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A collaborative culturally-centered and community-driven faith-based opioid recovery initiative: the Imani Breakthrough project

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ABSTRACT

The opioid crisis has become a complex and multifaceted societal challenge. For Black and Latinx individuals, access and engagement in effective treatment remains a high concern. Developed as the result of a collaborative culturally-responsive initiative, the Imani Breakthrough program has been hosted by Black and Latinx churches. It has helped participants improve their lives, feel valued by society, connect with others, and have positive relationships with their loved ones and community. This brief report highlights preliminary findings which demonstrate the strength of this model of care involving community churches, highlighting the need/potential for continued collaboration efforts.

KEYWORDS

Opioid recovery; cultural responsiveness; Black/African American and Latino/x; faith-based; substance use disorder; mental health; Community-based Participatory Research (CBPR).

Introduction

The opioid crisis has become a complex and multifaceted societal challenge. Drug overdoses, many involving opioids, are now the leading cause of accidental death in the United States (U. S.) (Mattson et al., 2021). Of the more than 70,000 drug overdose deaths in 2017, opioids were involved in almost 68% of cases (CDC, 2020; Scholl et. al., 2019). Social Inequities arising from structural racism – how systems, institutions and policies reinforce oppression and lead to differential access to power, privilege, and other resources for racial/ethnic minority groups (Agénor et al., 2021) – such as limited economic opportunities and involvement in the carceral system thereby eroding social capital in racially minoritized communities, are at the center of the opioid overdose crisis (Hart & Hart, 2019). The association between economic distress and opioid-related overdoses points to an association between fentanyl in combination with other substances (cocaine, alcohol, benzodiazepines, amphetamines) and decreased

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access to resources in Black and Latinx communities (Friedman et al., [in press](#); Rushovich et al., [2020](#)). In the U.S., while opioid-involved death rates for White individuals seem to be on the decline, the rates for Black and Latinx people are on an incline (Center for Disease Control (CDC), [2020](#); Furr-Holden, Milam, Wang, & Sadler, [2020](#)). In Connecticut, all racial and ethnic groups have experienced a significant increase in opioid-involved overdose deaths (Connecticut Office of the Chief Medical examiner, [2020](#); Dasgupta, Beletsky, & Ciccarone, [2018](#); Volkow & Blanco, [2020](#)). To better address the disparities for Black and Latinx communities in Connecticut, a community participatory development process was implemented to better target and adapt interventions for Black and Latinx communities. This brief report provides an overview of the process, the project developed, and includes preliminary findings about its service use and satisfaction.

For Black and Latinx individuals with mental health conditions, including substance use disorders (SUDs), access and engagement in effective mental health and addiction services remains a high concern. Treatment engagement rates are low compared to other racial/ethnic groups, with Black and Latinx populations being less likely than White people to seek mental health treatment (including alcohol and other drugs) (Maura & Weisman De Mamani, [2017](#); Mennis, Stahler, El Magd, & Baron, [2019](#)). Stigma of mental illness and addiction is a known barrier in initiating treatment among Black and Latinx individuals with SUDs (James & Jordan, [2018](#); Jordan, Babuscio, Nich, & Carroll, [in press](#)). This includes both internalized and perceived social stigma from others (Hines-Martin, Malone, Kim, & Brown-Piper, [2003](#)). Furthermore, when treatment is initiated, evidence suggests they are often not satisfied with the care received, which could influence treatment engagement (Acevedo et al., [2012](#)). As such, there is a need to invest in research that identifies alternate pathways to addiction and mental health treatment for racial/ethnic minority communities with addiction.

