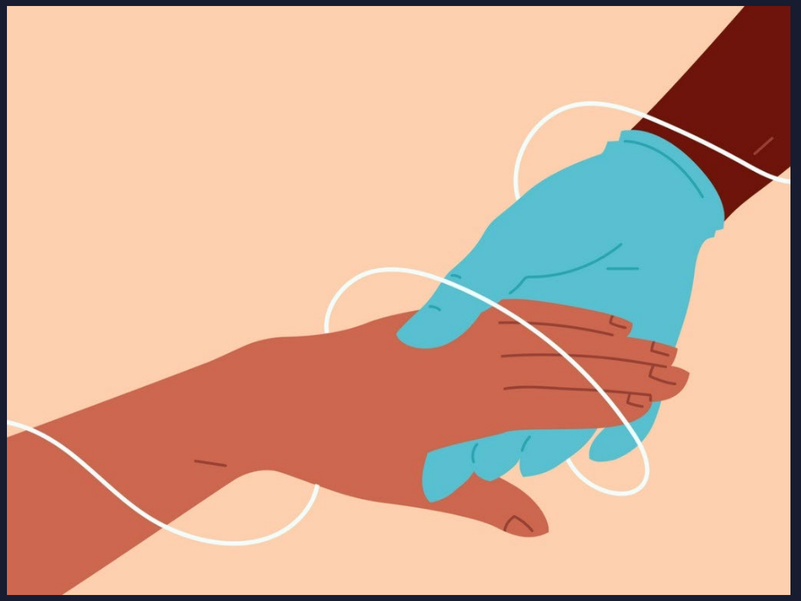
ASAM American Society *of* Addiction Medicine

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

Adopted July 28, 2022



ASAM, founded in 1954, is a professional medical society representing over 7,000 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

AGENDA

01 - Purpose

02 - Background

03 - Recommendations

Introduction

PUBLIC POLICY SERIES

- This public policy is the second in a three-part series of public policies on racial justice.
- ASAM summarizes the evidence that **systemic racism is a social determinant of health (SDoH)**, which has profound, deleterious effects on the lives and health of BIPOC[1] and racially and ethnically minoritized[2] and disenfranchised people.
- This work is part of ASAM's effort to recognize, understand, and then counteract the pervasive, historical, yet continuing adverse effects of systemic racism in America – with respect to full-spectrum addiction care.

[1] 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.

[2] 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.

Introduction

PUBLIC POLICY SERIES

- The first policy statement focuses on actions that addiction medicine professionals should take to tackle systemic causes of health disparities.
- Many choices made by healthcare professionals may reflect biases that operate in longstanding systems and policies that marginalize and exclude BIPOC.

The corrective response must consist of conscious efforts to overcome these biases and unjust systems.

Advancing Racial Justice in Health Care through Addiction Medicine

RESPONSIBILITY

- Healthcare professionals, healthcare systems, institutions, and organizations, professional medical entities, researchers, and health professional educators can take actions to help advance addiction medicine and its role in addressing health disparities for BIPOC.
- The criminal legal and child welfare systems have a long-standing role 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.
- There is a need for clinicians and patients to take responsibility for shared decision making with respect to full-spectrum addiction care.

Punitive responses have failed BIPOC who use substances. There is an urgent need for policy reforms that:

Prioritize full spectrum addiction care over punishment.

Reduce stigma against all people who use substances.

Enhance the health and wellbeing of all people who have the disease of addiction.

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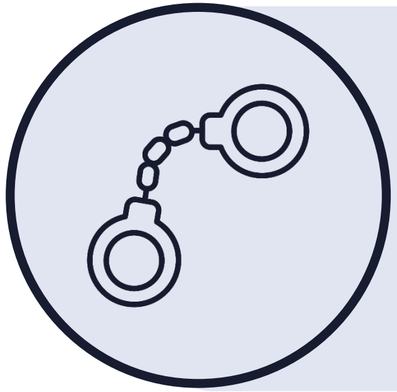
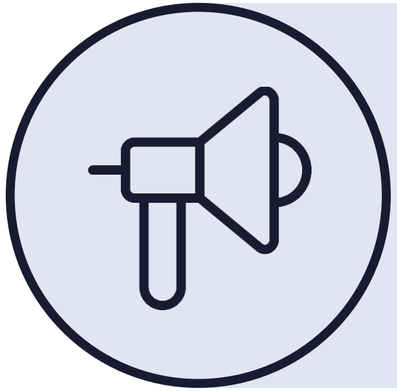
Background



BIPOC with SUD often do not receive evidence-based addiction care and are more likely than White people, because of substance use, to be treated punitively by the criminal legal and child welfare systems.



