Racial Disparities in Treatment for Pain and Opioid Use Disorder

How did we get here and where are we going?

Dr. Pooja Lagisetty
Assistant Professor
University of Michigan Medical School
Veterans Health Administration, Ann Arbor

No conflicts of interest

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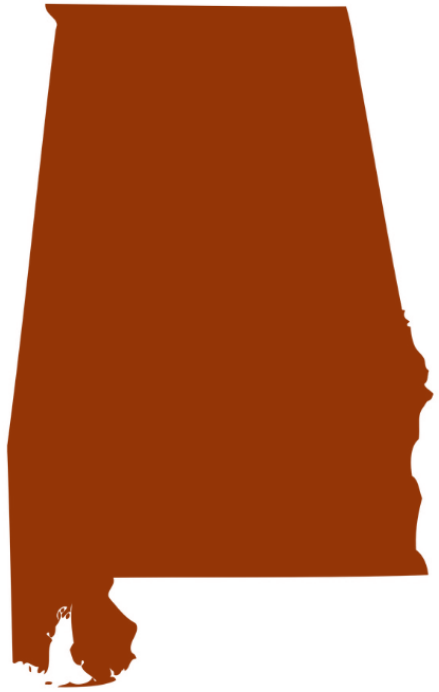
About Me



- Primary Care and Addiction Medicine Physician
- Research focuses on understanding how stigma, bias and racism affects access to care for patients with chronic pain and substance use disorders
- Became interested in addiction and racial disparities after growing up as a South Asian in Alabama

Objectives

- Review legislative history around addiction
- Discuss current opioid misuse and overdose rates by race
- Highlight disparities in access to treatment for pain and OUD
- Underscore why these disparities continue

A look at recent drug policy

1970s: A War on Drugs

"America's ***public enemy number one*** in the United States is drug abuse. In order to ***fight and defeat this enemy***, it necessary to wage a ***new all-out offensive***. I have asked the Congress to provide the legislative authority and the funds to fuel this kind of an offensive. This will be a worldwide offensive...It will be government wide….and it will be nationwide."

Richard Nixon
Press Conference, June 17, 1971
Source: Richard Nixon Foundation

National Institute for Drug Abuse (NIDA) established

1980s: Increasing Enforcement

1984 — **Comprehensive Crime Control Act:** enhanced penalties for violations of Controlled Substances Act

1986 — **Anti-Drug Abuse Act:**

- Established mandatory minimum sentences for drug-related offenses
- Different penalties created for different forms/amts of same drug (powder vs crack cocaine)

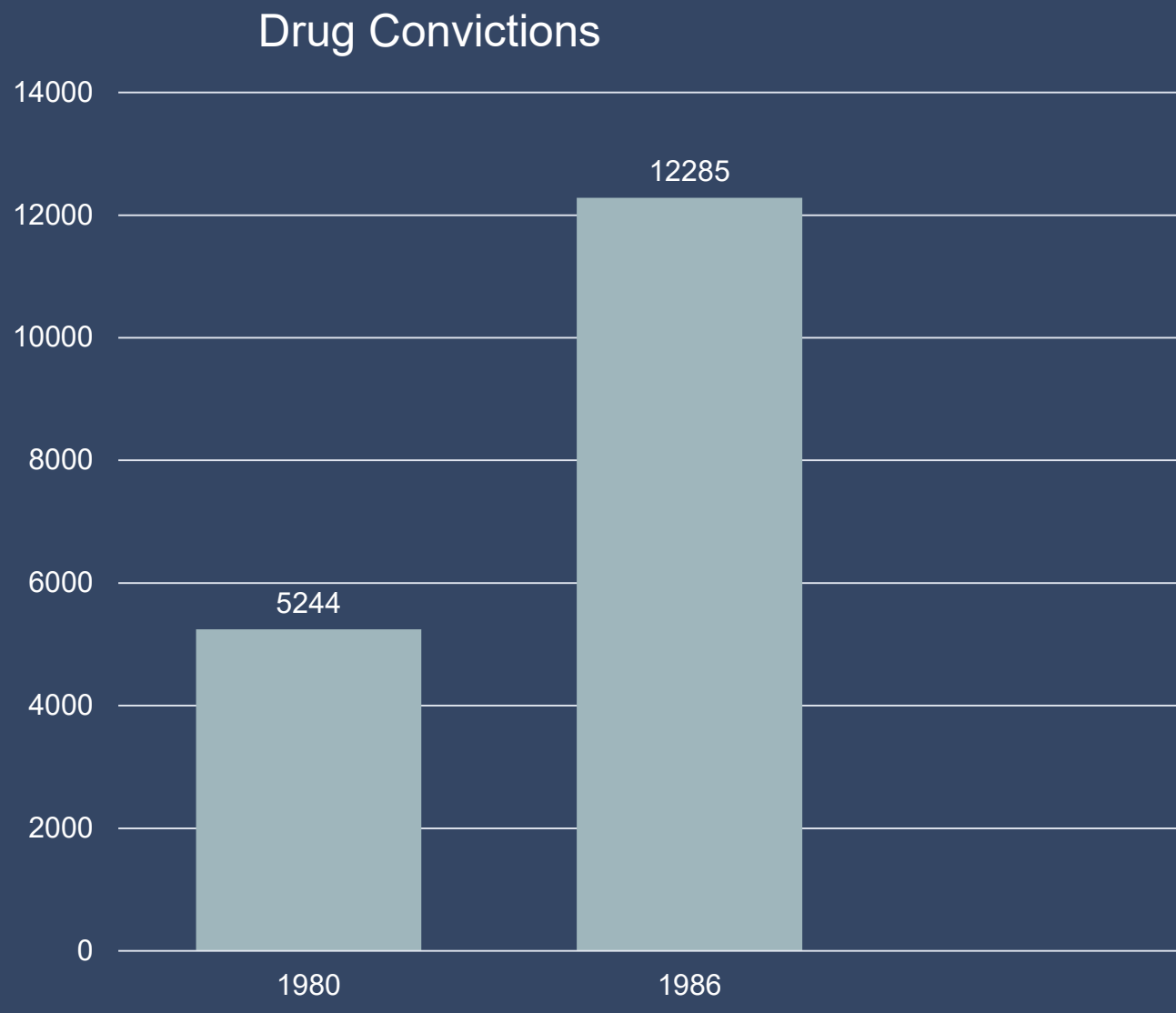
1988 — **Anti-Drug Abuse Act**: aimed at reducing drug supply

1980s: Increasing Enforcement

Drug convictions rose sharply:

- 1980: 5,244
- 1986: 12,285

51% of the increase of the total number of convictions during that time period were from drug convictions



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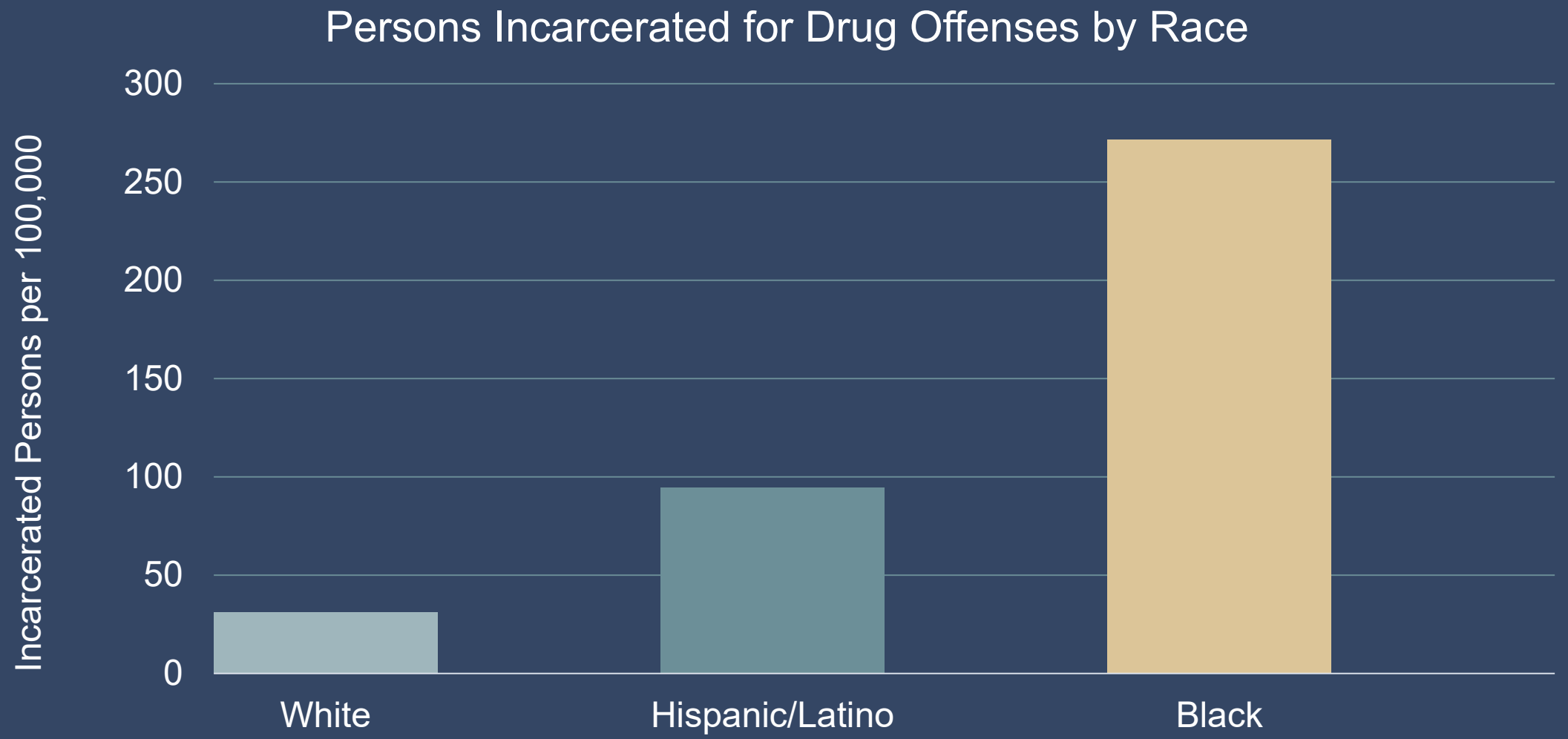
Race and Drug Criminalization

