Substance Use Disorder: Race and the Importance of Integrated Health Services

- Dr. Kimá Joy Taylor MD, MPH
- Managing Principal
- Anka Consulting LLC
- kimataylor@ankaconsultingllc.com
Substance Use Disorder- Race and the Importance of Integrated Health Services

- What is one thing that ties these systems together?
  - Substance Use Disorder System
  - Health System
  - Criminal Justice System

- If systems work together jointly to improve and continually assess improvement it is possible-this is the importance and promise of integrated health care

- FQHC’s could be seen as having a head start
Why this conversation?

Those who cannot remember the past are condemned to repeat it
George Santayana
Substance use systems and built in inequities

- 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; cocaine early 1900’s, amphetamines 1950’s, cocaine/crack 1980’s, etc.
- This is not the first time doctors have fueled an opioid epidemic (late 1800’s into early 1900’s—even Mary Todd Lincoln); supreme court legalized maintenance treatment in 1925
- 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
  - Harrison Act
Not the first time we muddled clinical intentions and reinforced systemic inequities, https://www.theatlantic.com/health/archive/2012/03/the-war-on-drugs-how-president-nixon-tied-addiction-to-crime/254319/

- December 1969- President Richard Nixon appointed Stephen Hess to the position of National Chairman of the White House Conference for Children and Youth.
- As heroin use was on the rise, primarily among returning Vietnam War veterans, the Nixon administration focused most of its resources on heroin to reduce crime linked to drug use.
- 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 became the main legal foundation for drug regulation in the U.S.
- To enforce the Act, a new agency was created in 1973, the Drug Enforcement Administration (DEA), into which the former BNDD was merged.
But, the nation embraced a 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 an interview with Dan Baum published in Harper magazine, Ehrlichman explained that the Nixon campaign had two enemies: “the antiwar left and black people.”

• 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
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
• 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 justice response enshrined inequity, fortified by almost every US President, but for Carter, lead to an equitable health based response to SUD?

• How can we expect a health system that was not even required to recognize SUD services until MHPEA ACA, a system that knows little about evidence informed, much less integrated culturally effective care expect immediate positive outcomes?

• How can we expect this of a health system that has health disparities in diabetes, hypertension, cervical and other cancers even when people “knew” and were taught what to do

• 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

- Hispanic: 35%
- Black / African American: 23%
- Asian / Hawaiian / Pacific Islander: 5%
- More than One Race: 3%

In total, 62% of health center patients are racial/ethnic minorities. *
Health Center Patients are Disproportionately Members of Racial/Ethnic Minority Groups

- Hispanic / Latino: 18% (Health Centers: 35%)
- African American / Black: 13% (Health Centers: 23%)
- Asian / Hawaiian / Pacific Islander: 6% (Health Centers: 5%)
- More than 1 Race: 2.6% (Health Centers: 3.2%)
- American Indian / Alaska Native: 1.3% (Health Centers: 1.4%)
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 borne the brunt of past punitive policies.
- FQHC’s have a vested interest because the fall out in terms of criminal justice, Behavioral and somatic 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?
• On a broad clinical level
  • Listen to your patients, their families, and communities. There are a lot of misperceptions, dangerous preconceived notions as well as good will.
  • Work towards providing holistic and integrated care either internal to your institution or with strong community based partners.
    • BUT--ensure these systems do not have their own built in inequities and if so, work to eradicate them
  • Work through moral misinterpretations
  • Look to training or refreshing staff on the evidence of SUD service while developing new evidence.
  • Meet patients where they are-who are they, what are their needs
    • Including but not limited to SDOH
  • Collect and use DATA!
  • Be nimble
Integration with health equity

• 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
Integration

- On a concrete level
  - Universally screen for all substances—not just the people “we think are likely to use substances.” Screen youth, adolescents, men, women, pregnant women etc.
    - Know why you are screening
    - Devise a strategy to include screening
    - Assess regularly—is this working for all members? If not, regroup
  - Provide brief intervention and counseling services;
    - Assess using data cut in many different ways across race, age, gender, sexual orientation
    - Talk to your patients!
  - 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
    - Continue other health services that patient desires
Integration

- Have the capacity to provide or refer patients for formal treatment including medications;
  - Provide or develop partnership so you can offer all evidence informed counseling and medications.
  - Treatment decisions should be made based on clinical and other needs as identified by patient
- 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
  - Do you have the capacity to provide help and/or refer to other community based service providers as needed?
- CONTINUE somatic, dental and other health services!!
• But, we have to understand and be honest about the current realities, disparities, lack of access, stigma
• We must be honest about the advocacy needed to ensure funding can meet the promises of integration
• 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