Systemic Racism and Substance Use Disorders

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ABSTRACT

Increasing attention to systemic racism in the United States in all aspects of life has sharpened focus on its effects on the health outcomes of Black, Latinx, and Indigenous populations. Racial disparities in substance use disorders remain a significant public health problem in mental health, and psychiatrists require sufficient knowledge and awareness to help address these disparities. First, this article reviews evidence of racial disparities in substance use disorders. We then discuss the historical and legal foundations of systemic racism and substance use disorder disparities and explore research examining the role of systemic racism in substance use disorder outcomes on structural and individual levels. Finally, we discuss recommendations for providing substance use disorder care in a more racially equitable manner. **[*Psychiatr Ann*. 2020;50(11):494-498.]**

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Disclosure: The authors have no relevant financial relationships to disclose.

doi:10.3928/00485713-20201008-01

Substance use disorders (SUD) represent a major health concern both nationally and globally, and psychiatrists play a key role in reducing the suffering associated with these conditions. Although recent decades have seen significant scientific breakthroughs in our understanding of SUD, expanding the tools available to psychiatrists, the persistence of racial disparities in SUD represent a continued significant failure in public health efforts. To address these disparities, psychiatrists must hold a clear understanding of the social and institutional factors that determine SUD outcomes. This article reviews racial disparities in SUD, examines their historical roots and explanatory theories for their persistence, and makes recommendations for providing racially equitable SUD care.

RACIAL DISPARITIES AND SUD

Burden of SUD in Black, Latinx, and Indigenous People

Although SUD are prevalent among all racial groups, the burden of disease is disproportionate among Black, Latinx, and Indigenous people. Indigenous youth have more than a 500% higher mortality rate due to opioid-related overdose compared to the general population, as well as the largest percent change increase in number of deaths between 1991 and 2015.[1] Black people are also disproportionately burdened by substance-related problems, with higher rates of morbidity, mortality, and adverse social and legal consequences.[2] From 1999 to 2001, Black people in metropolitan areas had higher substance-related death rates compared to other racial groups.[1] Overdose death rates from 2014 to 2017 increased in the Black population, with the sharpest rise from synthetic opioids, increasing by 818% compared to other races.[3] Among Latinx people, experiencing racial discrimination has been associated with an increased risk of alcohol use among women and an increased risk of drug use among men.[4] Although the total volume of drinks per month was not higher among Latinx people,[5] they experienced more adverse events and increased mortality related to alcoholic cirrhosis than other racial groups.[2,6]

Race and SUD Treatment Availability, Retention, and Outcomes

Treatment for SUD is less available for Black, Latinx, and Indigenous people than it is for White people. In the 2009 National Survey of Substance Abuse Treatment Services, counties that had no access to outpatient SUD facilities had a

higher percentage of residents who were Latinx, living in poverty, uninsured, and living in rural areas.[7] Furthermore, counties with a higher percentage of Black and Latinx residents were less likely to have an outpatient SUD facility that accepts Medicaid. The opioid crisis has further underscored differences in treatment availability. Despite an increase in opioid-related deaths, growth in buprenorphine treatment has been limited to populations with higher income and lower percentages of people who are not White.[8] From 2012 to 2015, buprenorphine was prescribed to 12.7 million White patients, compared to 363,000 people of other races or ethnicities.[9] In addition, one study found that Black, Latinx, and Indigenous people across treatment settings and types were less likely than White people to complete treatment, with these disparities also observed in posttreatment outcomes.[10] A recent study found Latinx clients receiving outpatient SUD treatment to be at greater risk than their White counterparts to be arrested for driving under the influence (DUI) in the year after treatment. Characteristics of clients' residential community were found to be important, with clients living in communities with a higher proportion of Black residents significantly more likely to have a DUI arrest in the year after beginning treatment.[10]

