

Structural Racism and the Opioid Overdose Epidemic: The Need for Antiracist Public Health Practice

Hillary V. Kunins, MD, MPH, MS

The opioid overdose epidemic has spurred local, state, and federal government funders to allocate new resources toward the development and implementation of innovative public health policies and practices to reduce drug overdose mortality. These new strategies, as the articles in this issue highlight, build on the fundamental principles of public health surveillance and primary, secondary, and tertiary prevention strategies to reduce opioid-specific risks. Topics addressed in this issue include implementation of opioid analgesic prescribing metrics and policy change, use of the Affordable Care Act mandate for hospitals to meet community health needs regarding substance use, novel access to addiction treatment via telemedicine, mortality review to solve system gaps, public information and education campaigns, and work to increase access to protective interventions such as syringe exchange and the medications for opioid use disorders (MOUDs) methadone and buprenorphine. These approaches to the opioid overdose epidemic exemplify some of the innovative health-led alternatives to the punitive approaches to drug use that have dominated policy and practice in the United States.

With these innovations and expanded resources, a public health approach has found some success. Nationally, the Centers for Disease Control and Prevention recently announced that US drug overdose deaths fell for the first time since 1999, with a 4% decrease in the overdose mortality rate from 2017 to 2018.¹ Similarly, in New York City (NYC), where we have implemented a broad overdose response plan,

HealingNYC,² we saw a 3% decrease in the rate of overdose deaths from 2017 to 2018.³

But these successes do not mean that our work is finished. In NYC, as well as in other jurisdictions, the decreases in overdose death were not equitably distributed. The highest overdose mortality rates were among middle-aged and older black New Yorkers in 2017.⁴ Although overdose mortality rates decreased in 2018 among blacks, a concerning increase among Latinx New Yorkers occurred.³ In addition, residents of NYC's poorest neighborhoods accounted for nearly one in 3 deaths in 2017 and comprised nearly double the number of deaths than among wealthier neighborhoods.³

To eradicate racial and economic disparities and achieve the full impact of a public health approach to drug policy, mere acknowledgment of the failure of punitive approaches is insufficient. A successful public health agenda instead must identify, undo, and repair the harms of structural racism, which underpins and drives our nation's punitive approach to drug policy and practice. With this commentary, I describe how structural racism has been and remains the primary driving force in US drug policy and how a fully successful public health approach needs to center racial equity in our collective response to the opioid overdose epidemic. Without naming structural racism and normalizing discussions of racism in public health and medicine, we are unlikely to realize the full impact of these recent innovations. Adopting a deliberate antiracist approach to drug policy and public health is essential to prevent us from implementing policies that, despite our best intentions, reinforce punitive approaches and continue to harm people of color.

Author Affiliation: Division of Mental Hygiene, New York City Department of Health and Mental Hygiene, Queens, New York.

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Correspondence: Hillary V. Kunins, MD, MPH, MS, Division of Mental Hygiene, New York City Department of Health and Mental Hygiene, 42-09 28th St, 19th Floor, Queens, NY 11101 (hkunins1@health.nyc.gov).

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Structural Racism as a Root Cause

Structural racism refers to a historically rooted and culturally reinforced system of discrimination.⁵ For this commentary, I use Bailey and colleagues' definition, which characterizes structural racism as "the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable

systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes.”^{5(p1455)} This definition allows us to think through the effects of racism in public health beyond the clinic and identify the insidious effects of racism across the social determinants of health. I will illustrate the effects of structural racism on drug policy and the opioid overdose epidemic with 2 examples.

Criminalization of blackness

As Michelle Alexander⁶ describes in her book, *The New Jim Crow*, structural racism in drug policy has been enacted through the inequitable arrest and incarceration of people of color for, among other charges, drug-related crimes. In particular, black individuals have been targeted, arrested, and incarcerated through overtly racist policies, such as stop-and-frisk, couched by policy makers as drug and crime control strategies.⁷ These drug control policies, collectively termed the “War on Drugs,” led to the mass incarceration of people with opioid and other substance use disorders.⁶

We know that incarceration worsens drug-related and overdose mortality following release from jail or prison; research shows that individuals are at 2 to 3 times greater risk for overdose or drug-related deaths after release, with that risk as high as 13 times during the first 2 weeks.^{8,9} Furthermore, our drug control policies exclude people with felony convictions from public housing and educational loans.¹⁰ These policies create a ripple effect across the social determinants of health that worsens social stability, family support, and economic opportunity; diminishing these individual- and community-level protective factors increases the likelihood and worsens the health consequences of substance use disorders.¹¹

