner, 2013). These findings hold true and are particularly troubling for subgroups, such as adolescents (Alegria et al., 2011; Cummings et al., 2012; Saloner et al., 2014), pregnant women (Salameh et al., 2019), and people who are incarcerated (Kerrison, 2018; Mansion & Chassin, 2016; Spinney et al., 2017). Despite efforts to increase access to care through the Affordable Care Act, early health insurance coverage gains were not associated with reductions in racial and ethnic disparities in substance use treatment access (Creedon & Cook, 2016). Even when treatment is received, there may be differences in the type of treatment provided. For example, studies show that Black/African American people have higher odds of methadone maintenance treatment for opioid use disorder than White people, but have lower odds of buprenorphine treatment, which can be prescribed in office-based settings (Hansen et al., 2016; Lagisetty et al., 2019).

Despite these noted disparities, limited research exists on identifying models of culturally and linguistically effective care that address SUD and social service needs among diverse people of color. Organizations providing SUD treatment experience limited resources, bandwidth, and expertise to track metrics and evaluate program effectiveness, which could help build the business case and evidence base for culturally responsive approaches (Bui et al., 2022).

In this brief, we assess whether and how rates of substance use and SUD among adults (ages 18 and older) differ by race and ethnicity. We combined five years of data, 2015-2019, from the National Survey on Drug Use and Health (NSDUH) to create sample sizes large enough to examine specific racial and ethnic groups for specific categories of drug use. Understanding substance use and SUD by race and ethnicity is critical to informing equitable policy and culturally effective prevention, treatment, and recovery efforts that can help address disparities in health and well-being.

METHODS

The NSDUH is an annual, nationally representative, cross-sectional survey of the United States civilian, non-institutionalized population ages 12 and older administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The NSDUH is the primary source of information on the prevalence, patterns, and consequences of alcohol and drug use among the survey population. The sample includes civilian residents of households, shelters, rooming houses, dormitories, military bases, and people without a permanent residence. After obtaining informed consent from respondents, the NSDUH uses computer-assisted self-interviews to collect data on substance use, including substances used and information about misuse.

We focused this analysis on the 214,505 respondents aged 18 years and older who completed the NSDUH between 2015 and 2019. We used data starting in 2015 due to a partial redesign of NSDUH in 2015 that resulted in substance use estimates from 2015 and later no longer being comparable to 2014 and earlier estimates. In addition, underlying survey instrument related changes and the challenges of fielding the NSDUH amid the COVID-19 pandemic resulted in SAMHSA issuing guidance to researchers to not combine 2020 data with prior years. This prevented us from using the 2020 and 2021 NSDUH.

We analyzed use of alcohol, marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, pain relievers, sedatives, stimulants, and tranquilizers in the past year. Because pain relievers, sedatives, stimulants, and tranquilizers can be prescribed for medical treatment, estimates in this analysis show self-reported misuse (i.e., use of these drugs in any way not directed by a doctor, such as use without a prescription of one's own or use in greater amounts, more often, or longer than directed).¹

We also computed rates of heavy alcohol use in the past month, defined as consuming five or more drinks on the same occasion for men or four or more drinks on the same occasion for women on each of five or more days in the past 30 days. Further, "occasion" is defined as the same time or within a couple hours of each other.

SUDs occur "when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home" (SAMHSA, 2020a). SUD was defined in the NSDUH as meeting criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition.

We estimated substance use and SUD by self-reported race and ethnicity. Aligned with Office of Management and Budget standards, NSDUH asks respondents about Hispanic, Latino, or Spanish origin or descent and asks about race (CBHSQ, 2019). Respondents may choose multiple race categories. Further, NSDUH allows respondents to provide more specific information for those who identify as Asian (Asian Indian; Chinese; Filipino; Japanese; Korean; Vietnamese; and Other Asian) and/or Hispanic, Latino, or Spanish (Mexican, Mexican American, Mexicano, or Chicano; Puerto Rican; Central or South American; Cuban or Cuban American; Dominican (from Dominican Republic); Spanish (from Spain); and Other). We used the race and ethnicity combination variable in the publicly available NSDUH dataset, which classifies respondents by Hispanic, Latino, or Spanish ethnicity and the following racial categories, which exclude those who identified as Hispanic/Latino: White, Black/African American, AI/AN, Native Hawaiian or other Pacific Islander (NHPI), Asian, or two or more races. The NHPI classification includes respondents who reported that they were Native Hawaiian, Guamanian or Chomorro, Samoan, and/or other Pacific Islander.