- Amount of crack cocaine vs powder cocaine to trigger federal criminal penalties set at a disparity of 1:100
- Policy rested on incarcerating black and Latino crack users, leaving white powder cocaine users untouched

Hansen & Netherland, Am J Public Health, 2016

Unequal Criminalization



Carson & Sabol, 2012

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2000s: A Shift Toward Treatment

- As prescription opioid misuse among whites increased, policy shifted toward a treatment focus
- Methadone was deemed inappropriate for the “suburban spread of narcotic addiction”
- Middle-class opioid-dependent people were thought to be more often employed and unwilling to comply with daily observed dosing methadone clinics that carried stigma

Hansen & Netherland, Am J Public Health, 2016

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2000s: A Shift Toward Treatment

2000

Drug Addiction Treatment Act (DATA 2000)

- Amends the Controlled Substances Act
- Allows ‘qualified physicians’ waivered through Center for Substance Abuse Treatment (CSAT) to prescribe schedule III, IV, and V medications in office-based setting
- Buprenorphine is currently the only schedule III drug approved for opioid use disorder

Why was the waiver put in place?

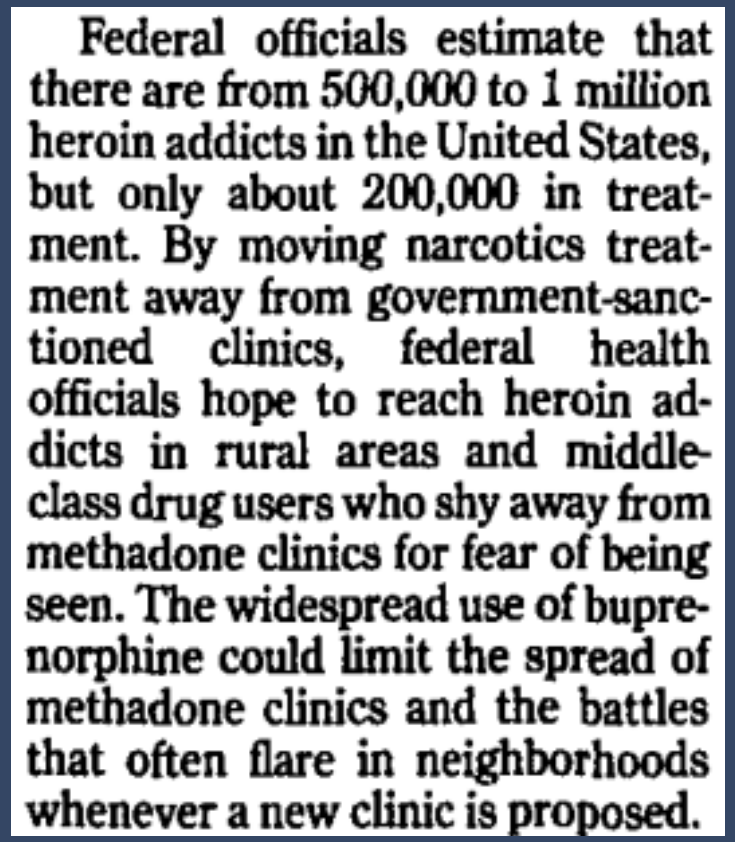
Excerpts from the Congressional Record highlight why DATA 2000 was approved

"Narcotic addiction is spreading from ***urban to suburban areas***. The current system, which tends to be concentrated in urban areas, is a ***poor fit for the suburban spread of narcotic addiction*** …"
Alan Leshner, NIDA

"[Buprenorphine] would be available not just to heroin addicts, but to anyone with an opiate problem, including ***citizens who would not normally be associated with the term addiction***."
Donna Shalala, HHS

The Washington Post, 10/19/2000

Why was the waiver put in place?



Federal officials estimate that there are from 500,000 to 1 million heroin addicts in the United States, but only about 200,000 in treatment. By moving narcotics treatment away from government-sanctioned clinics, federal health officials hope to reach heroin addicts in rural areas and middle-class drug users who shy away from methadone clinics for fear of being seen. The widespread use of buprenorphine could limit the spread of methadone clinics and the battles that often flare in neighborhoods whenever a new clinic is proposed.

- DATA 2000 was intended to increase treatment access for rural areas and middle class drug users
- Considered a shift toward leniency from heavily regulated methadone clinics

The Washington Post, 10/19/2000

Was buprenorphine provided equally?

Three years after approval of buprenorphine, patients taking buprenorphine:

- 91% were White
- Most were college educated and employed
- Dependent on prescription opioids

In contrast to methadone patients:

- Less often White
- Less likely to be college educated or employed
- Primarily used heroin

Hansen & Netherland, Am J Public Health, 2016

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2010s: Increasing Access for Treatment

2016

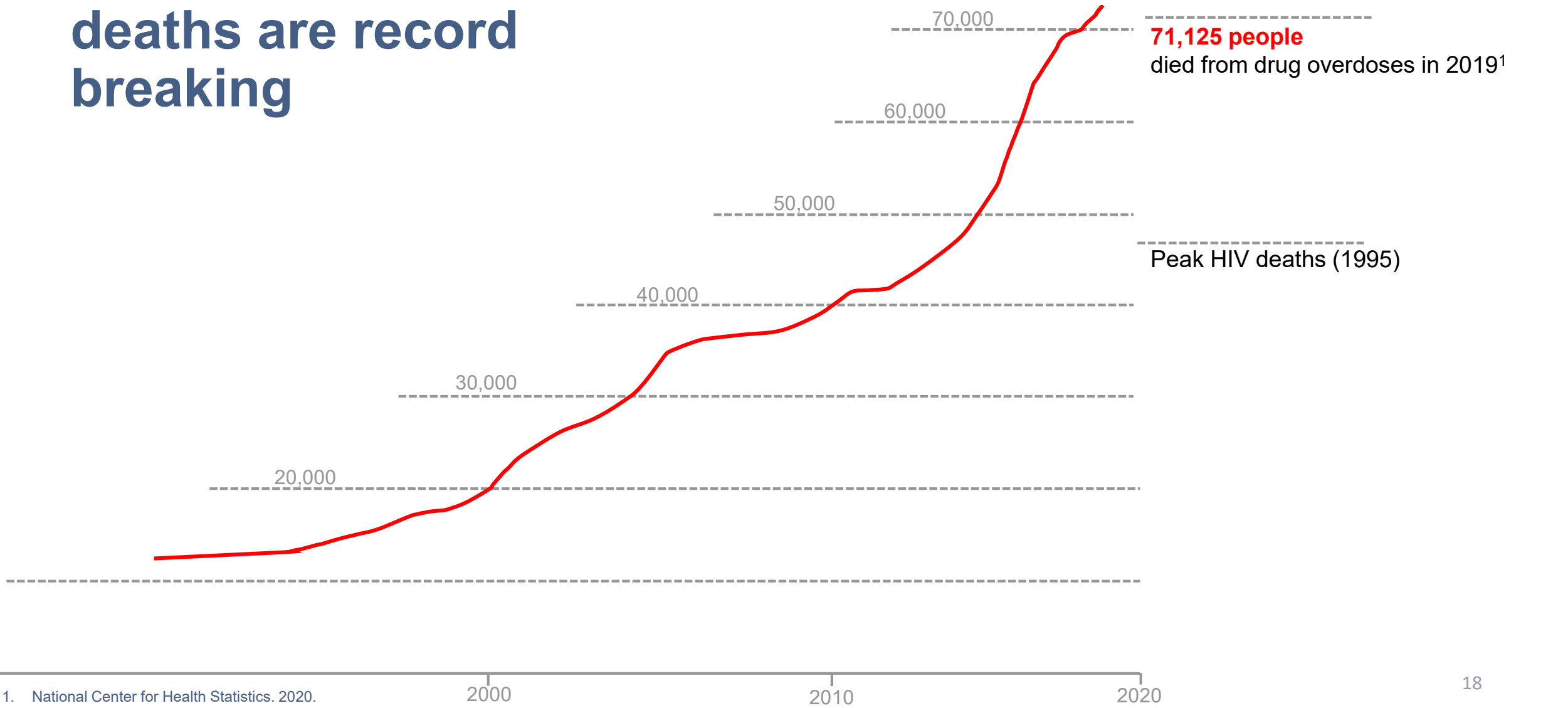
Comprehensive Addiction and Recovery Act (CARA 2016)

- NPs and PAs can prescribe buprenorphine
- Expanded naloxone through co-prescribing, pharmacist distribution and to law enforcement
- $103 million through Department of Justice for treatment alternatives to incarceration

With the focus on treatment for the past 20 years, how well are we doing?