Since the official start of the War on Drugs in 1971, black and brown communities have borne the brunt of harmful US drug policy. For example, the 1986 law separating criminal penalties for crack and powder cocaine directly targeted blacks, who were more likely than whites to use crack cocaine whereas whites were more likely to use powder cocaine.¹² People who used crack cocaine were caricatured in the media and by policy makers as criminal deviants, ostensibly deserving of harsh penalties.^{13,14} As the opioid overdose epidemic emerged in the early 2000s, however, the majority of overdose decedents were white.¹⁵ This tracked with a marked shift in drug policy rhetoric; white individuals who used opioid analgesics were portrayed as victims, deserving of compassion and treatment,

not punishment.^{14,16} It is important to note how these disparities took form historically through deliberate public policies if we are to implement different and antiracist approaches moving forward.

Inequitable access to treatment

A strong body of evidence indicates that the MOUDs methadone and buprenorphine are highly effective first-line treatments of opioid use disorder that reduce the risk of overdose.^{17,18} Both medications are tightly regulated, although buprenorphine can be prescribed by outpatient providers of any specialty following a prescription training whereas methadone is dispensed only through specialty treatment programs that typically require patients to make daily visits to receive medication. For some patients, the demands of methadone treatment can make it feel more like criminal supervision than health care.¹⁹ The limited availability of buprenorphine, due to federal regulations and inadequate reimbursement by public and commercial insurance, has meant that, in particular, people of color have less access to this more flexibly prescribed medication than to methadone.²⁰

This disparity in access is no accident. Buprenorphine, the first Food and Drug Administration (FDA)-approved MOUD since methadone, was approved in 2003. One expert testified to the US Congress arguing that methadone would not be acceptable to suburban middle-class people with opioid use disorders, using coded language for white people.²¹ Following buprenorphine’s FDA approval, racially targeted marketing took place.¹⁴ These policies and marketing strategies produced the disproportionate use of buprenorphine we see to this day, with greater increases in buprenorphine treatment among people and in neighborhoods that are white and wealthy.^{22,23} These structurally racist policies worsen the likelihood of successful opioid use disorder management for patients of color.²⁴ Through the lens of structural racism, it becomes clear how the primary national treatment-focused response to the opioid overdose epidemic prioritized white individuals and couched the epidemic as a white epidemic.¹⁴

Tools for Antiracist Public Health Practice

As public health officials and policy makers continue to innovate approaches to opioid overdose, we must foreground racial equity in order to reverse the epidemic in ways that achieve gains for people of color as well as whites. Public health scholarship offers several models for conducting antiracist research and practice. Jones²⁵ model emphasizes the importance of identifying and naming the mechanisms by

which institutionalized racism operates. Bailey and colleagues⁵ recommend prioritizing place-based, multisector, equity-oriented initiatives in tandem with policy reform to change the main levers that reproduce structural racism, such as punitive drug control policies. Ford and Jeffers²⁶ offer an approach termed Public Health Critical Race Praxis, particularly focused on research and highly applicable to program monitoring and evaluation. As a public health practitioner, I offer the following approach for other practitioners:

1. Ensure that existing and newly developed programs are place-based, multisector, and explicitly address racial equity.
2. Prioritize policy reform, with a focus on repealing punitive policies and assessment of impact on black people and other people of color.
3. Apply Public Health Critical Race Praxis to research and evaluation.

Taken together, implementing these models in our work with antiracism and racial equity foregrounded is a necessary first step for practitioners and policy makers to do everything we can to undo structural racism and end inequities for black people and other people of color.

Public Health Responses to the Opioid Overdose Epidemic

As the articles in this issue demonstrate, public health researchers and practitioners have made important strides in reducing the harms of the opioid overdose epidemic. It is necessary, however, to reappraise these successes through the lens of structural racism. Only then will we be able to move forward and build health equity through antiracist public health practice.

Opioid analgesic prescribing and mortality

It is well established that aggressive pharmaceutical marketing during the 1990s and early 2000s led to enormous increases in opioid prescribing and concomitant opioid analgesic involved overdose deaths.²⁷ To interrupt this trend, policy makers and health care providers appropriately reconsidered opioid prescribing practices, leading to the development and promulgation of government- and health system–led dissemination of opioid prescribing guidance,²⁸ as well as legislation imposing rigid limits in dosing and duration of prescriptions.²⁹ These policies have contributed to changes in prescribing patterns,^{30,31} reductions in the incidence of chronic opioid therapy,³² and decreases in opioid analgesic mortality.³³ The articles by Fulton-Kehoe and colleagues^{34,35} in this

issue illustrate the implementation of such prescribing practices in Washington State.