We compared estimates across racial and ethnic groups using unadjusted logistic regression. For each substance use, misuse, and use disorder outcome, we estimated prevalence levels for each racial/ethnic group, ordered them from lowest to highest, and identified the median group. We then used the median group as the reference level, allowing us to estimate which remaining groups had prevalence levels significantly lower or higher than the median. We conducted the analysis using Stata/MP 18 (StataCorp) and followed NSDUH guidelines for calculating and reporting (including suppressing) estimates, including the application of survey weights and variation estimation procedures accounting for the complex, multistage design of the survey.

Limitations

Because of the dataset used, this analysis has several limitations. First, the NSDUH data are self-reported and thus subject to recall and social desirability biases, which may vary by racial or ethnic group and type of substance use. For instance, one study found that social desirability concerns were more likely to affect drug use reporting quality in survey data for Black/African Americans respondents than for those from other

racial/ethnic groups--a difference that could be attributed to greater concerns with privacy and confidentiality given the population's historical experiences of oppression, discrimination, and exploitation; distrust of medical researchers; and greater risk of criminal prosecution for drug-related offenses (Johnson & Fendrich, 2005). Such issues may lead to under or overreporting (CBHSQ, 2015). However, NSDUH response rates are fairly high, ranging from 69.3% in 2015 to 66.6% in 2018 (CBHSQ, 2016, 2018, 2019). Second, the sample excludes active-duty military personnel, people in prisons and jails, and people who do not have homes and do not use shelters (CBHSQ, 2019). The literature has documented evidence showing that due to not including individuals who are incarcerated, experiencing homelessness, or hospitalized OUD rates in the NSDUH are 2-3 time lower than what it might be (Keyes et al., 2022). Specifically, recent analyses of other data sources have estimated that as many as 6-7 million United States adolescents and adults may meet criteria for OUD. If this suggests an overall underestimation based on the NSDUH data, a potential implication is that it could bias differences by race/ethnicity in unknown ways because we cannot assume such an underestimation would be proportionate to race/ethnicity. However, this limitation is not unique to NSDUH and is also applicable to other survey data as well. Third, this brief attempts to study patterns by specific racial and ethnic groups, but enormous heterogeneity exists within these groups (e.g., related to culture, language, age, citizenship, and immigration status). Because the publicly available NSDUH data exclude data for more specific subgroups, our ability to address this heterogeneity is limited, and sample size limitations make analysis of smaller racial and ethnic groups imprecise.

FINDINGS

Rates of Substance Use and Misuse by Race and Ethnicity

Our analysis of NSDUH data for adults ages 18 and older shows the rates of past-year alcohol use, substance use, and substance misuse were often similar across racial and ethnic groups, though there were some notable differences (**Table 1**). Here we summarize differences that were statistically significant at $p < 0.05$. For any past-year alcohol use, Black/African American adults were the median group with a self-reported rate of 61.8%. Asian adults (55.4%, $p < 0.001$) and AI/AN adults (56.5%, $p < 0.05$) reported statistically significant lower rates, while White adults (74.1%, $p < 0.001$), adults with more than one race (68.6%, $p < 0.001$), and Hispanic adults (64.0%, $p < 0.001$) all reported significantly higher rates. For heavy drinking in the past month, Hispanic adults were the median group with a rate of 5.1%. Asian adults (2.4%, $p < 0.001$) had a significantly lower rate of heavy drinking, while AI/AN adults (6.6%, $p < 0.05$), White adults (7.7%, $p < 0.001$), and adults with more than one race (8.1%, $p < 0.001$) had higher heavy drinking rates.

