Social Determinants of Health and Opioid Use Disorder in BIPOC Communities

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Housekeeping

- Today's webinar is being recorded and all participants will be kept in listen only mode.
- The recording and slides will be made available on the PCSS website within 2 weeks.
- There will be an opportunity to ask questions at the end of the webinar, so we encourage you to submit your questions throughout the webinar in the Q&A box located at the bottom of your screen.

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

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Today's Speakers

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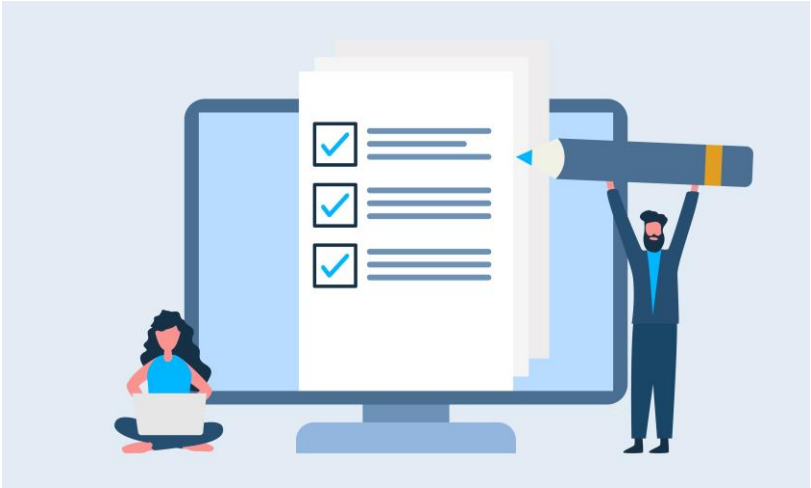
Disclosures

- Rachel Talley: Medical Advisor, Vanna Health
- Jessica Isom: None



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Target Audience

The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

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Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Examine how social determinants of health may impact initiation of and ongoing substance use
  - Discuss factors that facilitate and hinder engagement in long-term treatment and recovery for BIPOC individuals
  - Identify strategies for organizations to assess and address opioid use among BIPOC individuals through addressing social determinants of health

What are the Social Determinants of Mental Health?

Please share your responses in the chat

Social Determinants of Mental Health

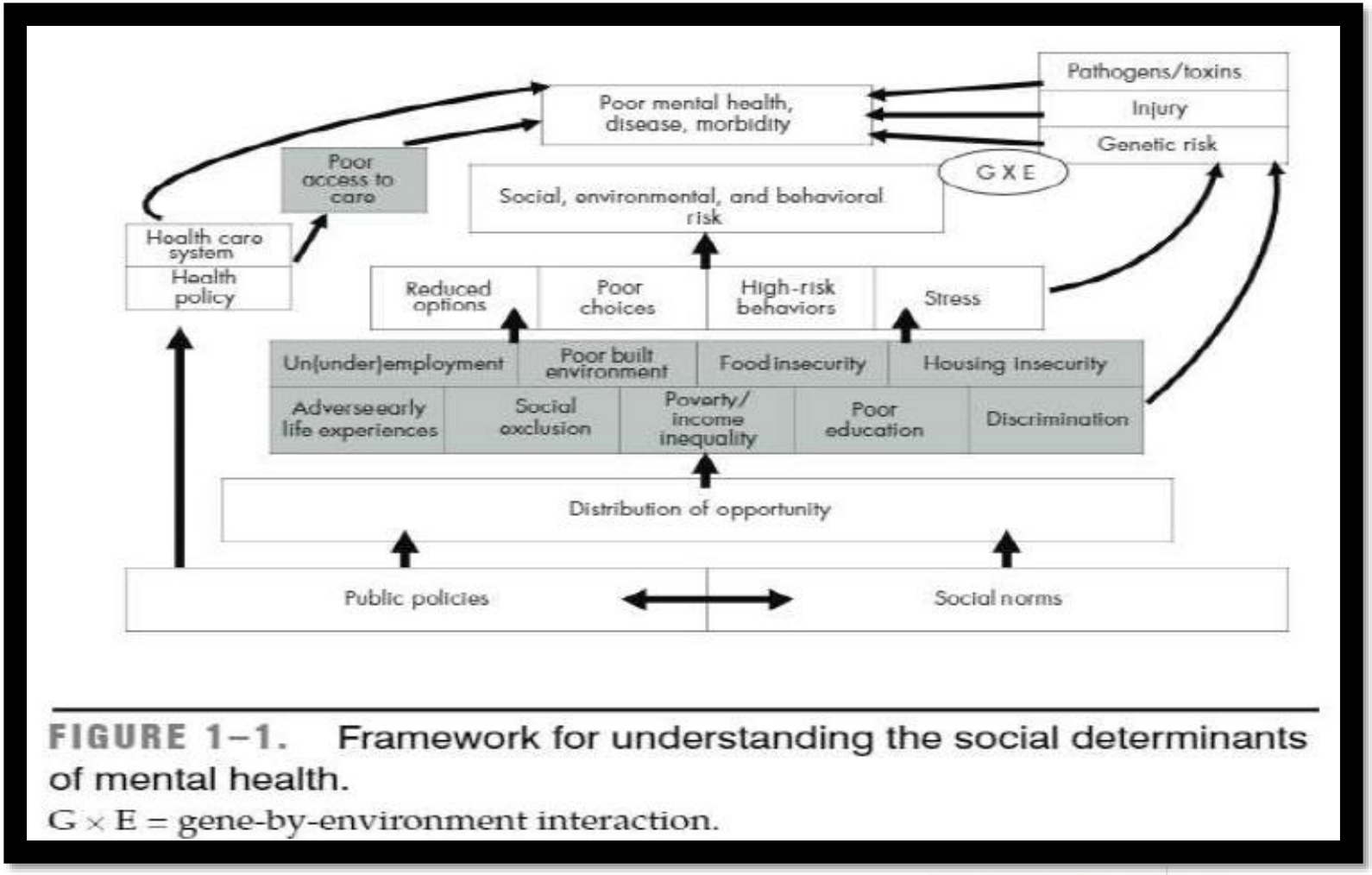


FIGURE 1–1. Framework for understanding the social determinants of mental health.

G × E = gene-by-environment interaction.

