



**ASAM** American Society of  
Addiction Medicine

## Public Policy Statement on Advancing Racial Justice in Health Care through Addiction Medicine

### Purpose

This is the second in a three-part series of public policies on racial justice through which ASAM summarizes the evidence that systemic racism is a major social determinant of health<sup>1</sup> with profound, deleterious effects on the lives and health of Black, American Indian/Alaska Native, Hispanic/Latinx, Asian, Pacific Islander, and other racially and ethnically minoritized\* and disenfranchised people (hereinafter collectively referred to as Black, Indigenous, People of Color (BIPOC)).<sup>2,3</sup> This series of policy statements is part of ASAM's effort to recognize, understand, and then counteract the adverse effects of America's pervasive, historical, yet continuing, systemic racism, specifically with respect to full-spectrum addiction care, including prevention, early intervention, harm reduction, diagnosis, treatment, and recovery.

The series' first policy statement<sup>4</sup> focuses on actions that addiction medicine professionals should take to tackle systemic causes of health disparities. It recognizes that many choices made by healthcare professionals, while not always the result of conscious or intentional racism, may nonetheless reflect biases that operate in the context of longstanding systems and policies that marginalize and exclude BIPOC.<sup>5</sup> The corrective response must consist of conscious efforts to overcome these biases and unjust systems.

This second policy statement focuses on actions that healthcare professionals, healthcare systems, institutions, and organizations, professional medical entities, researchers, and health professional educators can take to help advance addiction medicine and its role in addressing health disparities for BIPOC. It highlights the longstanding role of the criminal legal system and child welfare in inappropriately assuming responsibility for, or otherwise interfering upon, clinical decisions for people with substance use disorders (SUD), with the most adverse consequences disproportionately affecting BIPOC. Finally, it highlights the need for clinicians and patients to take responsibility for shared decision making with respect to full-spectrum addiction care.

By illustrating how punitive responses have failed BIPOC who use substances, ASAM intends to demonstrate the urgent need for policy reforms that prioritize full-spectrum addiction care over punishment, reduction of stigma against all people who use substances, and enhancement of the health and well-being of all people who have the disease of addiction.

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\* Scholars have advocated for use of the term "minoritized," which is used to refer to the same shared experience of exposure to systemic and individual racism in health and beyond and provides an understanding that people are actively minoritized by others, rather than naturally existing as a minority, as the terms racial or ethnic minorities imply.

## Background

As detailed below, BIPOC with SUD often do not receive evidence-based addiction care and are more likely than White people to be treated punitively by the criminal legal and child welfare systems as a result of substance use.<sup>6</sup> To rectify this situation, groundbreaking change will be required within the criminal legal and child welfare systems, in addition to major reforms within healthcare systems, institutions, and organizations, professional medical entities, health professional education, and medical research and practices.

### *Substandard care for BIPOC who use substances*

There is ample evidence of systemic racism within the U.S. healthcare system. In 2002, the Institute of Medicine concluded that “*racial and ethnic minorities receive lower-quality health care than white people—even when insurance status, income, age, and severity of conditions are comparable.*”<sup>7</sup> Health care still has far to go to address these inequities. For example, a study published in 2022 found that Black patients were 2.5 times as likely as White patients to have a negative descriptor (such as ‘resistant’ or ‘noncompliant’) included in their health record.<sup>8</sup>

The situation for BIPOC is equally bleak in addiction medicine, where BIPOC are less likely than White people to receive the standard of care in a range of areas. Examples include:

- Black patients are less likely to receive medication for alcohol use disorder.<sup>9</sup>
- BIPOC are less likely to be offered the standard of care—particularly buprenorphine—to treat opioid use disorder (OUD).<sup>10-14</sup>
- BIPOC are less likely to complete addiction treatment at least partly due to inequities in social determinants of health (SDoH) caused by structural racism, specifically, financial and housing instability.<sup>15</sup>
- BIPOC face more barriers than White individuals do in accessing harm reduction services.<sup>16-19</sup>

Changes in the current situation—including the adoption of an explicitly antiracist<sup>20</sup> approach, and the development of more equitable institutions and social conditions—are needed to address these and other problems faced by BIPOC who use substances.<sup>21</sup>

### *Use of punitive systems against BIPOC who use substances*

Overall, the United States’ use of punitive systems to address illicit substance use and SUD has been ineffective in addressing the nation’s overdose crisis, and larger policy changes—including an examination of appropriate penalties for personal drug use possession—are needed to reverse this approach. The impact of this failed approach has been felt most acutely by BIPOC.