For past-year marijuana use, White adults were the median group (15.9%). Asian adults (7.5%, $p < 0.001$) and Hispanic adults (13.2%, $p < 0.001$) were significantly less likely than the median group to have used marijuana in the past year. On the other hand, Black or African American adults (18.2%, $p < 0.001$), AI/AN adults (22.0%, $p < 0.001$), and adults with more than one race (25.6%, $p < 0.001$) all had significantly higher rates than White adults.

For past-year cocaine use, White adults were again the median group with a use rate of 2.2%. Only Asian adults had a significantly lower rate (1.0%, $p < 0.001$), and only adults with more than one race (3.8%, $p < 0.001$) had a significantly higher rate. All other groups ranged from 2.0% to 2.6%--rates that were not significantly different than the reference group.

For past-year heroin use, Black or African American adults had the median use rate of 0.3%. Only Asian adults had a significantly lower rate at less than 0.1% ($p < 0.001$). Rates for the remaining groups ranged from 0.2% to 0.5% and were not significantly different than the median group.

White adults had the median past-year use rate for methamphetamines (0.8%). Asian adults (0.1%, p<0.001) and Black/African American adults (0.3%, p<0.001) both had significantly lower rates compared to the median, while adults with more than one race (1.1%, p<0.05) and AI/AN adults (2.7%, p<0.001) had significantly higher rates than the median.

Hispanic adults were the median group for past-year rate of hallucinogen use (1.8%). Black/African American adults had a significantly lower use rate (1.4%, p<0.01), while White adults (2.0%, p<0.05), AI/AN adults (2.6%, p<0.05), and adults with more than one race (4.2%, p<0.001) all had significantly higher rates.

Table 1: Self-Reported Substance Use and Misuse in the Past Year among Adults Ages 18 and Older, by Race and Ethnicity, 2015-2019 (percent of racial or ethnic group population)

	White, Non-Hispanic	Black/African American, Non-Hispanic	American Indian or Alaska Native, Non-Hispanic	NHPI, Non-Hispanic	Asian, Non-Hispanic	2 or More Races, Non-Hispanic	Hispanic/Latino
Any alcohol use	74.1***	61.8 ^c	56.5*	57.0	55.4***	68.6***	64.0***
Heavy alcohol use in the past month ^a	7.7***	4.6	6.6*	5.1	2.4***	8.1***	5.1 ^c
Any marijuana use	15.9 ^c	18.2***	22.0***	14.6	7.5***	25.6***	13.2***
Any cocaine use	2.2 ^c	2.0	2.6	2.6	1.0***	3.8***	2.1
Any heroin use	0.4	0.3 ^c	0.4	0.3	<0.1**	0.5	0.2
Any methamphetamine use	0.8 ^c	0.3***	2.7***	1.2	0.1***	1.1*	0.7
Any hallucinogen use	2.0*	1.4**	2.6*	1.6	1.7	4.2***	1.8 ^c
Any inhalant use	0.5	0.3*	1.1*	0.7	0.5 ^c	1.0**	0.5
Pain reliever misuse ^b	4.3 ^c	3.7**	5.8*	4.8	1.7***	6.2***	4.1
Tranquilizer misuse ^b	2.6*	1.3*	1.8 ^c	1.7	0.7***	3.1**	1.9
Stimulant misuse ^b	2.4***	0.8***	1.4	1.5	1.2	3.3***	1.5 ^c
Sedative misuse ^b	0.6***	0.2	0.4	0.1	0.2*	0.9***	0.4 ^c

Sources: Estimates are from the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2015-2019.

