

# RACE AND SUBSTANCE USE DISORDERS

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# WHY IS THIS RACE AND SUD CONVERSATION IMPORTANT?

Those who cannot remember the past are  
condemned to repeat it.

George Santayana

# WHY IS AN SUD CONVERSATION IMPORTANT?

- This is not the first opioid epidemic-late 1800's, civil war, Vietnam era
  - “In the 1890s, the popular Sears and Roebuck catalogue included an offer for a syringe and small amount of cocaine for \$1.50.”
- This is not the first harmful substance use epidemic-those cited above as well as cocaine early 1900's, amphetamines 1950's, cocaine/crack 1980's
- This is not the first time doctors have fueled and opioid epidemic (late 1800's into early 1900's-even Mary Todd Lincoln)
- This is not the first time we have sought to regulate the prescriptions and found that people then turn to illicit drugs
- This is not the first time response and concern differs based on demographics

# NOT THE FIRST TIME OUR RESPONSES HAVE BEEN INADEQUATE- STEPWISE INSTEAD OF COMPREHENSIVE

- Regulate Providers and prescriptions
- Demonize/Criminalize some patients sympathize with others
- Criminalize those who provide illicit drugs
- Use a Moral Response in lieu of a clinical one-prohibition
- Rely on an inadequate treatment system with varying levels of quality
- Limit access to evidence based services in community and often in the justice system
- Using the justice system as a response and using justice system actors as diagnosing clinicians
- Slow to provide care to those who are not ready to enter treatment

# PRE-WAR ON DRUGS

[HTTPS://WWW.THEATLANTIC.COM/HEALTH/ARCHIVE/2012/03/THE-WAR-ON-DRUGS-HOW-PRESIDENT-NIXON-TIED-ADDICTION-TO-CRIME/254319/](https://www.theatlantic.com/health/archive/2012/03/the-war-on-drugs-how-president-nixon-tied-addiction-to-crime/254319/)

- “On December 5, 1969, President Richard Nixon appointed Stephen Hess to the position of National Chairman of the White House Conference for Children and Youth.
- The task force on drugs, composed of eight youths and four adults, forcefully argued for addressing the root causes of drug abuse, advocating therapy for addicts rather than incarceration or punishment. "We acknowledge that drug abuse is largely a symptom of the individual's inability to cope with his immediate personal environment," they conceded. "However, it must be understood that deep societal ills increase the individual's sense of personal alienation. Specifically, our society has permitted the perpetuation of the Indochina War, of institutional and personal racism, of the pollution of our environment, and of the urban crises.... If the administration is sincere in its concern with drug abuse, it must deal aggressively with the root causes as well as implement the recommendations contained herein.”

# WHY IS THIS SUD CONVERSATION IMPORTANT?

- Yet, with all that history, not only did we overprescribe, but even more important we did not and still do not screen for substance use nor do we willingly provide access to a continuum of evidence informed harm reduction services
- Even with overprescribing, had we been screening and serving on an integrated basis, could we have landed in a different place?
- You either have to be part of the solution, or you're going to be part of the problem.'
  - Eldridge Cleaver

# WHY IS THIS SUD AND RACE CONVERSATION IMPORTANT? MOST INFAMOUS-NIXON ERA RESPONSE

[HTTPS://WWW.SMARTDRUGPOLICY.ORG/NIXON-AND-THE-START-OF-THE-DRUG-WAR-1969-1974/](https://www.smartdrugpolicy.org/nixon-and-the-start-of-the-drug-war-1969-1974/)