Source: Compton M. T. & Shim R. S. (Eds.) (2015

Social Determinants of Mental Health

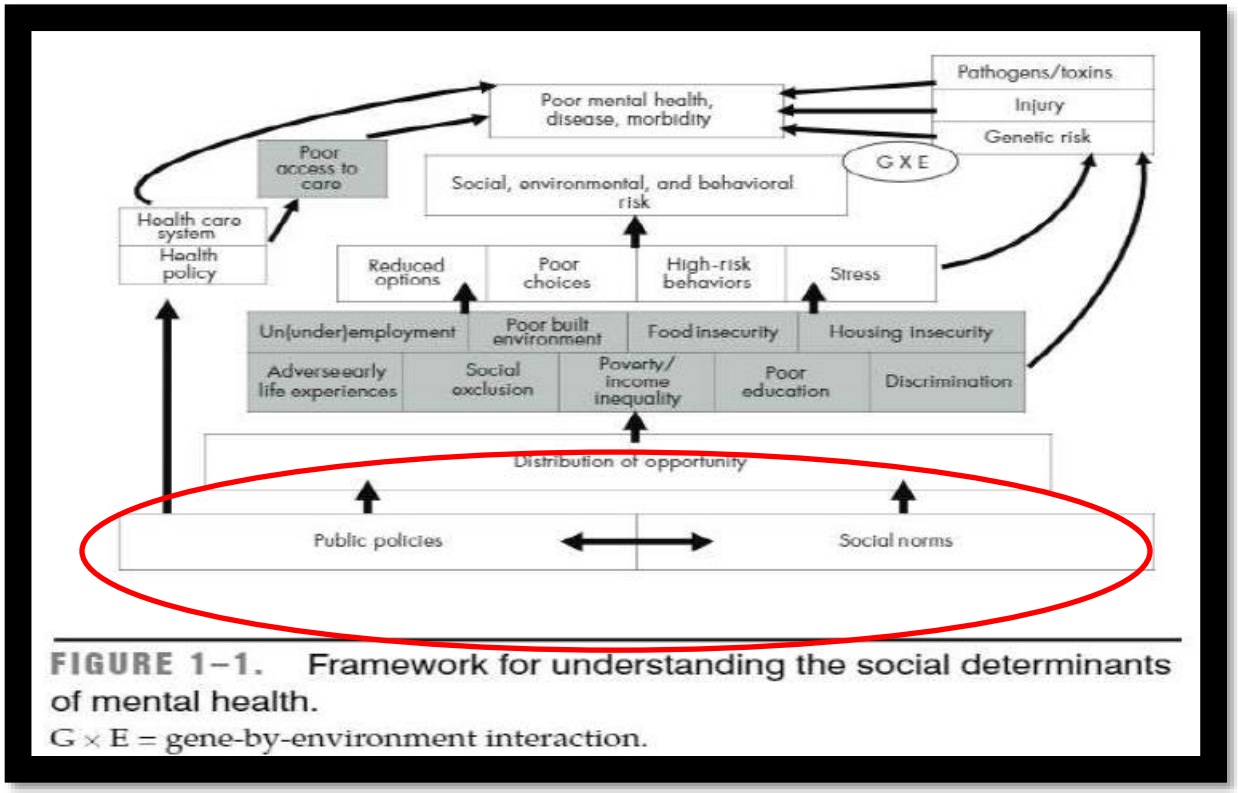
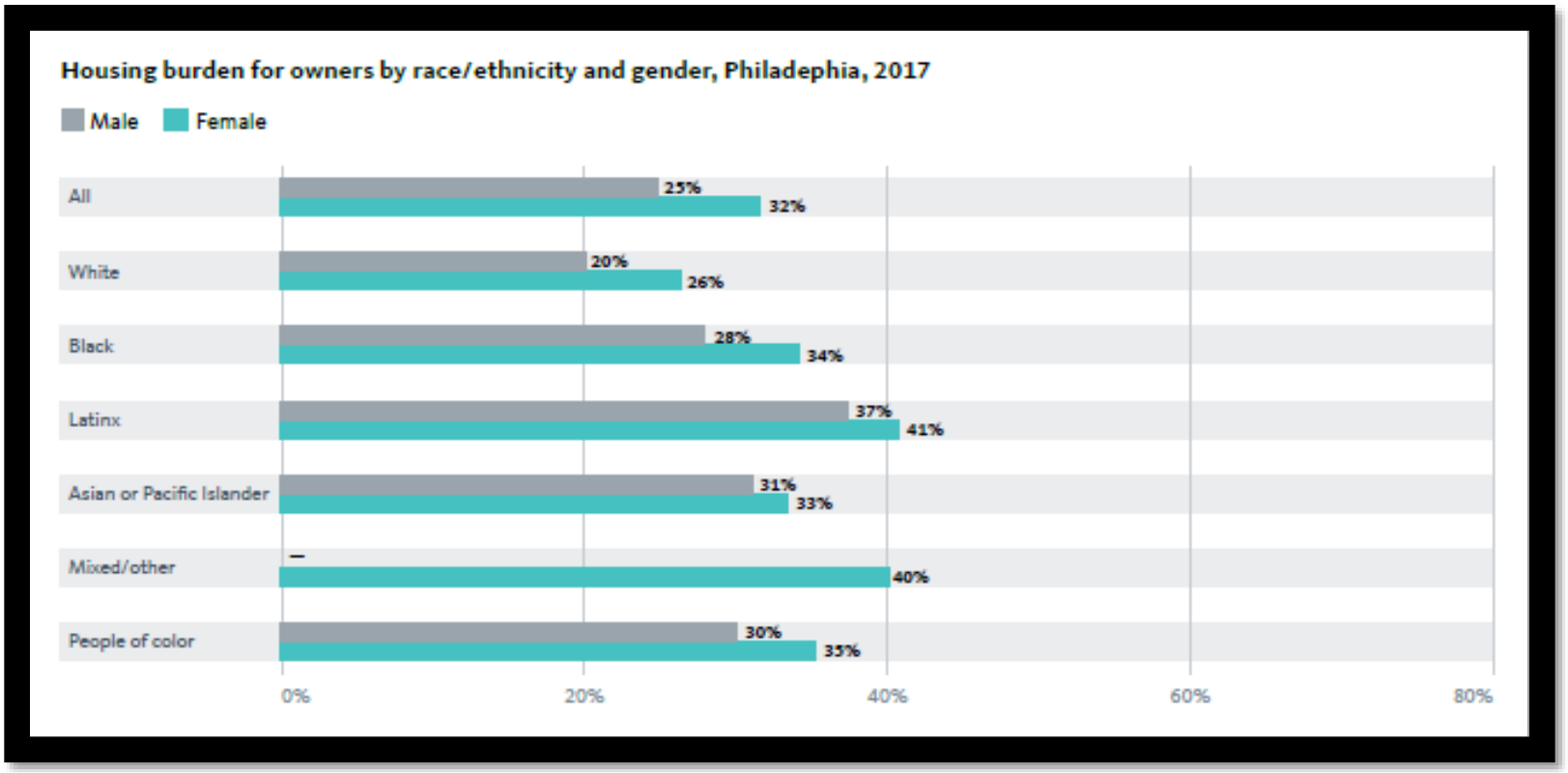


FIGURE 1–1. Framework for understanding the social determinants of mental health.
G × E = gene-by-environment interaction.

