SUD Treatment & the Black Community: Reckoning with the Past to Improve Present and Future

Daryl Shorter, MD
Associate Professor of Psychiatry
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Objectives

- Describe the history of the racialization of substance use in the United States and its relationship to the development of 19th and early 20th century drug laws.

- Summarize the impact of the War on Drugs upon communities of color in regard to disparities in incarceration, sentencing, and drug-related health outcomes.

- Identify specific health disparities impacting Black/African Americans in the treatment of SUD
“[Health] disparities are particularly stark in the field of substance use and substance use disorders, where entrenched punitive approaches have exacerbated stigma and made it hard to implement appropriate medical care. Abundant data show that Black people and other communities of color have been disproportionately harmed by decades of addressing drug use as a crime rather than as a matter of public health.”

Dr. Nora Volkow
Director, National Institute on Drug Abuse (NIDA)
Health (In)Equity & Substance Use

- Inequitable enforcement
  - Racialization of substance use (disorders)
  - War on Drugs
  - Disparities in incarceration, sentencing

- Ineffective punishment
  - Punishment does not reduce substance use / disorder

- Inequitable access to treatment
  - Criminalization of SUD → Diversion to carceral system rather than treatment
  - SUD treatment complicated by payor source, lack of cultural humility

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"Addiction should be treated, not penalized." Neuropsychopharmacology, 2021; 46: 2048-50.

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Racialization of Substance Use

- 1875: First US anti-drug law passed
  - Smoking opium in dens banned (San Francisco, CA)
  - Based upon fears about Chinese Americans

- 1906: Pure Food & Drug Act
  - Required identification of narcotics in products ("truth in labeling")
  - Laid groundwork for creation of Food and Drug Administration (FDA)

- 1900s: Increasing concern about cocaine use among Southern Blacks
  - Coca-Cola removes cocaine from formula & replaces with caffeine

- 1914: Harrison Tax Act
  - Criminalized non-medical use of narcotics (revenue generating, not police power)
  - MDs no longer able to prescribe narcotics for addiction treatment/maintenance of "dope fiends"
By 1914, 46 states had regulations on cocaine and 29 states had laws prohibiting opium, morphine & heroin.

Racialization of Substance Use → War on Drug (Users)

**Comprehensive Drug Abuse Prevention & Control Act**
- Controlled Substances Act: Regulates manufacture, importation, possession, use & distribution of certain substances
- Creates the “Schedules”

**Ford Presidency**
- Little governmental attention paid to drugs
- White Paper on Drug Abuse (1975) - classifies cannabis as “low priority”

**18 June 1971**

- Nixon declares “War on drugs”
  - 1974: Nixon resigns
  - 1973: Drug Enforcement Administration (DEA) established (replacing Bureau of Narcotics & Dangerous Drugs; Rockefeller Drug Laws)
  - 1972: Methadone receives FDA approval for treatment of OUD (Schedule II)

**1970**

**1974–1977**

**1977–1981**

**Carter Presidency**
- Campaigns on platform incl cannabis decriminalization (11 states decrim)
- ↑ Cocaine trafficking, media glamorization
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War on Drug (Users)

1981

Reagan elected, reprioritizes War on Drugs
- 1984: Nancy Reagan begins “Just Say No” campaign; Sentencing Reform Act abolishes federal parole
- 1985: Crack cocaine gains national attention

1986

Anti-Drug Abuse Act of 1986
- $1.7B: $671M – States; $241M (14%) – Treatment; $200M (12%) – Education; $97M – Prisons
- Mandatory Minimums: 5 gm of crack cocaine, but 500 gm of powder cocaine = automatic 5-year sentence. (80% of crack users were Black)

1988

Anti-Drug Abuse Act of 1988
- Additional $2.8B: ↑ federal anti-drug efforts; creates Office of National Drug Control Policy
- Death Penalty provision for murder committed during drug-related felonies (a step beyond mandatory life sentence)

Greatest domestic threat facing our nation...