A historically racialized, punitive approach to substance use in the United States has been weaponized against BIPOC, including the use of opium laws against Asian people, cannabis policy against Latinx people, and disparate cocaine sentencing laws against Black people.<sup>4</sup> In addition, methadone treatment for OUD was authorized during a time of racialized “anti-crime politics,” which resulted in a highly-regulated, closed clinic system that emphasized regulatory compliance more than treatment access.<sup>22,23</sup> Highly-detailed federal regulations that surround this specific medical practice have oriented it away from primary care<sup>24</sup> to the detriment of individualized patient care, and have contributed to racial health disparities among people with OUD.<sup>25,26</sup> Indeed, today’s racially-patterned access to methadone and buprenorphine for OUD denies Black and Hispanic/Latinx communities equitable access to

buprenorphine, which is a more flexible form of care.<sup>27</sup> Finally, perhaps one of the most compelling data points is that although Black and White Americans sell and use drugs at similar rates, Black people in the United States are 2.7 times as likely to be arrested for drug-related offenses and 6.5 times as likely as White people to be incarcerated for drug-related crimes.<sup>28,29</sup>

In general, the criminal legal system has done a poor job providing evidence-based care to people with SUD.<sup>6</sup> Fewer than 5% of people referred by the criminal legal system to specialty treatment programs for the treatment of OUD received standard of care medication.<sup>30</sup> In addition, very few carceral facilities offer medications for OUD, especially methadone or buprenorphine; people already treated with these medications are often forced to stop this life-saving therapy, suffer withdrawal, and risk overdose and overdose death. Disturbingly, this is happening against a backdrop of research indicating that individuals who are incarcerated are 129 times more likely to die from overdose within the first two weeks after release when compared to the general U.S. population – particularly from opioids.<sup>31</sup> Given the disproportionate involvement with the criminal legal system, this low standard of care poses a particular risk for BIPOC.

Healthcare professionals have participated in providing substandard care within the criminal legal system by ceding control over the treatment plans to criminal legal system authorities who are not clinicians. For example, the criminal legal system has been shown to: exclude the use of methadone or buprenorphine as treatment for persons under community correctional control, or impose limits on their use;<sup>32</sup> mandate treatment from a limited pool of addiction treatment providers with whom the system contracts, regardless of the individualized needs or third-party insurance coverage of the incarcerated person;<sup>33</sup> and refuse to provide methadone or buprenorphine while a person is incarcerated.<sup>34</sup> Further, the National Drug Court Institute has found that *“representation of African-American and Hispanic individuals in jails and prisons was nearly twice that of both drug courts and probation, and was also substantially higher among all arrestees for drug-related offenses.”*<sup>35</sup>

Research has found, in addition, that clinicians are more likely to order drug tests for BIPOC,<sup>36,37</sup> and positive drug test results can lead to negative consequences unrelated to health for BIPOC if disclosed by healthcare professionals to entities outside of health care.