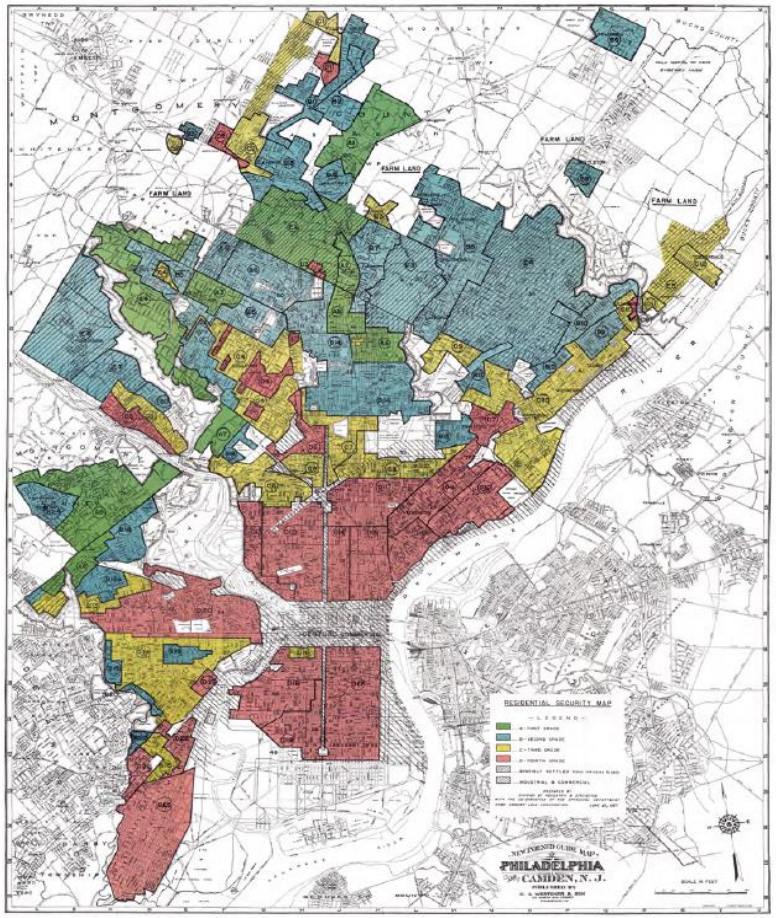
Disparities in the social determinants of mental health do not occur by accident

Rather, they are often driven by biases in social norms that drive discriminatory policies

Social Determinants of Mental Health



Social Determinants of Mental Health



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SDOMH and Substance Use: Housing Status as an Example

- Boston Health Care for the Homeless Program data, 2003 – 2017 (Fine et al 2022)
  - Drug overdose mortality rate **12** times higher among individuals experiencing homelessness as comparted with general adult population in Massachusetts
  - **91%** of overdose deaths in involved opioids

- Deaths among individuals experiencing homelessness in San Francisco, CA, 2016 – 2021 (Cawley et al 2022)
  - Deaths among individuals experiencing homelessness doubled during first year of COVID-19 pandemic
  - Proportion of deaths due to overdose: 34% → 82%
  - Proportion of fentanyl-involved cases: 6% → 68%

SDOMH and Substance Use: Employment Status as an Example

- Analysis of data from U.S. National Survey on Drug Use and Health, 2002 – 2010: Employment status strongly associated with problematic substance use (Compton et al 2014)
- Another analysis of U.S. NSDUH 2002 – 2015: state unemployment rate is positively associated with recent misuse of analgesics, oxycodone, and heroin (Carpenter et al 2017)
- 2017 National Bureau of analysis of CDC mortality data and state-level data on emergency department use: 1% increase in county unemployment associated with 3.6% increase in opioid death rate and 7% increase in opioid overdose ED visits (Hollingsworth et al 2017)
- National representative data 1993 – 2016: one unit increase in unemployment associated with 9% increase in opiate use treatment admissions (Azagba et al 2021)

Employment Status and Substance Use

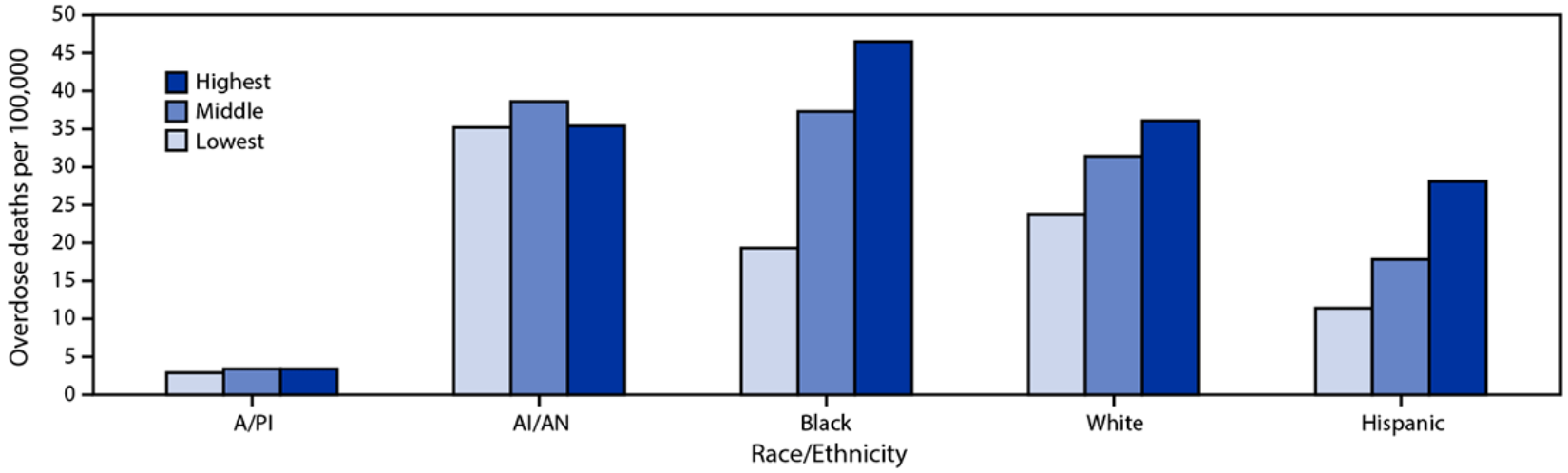
Table Unemployment, Past Month Heavy Alcohol Use, Illicit Drug Use and Tobacco Use, and Past Year Alcohol Abuse or Dependence, and Illicit Drug Abuse or Dependence among Employed and Unemployed Persons in the USA, Ages 18 and older, 2002 - 2010