- ↑ Spending
  - 4y total = $45B
- ↑ Enforcement
  - Military-grade equipment for anti-drug operations by local/state police

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War on Drug (Users)

1993: North American Free Trade Agreement (NAFTA)
- ↑ crossing borders (from 2.8M trucks (1994) to 4.3M (2001))
- ➔ 90% of cocaine from Colombia transported by truck (2003)

1996: Army General Barry McCaffrey named Director of ONDCP
1994: Violent Crime Control & Law Enforcement Act (AKA The Crime Bill) passed - ↑ prisons, police

Further militarization of Drug War under Clinton

1999: Plan Colombia
- ↑ Funding & training of Colombian military to eradicate coca cultivation & guerilla forces ($1.3B aid package – 4/5 for military)
Over next ~15 years, over $10B sent to Colombia. Estimated 220,000 people killed (~1965-2015), 7M displaced, 11K maimed by land mines (2nd only to Afghanistan)

Between 1980 and 1997, number of people incarcerated for non-violent, drug related crime rose from 50K ➔ 400K

War on Drug (Users) Ending?

2001-09: GW Bush Presidency
- 2004: Clean, Learn, Educate, Abolish, Neutralize, and Undermine Production of Methamphetamine (CLEAN-UP) Act passed
- 2003: Reducing Americans’ Vulnerability to Ecstasy (RAVE) Act proposed; follow-up bill, Illicit Drug Anti-Proliferation Act passed
- ↑ Drug use (e.g., young people w/past month use up from 11% (1991) ➔ 19% (2001)

Global Commission on Drug Policy issues report citing failure of “War on Drugs”
2011: “The global drug war has failed.”

2010: Fair Sentencing Act (FSA) ↓ discrepancy b/t crack and powder cocaine from 100:1 to 18:1
2009: “40 states begin to lower penalties, shorten mandatory minimums; “War on Drugs” term not used by Obama admin

Drug laws soften
Objectives

- Describe the history of the racialization of substance use in the United States and its relationship to the development of 19th and early 20th century drug laws.

- Summarize the impact of the War on Drugs upon communities of color in regard to disparities in incarceration, sentencing, and drug-related health outcomes.

- Identify specific health disparities impacting Black/African Americans in the treatment of SUD.

Was the War on Drugs a Failure?

- Did drug-related arrests decrease?

- Did number of persons in jails/prison decrease?

- Did rates of substance use decrease?

- Were health outcomes improved?

Impact of War on Drugs on Arrests

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Impact of War on Drugs on Arrests

Annual Number of Arrests for Cannabis Drug Offenses


Impact of War on Drugs on Arrests

Annual Number of Arrests for Heroin, Cocaine & Other Derivative Product Drug Offenses

Was the War on Drugs a Failure?

- Did drug-related arrests decrease? NO
- Did number of persons in jails & prison decrease?
- Did rates of substance use decrease?
- Were health outcomes improved?

After decades of sharp growth, incarceration in U.S. has waned

Incarceration rate per 100,000 adult residents

Source: Bureau of Justice Statistics.
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The Evolution Of America's Federal Prison Population

Federal inmates in custody on December 31 (excluding private prisons)

- Similar trend when looking at only federal prisons
- From 1980-2008, steady increase in number of inmates serving sentences of more than one year

Was the War on Drugs a Failure?

- Did drug-related arrests decrease?  NO
- Did number of persons in jails & prison decrease?
  - 1980 – 2008 = NO
  - 2008 – 2019 = YES (due to decline in violent & property crime)
- Did rates of substance use decrease?
- Were health outcomes improved?
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Past Month Use of Selected Illicit Drugs among Persons Age 12 or Older: 2002-10

Was the War on Drugs a Failure?

- Did drug-related arrests decrease?  NO
- Did number of persons in jails & prison decrease?
  - 1980 – 2008 = NO
  - 2008 – 2019 = YES (due to decline in violent & property crime)
- Did rates of substance use decrease? RELATIVELY FLAT
- Were health outcomes improved?
US Drug-Involved Overdose Deaths, 1999-2020

Hospitalization Rates for Excessive Alcohol Consumption, 1999-2008

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Was the War on Drugs a Failure?