#### *Racial inequities in child protective services response to pregnant and parenting people*

Parental substance use is a frequent cause of referrals to child welfare, especially during pregnancy and during or following childbirth. More than one-third of out-of-home placements noted parental substance use as a contributing factor.<sup>38</sup> As currently structured, however, healthcare providers often employ a faulty, underlying assumption that substance use in itself is “reportable” even when the “substance” is opioid agonist treatment for OUD (methadone or buprenorphine).<sup>39</sup> Most reports to child welfare occur for infants in the first year of life and originate from healthcare professionals.<sup>40</sup> Methods of screening<sup>41</sup> have historically relied on urine drug testing,<sup>42</sup> and healthcare professionals often perceive reporting results as mandatory.<sup>43</sup> The practice of “test and report” has been decried as medically unethical and public health ineffective by the American College of Obstetricians and Gynecologists (ACOG), *“The laws, regulations, and policies that require health care practitioners and human service workers to respond to substance use and substance use disorder in a primarily punitive way, require health care providers to function as agents of law enforcement.”*<sup>44</sup> In addition, child welfare reporting undermines patient trust, can discourage a pregnant person from seeking care for OUD for fear of child welfare involvement, contributes to provider moral injury, and worsens racial inequities. There are marked racial

inequities in the child welfare response,<sup>45</sup> from drug testing, to child welfare reporting, to foster placement, and to the termination of parental rights.<sup>39,46</sup> Though Black children are 14% of the children in the United States, they represent 23% of children in foster care and are less likely to be reunified with their families.<sup>47</sup> Despite documented evidence that Black and White people have comparable rates of substance use, reports reveal that more Black than White infants have been reported to child welfare due to parental substance use.<sup>41</sup>

#### *Antiracism efforts needed elsewhere within health care*

Just as the criminal legal and child welfare systems have had disproportionately damaging effects on BIPOC, so have many of the structures built and operated by healthcare professionals and administrators. Reforms are needed within healthcare systems, health professional schools, clinical research, and healthcare practice to address and eliminate health inequities.

The effects of SDoH on patient outcomes—particular among BIPOC—have been well-documented.<sup>48</sup> Unfortunately, many clinicians and healthcare systems are unprepared to screen for SDoH among their patients and then take action based on the screening results due to inadequate resources.<sup>49</sup> In many cases, community-based organizations may be logical partners to work with healthcare institutions.<sup>50</sup>

Reforms are needed throughout the clinical research enterprise to eliminate disparities. The construct of race is often applied inappropriately in clinical research; existing standards outline how researchers and journals should address this problem.<sup>51</sup> Additionally, BIPOC are underrepresented in clinical trials, yielding interventions that may not be culturally appropriate.<sup>52</sup> Finally, other research has demonstrated that BIPOC researchers are less likely to receive National Institutes of Health funding than White researchers.<sup>53,54</sup>

Other scholarship has highlighted the inappropriate use of race in clinical algorithms put forward by clinical societies and healthcare systems used to make clinical care decisions. Not only may this unnecessarily inject issues of race in clinical care, but the inclusion of race in algorithms may direct additional resources to White patients and away from BIPOC. One recent review found examples of this occurring in clinical fields ranging from cardiology to nephrology to obstetrics.<sup>55</sup>

The first document in this series proposed that addiction medicine providers should use trauma-informed care to help BIPOC overcome the trauma associated with racism and criminal legal system involvement. The principles and practice of trauma-informed care—a strengths-based care delivery approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives<sup>56,57</sup>—can promote a culture of safety, empowerment, and healing.<sup>58-60</sup> This approach is relevant for all healthcare professionals.

Increasing the diversity of the medical workforce, including across addiction medicine programs and practices, can also help improve patient care, satisfaction, and outcomes and alleviate health disparities.<sup>61-65</sup> According to the most recent data, less than 12% of physicians self-identified as Hispanic or Black, despite those two groups making up over 30% of the United States population. Trends among medical students show minimal, if any, improvements in medical school diversity.<sup>66</sup> Latinx-identified individuals comprise 5.5% of medical school faculty, Black or African American individuals comprise 3.6%, and American Indian or Alaska Native individuals comprise 0.2% of medical school faculty.<sup>67</sup>

