Public Policy Statement on Advancing Racial Justice in Addiction Medicine

Background

Addiction involves complex interactions among an individual's brain circuits, genetics, the environment, and their life experiences.[1] Racism disproportionately shapes the environment and life experiences of Black, Hispanic/Latinx, Asian, Pacific Islander, Native American, and other racially oppressed and disenfranchised people (hereinafter collectively referred to as Black, Indigenous, People of Color (BIPOC), adversely influencing both their risk of developing addiction and their access to evidence-based addiction treatment services. While police and civilian murders of Black people in the United States of America have highlighted the deadly consequences of racism, they have also illuminated the impact of the long-standing systemic racism in the United States. Systemic racism has been defined as "a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity."[2]

This is the first of a series of policy statements on racial justice through which ASAM reiterates the fundamental axiom that systemic racism is a social determinant of health[3] that has had profound, deleterious effects on the lives and health of BIPOC. These statements are part of ASAM's effort to recognize, understand, and then counteract the adverse effects of America's historical, pervasive, and continuing systemic racism, specifically with respect to addiction prevention, early intervention, diagnosis, treatment, and recovery. The goal of this series is to increase structural competency, defined as "the capacity… to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures,"[4,5] among addiction medicine professionals, public health authorities, policymakers and others with societal influence or authority. Structural competency bridges research on social determinants of health with clinical interventions, and prepares clinical trainees to act on systemic causes of health inequalities.

ASAM recognizes the racism and discrimination that BIPOC patients, their families, and addiction medicine professionals consistently face in their personal and professional lives. Every day, addiction medicine professionals confront the tragic consequences of racial injustice among the patients and communities we serve — from the disproportionate incarceration of BIPOC with the disease of addiction, to treatment barriers for many BIPOC, to rising overdose deaths and ongoing discrimination.[6,7]ASAM denounces and commits to challenging racial injustice by working toward solutions to the addiction crisis that recognize the role of systemic racism in creating and reinforcing health inequities.[8]

Drug policy has supported systemic racism. Drug controls arose from a mix of motives, some of which were laudable, but many of which were based in racist ideology. Racial bias has emerged in policies as written and applied. The impact of systemic racism in drug policy and addiction medicine is evident in:

- De-medicalization (from medicalization to criminalization): Addiction medicine is older than criminalization, but this initial era ended with the passage of the 1914 Harrison Narcotic Tax Act (Ch. 1 38 Stat 785) (HNTA). The passage of the HNTA as well as its enforcement was dominated by explicit racism directed against immigrant Asian and Hispanic/Latinx labor, Black men and concern about women stolen into "white slavery"[9] – and it ushered in a period that prioritized policing over public health.
- Criminal legal reform failures: Mandatory sentencing guidelines, codified in the 1984 Sentencing Reform Act, were intended to address racial inequities in the criminal legal system. However, unguided discretion at the local and prosecutorial level worsened inequities primarily through guilty pleas rather than judicial action. Systemic racism in drug policy is perhaps most easily recognized in the Anti-Drug Abuse Act of 1986, which enacted a 100-fold greater sentencing disparity for water-insoluble cocaine base ("crack") versus powder cocaine.
- Selective and discriminatory recognition of addiction as a medical condition: The federal and state response to crack use in the 1980s and 1990s focused funding on law enforcement, which was then targeted at BIPOC. Conversely, three-quarters of federal funding to address the opioid epidemic, associated more closely with white people, went to research, treatment, and prevention.[10] Media portrayals of Black and Hispanic/Latinx people who use heroin as criminals and white people who use prescription opioids as sympathetic victims reinforced the racialized policy response to drug use.[11]
- Inequitable expansion of treatment: Motivated, in part, by an association of the opioid crisis with white people and in response to the historic location of addiction treatment with the criminal legal system, the Drug Addiction Treatment Act of 2000 (DATA 2000) was enacted to expand care in the medical setting. However, the benefit of expanded treatment has been unequal. Opioid use disorder (OUD) treatment remains segregated, with Black and Hispanic/Latinx people more likely to receive methadone,[12] which is only available in highly regulated systems, and white people more likely than people of other races to receive buprenorphine, which is available in an office- based setting.[13]
- Beyond the multiple problems with the treatment of OUD, neglect of the health concerns of BIPOC communities continues in other ways: In 2020, sales restrictions were placed on flavored tobacco products except for those featuring menthol, the product most often used by Black people.[14] In essence, this prioritized tobacco company profits over the health of Black people. In addition, alcohol outlet density remains far greater in Black and Hispanic/Latinx neighborhoods.[15] Some have argued that this fact reflects structural racism in the built environment.[16, 17]