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- Did number of persons in jails & prison decrease?
  - 1980 – 2008 = NO
  - 2008 – 2019 = YES (due to decline in violent & property crime)
- Did rates of substance use decrease? RELATIVELY FLAT
- Were health outcomes improved?
  - Overdose Mortality; Alcohol consumption hospitalization = NO

Inequitable Enforcement
Ineffective Punishment
Inequitable Access
Inequitable Enforcement

- Racialization of substance use (disorders) → War on Drugs characterized by legal prohibition, bans, harsh penalties
- Investment of federal drug monies largely devoted to "supply" rather than prevention & treatment
- Laws enacted negatively impact communities of color disproportionately → Mass Incarceration


- Cannabis use at similar rates b/w Black & White people, but Black people nearly 4x more likely to be arrested\(^1\)


- In 2013, 277,000 people imprisoned for drug offense\(^3\)
  - 56% Black or Latinx (despite representing less than 25% of pop)

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Inequitable Enforcement

- High prevalence of prescription opioid use but low arrest rates compared with low rates of heroin use but higher arrest rates\(^1\)

- Disparity between powder & crack cocaine sentencing persists
  - 5-yr mandatory minimum triggered by 500gm powder or 5 gm crack
  - Reduced from 100:1 to 18:1 (Fair Sentencing Act, 2010)
  - Current proposed legislation does not eliminate disparity, only reduces

- Drug arrests among Blacks >>> Whites

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US Rates of Adult Drug Arrests by Race, 1980 – 2007
(rates calculated per 100,000 residents of each race)

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Past-month illicit drug use
2013 National Survey on Drug Use and Health

WHITE 9.5%
BLACK 10.5%

Drug-related arrests per 100,000 residents of each race
2013 FBI Uniform Crime Reports / US Census Bureau

WHITE 332
BLACK 879

Inequitable Enforcement
Ineffective Punishment
Inequitable Access

Health (In)Equity & Substance Use

- Inequitable enforcement
  - War on Drugs -- Communities of color disproportionately harmed by decades of addressing drug use as a crime rather than public health
  - Disparities in incarceration, sentencing

- Ineffective punishment
  - Punishment does not reduce substance use / disorder

- Inequitable access to treatment
  - Criminalization of SUD → Diversion to carceral system rather than treatment
  - SUD treatment complicated by payor source, lack of cultural humility

Ineffective Punishment

- Assumption: Loss of freedom is a deterrent to drug-related behavior (use, possession, or sale)
  - States with stricter laws should have lower drug use and arrest rates
  - Fatalities (e.g., overdose deaths) should also be impacted by lower rates of drug use, stricter penalties
Drug Imprisonment Not Correlated with Drug Arrests

Drug Imprisonment Rates

Drug Arrest Rates

Note: All rates are per 100,000 residents


Drug Imprisonment Not Correlated with Drug Use

Drug Imprisonment Rates

Drug Use Rates

Note: All rates are per 100,000 residents

Drug Imprisonment Not Correlated with Drug Overdoses

Drug Imprisonment Rates

Drug Overdose Death Rates

Note: All rates are per 100,000 residents


Drug Imprisonment Rank

Drug Use Rank

New Jersey imprisons drug offenders at a much lower rate than Tennessee, but the states' drug use rates are roughly the same.

Ineffective Punishment

- Loss of freedom is not a consistent deterrent to drug-related behavior

- No relationship between state incarceration rates or several drug-related outcomes
  - Drug arrest rates
  - Drug use rates
  - Drug overdose rates

- No statistically significant correlation between drug imprisonment rates and the rate of drug use across most states

Incarceration & Overdose Mortality


- N=30,237 released inmates
- 443 died during ~2y f/u

- 3.5x more likely to die than other state residents

- 12.7x more likely to die during 1st two weeks after release (#1: overdose)

- Regardless of offense

Binswanger et al. NEJM, 2007
SUD Diagnosis & Treatment among Inmates

- More than half of state prisoners & two-thirds of sentenced jail inmates with SUD
  - Female (70%) > Male (60%)
  - Persons incarcerated for property offense more likely to have SUD c/w violent crime
  - State prisoners 12x more likely than adults in general population to have SUD