## Recommendations

### Recommendations for reducing criminal legal system influence on addiction care:

1. Healthcare professionals should support the elimination of policies that restrict the use of evidence-based addiction treatment for people with SUD who are in carceral settings or under community correctional control. In particular, decisions which involve treatment plans—including the type, duration, choice of medication, and level of care—should be made by healthcare professionals rather than non-clinical authorities in criminal legal systems and should be consistent with standards of care. Given the disproportional involvement of BIPOC with criminal legal systems, such changes are critical to address inequities and help BIPOC receive evidence-based addiction care.
2. Healthcare professionals should support equitable practices in drug courts. Consistent with ASAM policy,<sup>32</sup> reforms to drug courts should provide individuals with equitable access to evidence-based treatment for SUD, including all FDA-approved addiction medications available in the community or via telehealth, and prohibit interference of non-clinicians with the clinician-patient relationship. Drug court reforms must address inequities within the drug court system.
3. Healthcare professionals should support legislative and regulatory changes to enhance harm reduction efforts, including overdose prevention sites, syringe service programs, exploring other medications for SUD, and drug checking services. Healthcare professionals should be able to refer people who use substances for evidence-based, harm reduction interventions or use those interventions as a standard part of patient care. Healthcare professionals should support equitable access to all evidence-based harm reduction services for people who need them, with a specific effort to increase the engagement of BIPOC communities in the development of such services.
4. Healthcare professionals should use caution in ordering drug tests (toxicology) and sharing clinical drug testing (toxicology) results with entities outside of health care, including those in the criminal legal and child welfare systems. The goals of healthcare and criminal legal and child welfare systems do not always align. Healthcare professionals should educate patients on confidentiality and the purpose of the external request and obtain informed consent before making any disclosures.<sup>68</sup>

### Recommendation for reducing child welfare system influence on addiction care

5. Healthcare professionals should support the removal of legal mandates and local practice standards to report pregnant or parenting people to child protective services or other government agencies on the sole basis of substance use or SUD. Such requirements can be harmful and discourage people from seeking addiction treatment and prenatal care, which can lead to worse health outcomes for pregnant person, parent, and infant.

## Recommendations for healthcare systems, institutions, and organizations, professional medical entities, and researchers

6. Dramatic action is needed within medical schools to address the lack of diversity in the general medical workforce. Efforts to increase diversity within the healthcare workforce are critical to improving addiction care. Organizations and institutions within healthcare systems must act with the understanding that there are structural implications to fostering a sense of belonging<sup>69</sup> for BIPOC patients who use substances and prioritize garnering points of view from a diverse group, not a select few.<sup>69</sup> To improve addiction care and research, healthcare systems must hire and compensate individuals from the communities that they serve. These systems demonstrate the value of diversity when they listen to and implement recommendations from diverse sources and mentor and promote diverse individuals to leadership positions within the system.
7. Healthcare systems should expand the range of evidence-based services they provide in order to meet the needs of BIPOC with SUD, including the initiation of medication for OUD (e.g. buprenorphine) and offering naloxone for overdose reversal in emergency departments, hospitals, other urgent care settings, and primary care settings. Under certain circumstances, failure to do so may be a violation of federal law, including the Civil Rights Act.<sup>70</sup>
8. All healthcare settings should consider and address social determinants of health—including housing, education, transportation, employment, and racism itself—as part of a patient’s comprehensive treatment and recovery. Providers should consider open access scheduling, mobile services, community-based sites, and expansion of telehealth or other remote service deliveries, and working with local community-based organizations<sup>71</sup> to help address those needs.
9. All healthcare settings—along with other professional medical entities—should assess their care systems, clinical guidelines and algorithms,<sup>72</sup> and policies through a health equity and racial justice lens and revise them as needed. For example, new care approaches, such as telemedicine, may unintentionally propagate inequities if not implemented appropriately.<sup>73,74</sup>
10. In medical journals, racism must be interrogated as a critical driver of racial health disparities in addiction medicine,<sup>51</sup> ensuring that clinical research related to addiction is reformed to be antiracist. BIPOC with lived experience should be better represented as part of clinical trials, including as part of the team conceptualizing, conducting, analyzing and interpreting, and disseminating the clinical research.<sup>52,75</sup> Research thus conducted can be applied to the explicit end goal of translating the findings into improved clinical practice for BIPOC who use substances. Efforts focused on community engagement, recruitment, and retention of a diverse pool of research participants is imperative to achieve this goal.<sup>69</sup>
11. In addition to implementing needed changes to address healthcare inequities and ensure that BIPOC have equal access to evidence-based addiction care, healthcare institutions should regularly assess whether their antiracist policy interventions are having their desired effect. Healthcare systems should involve BIPOC staff, BIPOC members of communities, particularly those BIPOC with lived experience, and BIPOC researchers as part of this process.<sup>69</sup>