	Unemp.	Employed	Unemp.	Employed	Unemp.	Employed	Unemp.	Employed
	% (S.E.)	% (S.E.)	% (S.E.)	% (S.E.)	% (S.E.)	% (S.E.)	% (S.E.)	% (S.E.)
Heavy Alcohol Use	**13.4 (0.64)**	**8.5 (0.14)‡**	**11.4 (0.59)**	**8.5 (0.14)‡**	**12.6 (1.06)**	**8.7(0.23)‡‡‡**	**11.2 (0.58)**	**8.4 (0.16)‡**
Heavy Alc Use, age 18-25	16.4 (0.68)	15.8 (0.24)	14.6 (0.64)	16.2 (0.25)‡	15.4 (0.96)	15.5 (0.44)	13.5 (0.57)	14.6 (0.31)
Heavy Alc Use, age 26-64	12.1 (0.90)	7.4 (0.16)‡	9.9 (0.85)	7.4 (0.16)‡	11.6 (1.58)	7.7 (0.27)‡	10.5 (0.83)	7.6 (0.19)‡‡‡
Illicit Drug Use	**18.3 (0.71)**	**8.5 (0.13)‡**	**17.9 (0.72)**	**8.8 (0.14)‡**	**19.5 (1.32)**	**8.5 (0.24)‡**	**17.2 (0.66)**	**8.9 (0.18)‡**
Tobacco Use	**49.4 (1.10)**	**33.8 (0.26)‡**	**49.9 (1.05)**	**33.1 (0.26)‡**	**47.3 (1.83)**	**32.0 (0.46)‡**	**45.6 (0.98)**	**30.3 (0.31)‡**
Alcohol Abuse or Dependence	**15.3 (0.72)**	**9.0 (0.13)‡**	**14.4 (0.73)**	**9.0 (0.13)‡**	**14.7 (1.04)**	**9.1 (0.25)‡**	**12.4 (0.57)**	**8.3 (0.16)‡**
Alcohol Ab/Dep, age 18-25/	19.7 (0.72)	18.0 (0.23)‡	17.9 (0.73)	18.2 (0.25)	20.0 (1.11)	18.1 (0.42)	16.2 (0.65)	16.9 (0.30)
Alcohol Ab/Dep, age 26-64	13.4 (1.03)	7.6 (0.15)‡	12.6 (1.05)	7.6 (0.15)‡	12.3 (1.48)	7.9 (0.29)‡‡	10.8 (0.81)	7.1 (0.18)‡
Illicit Drug Abuse or Dependence	**7.9 (0.50)**	**2.8 (0.07)‡**	**8.8 (0.50)**	**2.6 (0.07)‡**	**8.6 (0.80)**	**2.6 (0.11)‡**	**6.6 (0.37)**	**2.5 (0.08)‡**
Unemployment	**5.0 (0.10)Δ**		**4.6 (0.10)Δ**		**5.6 (0.20)Δ**		**9.2 (0.18)**	
	2002-2004		**2005-2007**		**2008**		**2009-2010**	

Source: Compton et al 2014

Opioid Use Disorder and BIPOC Communities

- Overdose deaths increased by **30%** between 2019 – 2020, primarily driven by fentanyl and synthetic fentanyl analogs
- Rate increases were highest among Blacks (44%) and American Indian/American Native (39%) populations (rate increase among Whites: 22%)



Source: CDC, 2022

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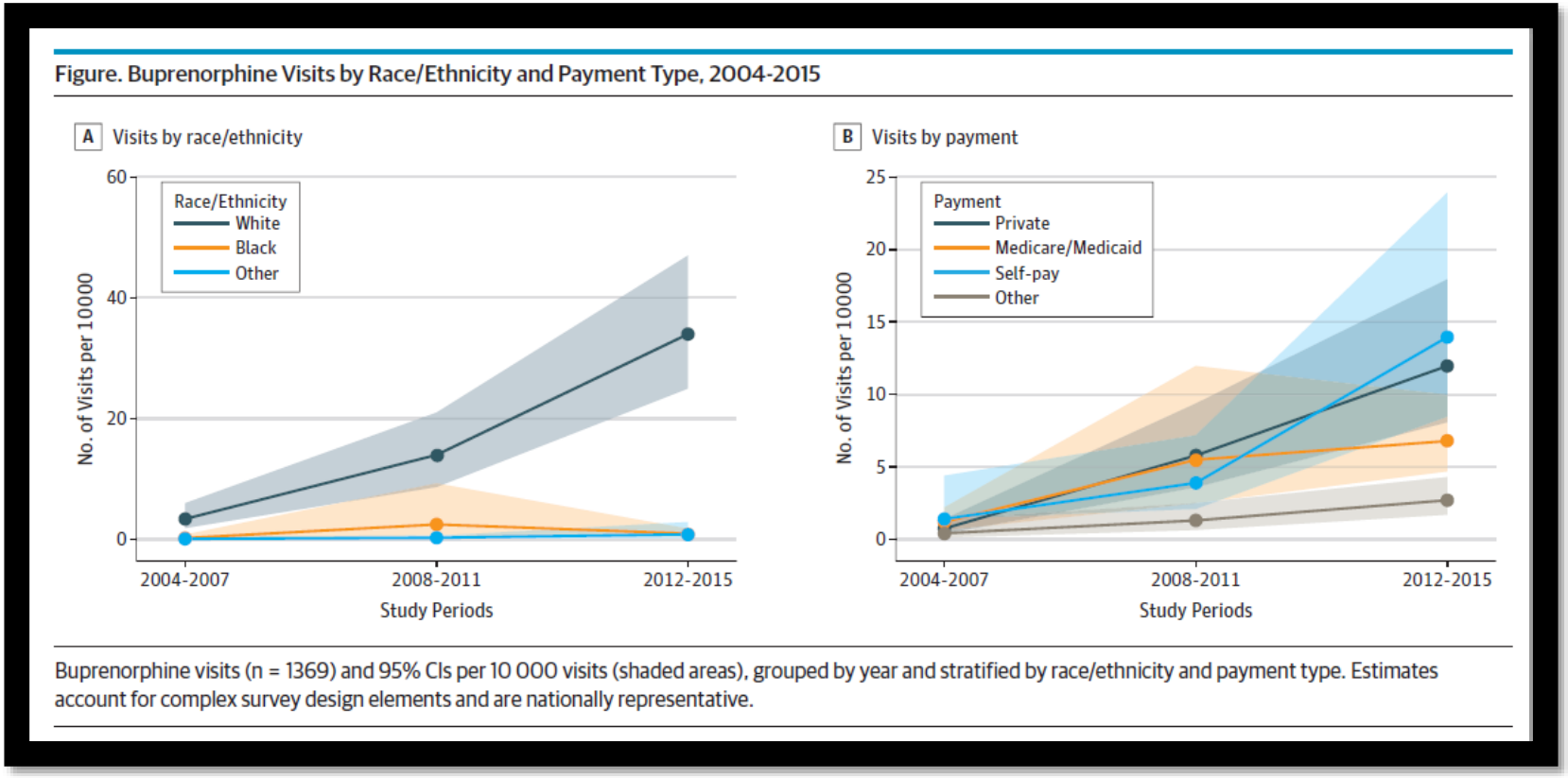
BIPOC Communities and OUD Treatment Engagement