- a. Heavy alcohol use is defined as drinking 5 or more drinks on the same occasion for men or 4 or more drinks on the same occasion for women on each of 5 or more days in the past 30 days. "Occasion" means at the same time or within a couple hours of each other.
- b. Because pain relievers, sedatives, stimulants, and tranquilizers can be prescribed for medical treatment, these measures show self-reported misuse. Misuse is defined as use of these drugs in any way not directed by a doctor (e.g., use without a prescription of one's own or use in greater amounts, more often, or longer than directed).
- c. For each substance, the group with the median use/misuse rate was used as the reference for tests of statistical significance.

*/**/*** The difference between this estimate and the estimate for the median reference group adults differs from zero at the 0.05/0.01/0.001 level, based on unadjusted logistic regression.

For past-year inhalant use, Asian adults had the median use rate at 0.5%. Black/African American adults were the only group with a significantly lower rate (0.3%, $p < 0.05$). On the other hand, adults with more than one race (1.0%, $p < 0.01$) and AI/AN adults (1.1%, $p < 0.05$) both had significantly higher rates.

For rates of pain reliever misuse in the past year, White adults were the median group with a rate of 4.3%. Black/African American adults (3.7%, $p < 0.01$) and Asian adults (1.7%, $p < 0.001$) had significantly lower misuse rates, while AI/AN adults (5.8%, $p < 0.05$) and adults with more than one race (6.2%, $p < 0.001$) had significantly higher misuse rates.

AI/AN adults had the median rate of past-year tranquilizer misuse at 1.8%. Black/African American adults (1.3%, $p < 0.05$) and Asian adults (0.7%, $p < 0.001$) had significantly lower misuse rates, but White adults (2.6%, $p < 0.05$) and adults with more than one race (3.1%, $p < 0.01$) each had significantly higher misuse rates than the median group.

Hispanic adults had the median rate of past-year stimulant use (1.5%). Only Black/African American adults had a significantly lower misuse rate (0.8%, $p < 0.001$), but both White adults (2.4%, $p < 0.001$) and adults with more than one race (3.3%, $p < 0.001$) had significantly higher misuse rates than the median group.

Finally, the median group for past-year rate of sedative misuse was Hispanic adults (0.4%). Asian adults (0.2%, $p < 0.05$) had a significantly lower misuse rate, and again White adults (0.6%, $p < 0.001$) and adults with more than one race (0.9%, $p < 0.001$) had significantly higher misuse rates than the median group.

Rates of Past-Year Substance Use Disorder by Race and Ethnicity

The overall prevalence of past-year of any SUD including alcohol ranged from 4.2% for Asian adults to 12.2% for AI/AN adults. The median group was Black/African American adults, who had a prevalence of any past-year SUD of 7.6%. The 4.2% prevalence for Asian adults was the only rate significantly lower than the median ($p < 0.001$). White adults (8.2%, $p < 0.05$), however, as well as adults with more than one race (10.8%, $p < 0.001$) and AI/AN adults (12.2%, $p < 0.001$) all had significantly higher rates of any past-year SUD than the median group.

Of all individual SUDs, alcohol use disorder was by far the most prevalent (**Table 2**). For many groups, alcohol use disorder was two or more times more prevalent than all other SUDs combined. Hispanic adults had the median past-year alcohol use disorder prevalence at 5.8%. For Asian adults (3.5%, $p < 0.001$) and Black or African American adults (5.2%, $p < 0.05$) the rate was significantly lower, while for adults with more than one race (7.4%, $p < 0.05$) and AI/AN adults (9.2%, $p < 0.001$), alcohol use disorder was significantly more common compared to the median group.

When examining the prevalence of having any of the remaining SUDs in the past year, excluding alcohol, rates were substantially lower across all racial/ethnic groups. The median group was NHPI adults, whose prevalence of any SUDs excluding alcohol was 3.0%. (By comparison, their alcohol use disorder prevalence was 7.3%.) Only Asian adults (1.2%, $p < 0.01$) had a prevalence of any non-alcohol SUDs that was significantly lower than the median level for NHPI adults. Both AI/AN adults (5.0%, $p < 0.05$) and adults with more than one race (5.2%, $p < 0.01$), however, had rates that were significantly higher than NHPI adults.