Recent research demonstrates that Black people rely on multiple modalities for support such as faith, religion, and social networks when in distress (Ormond, Barbour, Lewis, Montgomery, & Ponds, [2019](#)). For instance, Black people are more willing to seek SUD help from clergy and other faith leaders (Perron, Howard, Maitra, & Vaughn, et al., [2009](#)), as opposed to interfacing with physicians initially. Similarly, for Latinx populations, religion is seen as a coping mechanism when healing from distress (Caplan, [2019](#)), of which many from this culture see the experience of an SUD and accompanying stress as falling into this arena. To this end, religion and spirituality play important roles in the lives of Black and Latinx people, and the church exists as a prominent fixture in both communities, historically serving those in need (Blank, Mahmood, Fox, & Guterbock, [2002](#); Taylor, Ellison, Chatters, Levin, & Lincoln, [2000](#)). In a national survey of religious beliefs and practices, a higher proportion of Black and Latinx people indicated attending weekly religious services and an absolute belief in God, when compared to White people (Oxhandler, Edward, &

Achenbaum, 2018; Pew Research Center, 2014). Given the high cultural importance of religion and spirituality, Blacks and Latinx individuals may perceive their mental illness or addiction as a problem in need of a spiritual solution, reinforcing the help seeking behavioral pattern of engaging with clergy or attending church services instead of (or in addition to) exploring formal treatment options (Ayalon & Young, 2005). Continued education and outreach to faith-based institutions may prove a viable path to improve access to substance use treatment for these historically excluded populations.

Overview: the Imani Breakthrough opioid recovery project

In response to how the opioid crisis has affected the Black and Latinx communities in recent years in Connecticut, the Imani (meaning faith in Swahili) Breakthrough program was conceptualized in 2017. A community based participatory approach was central to its development, including the naming of the project. The Imani Breakthrough program provides an innovative, holistic, and culturally- responsive approach to engaging individuals into substance use treatment, by integrating the social determinants of health (SDOH) described as modifiable conditions in the environment that affect health outcomes (Marmot, 2005). SAMHSA's 8 dimensions of wellness, representing the SDOH, includes the attainment of wellness in each of the following areas: emotional, occupational, environmental, financial, physical, social, intellectual, and spiritual (Swarbrick, 2006; Swarbrick, Murphy, Zechner, Spagnolo, & Gill, et al., 2011). Imani places great importance on stability in each of SAMHSA's 8 *dimensions of wellness*, along with integration of *citizenship enhancement*, (Bellamy, Flanagan, Antunes, Davidson, & O'Connell, 2020; Clayton, O'Connell, Bellamy, Benedict, & Rowe, et al., 2013; Rowe et al., 2012; Rowe, 2015) a strong connection to the Rights, Responsibilities, Resources, Roles and Relationships necessary for recovery, and a sense of belonging that is validated by others) into learning about and building the resources each participant individually needs. Imani directly addresses many of the barriers and challenges faced by Black and Latinx people with an opioid use disorder (OUD), by providing twelve weeks of education related to the process of recovery including topics such as trauma and racism, followed by ten weeks of mutual support, and intensive wrap around support and coaching to target vulnerabilities in the SDOH.

In the group meetings, facilitators engage with participants in conversations utilizing different strategies such as role play or inviting guest speakers. Facilitators are people from the church community and people with lived experience in mental health conditions, including addiction. Group meeting topics vary in distribution, such as learning how to use naloxone to employment and self-care. In the individual coaching sessions, facilitators meet individually with participants in-person or over the phone, the objective is to have participants working on individual goals defined by each participant as a meaningful recovery goal that they need help with.

The church community also plays an important role in the Imani Breakthrough program. They help organize meetings, where members from the community might become guest speakers to talk about a specific topic and also are critical in the planning of the graduation ceremony, which marks the completion of the Imani program (6-month time table). In many churches, the community also learn about the program at the Sunday service, where participants are invited to tell their stories. In this process, stigma related to substance use is mitigated.

Overview: community participatory development process

Collaborative culturally-responsive initiatives need to be developed to address the opioid crisis in Black and Latinx communities. A key ally in this strategy are faith communities. The participatory process that helped develop and consolidate the Imani Breakthrough project as an efficacious intervention involved three components: 1) Learning through dialogue sessions; 2) Synthesizing and development; 3) Sustainability.