Source: Lagisetty et al 2019

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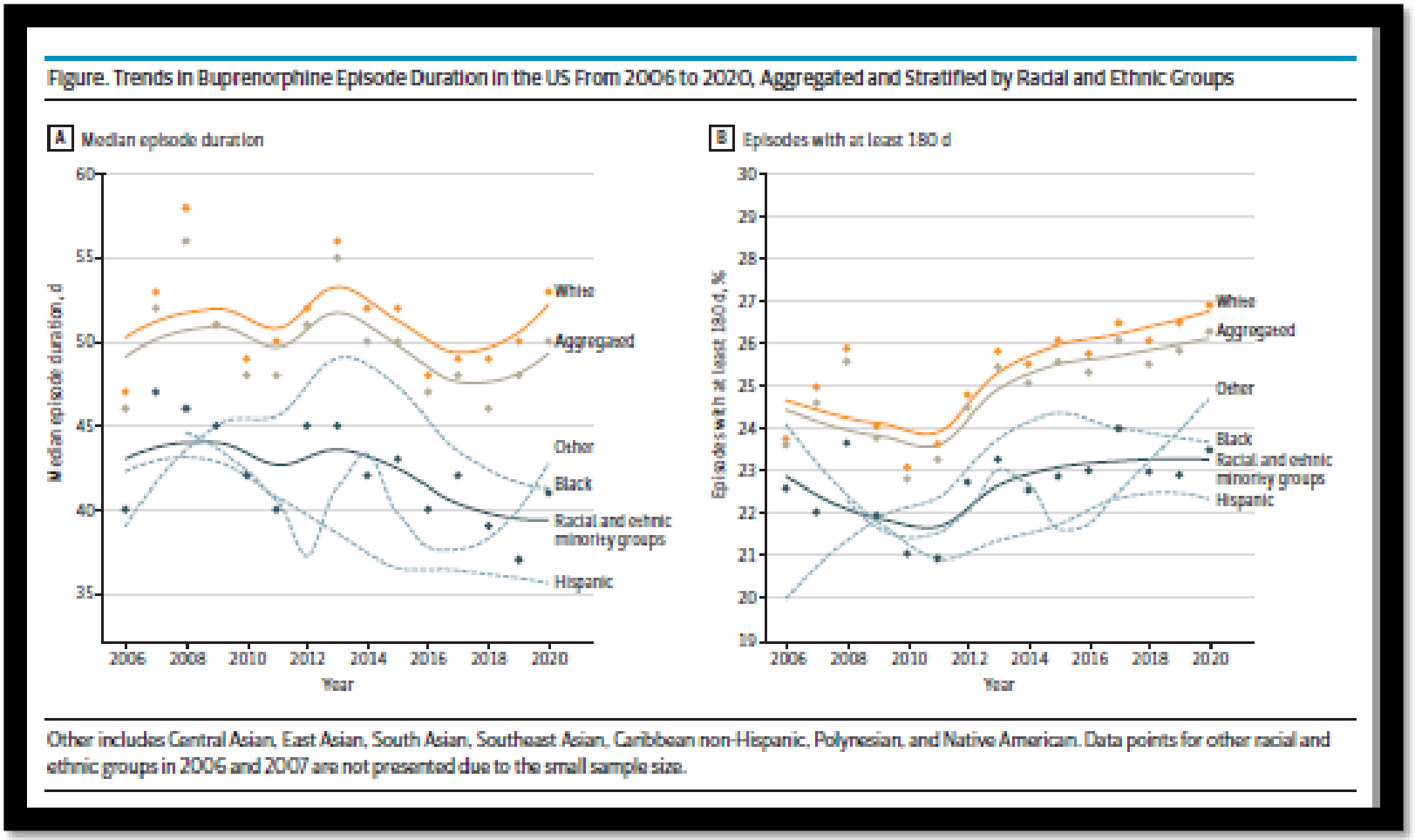
BIPOC Communities and OUD Treatment Engagement



Source: Dong et al, 2022

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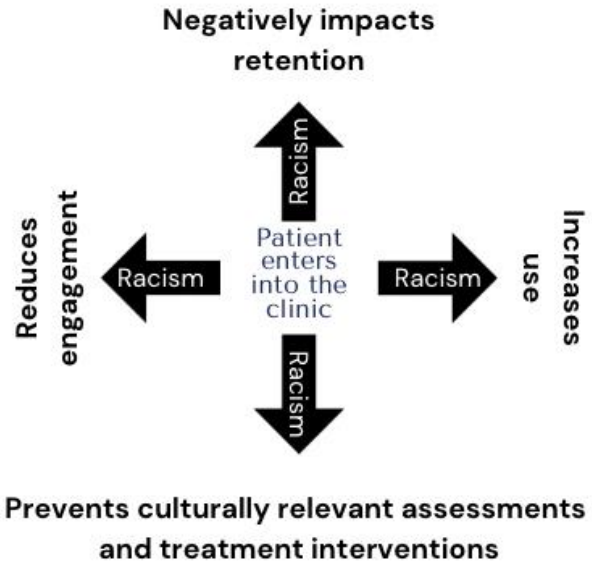
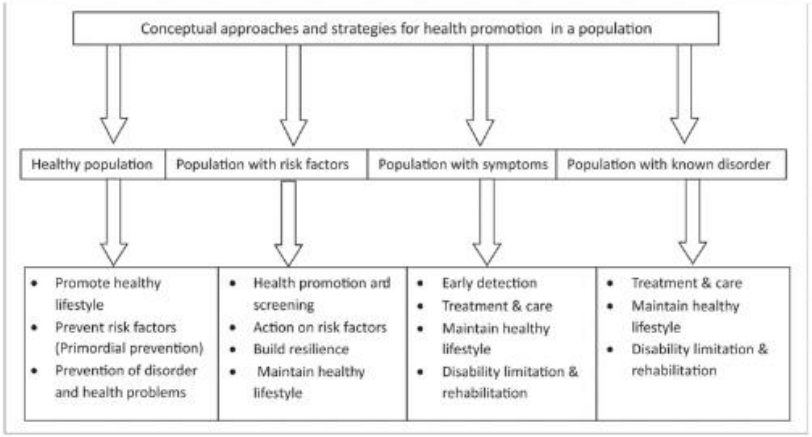
Racism & Discrimination as a SDOH



How does racism shape experiences of OUD?



Matsuzaka, S., & Knapp, M. (2020). Anti-racism and substance use treatment: Addiction does not discriminate, but do we?. Journal of ethnicity in substance abuse, 19(4), 567–593. https://doi.org/10.1080/15332640.2018.1548323

Facilitators of Treatment Initiation and Engagement for BIPOC with OUD

Betzaida, a 48-year-old woman from the Dominican Republic with OUD often sleeps in Dorchester off of Washington Street. She has presented to the area's Federally Qualified Health Center (FQHC) urgent care with concern for an intravenous drug use (IVDU) associated infection. She reports onset of a rash with streaks two days prior and a subjective fever.

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

- **“Doc, it’s been so hard for me with this rash. I’m worried.”**
- “Well, I have some questions for you. I’m glad you came in to see us.”

The physician offers antibiotics to treat the skin rash and astutely inquiries about recent IVDU.