CAUSES OF RACIAL DISPARITIES IN SUD

The importance of systemic racism in driving health outcomes has been increasingly studied in recent years. The best evidence to date suggests that systemic racism operates at institutional, social, and psychological levels in ways that shape numerous health outcomes. Funded research in SUD has largely focused on neurobiological etiologies and interventions, and thus the broader social forces that shape SUD-related racial disparities remain understudied. However, accumulated work in race and SUD have shed light on ways in which systemic racism may contribute to SUD racial disparities. Based on current work, factors that underpin SUD-related racial disparities in the United States include (1) deeply-rooted institutional racial biases that structure the experience of all Americans; (2) the effect of racism-related stressors on the biopsychosocial functioning of non-White people; and (3) the conscious and unconscious biases that shape behaviors directed at people of color, including among health care practitioners. It is important to recognize that systemic racism operates differently and has diverse effects on producing health disparities in different racial groups. In addition, the health effects of systemic racism in many groups, particularly in Indigenous, Asian, and Latinx populations, remain markedly understudied. Finally, systemic racism does not operate in isolation to produce disparities in health outcomes; rather, racism acts in concert with other forms of systemic discrimination such as sexism, homophobia and transphobia, and anti-immigrant bias.[11] Efforts to understand how these forms of discrimination operate together are often referred to as intersectionality.

Historical and Legal Roots of Racial Disparities in SUD

Current racial disparities in SUD outcomes find their antecedents in the overtly racist framework of early US drug policy.[12] The Harrison Act of 1914[13] began as a registration requirement for anyone who produced, manufactured, compounded, dispensed, sold, or distributed opium or coca products or derivatives. After its passage, this became legally interpreted to mean that opioids could not be prescribed to treat opioid addiction, as addiction was not considered a "disease" and thus not within the purview of physicians. The background and context of the law included government publications linking cocaine use with African Americans, and opioid use with Chinese Americans.[14] Media stories claimed that White women who used these substances were running off with men of different races. In an example published by *The New York Times* in 1914,[15] an article described how Black men become murderous, and better marksmen, under the influence of cocaine. Between 1898 and 1914, numerous articles[16-18] were published exaggerating the association between crime and cocaine use among Black men. Similarly, images of threat by Chinese immigrant opium dens proliferated. Soon after the passage of the Harrison Act, physicians became reluctant to treat addictions, and patients were forced to undergo abrupt withdrawal from narcotics.[19] Many people with SUD began as a consequence illicitly obtaining substances.[20,21] The Harrison Act set a precedent for future laws linking substance use, race, and fears of violent crime, including the 1934 Marijuana Tax Act that associated cannabis use with "Mexican reefer madness."[22]

"The War on Drugs," coined by President Richard Nixon in 1971 and expanded by President Ronald Reagan in the 1980s, was the national response to the opioid and crack epidemic that was devastating Black communities.[23] During this period, the size and presence of the federal drug control agencies increased and used measures such as mandatory sentencing and no-knock warrants.[23] As a result, and with the implementation of the Violent Crime Control and Law Enforcement Act of 1994 during President Bill Clinton's Administration, nonviolent drug offenses increased the incarcerated US population from 50,000 to 400,000 by 1997.[24] New policies intended to address drug use were developed using a racialized framework, and Black people were criminalized at much higher rates than White people. The effects of these policies are evident today

with Black people representing 12% of the US adult population in 2017 and making up roughly 30% of the incarcerated population.[23]

Structural Factors

Structural racism refers to how the collective practices of multiple interlocking institutions within a society have discriminatory effects based on race. These institutional systems include housing, education, health care systems, banks, and media representation.[11] Whereas in the past, many of these systems discriminated based on separating races in the language of the law—such as during the institution of slavery and Jim Crow law eras of US history—systemic discrimination is now more commonly seen in institutions that act in a *de facto* racially discriminatory manner.[25] An important example with respect to SUD and racial disparities is the criminal justice system, which in recent decades dramatically expanded its rate of incarceration, largely due to an increase in criminal justice responses to substance misuse, disproportionately affecting Black and Latinx people, exemplified by the "War on Drugs" described above.[26] This "war" has selectively targeted Black neighborhoods and imposed significantly harsher penalties for identical drugs in forms more commonly used by Black people rather than White people.[27] In addition to its destructive effects on the lives of incarcerated people and the major disruptions placed on families, the "War on Drugs" increased the stigma associated with seeking substance use treatment in communities of color, and particularly increased the fear of coming forward with substance use problems due to the threat of harsh criminal justice penalties.