The contemporary consequence of this racist history is seen in:

- The lack of focus on evidence-based SUD prevention research among BIPOC[18, 19] and lack of access to secondary prevention interventions such as overdose education and naloxone distribution programs within BIPOC communities;[20, 21]
- The lower availability of evidence-based treatment (particularly buprenorphine) for BIPOC and the continued experience of discrimination within treatment programs and systems;[22]

- The unequal deployment of drug testing with markedly different consequences for BIPOC when their test results are positive;[23, 24]
- The underrepresentation of BIPOC in scientific studies, thus yielding interventions that may not be culturally appropriate;[25, 26] and
- Markedly different rates of incarceration despite national survey data that suggest that BIPOC and whites use drugs at similar rates.[27]

The overcriminalization of drug use by BIPOC and disparate policing of BIPOC who use drugs is well documented.[22] The effects of this discrimination are devastating and lasting. Addiction medicine professionals are too often silent and accepting of a system that mandates inappropriate treatment.

Both racism and criminal-legal system involvement are traumatizing. Addiction medicine professionals have the opportunity to counteract that trauma in their practices through trauma-informed care. 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[28, 29] – can promote a culture of safety, empowerment, and healing.[30, 31, 32] Increasing the diversity of the addiction medicine workforce and staff of addiction medicine programs and practices can also help improve patient care, satisfaction, and outcomes and alleviate health disparities.[33, 34, 35, 36] While these issues extend beyond addiction medicine, this statement focuses on steps that addiction medicine professionals and all health care professionals who treat patients with addiction can take to advance racial justice. Subsequent statements will address broader public health and social issues and make recommendations for broader policy and societal change.

Recommendations

The American Society of Addiction Medicine recommends:

1) Addiction medicine professionals should examine their own motivations, biases, and practices related to BIPOC to deliver equitable, compassionate, and anti-racism-informed[37] medical care to all patients. Research is needed to identify best practices for motivating and facilitating such an examination.
2) Addiction medicine professionals must lead medical practices and treatment programs that acknowledge and respond to patients' experiences of racism by (a) trusting and respecting patients' experiences through trauma-informed care, (b) assessing 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 BIPOC patient satisfaction and retention in treatment.
3) Addiction medicine professionals should develop proficiency[38] in, practice, and demonstrate leadership in trauma-informed care as well as structural competency, so that they can (a) understand 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 prevention, treatment and recovery supports; and (c) collaborate with community leaders and health professionals with humility and patience.[39]

4) Providers of addiction medicine training in medical school, residency, fellowship and continuing medical education (CME) programs should review their curricula to identify gaps related to trauma-informed care, structural competency, and racial understanding. Clinical educators should develop and promote 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 more frequently by the criminal legal system due to disparate policing and then are referred or mandated to addiction treatment.
5) Addiction medicine professionals should advocate for policies that lead to a more diverse addiction treatment workforce and should seek opportunities to mentor BIPOC clinicians into the field. Robust funding should be made available and targeted for scholarships and loan repayment for BIPOC addiction medicine professionals.
6) Addiction medicine professionals should advocate for policies that ensure BIPOC at risk of, or with, addiction have equitable access to evidence-based prevention, early intervention, treatment, and harm reduction services. Further, addiction medicine professionals should advocate for policies that are designed to eliminate structural inequalities in social and economic factors that influence substance use and addiction (e.g., law enforcement practices and access to housing, education, and health care), as these social determinants of health contribute to health disparities between BIPOC and white people.
7) Addiction-related research should strive to include an equitable representation of BIPOC researchers and participants in study design, implementation, and dissemination of results. Addiction-related research should evaluate the impact of systemic racism on drug use; risk and protective factors for addiction; and access to prevention interventions, treatment and harm reduction options, and recovery support services. Clinical resources and recommendations should be designed with consideration of the broad social, political, and economic structures that affect health and illness. Community-based participatory research methods can help build trust between researchers and BIPOC given historical research practices.

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References

[1] See ASAM Definition of Addiction: https://www.asam.org/Quality-Science/definition-of-addiction

[2] Full definition: "A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist." Aspen Institute. "11 Terms You Should Know to Better Understand Structural Racism." July 11, 2016. Available at https://www.aspeninstitute.org/blog-posts/structural-racism-definition/

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