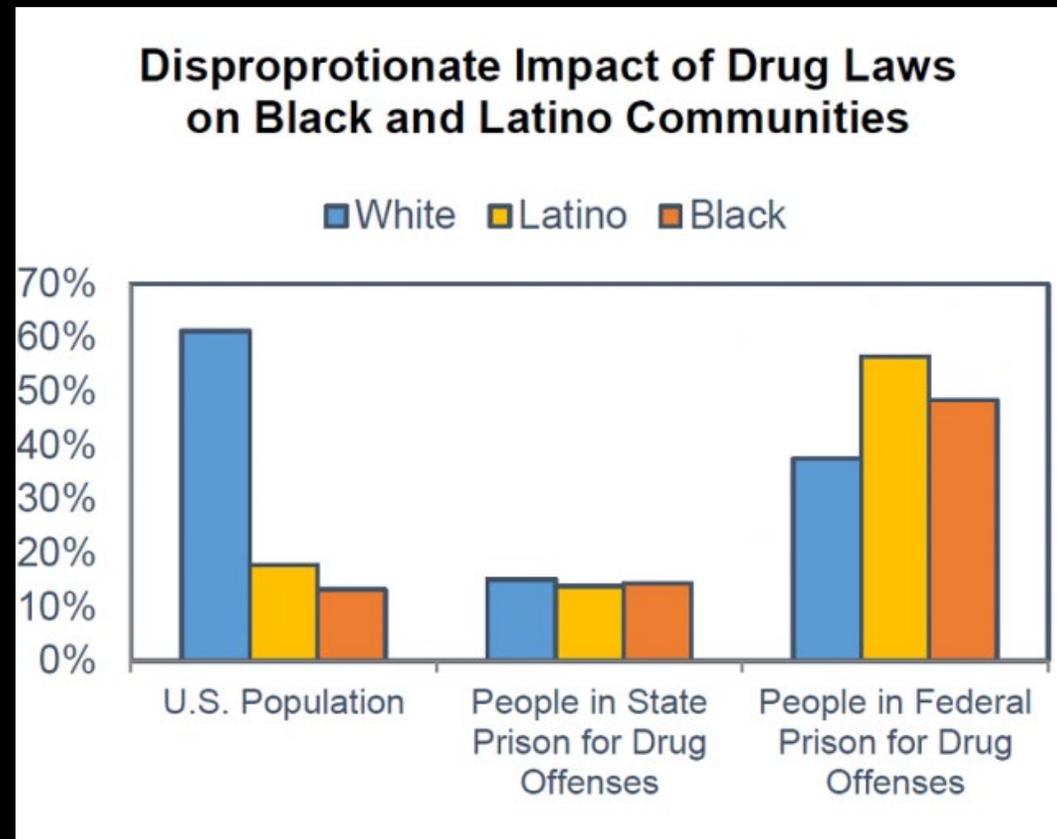
- As heroin use was on the rise, primarily among returning Vietnam War veterans, the Nixon administration focused most of its resources on that particular narcotic, especially to reduce crime linked to drug use. On the treatment side, Nixon created the first federal methadone program (see [Treating Heroin Addiction](#)), and dedicated 75% of the total drug budget to treatment and rehabilitation.
- In 1970, the Comprehensive Drug Abuse Prevention and Control Act of 1970 was created and became the main legal foundation for drug regulation in the U.S. It consolidated all previous laws regulating the production and distribution of narcotics, stimulants, depressants, hallucinogens, and any other chemical substance considered to have a potential for abuse. To enforce the Act, a new agency was created in 1973, the Drug Enforcement Administration (DEA), into which the former BNDD was merged.

# WHY IS THE RACE AND SUD CONVERSATION SO IMPORTANT? THE OTHER REASON FOR THE WAR ON DRUGS-THOUGH NOT THE FIRST RACE DRIVEN PUNITIVE RESPONSE

- “During a 1994 interview, President Nixon’s domestic policy chief, John Ehrlichman, provided inside information suggesting that the War on Drugs campaign had ulterior motives, which mainly involved helping Nixon keep his job.
- In the interview, conducted by journalist Dan Baum and published in Harper magazine, Ehrlichman explained that the Nixon campaign had two enemies: “the antiwar left and black people.” His comments led many to question Nixon’s intentions in advocating for drug reform and whether racism played a role.
- Ehrlichman was quoted as saying: “We knew we couldn’t make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did.””
- <https://www.history.com/topics/the-war-on-drugs>

# THE AFFECTS

[HTTP://WWW.DRUGPOLICY.ORG/RESOURCE/DRUG-WAR-MASS-INCARCERATION-AND-RACE-ENGLISHSPANISH](http://www.drugpolicy.org/resource/drug-war-mass-incarceration-and-race-englishspanish)