The *Learning through dialogue* sessions consisted of a series of conversations with community members and faith-based leaders about substance use and the opioid crisis. Conversations took place around the state at various churches. Through these conversations we learned about the community experiences and concerns related to substance use and, most importantly, about the interest of faith communities in getting more involved to help address the opioid use crisis. The community members talked about the disparities in treatment for Black and Latinx people, and particularly were concerned that White people were now getting all the attention while Black and Brown people continue to suffer from opioid overdoses with an accompanying rise in deaths. The second component, *Synthesizing and development* involved conversations with the organizing team, using suggestions from the first component, the community conversations, to modify and develop the faith-based recovery program to focus on wholistic health (mental and physical health). Here is where there was an emphasis in involving community partners to better address any inequities in the SDOH. The third component, *Sustainability*, involved the development and execution of a series of educational sessions with the different churches and their community about substance use and the opioid crisis. These educational sessions were developed based on the dialogue sessions and the synthesis and development of the Imani program. They were integral to the initiative, even though there was no funding directed to this effort. Trainings were developed and conducted by pastors and community leaders, in collaboration with psychologists and psychiatrists.

Preliminary findings: Imani Breakthrough and culture

For Black and Latinx people, religious practice functions as a social resource for coping with substance use (Alegría, et al., 2006; Alegría et al., 2007;

Villatoro, Dixon, & Mays, 2016). In this sense, the strategies for the intervention included the importance of a spiritual and holistic health view, rather than attempting to impose tenants of traditional substance use programs upon participants. Imani is based on the value of lived experience, culturally-responsive care, and tenets such as choice, autonomy, and trust – all necessary strategies to help deliver the program content, which is based on the SDOH, 8 Dimensions of Wellness, and the Citizenship framework. In creating a safe space to talk about their life experiences, participants developed a strong connection with the other participants and with facilitators.

Socio-demographic and clinical characteristics of the population served by the Imani Breakthrough program

In its two years of existence, the Imani Breakthrough program has been hosted by eight different churches (4 Black churches and 4 Latinx churches) located in five different cities in Connecticut. It has served 900 unique individuals. The average age of participants was 46 years old (SD 12 years). In the four cohorts, there were more men than women participating (60% vs 40%). Regarding sexual orientation, 15% identified as gay, lesbian, or bisexual, the remaining (85%) as heterosexual. Regarding ethnic racial identity, 29% identified as Latinx, 53% identified as Black/African American, and 27% identified as White. Sixty-six percent (66%) reported being single, 18% reported being in a relationship, 10% were married, and 2% were divorced. Among participants, 33% responded that they had not completed high school, 48% completed high school, 9% had some college, 6% completed college, and 4% had completed university or had a higher degree. Only 17% were currently employed. More than half (53%) were not satisfied with where they lived. A significant majority (75%) had been homeless at least once, with 49% saying that they had been homeless 3 or more times. The majority (68%) have a history of incarceration, with 19% currently on probation or parole. When it comes to substance use services, 63% were not receiving traditional substance use services. For mental health services, 39% who responded to this question said that they were currently receiving services, although 53% of participants did not answer this question. When reporting history of substance use, 70% said that they had a history of cigarette smoking, 45% reported alcohol use, 35% cocaine use, 29% an opioid use, 38% cannabis, and 16% reported the use of another substance (such as benzodiazepine, methamphetamine, LSD, etc.). The majority of participants reported receiving inpatient treatment at least once (75%) over their lifetime. For those with a history of inpatient treatment, the mean number of hospitalizations reported was five. A significant group of participants (44%) had experienced abuse as a child, 50% witnessed abuse as a child, 65% experienced violence as an adult, and 69% has witnessed violence as adult.

Table 1. Demographic information of participants.