- Only 11% of inmates receive SUD care
  - Latinx inmates less likely to receive treatment


Health Disparities after Release

- Successful reentry & community integration is challenging
  - Federal prisoners have higher rates of schizophrenia, dysthymia, and Bipolar disorder → lack of outpatient MH f/u

- Inmates living in poverty prior to incarceration & exposed to lower quality services return to poverty (or worse)

- Inmates w/HIV treated while incarcerated return to prison following release with higher VL than reported at first release

- While ~70% of inmates with medical illness see HCW while incarcerated, may have limited access upon release

Schnittker, Massoglia, Uiggen, 2011.
Substance Use after Release

- Some studies suggest ↓ substance use post-incarceration
  - Postrelease employment & health insurance → ↓ rearrest, drug use

- Policy and service gaps re: employment, housing, healthcare, and SUD treatment ↓ successful reentry

- Generally, rates of illegal substance & medication use ↑ post-incarceration

Proportion of respondents in the year after prison release reporting use of: (1) hard drugs, (2) cannabis, (3) medications for mental health, (4) medications for pain

- Boston Reentry Study (2012-14)
- N = 111 respondents
- Four (4) interviews over 1st year
- Higher rates of illegal drug use, cannabis use after release
- “Hard” drug use almost exclusively in those w/SUD hx
- Higher rates of MH medication adherence among persons w/SUD hx

Western & Simes, 2019.
Ineffective Punishment

- Punishment/incarceration does not ↓ substance use rates

- Incarceration → ↑ Mortality
  - 13x more likely than gen pop to die (in first 2 weeks after release)
  - Overdose is leading cause (129% greater risk)

- Inmates are not receiving necessary treatment for SUD

- Punishment may have a negligible(?) effect on public safety
  - Crime rates have been trending downward since 1990
Health (In)Equity & Substance Use

- Inequitable enforcement
  - War on Drugs -- Communities of color disproportionately harmed by decades of addressing drug use as a crime rather than public health
  - Disparities in incarceration, sentencing

- Ineffective punishment
  - Punishment does not reduce substance use / disorder

- Inequitable access to treatment
  - Criminalization of SUD → Diversion to carceral system rather than treatment
  - Systemic barriers to SUD treatment

Inequitable Access to Treatment

- Black and Latinx people more likely to be imprisoned after drug arrests than to be diverted into treatment programs

- Study modeling a 2001 change in California sentencing policy for convicted non-violent drug offenders

  - Found substantial reductions in probability of a prison sentence but not for Blacks
  - Blacks remain more likely to go to prison than similarly situated Whites
  - More referrals to treatment for Blacks

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Inequitable Access to Treatment

- Uneven distribution of SUD care between Blacks & Whites
  - Blacks more likely to have delays entering care (4-5 yrs)
  - Greater progression of SUD, ↑ rates of overdose, poorer outcomes

- Inequitable even when accessing care
  - Black youth with OUD less likely to be prescribed medication treatment (42-49%)
  - Black patients with OUD 77% less likely to receive Buprenorphine

References:
1. Lewis B et al. J Ethn Subst Abus. 2018
2. Hadland et al. JAMA Pediatr. 2017
3. Hadland SE et al. JAMA Pediatr. 2018
4. Lagisetty et al. JAMA Psychiatry, 2019

Effects of Imprisonment

- Isolation, worsened mental health → increased drug misuse, recurrence

- Criminal record → reduces options (higher education, employment)

- Loss of custody of children, involvement of child welfare system

- 1/9 (11.4%) Black children and 1/28 (3.5%) of Latinx children have an incarcerated parent c/w 1 in 57 (1.8%) of White children

“Addiction should be treated, not penalized.” Neuropsychopharmacology, 2021; 46: 2048-50.
The ‘War on Drugs’ did not consistently result in reductions in drug-related arrests, number of persons incarcerated, rates of substance use disorder.

Health outcomes such as risk of overdose death are negatively impacted by incarceration.