- “When I see rashes like this, and marks like those, I wonder if you’ve been using drugs Betzaida?”
- **“Yes. I have. Things have been so hard for me.”**

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Betzaida confirms injecting heroin on a regular basis. The admission is for her is a first time sharing her drug use. She's felt significant shame and embarrassment around her use as she knows her family would disapprove and her only daughter would be disappointed.

- **"I've told no one. I can't tell anyone. My life is a mess. I'm so alone and I'm scared."**

- "Well, hang in there. Let's get you information on how to stop using that drug. It's not good for you."

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

She is given a referral pamphlet for the SUD team and offered an intake with the suboxone clinic. Betzaida requests a pamphlet in Spanish, which is not available in the clinic. She asks whether there are evening hours for the clinic.

- **"I have so many questions. I hope that's okay."**

As she leaves the urgent care, she is observed eying the security guard closely. Dressed in soiled clothing, she's used to stares and such though asks herself "Why is the police here? What kind of place is this?"

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

Two weeks later, Betzaida returns to the urgent care clinic with a chief complaint of malodorous vaginal discharge. She reports recent unprotected sex, as a result of sexual assault in an area shelter.

- **“I’ve really been going through some things. I have no one. Yes, I’m still using. What else can I do?”**

Due to her escalating heroin use, she lost her job and apartment six months ago. She had been a store stock clerk and had worked alongside a group of people she got along well with. They’d lost contact since being unemployed and without a home.

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

She describes a depressed mood and passive thoughts of not caring if she wakes up in the morning. Betzaida also reports significant shame regarding her ongoing IVDU and the problems it is causing for her life.

- **"I did this to myself. I'm to blame. I should have been stronger. And now, every day, I'm abusing myself with this drug. What's wrong with me?"**

She updates the physician on missing the intake appointment at the suboxone clinic and asks to be offered another date.

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

- "We are very limited in our resources here. You have to be more responsible and respectful. That's what we expect here."

She expresses concerns for "getting in trouble," if she attends the appointment and points to the security guard.

- **"I've been to prison before. It wasn't my fault but…is this really a clinic? I can't read English well…I know they deported some folks I knew…I'm really uncomfortable. Can I go somewhere else, please?"**

She is reassured that the services are not offered in connection with law enforcement and is given another appointment for the following day.

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

Betzaida arrives to her intake appointment two hours late citing issues with public transportation.

- "Ma'am, we have a full schedule today. I see this is your second no show."
- **"So sorry. I can leave."**
- "Have a seat ma'am, you're lucky there's a slot I've put you in."

She meets with an intake coordinator who presents the information on suboxone in a rushed manner supplemented by written materials.

- **"Your addiction is killing you. Look what you've done to your body. You need our help. We can save your life."**

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

The images on the patient education materials, similar to the pamphlet, do not appear similar to Betzaida or her family members. She again struggles to read the text written in English and denies having questions about the medication when asked.

- **As she mumbles through the intake, she's thinking "What have I done to myself? She's right. I've lost control and taking more drugs is the answer she's saying. I can't do this. What would my family think about this? Replacing one terrible drug with another. Pray, they would say I think."**

While in the waiting room prior to her meeting with the service provider who will prescribe suboxone, Betzaida decides she is not ready for initiation and quickly exits the building.

Facilitation of and Barriers to Treatment Initiation and Engagement for BIPOC with OUD

After two weeks, she's found unresponsive in an area shelter and is pronounced dead on the scene after three rounds of narcan administration.

- What facilitators of treatment initiation and engagement are missing here?

- What are the possible pivots in this case at the provider and organizational level?

Barriers to Treatment Initiation and Engagement for BIPOC with OUD

What facilitators of treatment initiation and engagement are highlighted here?

Analysis of data from Best Practices and Barriers to Engaging People with Substance Use Disorders in Treatment by ASPE (O'Brien, et al 2017)

- **Individual**: sex (female), co-occurring conditions, stigma, cultural sensitivity and responsiveness
- **Provider**: workforce shortages, selectivity in insurance acceptance (Medicaid), attitudes towards OUD/stigma, lack of screening, limited case management support
- **Environmental & health plan factors**: shortage of residential treatment beds, available IOP/PHP & outpatient services, Medicaid insurance coverage of residential treatment, insurance reimbursement for peer and recovery supports, low reimbursement rates

Barriers to Treatment Initiation and Engagement for BIPOC with OUD

Table 2.

Summary of results reported in systematic reviews for barriers of SUD treatment.

Level	Barriers [a]
Individual	*Wrong belief about treatment:* Belief that treatment was unnecessary (3, 8), preferring to withdraw alone without assistance (2, 8), beliefs about methadone (2, 10)
	Perceived fears: Fear of incarceration (4), Fear of stigma (4), Fear of inconvenience (4), Fear of loss custody of children (for mothers) (4), Fear of suspension or termination of parental rights (4), Fear of withdrawal symptoms (10), Fear of life without the stability and routine of taking methadone (10)
	Personal traits: Low self-esteem (10), Individuals' self-concepts (10), Low self-confidence (10), Identity difficulties (10), Privacy concerns (2, 3, 8), Loneliness (10), Motivational factors (1, 3, 8, 9, 10). Poor coping styles to deal with difficulties (1, 5, 6) problem with emotional management (1, 10).
	Psychiatric comorbidities: (1, 3, 10)
Social	*Stigma and lack of social support:* Embarrassment or stigma (1, 2, 5, 8), Lack of social capital or social support (1, 3, 4, 5, 8), Not having anything else going on in one's life (10)
	Family factors: Influence of habits of spouse/partner/family members/peers to drugs (6), Partner dropped out (10), Partners violence (10), No supportive family (1)
	Friends network: Non supportive friends (1), Difficulties with establishing a non-drug using network of friends, and severing ties with existing drug-using networks (10), Over-reliance on other clients (10) Secrecy or fear about the past in new interpersonal relations (10), Negative role model (10), Lack of models who have successfully recovered (10)
	Problems with a therapeutic team: None emphatic relationship from treatment staff (1, 2, 3, 4, 11), Poor therapeutic relationship between patients and practitioner (11), Tensions between peer workers and programme staff (5), Wrong belief about people who use drug among therapeutic team(5), Very dependent relationships with treatment staff (10), Clients' passivity in accepting staffs' attitudes (10)
Structural	*Problems related to treatment provider services:* Insufficient places (1, 2, 3, 8, 11), Waiting lists/times (2, 8, 11), Unsuitable/ineffective services for people with mental illness (1, 4, 8),

- *Wrong belief about treatment*
- *Family factors*
- *Stigma*
- *Psychiatric comorbidities*
- *Problems with a therapeutic team*
- *Perceived fears*

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Barriers to Treatment Initiation and Engagement for BIPOC with OUD

Table 2.

Summary of results reported in systematic reviews for barriers of SUD treatment.