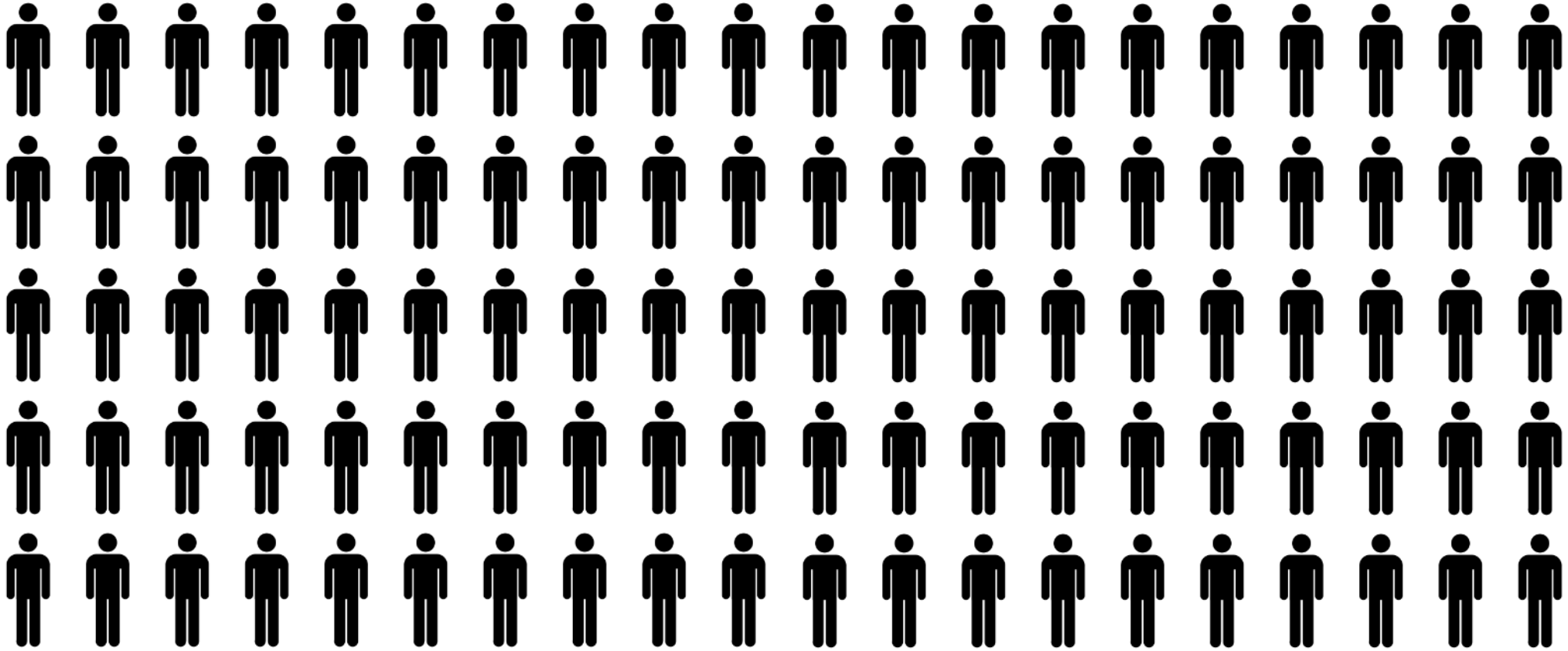
Despite a focus on treatment, overdose deaths are record breaking

Overdoses have risen 18% in 2020 due to COVID-19[2]



1. National Center for Health Statistics. 2020.
2. ODMAP. COVID-19 Impact on US National Overdose Crisis. 2020

A treatment gap remains



People with OUD

NSDUH, 2019

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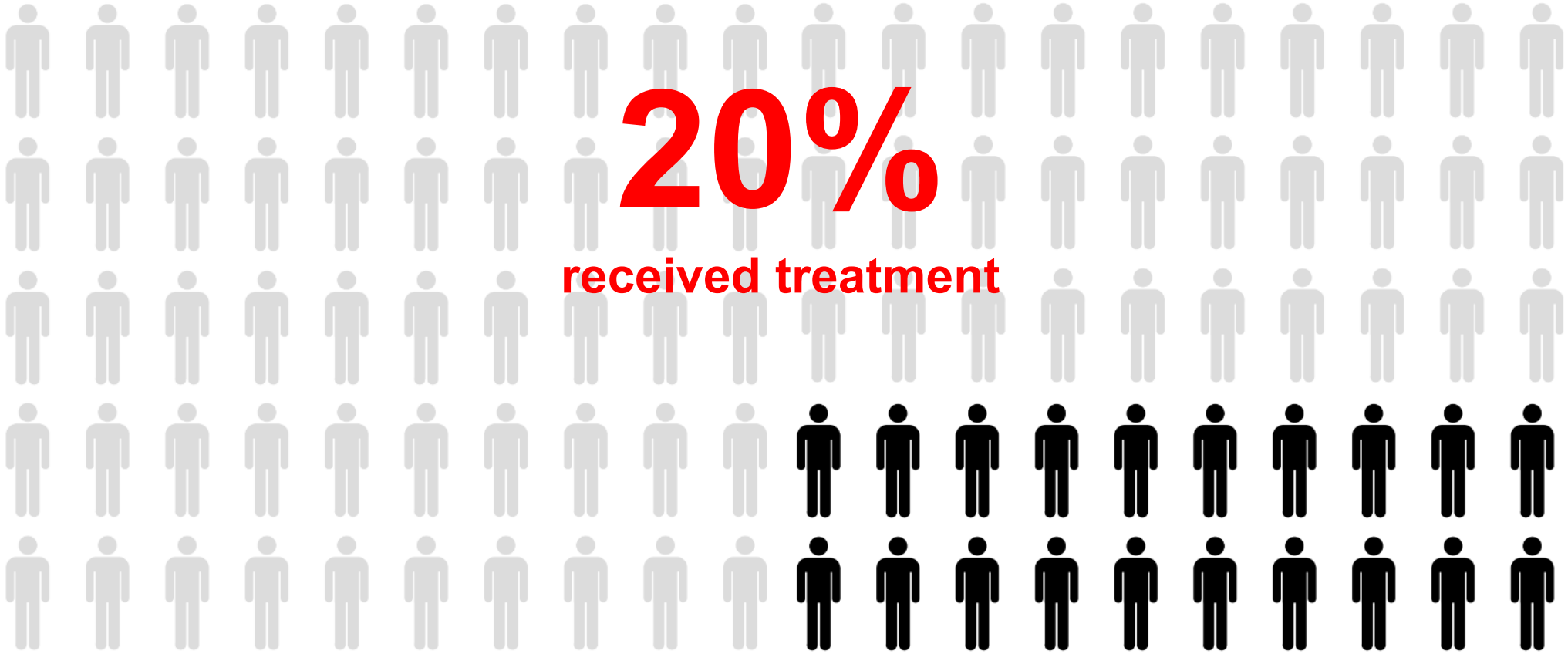
A treatment gap remains