Groundbreaking change is required within the criminal legal and child welfare systems and major reforms are required within healthcare systems, institutions, and organizations, professional medical entities, health professional education, and medical research and practices to rectify this situation.

Ample Evidence of Systematic Racism in U.S. Healthcare System

THE STATE OF HEALTH CARE

- The Institute of Medicine in 2002 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.*"
- **Health care still has far to go to address these inequities.**

2.5x

In 2022, Black patients were 2.5 times as likely as White patients to have a negative descriptor, such as 'resistant' or 'non-compliant' in their health record.

Substandard Care for BIPOC Who Use Substances

BIPOC are less likely than White people to receive the standard of care in a range of areas in addiction medicine:

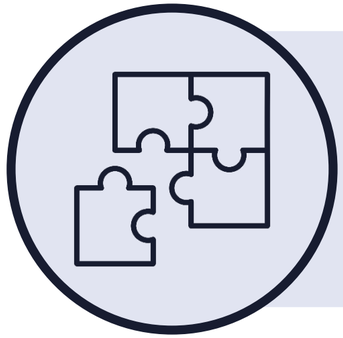
Black patients are less likely to receive medication for alcohol use disorder.

BIPOC are less likely to receive the standard of care for opioid use disorder (OUD), particularly buprenorphine.

BIPOC are less likely to complete addiction treatment, partly due to inequities in SDoH; structural racism; financial and housing instability.

BIPOC face more barriers in accessing harm reduction services.

The Use of Punitive Systems Against BIPOC Who Use Substances Must Change



A historically racialized, punitive approach to substance use in the U.S. has been weaponized against BIPOC; adoption of an explicitly antiracist approach and development of more equitable institutions and social conditions are needed.

PUNITIVE SYSTEMS

- The U.S.' use of punitive systems to address substance use and SUD has been ineffective at addressing the nation's overdose crisis.
- Larger policy changes, including an examination of appropriate penalties for personal drug use possession, are needed to reverse this approach, which is most acutely felt by BIPOC.

The Punitive Approach Against BIPOC is Exemplified in Methadone Treatment for OUD

Black and White Americans sells and use drugs at similar rates.

Black people in the U.S. 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.

Methadone treatment for OUD was authorized during a time of racialized “anti-crime politics.”

The result is a highly regulated, closed clinic system that emphasizes regulatory compliance over treatment access.

Highly detailed federal regulations orient methadone treatment for OUD away from primary care to the detriment of individualized patient care.

Current regulation of methadone contributes to racial health disparities among people with OUD.

The Low Standard of Addiction Care in Carceral Settings Disproportionately Affect BIPOC

The criminal legal system has done a poor job providing evidence-based care to people with SUD; the low standard of care poses particular risk for BIPOC given the disproportionate involvement with the criminal legal system.

<5% 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.

Very few carceral facilities offer (and some refuse to offer) medications for OUD, especially methadone or buprenorphine.

Incarcerated people under treatment with medications for OUD *are often forced to stop, suffer withdrawal, and risk overdose and death.*

129x Incarcerated individuals are 129 times more likely to die from overdose within two weeks after release, when compared to the general U.S. population.

Health Care Professionals Have Ceded Treatment Control to Criminal Legal Authorities

Healthcare professionals have ceded control over treatment plans to criminal legal authorities who are not clinicians, and thus have participated in providing substandard care within the criminal legal system. The criminal legal system has been shown to:

<5% Exclude or impose limits on methadone or buprenorphine for persons under community correctional control.

Limit addiction treatment to mandated, contracted providers, regardless of individual needs or insurance coverage.

African American and Hispanic individuals in jails and prisons are represented at nearly twice the rate in both drug courts and probation; arrest rates are also substantially higher for drug-related offenses.

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.

Methods of screening have historically relied on urine or toxicology drug testing, and healthcare professionals often perceive reporting results as mandatory.

The practice of "test and report" has ben 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."*

Reports to Child Protective Services of Substance Use by Pregnant and Parenting People

Most reports to child welfare occur for infants in the first year of life and originate from healthcare professionals.

Healthcare providers often employ a faulty assumption that substance use is “reportable” even when the “substance” is methadone or buprenorphine.