Inequities in diversion from the carceral system to treatment programs disproportionately impact Black and Brown persons.
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Health disparities are systematic, plausibly avoidable health differences that adversely affect socially disadvantaged groups.

Socially disadvantaged groups include persons defined by race/ethnicity, skin color, religion, or nationality, socioeconomic resources, gender, sexual orientation, gender identity, age, geography, disability, illness, political or other affiliation, or other characteristics associated with discrimination or marginalization.
“A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

Diversity & Disparities

- Members of socially disadvantaged groups are either (a) more likely to develop a substance use disorder and/or (b) more likely to suffer negative consequences from substance use.

- Among those with SUDs, racial/ethnic minoritized populations, women, LGBTQ+ folx, and persons living with disabilities generally have worse health & social outcomes.

Diversity & Disparities

- Health disparities do not refer to all health differences.

- Specific subset of health differences relevant to social justice.

- Arise from intentional or unintentional discrimination or marginalization.
Women have longer life expectancy

Men (as a group) have more wealth, influence, prestige

Gender-based difference in life expectancy for men is not a social injustice, therefore not a health disparity or equity issue

Diversity & Disparities

Disparities in health and its determinants are the metric for assessing health equity which focuses on reducing disparities.

Health equity is social justice in health
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Psychosocial factors relevant to adolescent substance use based on Bronfenbrenner’s Bioecological Model. (adapted from Trucco, 2020)

Alcohol Initiates among African Americans

No differences between prior year estimates and the 2018 estimates are statistically significant at the .05 level.
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Alcohol Initiates among Latinx

PAST YEAR, 2015-2018 NSDUH, Hispanic 12+

Overall US population 12-17 9.6%

Alcohol Initiates among Asian/NHOPI

PAST YEAR, 2015-2018 NSDUH, Asian/NHOPI 12+

Overall US population 12-17 9.6%

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Alcohol Initiates among AI/AN

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17</td>
<td>11K</td>
<td>7.4%</td>
<td>13K</td>
<td>8.0%</td>
</tr>
<tr>
<td>18-25</td>
<td>5K</td>
<td>5.5%</td>
<td>6K</td>
<td>2.9%</td>
</tr>
<tr>
<td>26 or Older</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Overall US population 12-17: 9.6%

- Lower
- Equivalent
- Lower*
- Lower

*No differences between prior year estimates and the 2018 estimates are statistically significant at the .05 level.
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Alcohol Use among African Americans

Overall US population 18-25 55.1%

Overall US population 26+ 55.3%

Overall US population 12-17 9.0%
Alcohol Use Disorder among African Americans

Overall US population 12-17: 1.6%
Overall US population 18-25: 10.1%
Overall US population 26+: 5.1%

Drug Use among African Americans

Marijuana: 17.8% (5.9M)
Psychotherapeutic Drugs: 4.6% (1.5M)
Cocaine: 1.8% (577K)
Hallucinogens: 1.4% (474K)
Inhalants: 0.5% (175K)
Heroin: 0.4% (135K)
Methamphetamines: 0.2% (64K)

Overall US population 12+: 6.2%
Overall US population 12+: 15.9%
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Alcohol Use among Latinx

Overall US population 18-25 55.1%
Overall US population 26+ 55.3%
Overall US population 12-17 9.0%

Alcohol Use Disorder among Hispanics

Overall US population 18-25 10.1%
Overall US population 26+ 5.1%
Overall US population 12-17 1.6%
Drug Use among Latinx

Marijuana: 13.6% (6.3M) Overall US population 12+
Psychotherapeutic Drugs: 5.9% (2.7M)
Cocaine: 1.9% (891K)
Hallucinogens: 1.8% (847K)
Methamphetamines: 0.7% (319M)
Inhalants: 0.7% (317K)
Heroin: 0.2% (107K)

Alcohol Use among Asian/NHOPI

Overall US population 12-17: 55.1%
Overall US population 18-25: 43.9%
Overall US population 26+ 42.3%

No differences between prior year estimates and the 2018 estimates are statistically significant at the .05 level.
Alcohol Use Disorder among Asian/NHOPI