# THE AFFECTS

[HTTP://WWW.DRUGPOLICY.ORG/RESOURCE/DRUG-WAR-MASS-INCARCERATION-AND-RACE-ENGLISHSPANISH](http://www.drugpolicy.org/resource/drug-war-mass-incarceration-and-race-englishspanish)

- “There were more than 1.5 million drug arrests in the U.S. in 2016. The vast majority – more than 80% – were for possession only.”
- “People of color experience discrimination at every stage of the judicial system and are more likely to be stopped, searched, arrested, convicted, harshly sentenced and saddled with a lifelong criminal record. This is particularly the case for drug law violations.
- “Research shows that prosecutors are twice as likely to pursue a mandatory minimum sentence for black people as for white people charged with the same offense. Among people who received a mandatory minimum sentence in 2011, 38% were Latino and 31% were black.”

# THE AFFECTS

[HTTPS://WWW.HRW.ORG/LEGACY/CAMPAIGNS/DRUGS/WAR/KEY-FACTS.HTM](https://www.hrw.org/legacy/campaigns/drugs/war/key-facts.htm)

- Nationwide, blacks comprise 62 percent of drug offenders admitted to state prison. In seven states, blacks constitute between 80 and 90 percent of all people sent to prison on drug charges.
- Nationwide, black men are sent to state prison on drug charges at 13 times the rate of white men.
- Two out of five blacks sent to prison are convicted of drug offenses, compared to one in four whites.
- Black men are incarcerated at 9.6 times the rate of white men. In eleven states, they are incarcerated at rates that are 12 to 26 times greater than that of white men.
- Nationwide, one in every 20 black men over the age of 18 is in prison. In five states, between one in 13 and one in 14 black men is in prison.
- One in every 20 black men over the age of 18 in the United States is in state or federal prison, compared to one in 180 white men.
- More people are sent to prison in the United States for nonviolent drug offenses than for crimes of violence.

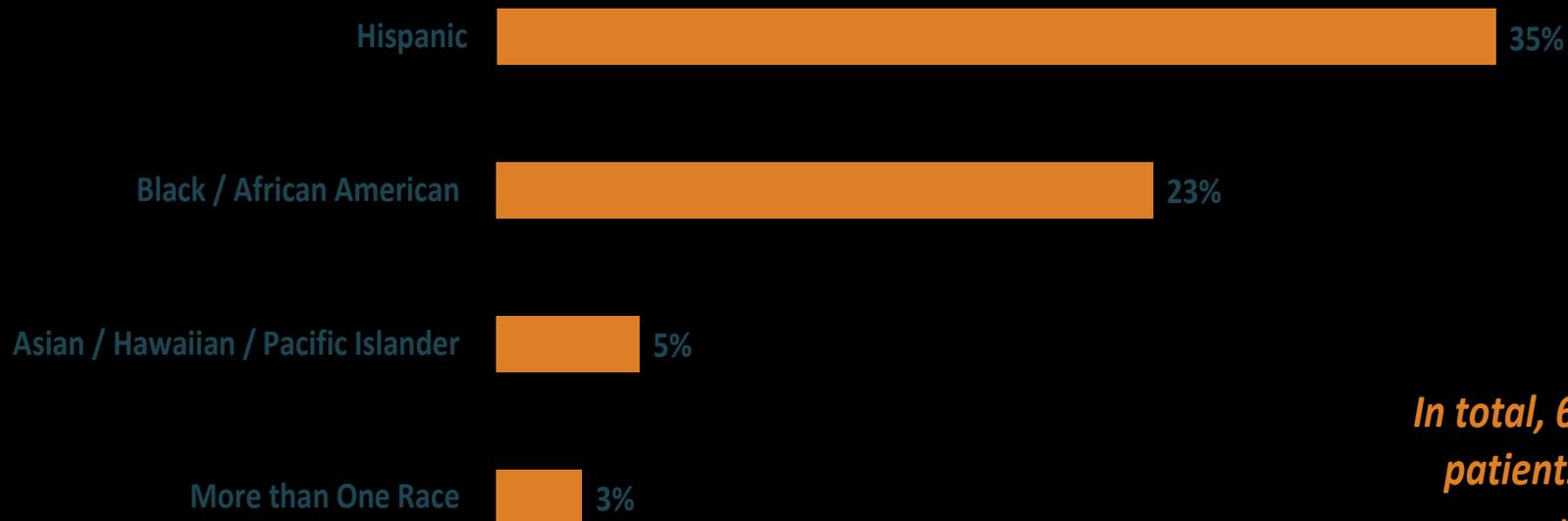
# WHAT DID THE PAST PRODUCE?

