People are Doing Group Therapy in Their Own Communities! What Must We do to Expand Addictions, Mental Health, and Wellbeing in Cultural Communities?

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Editor's note: *This op-ed was written by Dr. Deborah Haskins, Ph.D., LCPC, ACS, MAC, ICGC II, BACC, ICGSO, CGT. Dr. Haskins is a retired Counselor Educator (25 years) and received her Ph.D. in Pastoral Counseling from Loyola College, Maryland. Dr. Haskins is a Licensed Clinical Professional Counselor, an Internationally Certified Gambling Counselor- II, Board Approved Clinical Consultant, Master Addictions Counselor, and IGCCB Certified Gambling Trainer. She is President Emerita of the Maryland Council on Problem Gambling and is a recognized leader for over 30 years in disordered gambling and over 35 years in cultural humility, health equity, and community wellness. She received the 2021 National Council on Problem Gambling Monsignor Joseph Dunne Lifetime Achievement Award for Advocacy.*

Did you know the United States *National Survey on Drug Use and Health* (NSDUH) reported in 2022, that an estimated 54.6 million people aged 12 and older needed treatment for a substance use disorder in the past year, but that only 24% of those received any help for substance use disorder? Layered atop these alarming statistics, gambling has expanded worldwide, including sports betting and online betting. An estimated 1% of the general population meet the criteria of disordered gambling and many more appear functional but experience serious gambling-related harm. The rates of treatment seeking for disordered gambling have not increased

substantially in the last decade despite prevention and public awareness efforts. When it comes to addiction, why hasn't the "treatment access dial" moved significantly?

These harms are not evenly distributed, as the COVID-19 pandemic taught us that. As my colleague Dr. Diane Reese remarked, "We were hiding behind the curtain of health disparities." I call this "hiding behind the draperies," because we have known for years that BIPOC communities are suffering life, health, and economic disparities and are dying at alarming rates compared to White and European-descent persons.

With all the scientific advancements, technology, and collective brilliance among public health professionals, scientists, and others, why do we still struggle to provide accessible services that reflect health equity strategic initiatives, address social injustices, and remove systemic and structural inequalities? These inequalities are often the real threats to mental health and wellbeing and explain contextual influences on the "soul behind the high!"

Recently, I provided disordered and problem gambling workforce development in a jurisdiction serving largely BIPOC communities. I asked the leaders: *Are your addiction services located in the communities where many BIPOC reside, experience higher rates of Social Determinants of Health and multiple levels of individual, family, and community adversities, and experience higher rates of opioid deaths and higher mortality rates? The answer was: No, we do not have services in the communities with concentrated poverty and marginalization experiences.* I wanted to scream! Why? Because how can we expect a person who literally feels "beat down by life" to reach out for services not accessibly located and take their unlivable wages earned from jobs providing limited benefits (e.g., insurance, sick leave) to access healthcare? When people are in a crisis from the effects of addiction and mental health threats, the "window of care" is very short! People feel shame, guilt, and stigma from addiction and mental illness, and they cannot take on additional burdens to access care. Telehealth options help, but many community members lack the necessary devices or broadband access.

It is my observation, after providing health equity and social justice-integrated services, that "People are doing group therapy in their own communities!" Their form of "group therapy" includes connecting with persons within their own cultural identities (e.g., LGBTQIA+, racial, ethnic, veterans, disability, trauma

survivors, immigrants), via social media, podcasts, Artificial Intelligence and technology interactions (i.e., apps), and "Club Houses," which were developed 75 years ago in New York as informal supportive gathering for persons with mental illness. People often do not access our disordered/problem gambling, addiction, or mental health services; they know these services are not accessible and do not reflect their cultural values or lived experiences. Many seek help from their faith, spiritual, and indigenous healers when experiencing distress. I have argued that congregational support must include problem gambling education and links to community-based resources, such as professional treatment and peer recovery groups like Gamblers Anonymous, Smart Recovery, and Gam-Anon. Why would people use a health service or product that does not meet their lived experiences needs and lacks acknowledgement of cultural, social justice, and health equity considerations? There is a saying that "Depressed persons are the most realistic." Why? Because they know they are depressed and cannot perform certain demands. Well, consumers and community members are realistic—they know healthcare was not designed for their community and they will not participate in a process or product that lacks a "goodness of fit."

How can we promote equitable access to treatment and recovery-oriented systems of care? I have four recommendations, and they are not complex. First, locate health resources at the community level. Case in point: a Target store closed in my community (Baltimore, MD), and one investor who is committed to equity donated the store space to the community. In July 2024, the University of Maryland just announced plans to open in this former Target store. This research medical institution will provide primary care, specialists, mental health services, and nutrition services. For example, the new site will offer cardiology services, which is key because this West Baltimore location is home to a largely African American community who suffer higher rates of hypertension, stroke, and heart disease. People will be able to walk to these accessible services if they need to.

There are also parts of rural America struggling with poverty, lack of transportation, and an even blighter reality of medical and mental health care. When facilitating a problem gambling town hall meeting at one of the rural churches, I learned that the volunteer fire department "drops $7000" in one night of gambling payouts in an effort to fund itself. I asked, "Why is the volunteer fire department hosting gambling games?" I was told, "The State doesn't care for us out here…so we have to take care of ourselves!" Isn't this the same "solution gambling" that individuals and families use? People will do what they must to

survive, including community stakeholders.

Second, behavioral health providers and primary medical professionals must build relationships with community stakeholders, such as faith/spiritual/indigenous healers, small businesses, educators, schools, health systems, and these groups must collaborate to address health inequities, including addictions and risky gambling/gaming. Ask, *"What are the conditions contributing to material poverty and adversity, including community adversity?" "In what ways does lack of transportation limit persons' access to better jobs?" "How do gentrification and systemic racism affect wellbeing?*" Community-based teams banding together to address policy and structural change for sustainable, long-term improvements could lead to population-level change. For example, during the past two years I led advocacy with my Delegate (Dalya Attar, Maryland) for changes to the Maryland Criminal Injuries Compensation Fund. Our work produced a comprehensive reform informed by our own lived experiences as a family suffering homicidal trauma. People self-medicate trauma and adversity with gambling, substances, and other risky behaviors and may see substances and gambling as more accessible when they struggle to breathe through trauma. Now, the Maryland law is changed with increases to fund allocations (health/mental health support), and direct payments to trauma-informed care practitioners. We must move away from only providing "band aid" remedies to population-level remedies.

Third, provide culturally sensitive and social justice-infused services. For example, Victor Ortiz, MSW and his team in the Massachusetts Department of Public Health, Office of Problem Gambling Services implemented a health-equity and social justice framework to address gambling-related harm. They developed an Ambassadors Program designed to reach men of color, consistently one of the largest at-risk groups. Ambassadors are educated on problem gambling and co-occurring substance use disorders/mental health/public health and then work grassroots in their communities, engage with community members, and link persons to community-based resources. This Ambassadors Program has reached over eight thousand persons! In my close to 40 years as a professional counselor, I have not reached eight thousand people! This would equate to two hundred people seeking my services annually. We must return to community-based, culturally, health equity, and social justice informed and responsive care. When people see helpers who look like them and who understand their lives/stories, they are more likely to "keep coming back," which is what we encourage in 12-

step addictions fellowships.

Fourth and finally, we must move from the limited Western healthcare models focusing on disease and flexibly use integrated models that communicate to community members, *"I see you; I hear you; I support you!"* People will continue doing group therapy in their own communities! Why? Because these are native, local, natural healing resources they are familiar with. Let each of us partner with community-level "group therapists" as we increase our advocacy and support to help heal our communities and the world.

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