May 4, 2022

Recommendations on Structural Competency in Substance Use Disorder Treatment

New York State Office of Addiction Services and Supports (OASAS) Medical Advisory Panel (MAP)

Racism can be defined as a complex range of social structures, interpersonal interactions, and beliefs by which the group in power categorizes people into socially constructed "races" and creates a racial hierarchy in which racial and ethnic minority groups are devalued, disempowered, and denied equal access to resources.[1] Black, Hispanic, Asian, Pacific Islander, Native American and other racially oppressed and marginalized people disproportionately have had their environments and their life experiences affected by racism.[2] Structural racism, one of the four different types of racism that also includes institutional, interpersonal, and internalized racism[3], is the manner by which systems such as health care, education, employment, housing, and public health are designed to provide advantages to the majority and to disadvantage racial and ethnic minorities.[4] Laws and policies have been used over time to promote structural racism[3] with drug policy in the United States clearly demonstrating this phenomenon.

The Anti-Opium Act of 1909, for example, made smoking opium, the preferred means of use by Chinese people, a federal offense but made an exception for drinking and injecting tinctures of opium that was popular among White people.[5] While the Harrison Narcotic Tax Act of 1914 was passed as a means of taxing and commercially regulating the production, importation, and distribution of opium and coca leaves, and products made from them,[6] its enforcement effectively criminalized the use of opium and cocaine. Cocaine became a focus for criminalization in the early 20th century because of unfounded newspaper accounts of violence, particularly against Southern White women, allegedly committed by Black people using excessive amounts of cocaine. [5,7] According to Sandy,[7] the press depicted Black people in this manner even though there was no evidence of excessive cocaine use among Black people to give White people a suitable justification for their racial fears. Similarly, unproven newspaper reports of violence and other criminal behavior allegedly committed by Mexican immigrants who smoked cannabis were motivated by social and economic forces that sought to limit Mexican migration to the United States.[8] Political pressure on the federal government from law enforcement to address this "marihuana problem" among Mexican immigrants influenced the 1937 passage of the Marihuana Tax Act that levied taxes and other restrictions on cannabis. [8]

This criminalization of certain substances ultimately led in more recent times to racial inequities in the legal consequences for their possession and sale. Water-insoluble cocaine base, otherwise known as crack cocaine, became available widely in the early 1980s and offered an inexpensive alternative to powder cocaine for poorer Americans, many of whom were Black people. A fear perpetuated by the media by the mid-1980s that crack cocaine was destroying America's inner cities where many racial and ethnic minorities resided, and dramatic claims about crack cocaine's unpredictable and deadly effects that were not supported by scientific evidence led to the passage of the Anti-Drug Act in 1986.[9] This Act instituted mandatory minimum sentences for federal drug trafficking offenses and created a 100:1 sentencing disparity between powder and crack cocaine. This disparity in sentencing, due in part to White people being more likely to use powder cocaine and Black people more likely to use crack cocaine,[10] led to Black people receiving longer prison sentences for drug related offenses than did White people.[8] The situation worsened in 1988 when Congress passed the Omnibus Anti-Drug Abuse Act that created a mandatory minimum sentence for simple possession of 5 grams of crack or more.[9] The result of these policies has been decades of mass incarceration of Black and other

racially oppressed and marginalized people. In addition to taking away their freedom, incarceration also denied them access to education, employment, economic opportunities, appropriate health care, housing, voting rights, and important familial and social relationships not only during the period of incarceration but for many years afterwards.[11]

Within the substance use disorder treatment system, structural racism is most evident in the treatment of opioid use disorder (OUD). Both methadone and buprenorphine are evidence-based medications for the treatment of OUD but access to these medications has been racially segregated. Federally regulated opioid treatment programs (OTPs) that dispense methadone have been located in greater numbers in areas where Black and Hispanic residents predominate[12] and the choice of location has been cited as a purposeful policy decision during the 1970s to reduce substance use related crime and to placate powerful community groups who objected to having OTPs established in their neighborhoods .[13] Not surprisingly, the result has been an ongoing racialization of medications for OUD where Black and Hispanic individuals are more likely to be treated with methadone,[14.15] even though buprenorphine has been approved for the treatment of OUD in the United States since 2002. Prescribing buprenorphine less frequently to Black and Hispanic people also may have been related to specific efforts to market buprenorphine to White middle-class individuals living in suburban and rural areas who had developed OUD not because they were 'criminals,' as the media had portrayed Black and Hispanic individuals with OUD, but because they were the victims of pharmaceutical company greed and inappropriate prescribing practices by physicians.[16,17] Indeed, one study showed that between 2004 and 2015, White individuals were 35 times more likely to receive a buprenorphine prescription than Black individuals and individuals of other races.[18] This disparity in access to buprenorphine may be one of the factors that has contributed to the increase in rates of opioid overdose deaths among older non-Hispanic Black men since 2013.[19]

On May 19, 2021, the NYS OASAS Medical Advisory Panel (MAP) hosted Helena Hansen, MD, PhD, Professor and Chair of Research Theme in Translational Social Science and Health Equity, and Associate Director of the Center of Social Medicine at UCLA's David Geffen School of Medicine, for a presentation and discussion on "Opioids, Race, and Structural Competency." Structural competency is defined "as the trained ability to discern how a host of issues defined clinically as symptoms, attitudes or diseases also represent the downstream application of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even the very definitions of illness itself."[20] Structural competency aims to develop a language and set of interventions that reduce health inequities at the level of neighborhoods, institutions, and policies.

The skills heath care providers need to develop to advance structural competency include:[20,21]

1. Recognizing how economic, physical, and socio-political forces shape clinical interactions between providers and patients.
2. Reimagining "cultural" formulations that focus on the cultural aspects of patients' illness and the different sociologic and cultural backgrounds of patients and providers in structural terms that consider neighborhood and institutional factors as well.
3. Working to address the systemic needs of the patient population they serve through community-, service agency-, or policy-based projects.
4. Collaborating across disciplines and with community members to effect structural change with the understanding that such change takes time and involves a long-term commitment.

The NYS OASAS Medical Advisory Panel (MAP) recommends that the principles of structural competency are adopted by substance use disorder treatment programs to lessen inequities and foster social justice within substance use disorder treatment. An ongoing priority for the OASAS MAP will be determining the action steps needed to achieve structural competency in substance use disorder treatment programs.

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