People with OUD

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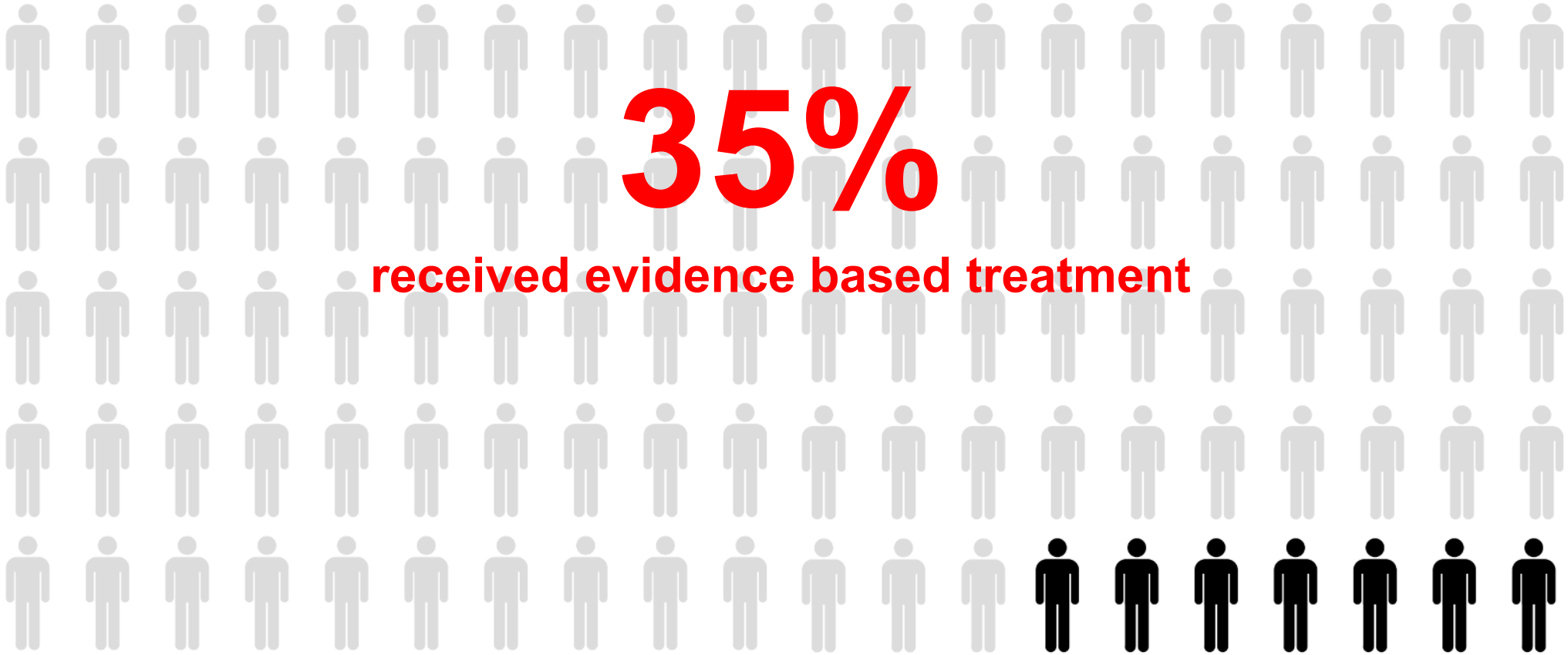

NSDUH, 2019

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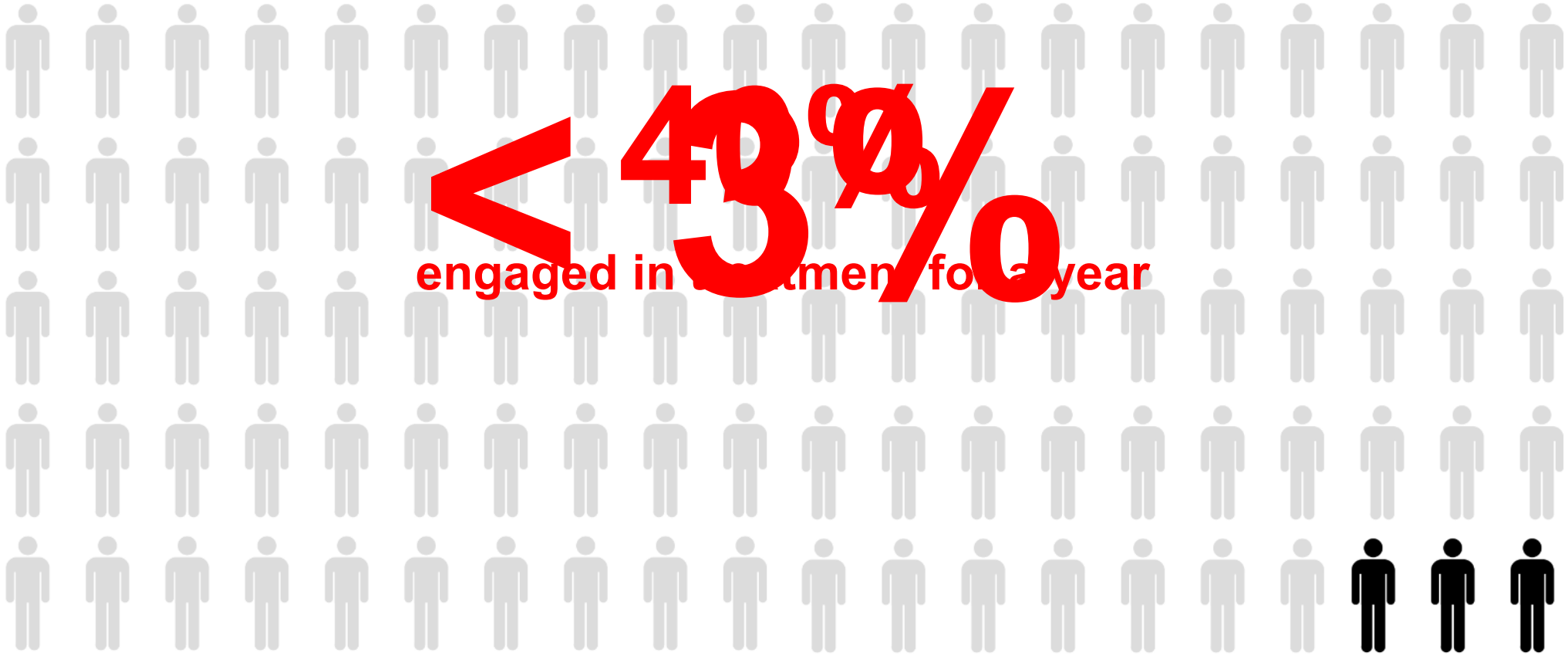

People with OUD

NSDUH, 2019

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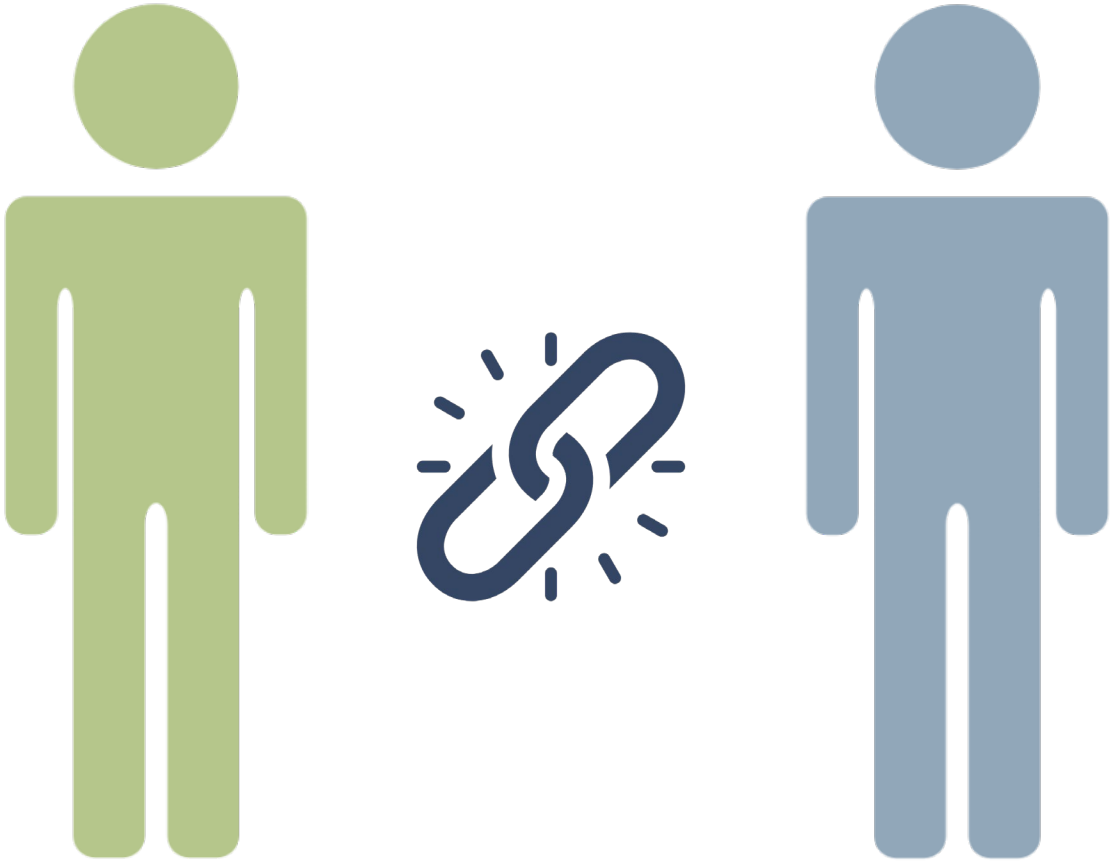
Who does this epidemic affect?