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-17</td>
<td>23K</td>
<td>15K</td>
<td>12K</td>
<td>17K</td>
</tr>
<tr>
<td>18-25</td>
<td>6.8%</td>
<td>6.6%</td>
<td>5.6%</td>
<td>6.6%</td>
</tr>
<tr>
<td>26 or Older</td>
<td>2.6%</td>
<td>2.6%</td>
<td>2.6%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Overall US population 18-25: 10.1%

*Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

Drug Use among Asian/NHOPI

<table>
<thead>
<tr>
<th>Substance</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>332K</td>
<td>334K</td>
<td>331K</td>
<td>418K</td>
</tr>
<tr>
<td>Other Psychotherapeutic Drugs</td>
<td>557K</td>
<td>557K</td>
<td>557K</td>
<td>557K</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>283K</td>
<td>283K</td>
<td>283K</td>
<td>283K</td>
</tr>
<tr>
<td>Cocaine</td>
<td>243K</td>
<td>243K</td>
<td>243K</td>
<td>243K</td>
</tr>
<tr>
<td>Inhalants</td>
<td>105K</td>
<td>105K</td>
<td>105K</td>
<td>105K</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>46K</td>
<td>46K</td>
<td>46K</td>
<td>46K</td>
</tr>
<tr>
<td>Heroin</td>
<td>&lt;7K</td>
<td>&lt;7K</td>
<td>&lt;7K</td>
<td>&lt;7K</td>
</tr>
</tbody>
</table>

Overall US population 12+: 6.2%

Overall increase from 2017: 7.2%
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Alcohol Use among AI/AN

PAST MONTH, 2015-2018 NSDUH, AI/AN 12+

Overall US population 18-25: 55.1%
Overall US population 26+: 55.3%
Overall US population 12-17: 9.0%

Alcohol Use Disorder among AI/AN

PAST YEAR, 2015-2018 NSDUH, AI/AN 12+

Overall US population 18-25: 10.1%
Overall US population 26+: 5.1%
Illicit Drug Use among AI/AN

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Overall US population 12+</th>
<th>Black/African Americans</th>
<th>Latinx</th>
<th>Asian/Native Hawaiian and Other Pacific Islander</th>
<th>American Indian/Alaskan Native</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>23.6% 384K</td>
<td>Lower</td>
<td>Equivalent</td>
<td>Lower – Cannabis; Lower – Psychotherapeutics</td>
<td>Higher – Cannabis; Higher – Psychotherapeutics</td>
</tr>
<tr>
<td>Psychotherapeutic Drugs</td>
<td>7.4% 127K</td>
<td>Lower</td>
<td>Equivalent</td>
<td>Lower – Cannabis; Lower – Psychotherapeutics</td>
<td>Higher – Cannabis; Higher – Psychotherapeutics</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>2.4% 39K</td>
<td>Lower</td>
<td>Lower</td>
<td>Lower – Cannabis; Lower – Psychotherapeutics</td>
<td>Higher – Cannabis; Higher – Psychotherapeutics</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.9% 31K</td>
<td>Equivalent</td>
<td>Equivalent</td>
<td>Lower – Cannabis; Lower – Psychotherapeutics</td>
<td>Higher – Cannabis; Higher – Psychotherapeutics</td>
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<td>Equivalent</td>
<td>Equivalent</td>
<td>Lower – Cannabis; Lower – Psychotherapeutics</td>
<td>Higher – Cannabis; Higher – Psychotherapeutics</td>
</tr>
<tr>
<td>Inhalants</td>
<td>1.2% 20K</td>
<td>Equivalent</td>
<td>Equivalent</td>
<td>Lower – Cannabis; Lower – Psychotherapeutics</td>
<td>Higher – Cannabis; Higher – Psychotherapeutics</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.3% 5K</td>
<td>Equivalent</td>
<td>Equivalent</td>
<td>Lower – Cannabis; Lower – Psychotherapeutics</td>
<td>Higher – Cannabis; Higher – Psychotherapeutics</td>
</tr>
</tbody>
</table>
Racial/Ethnic Minoritized Populations with SUD have Worse Health Outcomes