## Recommendations for healthcare professionals and their medical practices

12. Healthcare professionals should advocate for substance use to be addressed as a health issue, and addiction as a treatable, chronic medical disease and not be addressed by the criminal legal system with arrest and incarceration. The criminal legal system should not be used to interfere with, or influence, the assessment, diagnosis, or treatment decisions of those with SUD. Too often, these clinical decisions have been relinquished by healthcare professionals to the criminal legal system. Given that the criminal legal system has had inequitably detrimental effects on BIPOC, reforms within this system are particularly needed to achieve racial justice.
13. Healthcare professionals should regularly examine their practices and whether they deliver health care services in a biased way. When biases are identified, action should be taken to counter biased practices in order to deliver equitable, compassionate and anti-racism-informed<sup>4</sup> addiction care to all people who need it.
14. Healthcare professionals must lead medical practices that acknowledge and respond to experiences of racism of BIPOC patients who use substances by (a) trusting and respecting those patients' experiences through trauma-informed care, (b) assessing those patients for social determinants of health, including those that are linked to racism, and connecting them with community resources, and (c) evaluating their medical practices based on staff diversity and inclusion as well as patient satisfaction and retention in treatment among their BIPOC patients with SUD.
15. Healthcare professionals should develop proficiency<sup>4</sup> in, practice, and demonstrate leadership in trauma-informed care for BIPOC patients who use substances as well as structural competency<sup>†</sup>, so that they can (a) understand those patient experiences in the context of structural factors that influence their health; (b) intervene to address those structural factors, such as inequalities in law enforcement, housing, education, access to health care, and other resources, that put patients at risk for unhealthy substance use and addiction or limit their access to addiction prevention, treatment and recovery supports; and (c) collaborate with community leaders with humility.<sup>4,76</sup>
16. Preventing, screening for, assessing and intervening regarding SUD should be considered an essential part of general medical practice. In working with BIPOC who use substances, this includes healthcare professionals having the skills and training to prescribe a range of treatment approaches, including addiction medications.

## Recommendations for healthcare professional education and training

17. Providers of training in medical school, residency, fellowship and continuing medical education (CME) programs should review their curricula to identify gaps related to addiction care, trauma-informed care, structural competency, and racial understanding. Clinical educators should develop and promote addiction medicine training courses grounded in trauma-informed care and structural competency to improve the outcomes of patients who are socially marginalized by virtue of their race, e.g., those who are identified by the criminal legal system due to disparate policing and then are referred or mandated to addiction treatment. Education and training of healthcare professionals on addiction care should be evaluated to ensure

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<sup>†</sup> In the first policy statement in this series, the cited definition of “structural competency” is “the capacity... to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures.”

content aligns with the principles of cultural sensitivity and inclusion, health equity, and racial justice.

18. Healthcare professionals should advocate for creation and implementation of policies that lead to a more diverse clinical workforce equipped to treat SUD<sup>69</sup> and should seek opportunities to mentor BIPOC physicians and other clinicians. The outcomes of these policies should be regularly assessed to ensure that they are achieving their stated goals. Robust funding should be made available and targeted for scholarships and loan repayment for BIPOC healthcare professionals who treat SUD.

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**American Society of Addiction Medicine**  
11400 Rockville Pike, Suite 200, Rockville, MD 20852  
Phone: 301.656.3920 | Fax: 301.656.3815

[www.ASAM.org](http://www.ASAM.org)



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