10 million people with chronic pain are prescribed opioids



Pain

Addiction

1.6 million people had an opioid use disorder in 2019

NSDUH, 2019

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Treatment for Pain

JAMA Network

Trends in Opioid Prescribing by Race/Ethnicity for Patients Seeking Care in US Emergency Departments

Reviewed ED visits from 1993-2005 from NHAMCS

Reviewed all pain-related visits

Measured if visits resulted in an opioid prescription

Pletcher, et al., *JAMA*, 2008

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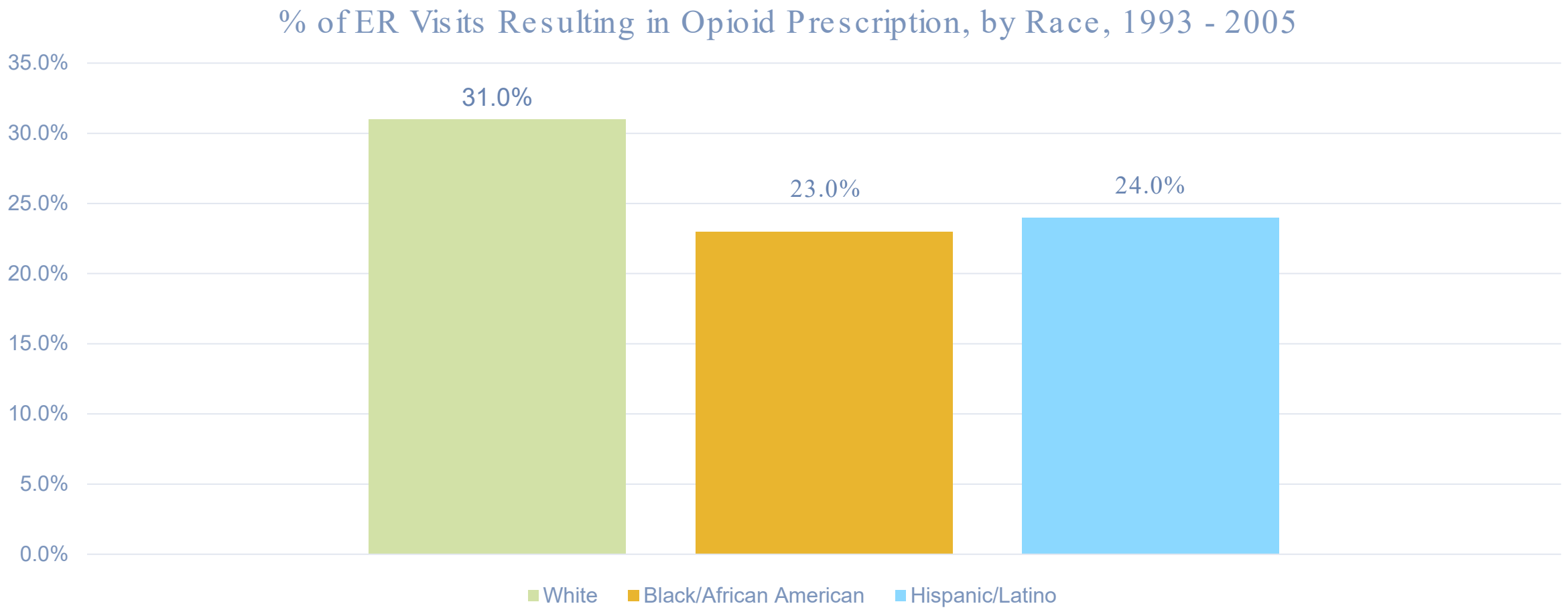
Less likely to receive an opioid for pain



Pletcher, et al., *JAMA,* 2008

Less likely to receive an opioid for pain

A 2012 meta-analysis showed that:

Hispanics were **22%** less likely **&** Blacks were **29%** less likely

to receive an opioid prescription than their White counterparts.

Meghani, et al. *Pain Medicine,* 2012

Differences in dosing and wait times

Not only are minorities less likely to receive ANY pain medication, but they're also more likely to:

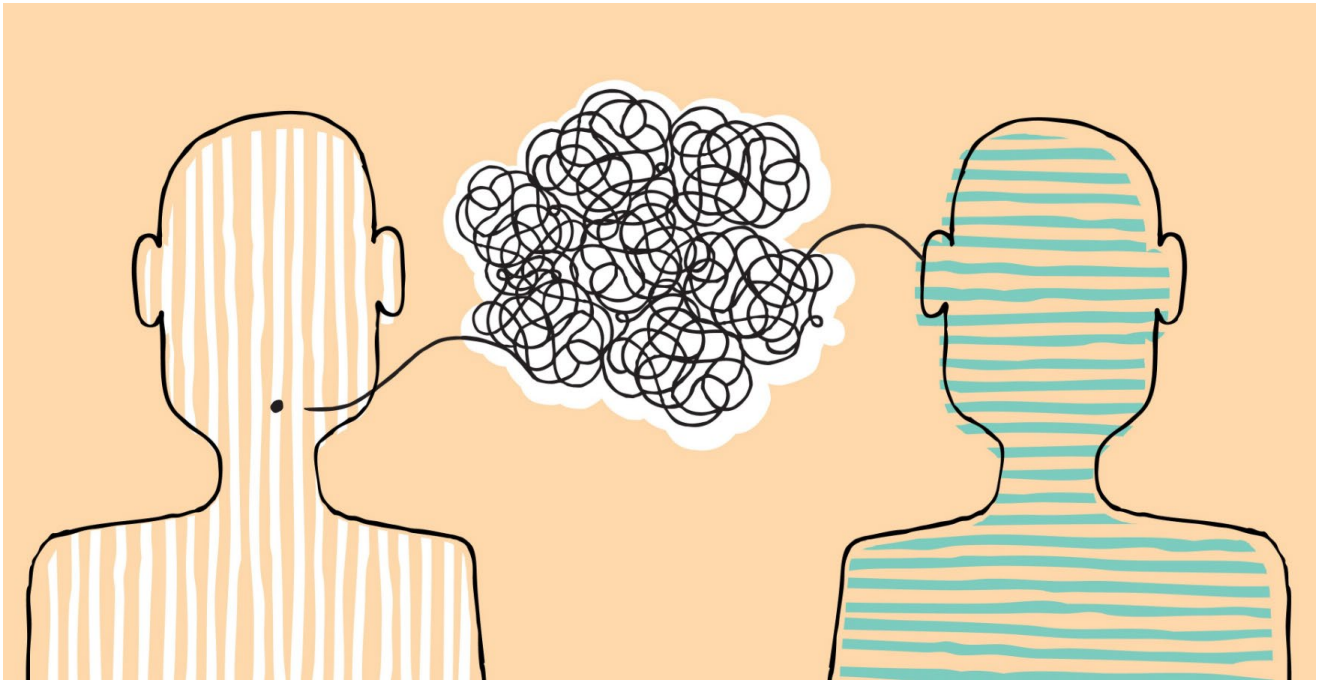
Receive **lower doses** of pain medications[1]

Experience **longer wait times** to receive pain medication[2]

1. Cleeland, et al. *Ann Intern Med.* 1997
2. Epps, et al. *Pain Manag Nurs,* 2008

Why does this happen?

Racial and ethnic minorities more likely to experience **miscommunication** or **misinterpretation** about pain with medical providers



Shavers, et al. *J Health Care Poor Underserved.* 2010

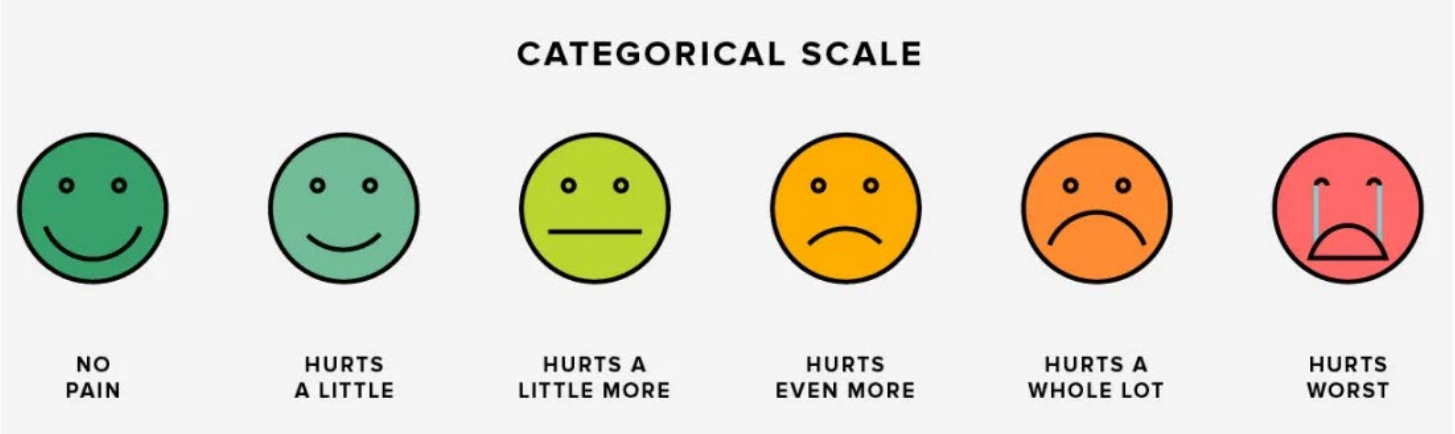
Why does this happen?