- Black & Latinx ↑ alcohol related illness and neg MH symptoms
- ↑ rates of cocaine-related overdose deaths among Black & Latinx populations

- Black people c/w other racial/ethnic groups >>> alcohol-related liver disease, substance-related disability & premature death
- More likely to suffer negative drug-related consequences incl ↑ rates of Hep C & HIV

- Latinx people with higher DUI fatalities

- Higher rates of involvement in the carceral system

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Between 2018 and 2020, drug overdose death rates increased across all racial and ethnic groups, but increases were largest for Black and American Indian and Alaskan Native people

Drug Overdose Deaths Per 100,000, by Race/Ethnicity

- White: 19.1 (Jan-Sep 2018), 19.0 (Jan-Sep 2019), 23.6 (Jan-Sep 2020)
- Black: 16.7 (Jan-Sep 2018), 18.0 (Jan-Sep 2019), 18.6 (Jan-Sep 2020)
- Hispanic: 8.0 (Jan-Sep 2018), 9.1 (Jan-Sep 2019), 12.8 (Jan-Sep 2020)
- Asian: 2.5 (Jan-Sep 2018), 2.6 (Jan-Sep 2019), 3.7 (Jan-Sep 2020)
- AI/AN: 18.8 (Jan-Sep 2018), 22.3 (Jan-Sep 2019), 29.8 (Jan-Sep 2020)
- NHOP: 10.4 (Jan-Sep 2018), 7.5 (Jan-Sep 2019), 11.2 (Jan-Sep 2020)

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KFF August 12, 2021
• White people continue to account for the largest share of deaths due to drug overdose, but people of color represent a growing share of drug overdose deaths over time.

• Between 2016 and 2020, the share of drug overdose deaths among White people fell from 78% to 69%, while the share of deaths among Black and Latinx people rose (from 11% to 17% and 8% to 12%, respectively).

• As a result, Black people now account for a disproportionate share of drug overdose deaths relative to US population.

Racial/Ethnic Disparities in SUD Diagnosis

• Racial/ethnic minoritized adolescents initiate alcohol use at or below US rates

• Black, Latinx & Asian/NHOPI communities have AUD rates at or below US rates

• Negative consequences for Black & Latinx communities are disproportionate

• AI/AN communities are particularly vulnerable, with higher rates of AUD (adults) and drug (cannabis) use

• Drug overdose rates among all groups, but greater acceleration of rate among people of color
Objectives

- Describe sociocultural factors which contribute to psychological stress among diverse groups and increase susceptibility to SUD development

- Recognize barriers to care in the practice of SUD treatment and develop strategies to promote equity and inclusivity in addiction clinical settings
Engagement in the Black Community: A Focus on Trauma

Social Determinants of Mental Health

- **Structural**
  - Racism
  - Sex Discrimination
  - White Supremacy
  - Jim Crow Laws, Slavery

- **Systemic**
  - Biases (Explicit & Implicit)
  - Education about Healthcare
  - Lower SES
  - Lower Income, Food Insufficiency

- **Neighborhood**
  - Housing Instability, Transportation, Toxic Exposures, Safety, Violence

- **Interpersonal**
  - Adversity in Childhood
  - Negative Life Events
  - Lack of Social/Emotional Support
  - Living Alone
  - Mistrust of Systems & Providers
  - Experiences with Manifested Racism

Allelic variations that confer genetic Risk for SUD or for Neuropsychiatric Disorders

Substance Use Disorder (SUD)
- Greater Rate of OUD/SUD and Overdose
- Disparities in Neuropsychiatric Health Care
- Decreased Quality of Life

Gene and Environment interactions

Intersectionality & Multidenity

- Women underutilize SUD treatment services
  - More fearful of being identified/labeled as having SUD
  - Lower problem recognition, perceived need for treatment
  - Logistical barriers (not having insurance, childcare, time, or knowing where to go for help)
  - Less social pressure to seek treatment (especially family)
  - Less likely to report work or legal consequences which create motivation

Pinedo et al., 2020
Intersectionality & Multidientity

- Queer people of color (POCs)
- Ostracism from racial/ethnic group
- Racism within queer community
- Feeling of not belonging anywhere
- Creation of conflict of loyalty