- Even in the face of the current epidemic, we do not have the proper frame and systems to adequately address opioid or any other substance use disorder.
- How does a system with enshrined inequity, which has been fortified by almost every US President, but for Carter, lead to an equitable health based response to SUD?
- Passively it does not. We have to engage and change all aspects of the health system to insure people receive holistic, integrated care
- Those who have been left out previously will continue to be in jeopardy... and who are those people?

# MANY OF THEM ARE FQHC PATIENTS

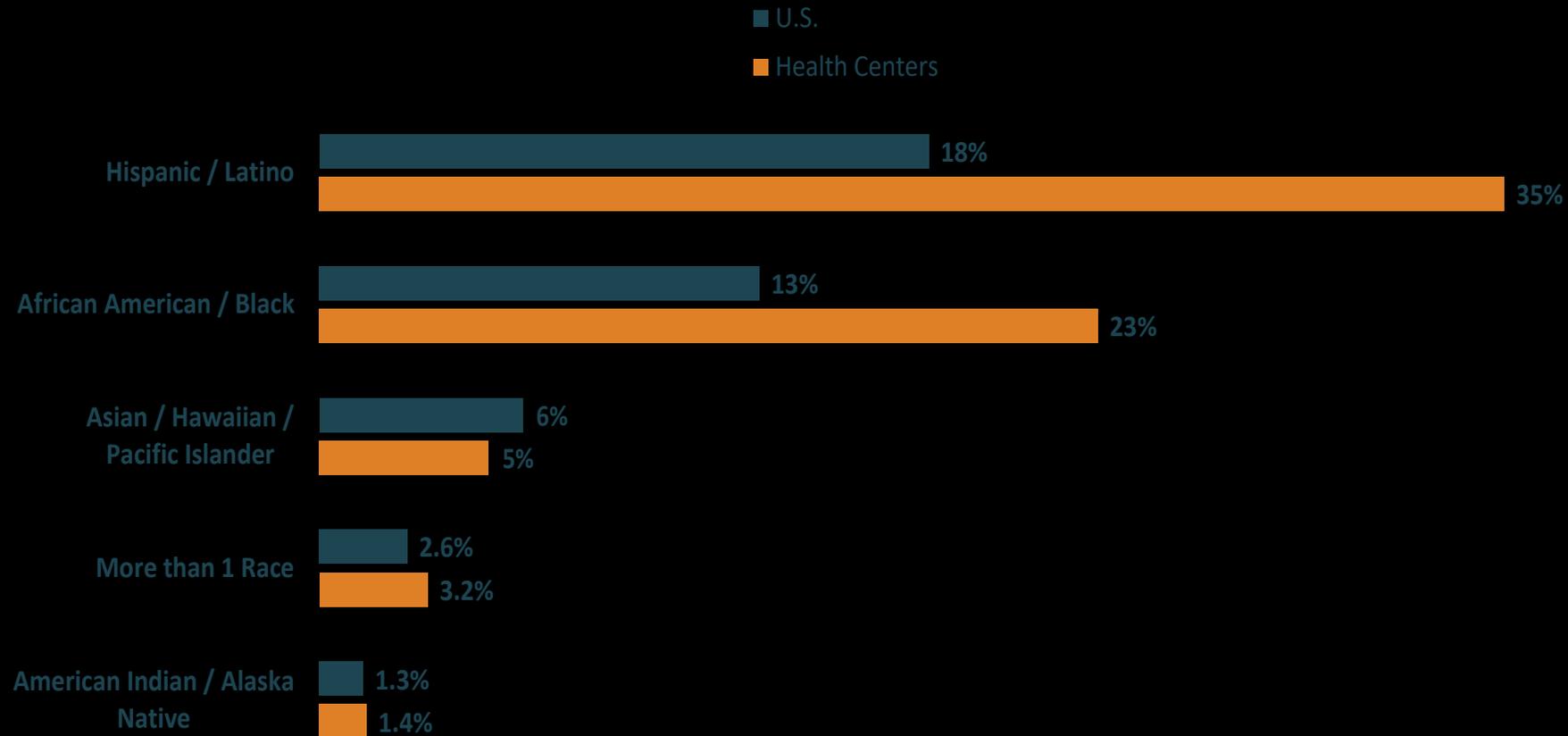
Figure 1.10

## Most Health Center Patients are Members of Racial/Ethnic Minority Groups



*In total, 62% of health center patients are racial/ethnic minorities.\**

# Health Center Patients are Disproportionately Members of Racial/Ethnic Minority Groups



# THIS COULD BE THE FIRST TIME WE CAN REMEMBER THE PAST AND DO A BETTER JOB- FOR ALL POPULATIONS

- Federally Qualified Health Centers could take the lead
- They have a vested interest for the health of their individual patients, their families and the communities in which they are centered-the populations who due to race, class, ethnicity have born the brunt of past punitive policies
- FQHC's have a vested interest because the fall out in terms of criminal and health outcomes will fall heavily on their populations ultimately affecting patients health outcomes and FQHC payments especially as we move to value based care

# HOW CAN WE NOT TALK/THINK ABOUT RACE, ETHNICITY, CLASS AND THIS EPIDEMIC IF WE TRULY WANT TO CARE FOR OUR PATIENTS

- How can we maintain that this is just a public health crisis brought on by prescribing if we want to help our patients? Why do we not screen and serve within the community all populations who use substances regardless of the substance?
- How can we use the language of the drug war if we want to help our patients? We must not buy into societal stigma and work to improve the policies, practice and payments needed to improve outcomes
- How can we only create a opioid based SUD system when we know our patients use drugs other than opioids and that we need a complete continuum and system of care?

# RACE AND SUD

- On a clinical level; listen to your patients, their families, and communities. Work towards providing holistic and integrated care. Meet patients where they are. This includes, but is not limited to