Some doctors still **choose to believe that pain levels are lower** for Blacks than Whites or that minorities are '**drug seekers**'

Shavers, et al. *J Health Care Poor Underserved.* 2010

Why does this happen?

Physicians are **more likely to underestimate the amount of pain** that African American are experiencing



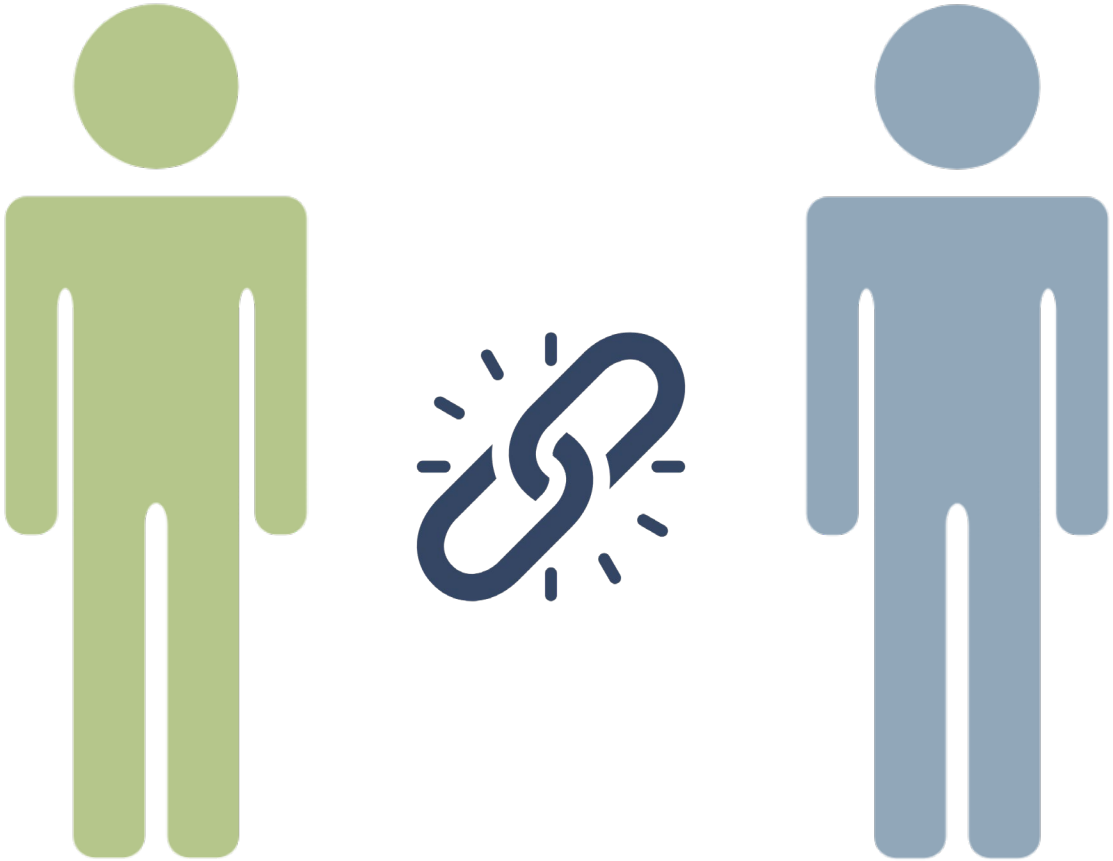
Shavers, et al. *J Health Care Poor Underserved.* 2010

Isn't less opioid prescribing a good thing?

- Undertreating anyone's pain because of race is unacceptable and discriminatory
- Any benefit experienced by less prescribing is far outweighed by how policies and treatments for addiction have disproportionately harmed people of color.
- The transient benefit from less prescribing has passed and overdose rates are rising greater in non-White populations

Who does this epidemic affect?

10 million people with chronic pain are prescribed opioids



Pain

Addiction

1.6 million people had an opioid use disorder in 2019

NSDUH, 2019

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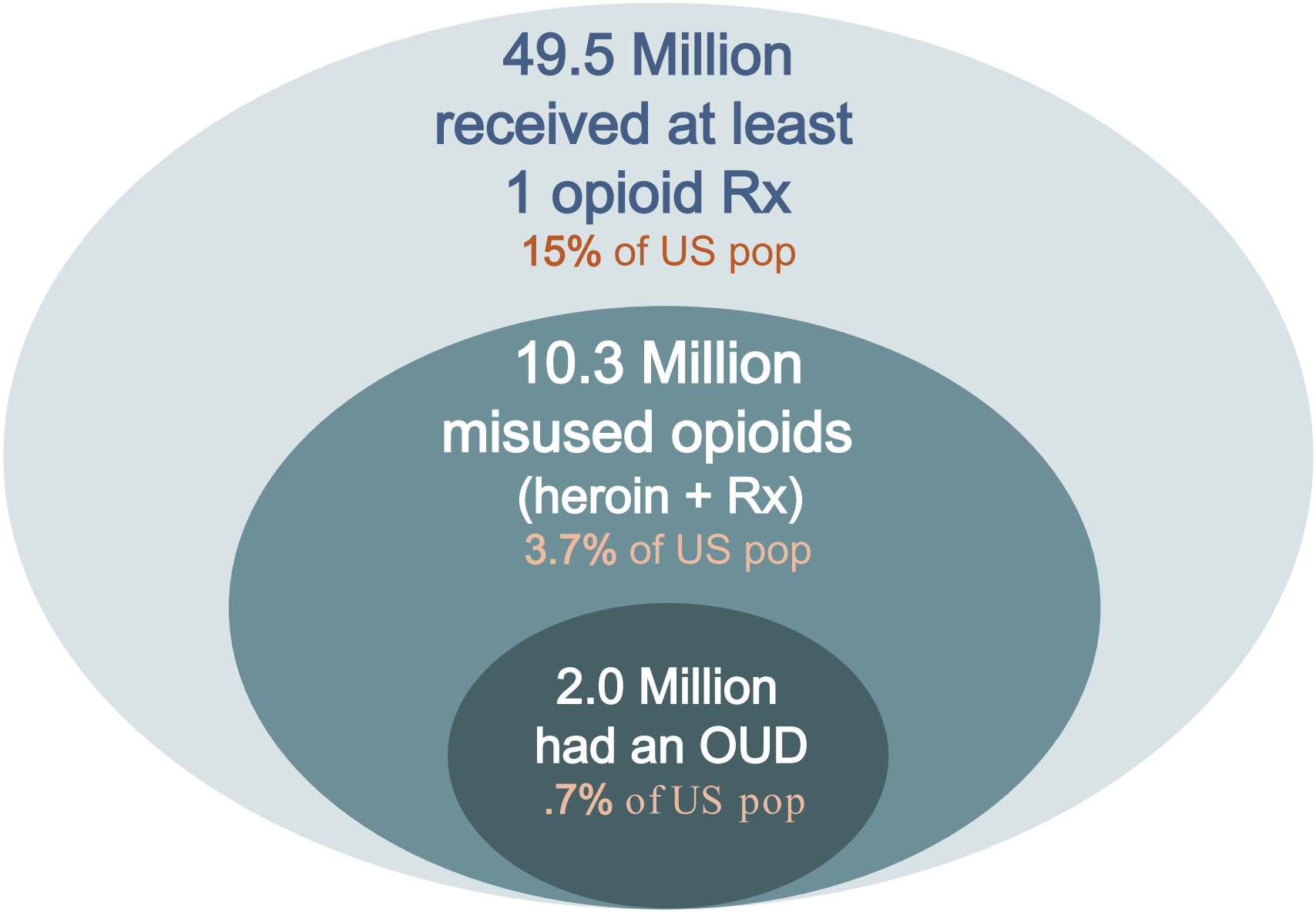
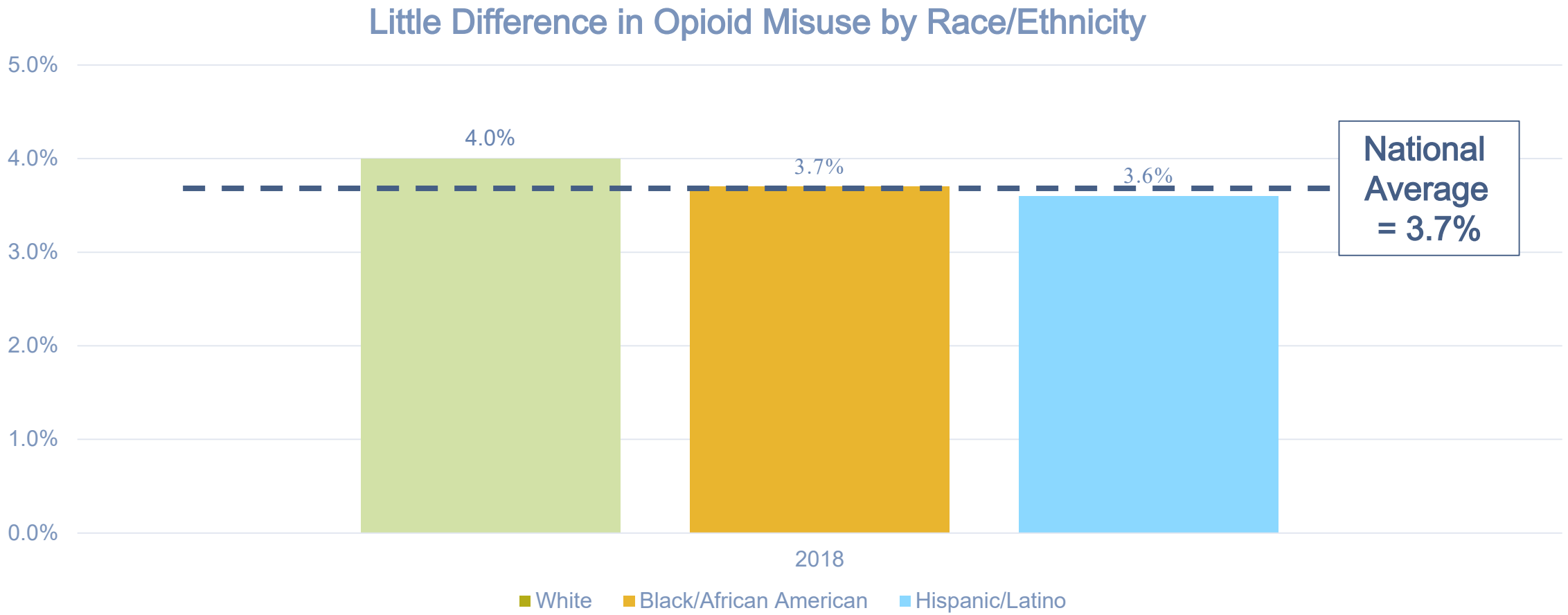
How common is opioid use and misuse?