Age M(SD)	46(12)
Relationship Status (%)	
Single	66%
Married	10%
Divorced	2%
In Relationship	18%
Ethnic/Racial Identity (%)	
Black/African American	53%
Latinx	29%
White	27%
Gender (%)	
Male	60%
Female	40%
Education (%)	
Did Not Complete High School	33%
High School Diploma	48%
Some College	9%
Completed College	6%
Completed University	4%
Currently Employed (%)	
Yes	17%
No	83%
Legal Involvement (%)	
History of Incarceration	68%
Current Parole/Probation	19%

Regarding spirituality, 47% practiced a religion or endorsed being spiritual. Thirty two percent (32%) attended a self-help or support group (Table 1).

Preliminary results from participatory conversation with participants and facilitators

Three focused discussions took place with the 13 facilitators (across 8 churches) and two focused discussions, involving 20 participants who graduated from the program, helped with the evaluation process. We conducted semi-structured discussion sessions at the churches to talk about questions including: 1. “How has this project assisted you in your recovery?” 2. “What more could faith-based recovery approaches do to get people involved?” 3. How has the approach used at Imani worked compared to others? 4. What was your experience like with drug treatment before participating in the program?

The findings showed many aspects of how the program helped participants improve their lives such as building goals, being recognized as productive and valued members of society, connecting with others, and having a positive relationship with their loved ones and their community. Eight main themes emerged from these focus groups. They reflect the collective views of participants such as: Empowerment and decision making; relationships and self-respect; autonomy and freedom; spirituality and belief; choice and trust; and options and engagement. The voices and perspectives of participants reflected

the thoughts shared by the facilitators about their perceptions of the program. Six main themes were related to the impact of IMANI on the participants' lives:

1. Empowerment and decision making

"IMANI is about avoiding judgment; it is a free zone, a positive group where we can understand people's feelings and reactions. Drugs call us all the time. It is in the back of your mind. Here I learned to cope with the demon." (Participant)

"They felt validated in their feelings. They can speak and ask for information. They know that we will provide resources for them. It is about language and connection." (Facilitator)

2. Relationships and self-respect

"It is a group learning process. We can share different opinions and be respected for that. We learn from each other; everything that you learn helps you in your recovery process; you are not alone. For many years I was alone. The drugs were my companion." (Participant)

"They got information about jobs, GED, treatment, housing, and they build relationships during the program." (Facilitator)

3. Autonomy and freedom

"Here, I can speak with my mouth, my heart, and that is why I like this program." (Participant)

"We build with them trust. It is very important to them. They come from a lot of loss and trust is significant in their lives." (Facilitator)

4. Spirituality and belief

"Spiritually is a motivation. Sometimes it is the only thing that you have. Helps me validate my feelings because I have so many thoughts and I believe that it is important. My power comes from my thoughts, my values too;" (Participant)

"The program is in the right place because it is about connection. We connect with our brothers and sisters, we connect with God, we connect with a kind of power, we empower people in their feelings. The church is the place where people like to go to connect with something else." (Facilitator)

5. Choice and trust

"Other programs, everything is mandated. (They say . . .) It's my way or the highway." (Participant)

"(In other programs . . .) They are not peer to peer. They are very structural." (Facilitator)

6. Options and engagement

"MAT providers could be a conflict in the group, but after the group it could be very helpful." (Participant)

"They can help to build connections with providers." (Facilitator)

Conclusion

As the opioid epidemic continues to devastate communities nationwide, communities of color face worsened health outcomes. Research has demonstrated disparities in substance use treatment utilization among Black and Latinx communities, highlighting the need for newly developed service models to best meet the needs of these underserved populations. Researchers continue to make a call for action, specifically involving Black and Latinx churches in this effort, given the role of the church in the community and the cultural importance of religiosity/spirituality amongst these groups (Jordan et al., in press; Ormond et al., 2019). When examining high treatment need, limited access to care, and longstanding cultural beliefs about mental health and addiction treatment; research must begin to develop and collaborate with community-based institutions to best serve the need of Black and Latinx populations. Collaborating with community churches and involving community leaders in health promotion efforts could offer significant contributions in designing treatment models that are culturally aligned. The results of the Imani Breakthrough project demonstrate the strength of this model of care involving community churches, highlighting the potential for continued collaboration efforts.

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