LGBTQ Mental Health: Risk Factors

- Lack of institutionalized protections
- Biased-based bullying ➔ effects of victimization
- Family rejection
LGBTQ Mental Health: Protective Factors (1)

- Family acceptance
  - Greater self-esteem, social support, general health status
  - Protects against depression, SUD, SI/behaviors

- Romantic relationships among youth
  - ↓ Impact of expected rejection

LGBTQ Mental Health: Protective Factors (2)

- Community Characteristics
  - More protections for LGBT couples
  - ↑ Registered Democrats
  - Presence of Gay-Straight Alliances (GSAs) in schools
  - Specific nondiscrimination policies

↓ suicide attempts among LGBT youth

Hatzenbuehler, 2011
### Barriers to Care – Race/Ethnicity

| Cultural factors (family involvement, stigma/taboo, loss of “face”) |
| Perceptions re: need for treatment ("I can handle it"), efficacy of care |
| Recovery goals inconsistent with total abstinence |
| Language barriers; geographical barriers (AI/AN) |
| Immigration/acculturation; questions re: Western approaches to healing |
| Concerns re: loss of family (Black/AA); fear of arrest |

Pinedo et al., 2018; Ja & Aoki, 2012; Keen et al., 2014; Legha et al., 2014
Small Group Activity: Solutions

We have just discussed numerous barriers to Black people seeking and receiving SUD care. Pick one of the following barriers that you/your organization have encountered and brainstorm how you might go about overcoming this barrier.

- Who do you need to engage?
- What resources will you need?
- Where and how will these resources be delivered?
- Over what time can these changes be implemented?

Challenges to address:

- Limited numbers of Black women presenting to your organization for treatment
- Black men presenting for an initial appointment but not coming back for second, follow-up appointment
- Continued use of methamphetamine by Black gay men and transgender women
- Black patients report limited support from their families when seeking treatment
- Decreased prescribing of medications (Buprenorphine) for Black patients with opioid use disorder
Promoting Organizational Change

- Top down as well as bottom-up approach required
  - Diversity among leadership, training/expertise

- Staff diversity → client/patient diversity
  - Recruitment & retention are key
  - Pipeline, workforce development

- Organizational readiness for change ≠ cultural competence
  - Knowledge of minoritized, vulnerable communities assoc w positive climate of inclusion

Inclusivity in SUD Care

- Creating an inclusive environment begins in the parking lot, continues in the waiting room, and lives within the hallways and treatment rooms of the healthcare setting.

- Our conversation with patients, families, and communities must prioritize the use of language that does not add to stigma or harm.

Inclusivity in SUD Care

- If a microaggression occurs, it is important to combat our natural inclination to diffuse uncomfortable situations. After allowing for self-reflection, approach with curiosity & share your experience of things with “I” statements.

- Continue to push organizations to promote diversity in staff with a focus on recruitment and retention. Safety should include not only our patients, but clinicians and staff, too.
Inclusivity in SUD Care

- Clinicians play an important role in creation of safe and affirming health care environments

- When thinking about interventions, consider how best to ensure that treatment can be equitably administered, reducing barriers to acquisition and treatment.

Conclusions

- Stigma and discrimination against Black people substantially heightens vulnerability to medical and mental health conditions through a variety of psychological and social means

- Protective factors for LGBTQ+ people such as nondiscrimination policies, family acceptance, and access to one or more supportive adults can reduce negative esteem and significantly improve psychological outcomes
Conclusions

- Support for pregnant and parenting Black women/persons can also include services for children and may increase treatment engagement and retention.
- Use of pharmacotherapy to treat SUD is a critical component of our overall strategy in managing these conditions and should not wait. Promoting use of medications is an important part of work with Black communities.

Where do we go from here?

- Approach SUD as public health issue rather than crime
- Advocate/vote locally for drug courts & diversion programs
- Push for policies decriminalizing drug possession through your professional organizations
Engagement in the Black Community: A Focus on Trauma

Presented by Daryl Shorter