>1/3 More than one-third of out-of-home placements noted parental substance use as a contributing factor.

Child welfare reporting undermines patient trust and contributes to provider moral injury.

Racial Inequities in Child Protective Services' Response to Pregnant and Parenting People

Reporting can discourage a pregnant person from seeking care for OUD for fear of child welfare involvement and worsens racial inequities. There are marked racial inequities in the response from child welfare, in:

Toxicology testing

Reports to child welfare

- More Black than White infants are reported to child welfare due to parental substance abuse.

Foster placements

- Although Black children comprise 14% of children, they represent 23% of children in foster care, and are less likely to be reunified with their families.

Termination of parental rights

Antiracism Efforts are Needed Elsewhere within Health Care

Many of the structures built and operated by healthcare professionals and administrators also have damaging effects on BIPOC, calling for reforms to address and eliminate inequities within healthcare systems, health professional schools, clinical research and healthcare practice.

The effects of inequities in SDoH have been well-documented on patient outcomes, particularly among BIPOC.

Many clinicians and healthcare systems are unfortunately unprepared to, among their patients screen for SDoH and act based on the screening results, due to inadequate resources.

In many cases, community-based organizations may be logical partners to work with healthcare institutions.

Reforms are Needed to 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.

BIPOC are underrepresented in clinical trials, yielding interventions that may not be culturally appropriate.

Other research has demonstrated that BIPOC researchers are less likely to receive National Institutes of Helath (NIH) funding than White researchers.

Reforms are Needed to Healthcare Systems and Clinical Care

ALGORITHMS

- **Clinical algorithms of race, put forward by clinical societies and healthcare systems, are inappropriately used to make clinical care decisions.**
- This can unnecessarily inject issues of race in clinical care.
- The inclusion of race in algorithms may direct additional resources to White patients and away from BIPOC.

Examples of this occurring in clinical fields ranging from cardiology to nephrology to obstetrics.

Health Care Professionals Should Provide Trauma-Informed Care

ASAM's first policy suggested that addiction medicine professionals should use *trauma-informed care to help BIPOC overcome the trauma associated with racism and criminal legal system involvement.*

TRAUMA-INFORMED CARE

- **Trauma-informed care is 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.**
- Trauma-informed care can promote a culture of safety, empowerment, and healing.
- All health care professionals can provide trauma-informed care.

Diversity of the Medical Workforce Should be Increased

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.

<12% Less than 12% of physicians self-identified as Hispanic or Black, despite those two groups making up over 30% of the U.S. population.

Trends among medical students show minimal, if any, improvements in medical school diversity.

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.

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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. 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.

Recommendations for Reducing Criminal Legal System Influence on Addiction Care

2

Healthcare professionals should support equitable practices in drug courts. Consistent with ASAM policy, 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.

Recommendations for Reducing Criminal Legal System Influence on Addiction Care

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.

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Recommendations for Healthcare Systems, Institutions, and Organizations, Professional Medical Entities, and Researchers

6

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 a belonging for BIPOC patients who use substances and prioritize garnering points of view from a diverse group, not a select few.

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.

Recommendations for Healthcare Systems, Institutions, and Organizations, Professional Medical Entities, and Researchers

7

Healthcare systems should expand the range of evidence-based services they provide 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.

8

All healthcare settings should consider and address SDoH—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 to help address those needs.

Recommendations for Healthcare Systems, Institutions, and Organizations, Professional Medical Entities, and Researchers

9

All healthcare settings—along with other professional medical entities—**should assess their care systems, clinical guidelines and algorithms, 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.

10

In medical journals, racism must be interrogated as a critical driver of racial health disparities in addiction medicine, 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. 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.

Recommendations for Healthcare Systems, Institutions, and Organizations, Professional Medical Entities, and Researchers

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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.

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.

Recommendations for Healthcare Professionals and their Medical Practices

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 to deliver equitable, compassionate, and anti-racism-informed 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 SDoH, including those that are linked to racism, and connecting them with community resources.**
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.**

Recommendations for Healthcare Professionals and their Medical Practices

15

Healthcare professionals should develop proficiency in, practice, and *demonstrate leadership in trauma-informed care for BIPOC patients who use substances as well as structural competency*[3], 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
c. Collaborate with community leaders with humility.

[3] "Structural competency" is "the capacity… to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures."

Recommendations for Healthcare Professionals and their Medical Practices

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 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 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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