Across the remaining individual SUDs, there were a number of statistically significant differences when comparing against the median racial/ethnic group for each substance. Prevalence levels were consistently quite low and similar across racial/ethnic groups, however, and for most substances, prevalence levels were no greater than 1.0%. An exception was marijuana use disorder, which ranged from 0.8% for Asian adults to 3.0% for adults with more than one race. The median group was Hispanic adults, who had a past-year prevalence

level of 1.6%. The 0.8% rate for Asian adults was significantly lower than this ($p < 0.001$), as was the rate for White adults (1.3%, $p < 0.01$). Black/African American adults (2.2%, $p < 0.001$), AI/AN adults (2.3%, $p < 0.05$), and the aforementioned group with the highest prevalence, adults with more than one race (3.0%, $p < 0.001$), all had significantly higher levels of past-year marijuana use disorder than the median.

Table 2: Any SUD and Specific SUDs in the Past Year among Adults Ages 18 and Older, by Race and Ethnicity, 2015-2019 (percent of racial or ethnic group population)

	White, Non-Hispanic	Black/African American, Non-Hispanic	American Indian or Alaska Native, Non-Hispanic	NHPI, Non-Hispanic	Asian, Non-Hispanic	2 or More Races, Non-Hispanic	Hispanic/Latino
Any SUD ^a	8.2*	7.6 ^b	12.2***	7.3	4.2***	10.8***	7.5*
Any SUD, excluding alcohol use disorder	2.8	3.4	5.0*	3.0 ^b	1.2**	5.2**	2.7
Alcohol use disorder	6.2	5.2*	9.2***	5.5	3.5***	7.4*	5.8 ^b
Marijuana use disorder	1.3**	2.2***	2.3*	1.5	0.8***	3.0***	1.6 ^b
Cocaine use disorder	0.3	0.6***	0.5	0.4 ^b	0.1*	0.5	0.3
Opioid use disorder	0.9	0.7 ^b	1.2*	0.5	0.2**	1.4**	0.6**
Methamphetamine use disorder	0.4	0.1***	1.7***	1.0	0.1**	0.7	0.4 ^b
Hallucinogen use disorder	0.1	0.1	0.2	<0.1	0.1 ^b	0.2	0.1
Inhalant use disorder	<0.1	<0.1	<0.1	0.2	<0.1	<0.1	<0.1 ^b
Tranquilizer use disorder	0.3	0.2	0.3	0.2 ^b	0.1	0.5	0.2
Stimulant use disorder	0.2 ^b	0.1***	0.3	0.4	0.1***	0.3	0.1***
Sedative use disorder	0.1	<0.1	0.1 ^b	0.1	<0.1	0.1	<0.1

Source: Estimates are from the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2015-2019.

- a. Any SUD includes respondents with alcohol use disorder or who report abuse of or dependence on any of the following illicit drugs: cocaine, hallucinogens, heroin, inhalants, marijuana, methamphetamine, pain relievers, sedatives, stimulants, and tranquilizers.
- b. For each substance, the group with the median use disorder rate was used as the reference for tests of statistical significance.

*/**/*** The difference between this estimate and the estimate for the median reference group adults differs from zero at the 0.05/0.01/0.001 level, based on unadjusted logistic regression.

DISCUSSION

In this study of national survey data from 2015-2019, we examined United States adults' rates of substance use, misuse, and SUD across racial and ethnic groups, finding that rates were often similar across groups. At the same time, we did find statistically significant differences between racial/ethnic groups for many substances when comparing to the group with the median level of use for each substance we examined. We also found that no one group tended to be the median across substances but that some groups were more likely to have the lowest and highest rates of use, misuse, and use disorder.

People with SUDs are at higher risk of adverse consequences of drug and alcohol use, such as health, social, and employment problems, incarceration, and death, and have the greatest need for services and treatment. Fortunately, SUDs are preventable and treatable with culturally and linguistically effective prevention, treatment, medication, harm reduction, and social services and supports.