Because of structural racism, black people and other people of color have less access to effective pain control, a disparity that was documented during the emergence of the opioid overdose epidemic.^{36,37} Further studies show disparate monitoring, discontinuation, and dosing of opioids in this era of opioid guideline dissemination. In an early study, black patients were more likely to receive urine tests as part of opioid therapy³⁸ and, more recently, were 2.1 and 3.3 times more likely than whites to have opioid therapy discontinued for respective cannabis and cocaine use.³⁹ Black patients also were at increased odds of opioid dose reduction during pain treatment compared with whites.⁴⁰ Of course, prescribing patterns are intermediate outcomes and may not be associated with worse health outcomes for people of color.⁴¹ These findings, however, point to the urgency of monitoring the impact of opioid prescribing policies, naming the contribution of structural racism as a driver for how these are applied, and taking steps such as implicit bias training for health professionals and monitoring policy application to promote equitable outcomes.

Public health surveillance and data sharing

Another central innovation from this epidemic has been the great deal of resources dedicated to improving public health surveillance of overdose. This has led to, among other benefits, reduced lag time in overdose mortality data and enhanced data sharing across sectors.⁴² These enhancements have improved the quality and utility of surveillance data, such as toxicological data from medical examiners, and generated targeted and tailored public health responses.⁴³

Two studies in this issue demonstrate how public health practitioners have used data sharing to develop targeted interventions. Allen and colleagues⁴⁴ describe a targeted fentanyl education campaign developed from enhanced surveillance. Hackman and colleagues⁴⁵ describe the use of data sharing, with strict confidentiality protections, to conduct mortality reviews across sectors. In the case of mortality review, there is tremendous opportunity to use a racial equity lens to both interpret data and identify policies and practices that could reduce the health consequences of substance use. Such a lens might assist policy makers to prioritize, for example, ways to reduce criminal justice involvement and increase access to effective treatment without the use of coercion.⁴⁶

Foregrounding racial equity makes visible the inequitable risks of data sharing, particularly for black people and other people of color. For example, data sharing between the health care and the child welfare

sectors has led to the racist implementation of drug screening policies for mothers with histories of drug use, disproportionately criminalizing black women.⁴⁷ “Door knocking” interventions, a relatively new practice that has been implemented in numerous jurisdictions nationwide, use police officers to follow up with individuals who experienced an overdose and sometimes rely on data sharing between public health and law enforcement actors.^{48,49} Police officers’ access to health-related data can occur via several routes, including possession and retention of data through their role as first responders, coincidental with an emergency service response, or through cross-sector sharing. Application of Public Health Critical Race Praxis to the evaluation of these new interventions supports an examination of both their potential positive effects (eg, reducing risk of overdose) and negative effects (eg, increasing stigma, fear, and help-seeking avoidance that increase the risk of overdose). An antiracist lens leads us to hypothesize and then examine whether these effects differ by race because of structural racism.

Conclusions

The consequences of discrimination against people who use drugs and structural racism against people of color have preserved punitive approaches and diminished the effectiveness of health-oriented approaches. As public health practitioners, researchers, and policy makers, we must scrutinize the conception and impact of our programs and policies to be sure we do not reproduce structural racism and its consequences, such as stigma and criminalization. Furthermore, we must be sure to assess health outcomes, not just intermediate or proxy outcomes such as prescribing patterns, and be sure that our intermediate outcomes really do reflect the health outcomes we wish to change.

The articles in this issue demonstrate the step forward that public health has made since the start of the opioid overdose epidemic, but we cannot rest on our success in the absence of absolute gains, as well as reductions in disparities between people of color and white people. Public health leaders need to foreground racial equity to achieve the gains that are—for the first time in the field of substance use—imaginable in the United States. This means using antiracist public health practice to be vigilant about what practices and policies we implement and anticipate their unintended consequences, including how we measure and test their impact, so that all people, but particularly people of color, benefit. It is crucial that we work for deep, structural changes to the apparatuses that for so long punished people and communities affected by drug use, using the power of antiracist public health

practice to treat people who use drugs with dignity and respect.

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