	11), Poor therapeutic relationship between patients and practitioner (11), Tensions between peer workers and programme staff (5), Wrong belief about people who use drug among therapeutic team(5), Very dependent relationships with treatment staff (10), Clients' passivity in accepting staffs' attitudes (10)
Structural	*Problems related to treatment provider services:* Insufficient places (1, 2, 3, 8, 11), Waiting lists/times (2, 8, 11), Unsuitable/ineffective services for people with mental illness (1, 4, 8), Expensive costs and financial problems (8, 9, 11), Lack of available ancillary psychosocial services (10), Staff attitudes service providers (8), Lack of training in both nurses and General physicians(GPs) (11, 2), Lack of appropriate skill for non-physician team members for high-quality care (2, 10), A lack of primary care SUD fellowship (10), Lack of connection between emergency care and professional medical treatment (5). Insufficient training and support for peers (5) Lack of availability of peer workers (5), Lack of suitable treatment system for both genders (1, 2, 4, 8, 10, 11, 12), Ideology of treatment (9), Treatment intensity (10), Clinical inertia among nurses (11), GPs attitude to drug or alcohol (6), Therapeutic impasse (10), Failure to ground programming in the lived experiences of person who previously used drug (1, 2, 5), Lack of qualified workforce (2), The lack of appropriate treatment protocols (2), The preference for a forced detoxification approach instead of medical approach in some setting such as correctional-educational environments (2), Lack of adherence to treatment protocol (2). *Legal barriers:* Restrictive policies (lack of a legal structure for various organisational relationships, such as prisons and medical settings that patients could follow their treatment) (2), Implications for child custody arrangements for parents who use drug or alcohol (8), Misuse of prescribed medications (7, 10), Prescription challenges (10). *Policy barriers:* Exclusionary attitudes, policies and programmes (5), Policies which favour enforcement rather than harm reduction (5), Lack of focus on vulnerable sub-communities despite identified needs (5), No decision-making lived experiences of person who us drug (5) Failing to address social determinants of health (5), No considering contextual factors (5), Lack of focus during outreach on housing, jobs (5), The continued criminalisation of drug use (and people who use drugs) (5), Policies that favour enforcement (5, 1), Lack of linkage or coordination between correctional and community medications for treatment of opioid use disorder (MOUD) treatment providers (2).

- *Exclusionary attitudes*
- *Lack of harm reduction interventions*
- *Failure to address SDOH*

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Facilitators of Treatment Initiation and Engagement for BIPOC with OUD

Table 3.

Summary of results reported in systematic reviews for facilitators of SUD treatment.

Levels	Facilitatorsa
Individual	*Personal motivation:* Establishment of a non-addict identity (10), Personal motivation (1, 4, 5)
Social	*Family:* Supportive family (3)
	Friends: Influential safe peers (5), Safe model of peers (5), Supportive friends (1, 4)
	Treatment team: A supportive and confidential individual counselling approach and Trusting relationship with the treatment team (1, 2, 4, 9, 12)
Structural	*The setting of treatment provider services:* Training of key skills for creating an opportunity for children to be with parents (for mothers) (1, 2), Availability of effective treatment (3, 12), Appropriate context for discussion (11), Open communication between the NCM and SUD counsellors (7), Training for GPs and staff (3, 11, 7), Access to financial support (3, 4, 10, 7), Peer involvement in the governance and management of the programme (5), The direct participation of people who use drugs as outreach workers (5).
	The logistic of treatment programme: Implementation of prior experiences and management stability (11), Multidisciplinary and coordinated care delivery models (7), Employ clinical pharmacists for medication dosing management (11), Developing systems that provide care & feedback for patients (11), Home induction helping (11), Case management, & counselling for complicated patients (11), The use of culturally relevant programming (5), Flexible models of service delivery which are open to change (5), The inclusion of structural interventions which address broader issues (5), Women-only programme for females (12), Residential treatment (12), Providing child care (1, 4, 12), Intensive case management and aftercare support (12)
	Policy and other organisation: A positive relationship between the institution and the broader community, political support, policy support and recognition as a valuable organisation by local health authorities (5), Peer influence and social networks; providing training and support to peers in their work (5), Successful harm reduction programmes (5) The leadership of peers in promoting health fosters behaviour change (5), Hiring female peer outreach workers to specifically target vulnerable populations (5), Offering women-friendly outreach kits and referrals to female-specific services (5), Police support (5).

- *How might these have benefited Betzaida?*

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Organizational Equitymindedness

Improve Access:

- time of day to address work schedules that include late shifts and multiple jobs
- targeted marketing and advertising to racially minoritized communities
- locate scholarship programs for financially limited persons with SUD in need of residential treatment
- transparency on recognition of how racism shapes SUD services and the need for antiracism in the program's policies, practices and norms

Organizational Equitymindedness

Improve Intake Process:

- ensure screenings include assessment for SDOH that might prove as barriers to engagement to inform future iterations of change (structural vulnerability tool as an example)
- ensure screenings specifically address experiences of or concerns for discrimination and mistreatment related to accessing treatment
- collect demographic information on self-identified race/ethnicity as well as other identities that can ultimately be disaggregated to assess for disparities (and to inform future iterations of change; who's missing? not being retained?)