  - Universally screen for all substances-not just the people “we think are likely to use substances.” Screen youth, adolescents, men, women, pregnant women etc.
  - Provide brief intervention and counseling services
  - Have the capacity to provide or refer patients for secondary prevention services-not everyone wants or is ready to enter treatment; they should have access to services that will keep them as healthy as possible
  - Have the capacity to provide or refer patients for formal treatment including medications; patients should have access to all types of medications and make decisions with their providers based on their clinical and other needs
  - Create relationships with patients to understand their journey, be prepared to engage and refer for recovery and other social services throughout their care cycle
  - Recognize the stigma that comes with and SUD diagnosis and the external pressures your patients face-including the threats of the justice system, housing and employment barriers and more

# RACE AND SUD

- Health Equity can happen!
- Speak up for policies that will allow your community to provide and adequately pay for/sustain a full range of culturally effective substance use services –prevention, harm reduction, formal treatment, medication assisted treatment of all types, recovery services—for all patients and all types of substances –use the opioid epidemic as a start not the end of system creation
- Speak up for policies that address social determinants of health. When left unaddressed, these can lead to poorer SUD outcomes as they do with other health outcomes
- Speak against policies that unfairly punish those with SUD instead of treating it as a chronic disease; especially those that create disparities—look at data so you can identify disparities before they are entrenched

# RACE AND SUD

- Health Equity can happen!
- But, we have to understand and be honest about the current realities, disparities, lack of access, stigma
- We must bring in the communities we serve and hear what they need and then advocates for policies and programs that serve their needs
- We must learn and incorporate the science frame not the stigma frame-just as we do with other chronic diseases and then assess outcomes-are our changes working, why? Why not?
- FQHC's can lead the charge just as they have in the past and then can be the members calling for sustainability