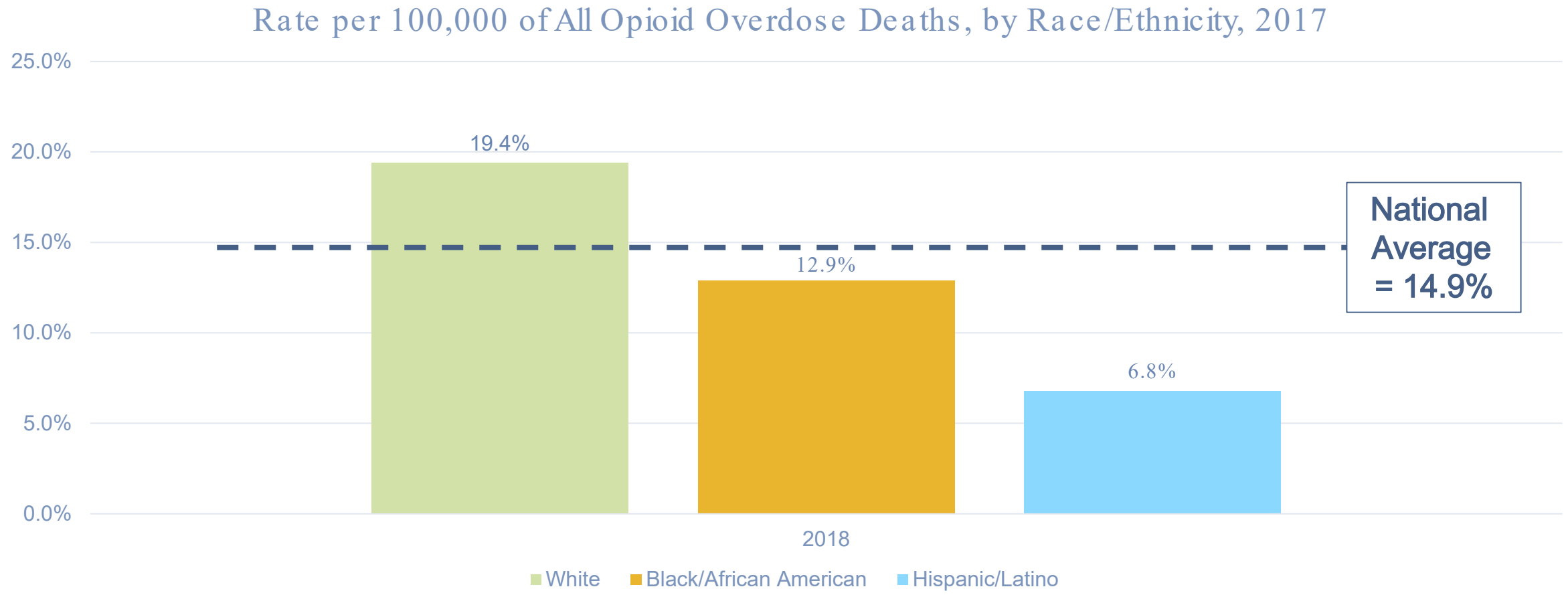


2019 CDC Annual Surveillance Report of Drug-Related Risks and Outcomes

Does misuse differ by race?



Overdose rates by Race/Ethnicity



2019 CDC Annual Surveillance Report of Drug-Related Risks and Outcomes

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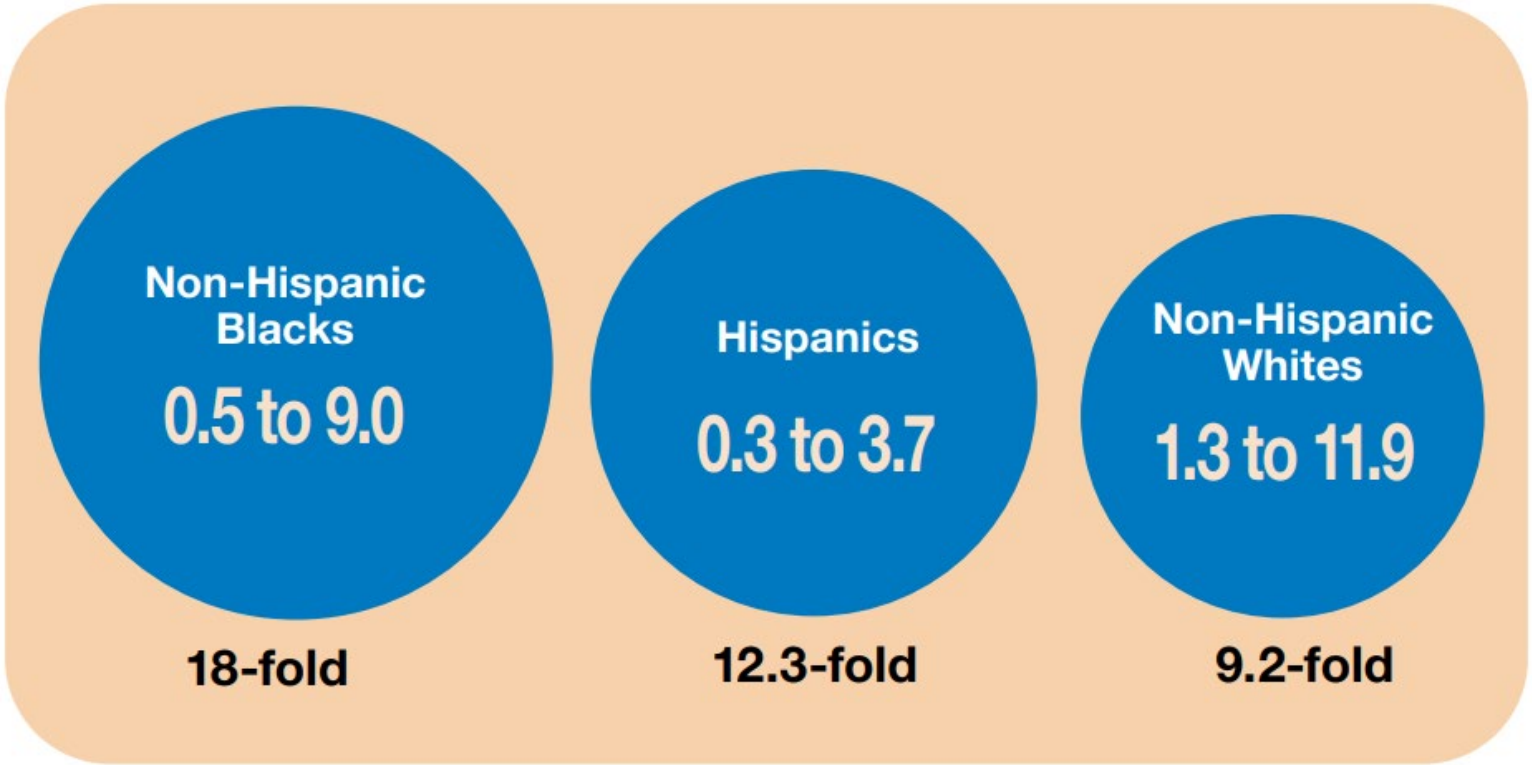
Black/Hispanic overdoses rising at a higher rate