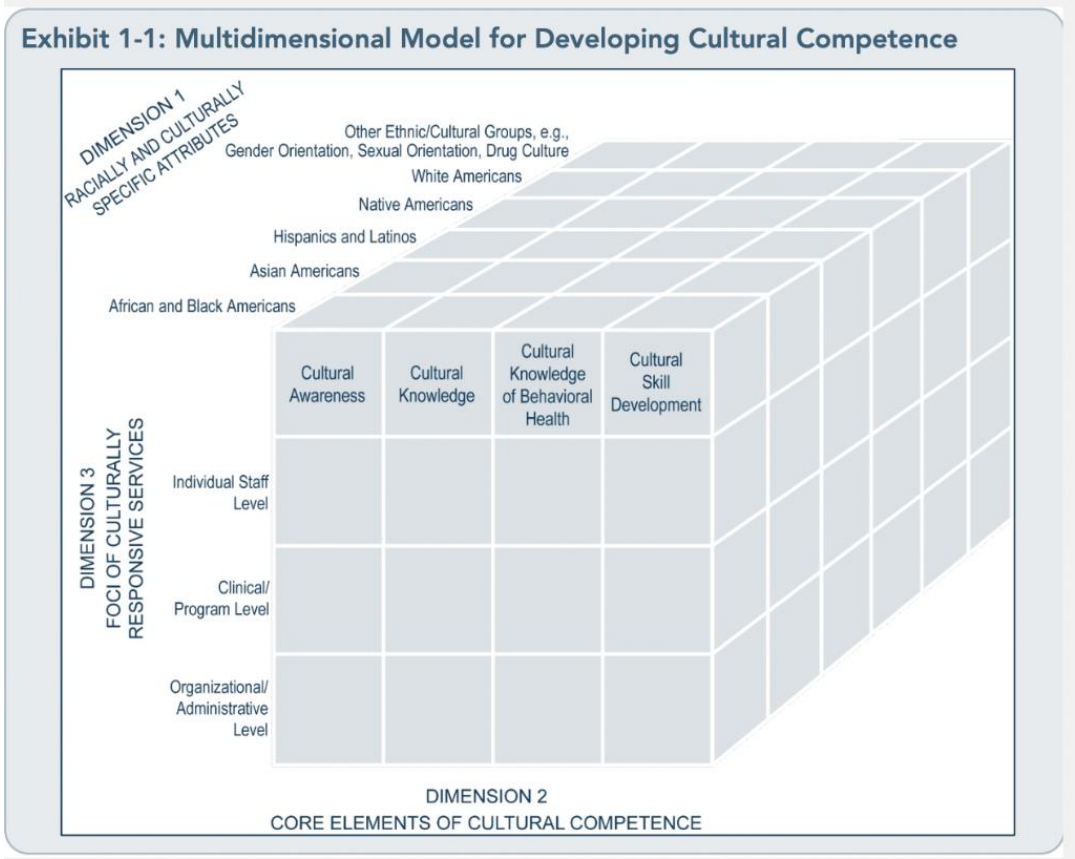
Organizational Equitymindedness

Improve Engagement:

- ensure satisfaction surveys specifically inquire about experiences of or concerns for discrimination and mistreatment related to accessing treatment
- connect shared decision making models to implicit bias concepts and skills (how might stereotypes, racial anxiety and racial stereotype threat impact shared decision making?)
- include individuals with lived experience, specifically racialized minorities, in the process for program development and improvement

Organizational Equitymindedness

Enhance Cultural Sensitivity and Responsiveness of Services



Organizational Equitymindedness

Enhance Cultural Sensitivity and Responsiveness of Services

- create a widely publicized and transparent process for reporting and addressing experiences of or concerns for discrimination and mistreatment related to accessing treatment
- develop a systems resource guide for clients/patients
- attend programming from intersectional support groups to increase a knowledge base/skillset for culturally responsive care

Organizational Equitymindedness

Enhance Cultural Sensitivity and Responsiveness of Services

- increase the racial literacy of staff and leadership
- train staff and leadership to recognize and respond to racial and other microaggressions in the workplace and in treatment contexts
- clinical leadership ensures race, ethnicity, gender, language and culture are explicitly discussed in case reviews and multi-disciplinary team reviews.

Organizational Equitymindedness

Enhance Cultural Sensitivity and Responsiveness of Services

- raise awareness of impact of disparities, assumptions and stereotypes on engagement and successful treatment
- bring to surface and discussing staff beliefs, attitudes and values related to race, ethnicity, linguistic minorities and culture
- understand that in the treatment relationship, the individual served is the expert on his or her culture
- promote recognition that culturally responsive care improves capacity to provide high-quality care.

Organizational Equitymindedness

Policy Interventions

- prioritize crisis services in communities of color that may avoid emergency services due to fear of police response
- implement an ongoing process that includes representative members of local/state BIPOC communities to evaluate current mental health services in order to identify disparities, analyze barriers to care, implement effective policy changes, and hold stakeholders accountable
- ensure all social determinants that are affecting racially minoritized communities' mental health outcomes are being considered and identified
- advocate for policies that expand access to telehealth, improve pharmaceutical benefits
- engage in regular needs assessments and communicate with community members to identify unmet needs.

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Questions?

PCSS Providers Clinical Support System

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- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD)**.
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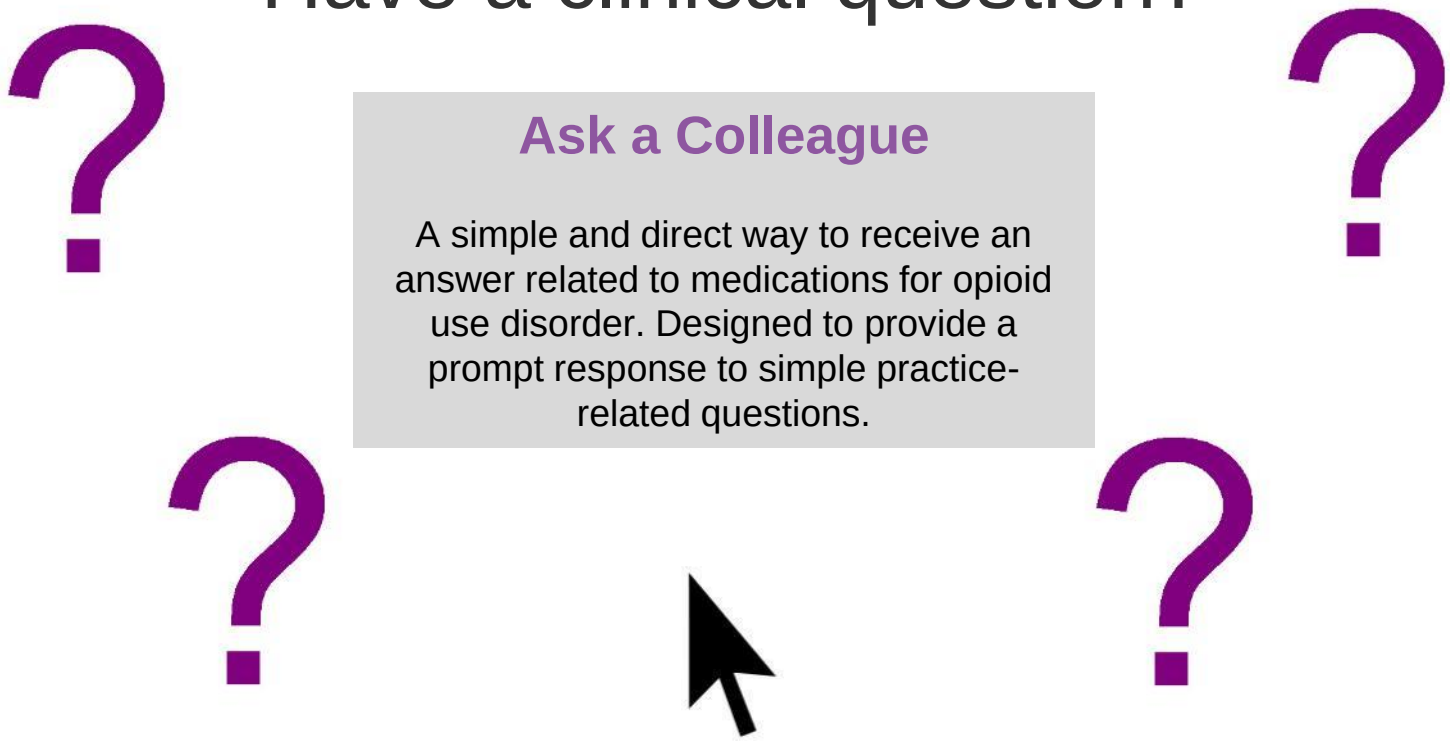

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American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
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