Among the most notable differences in SUD rates by race and ethnicity were the higher rates of four different SUDs (alcohol, marijuana, opioid use disorder, and all SUDs combined) for those reporting two or more races and for AI/AN adults compared to the median group for each SUD. Virtually no research exists to understand unique risk factors or considerations for approaches to care for people with SUD who identify as two or more races. This is an important gap given that this population is rapidly growing and has elevated substance use and SUD rates (CBHSQ, 2021; Jones & Bullock, 2012). In addition, AI/AN adults also had a higher rate of methamphetamine use disorder than the median. With rates of stimulant-related overdose deaths having increased rapidly overall (CDC, 2021; National Institute on Drug Abuse, 2020), addressing the higher rate of methamphetamine use disorder among AI/AN adults in a culturally effective way is especially critical.

Other differences in SUD rates, though modest, are also important for clinicians and policymakers to study. Expanding policy attention to address these differences and disparities could help improve the nation's response to the epidemic's shift toward fentanyl, and methamphetamines; and increase attention to the options to avoid overdose in communities of color, where overdose mortality is often driven by substances other than opioids (Shiels et al., 2018).

As noted, AI/AN adults had a higher rate of methamphetamine use disorder during our study period. Meanwhile, Black/African American adults had a higher rate of cocaine use disorder compared to the median. The rate of overdose deaths linked to psychostimulants, including methamphetamine and cocaine, increased 28% between 2018 and 2019 and has increased more than threefold over the past five years, with a substantial share involving more than one substance (e.g., including fentanyl) (CDC, 2021; National Institute on Drug Abuse, 2020). Yet guidance related to stimulant overdose prevention and treatment (e.g., SAMHSA, 2020b) is limited compared with the vast research and guidance related to opioid overdose. For the treatment of stimulant use disorders, evidence supports the efficacy of contingency management, a psychosocial intervention that involves reinforcing recovery-oriented behaviors (e.g., abstinence, treatment session attendance, medication adherence) with items of value (Glass et al., 2020). However, various policy barriers impede its availability, including limited health insurance coverage and restrictions on incentive values in certain federal programs. Culturally informed guidance on addressing stimulant use and overdose prevention is needed, especially for disproportionately affected communities of color. Further, though people who use a substance may not have a substance use *disorder*, they may benefit from receiving culturally informed prevention and early-intervention services.

The findings that substance use and SUD rates were often at the median or below median for Black/African American and Hispanic/Latino adults contrasts with the racialized and criminalized history of substance use policy in the United States, which has resulted in disproportionate criminal justice involvement for drug offenses among people of color. More effective and equitable outcomes may be achieved through an approach to measuring and treating substance use that uses a more intersectional lens, is culturally and linguistically competent, and more consistently relies on evidence-informed care. Paying more careful attention to differences within groups in future research, both related to smaller racial and ethnic groups and to other, intersecting sociodemographic identities (e.g., age, sex, gender identity, sexual orientation), can improve understanding of how the need for substance use services intersects with the needs of historically and systematically disadvantaged populations, such as communities of color, women, and LGBTQ+ communities, but not always in expected ways.

CONCLUSION

To address the varied needs of different communities of color, additional guidance and research is needed to support clinicians in providing evidence-informed, culturally effective SUD prevention and treatment services. More support is also needed for communities of color to lead the development, evaluation, and implementation of effective models that provide care for people who have unhealthy substance use in their communities. The HHS Overdose Prevention Strategy outlines policy initiatives and strategies to increase the availability of culturally competent care, to address underlying social determinants of health that increase risk of substance use and SUDs within communities of color, and to provide evidence-based SUD treatment to heavily impacted communities. Policy and research attention to differences in and accessibility of the types of care that are culturally and clinically effective for different racial and ethnic groups is critical. These approaches would both help address the specific needs described in this analysis and promote equitable health care access and outcomes for all people regardless of race or ethnicity.

ENDNOTES

1. NSDUH survey language uses the word doctor, but other providers could prescribe these substances, depending on state scope-of-practice laws.

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