Racism and Stress

Psychological stress has long been seen as an important precipitant in the development of SUD. In the case of people of color, increased levels of stress may be caused by both daily interpersonal slights and microaggressions associated with racial identity, as well as by the stress associated with the greater likelihood of experiencing other forms of structural racial disadvantage, such as living in resource-poor neighborhoods or having less access to education, unemployment, or financial institutions. Several studies have found that discrimination is associated with greater likelihood of substance use.[28,29] Some research has suggested substance use may represent a form of attempting to reduce the psychological distress associated with chronic racial discrimination, whereas more recent work has suggested that chronic stress associated with racial discrimination may create neurobiological vulnerabilities to SUD.[30] Other scholars have suggested that the role of historical and current trauma, rooted in the aftermath of such experiences as the European colonization of Indigenous people and the periods of the institution of slavery and Jim Crow laws for African Americans, are important drivers of substance use disparities in the US.[31]

Biases within Substance Use Treatment Systems

There is a substantial body of work that has found that racial biases shape behavior, leading to barriers in housing, employment, and access to financial resources for Black, Latinx, and other people of color.[32] Implicit bias refers to unconscious mental processes that lead to unrecognized negative feelings and judgments toward specific people based on their group affiliation or identity, including racial identity.[33] Included in this work is research showing that clinician bias shapes their health care decision-making.[33] For example, there has been a long history, corroborated by recent empirical evidence, that physicians are more likely to underrate the pain experiences of Black patients, including holding the conscious belief that Black people are less sensitive to pain.[34] Clinician bias may help explain why people of color in medication-assisted treatment for opioid use disorder (MOUD) are less likely to be prescribed buprenorphine and more likely to be prescribed methadone, which is often subject to significant regulatory burden including daily pick-ups, in contrast to White people, who are more likely to be prescribed buprenorphine.[35]

RECOMMENDATIONS

Best practices in the treatment of SUD are clearly defined and should be distributed equally among racial groups. Crucial to the treatment of SUD in Black, Latinx, and Indigenous communities is addressing decades of violence, poverty, stigmatization, widespread incarceration, and generational substance use.[23] A culturally sensitive approach to treatment includes collaborations between health care systems and community leaders to identify and address social determinants of health. Understanding a community's relationship to places of worship, housing circumstances, places of employment, and cultural centers can help identify public policy needs and facilitate access to evidence-based approaches to treatment.[36] Economic stability and neighborhood safety can affect the overall health of residents in the community and contribute to persistent SUD. Treatment plans that involve case management services can help address some of the psychosocial needs of people with SUD by increasing social services access. Equally important is identifying services already present and trusted within communities to distribute accurate information, reduce stigma associated with seeking treatment, and linking to evidence-based programs.[37] Community members reluctant to engage with medical systems—sometimes due to fear of reprisal or mistrust of health care systems—may be more likely

to engage with indigenous leaders or peer recovery networks. These agencies are vital for spreading treatment information and increasing access to harm reduction initiatives such as naloxone, sterile syringes, and sexually transmitted infection prevention.

Novel, multicomponent treatment approaches to SUD within hospital systems are also opportunities to address social determinants of health. Hospital systems within low income and ethnically diverse communities have become necessary hubs for implementing low-barrier access to broad substance use treatment. Furthermore, hospitals can prevent morbidity and mortality and connect patients with psychosocial and behavioral services by integrating addiction treatment within primary care, case management, infectious diseases treatment, and gynecological and behavioral health services.

To further reduce gaps in addiction treatment services, medical education would need to broaden to include training in unconscious bias and stereotyping, person-centered care approaches that have enhanced social/structural determinants of health components, and training in cultural humility, a stance of self-critique and openness to cultural perspectives beyond one's own.[38] Medical training institutions can use such curricula to better train clinicians in delivering addiction treatment to socioeconomically and racially diverse populations. This can be further enhanced by partnering educational curricula with community groups. From a legal standpoint, federal drug policy should deemphasize criminalization of drug use and expand access to evidence-based treatments—medical and psychosocial—for SUD.

CONCLUSIONS

Addiction policy and treatment has historically been tied to discrimination and criminalization efforts. Recent events calling attention to systemic racism, occurring against the backdrop of the opioid epidemic, represent an opportunity to promote policy-based, evidence-based treatments and at the same time remedying the long-standing, multigenerational consequences of punitive and discriminatory systemic factors. Many approaches are discussed here, including collaborating with and working within communities, increasing access to harm-reduction strategies and MOUD, providing multicomponent care in hospitals, increasing the diversity of clinicians, and providing antiracist training for clinicians now and for those who will train in the future.

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