Individual who are Black and Hispanic are experiencing a faster increase in rates of drug overdose deaths involving opioids

Figure 2. Magnitude of increase in drug overdose deaths involving synthetic opioids other than methadone per 100,000 population, by ethnicity, 2013-2017

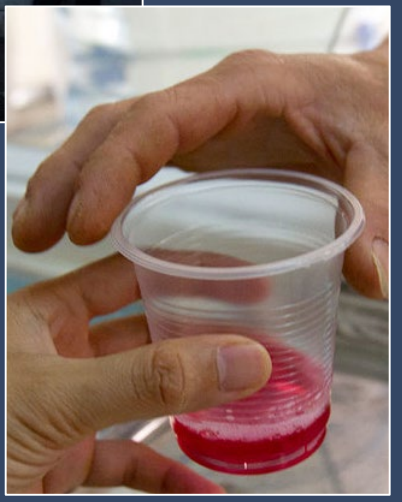


Misperceptions on diagnosis worsen disparities in treatment

Medications for Opioid Use Disorder

Methadone

- Only administered at federally regulated OTP
- Public setting
- Daily dosing



Medications for Opioid Use Disorder

Buprenorphine

- Only administered by ‘waivered’ physician
- Private office-based setting
- Dosed weekly/monthly

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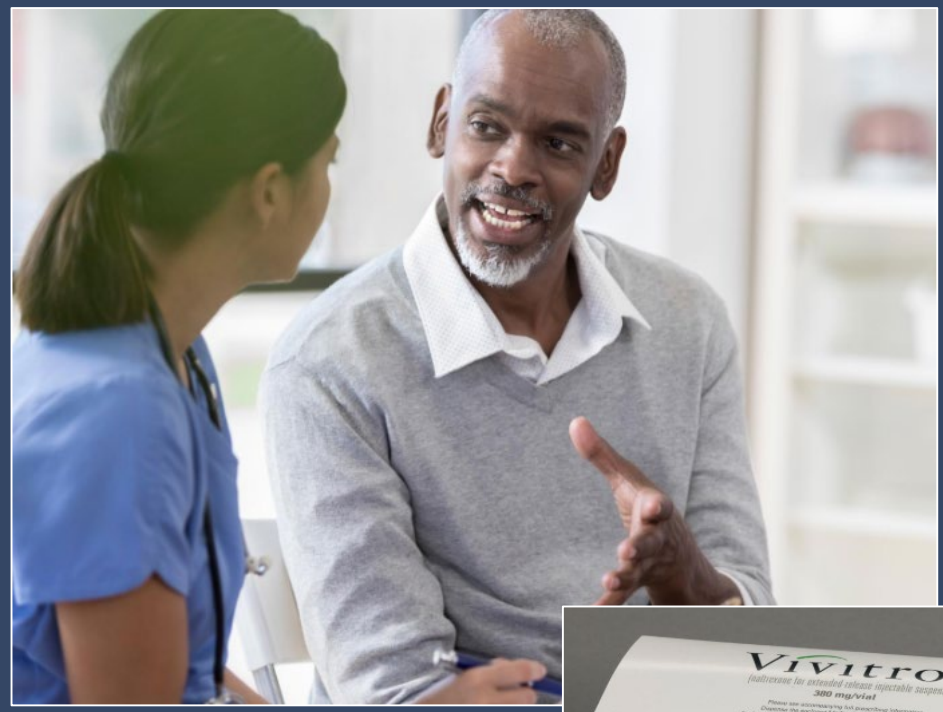
Medications for Opioid Use Disorder

Naltrexone

- Administered by any prescriber
- Injectable
- Uptake limited

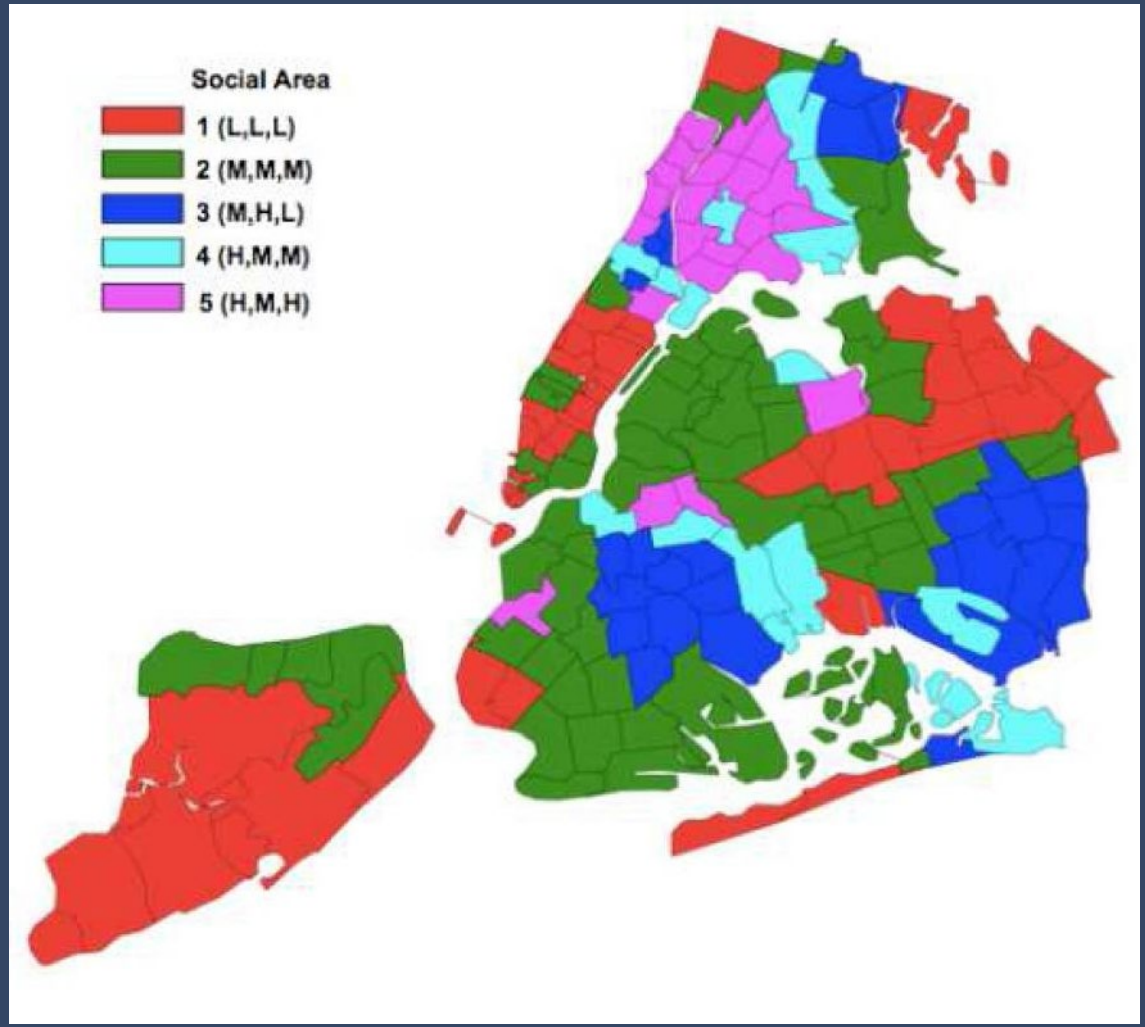


Only 3 drugs

Ideally, *everyone* should have access to all three options

Separate and unequal treatment options

NYC study found that residential **areas with highest proportion of Black and Latino low -income individuals had highest methadone treatment** rate while buprenorphine & naltrexone are more accessible in areas with White, high-income patients



Hansen, et al, *J Behav Health Serv Res*, 2014

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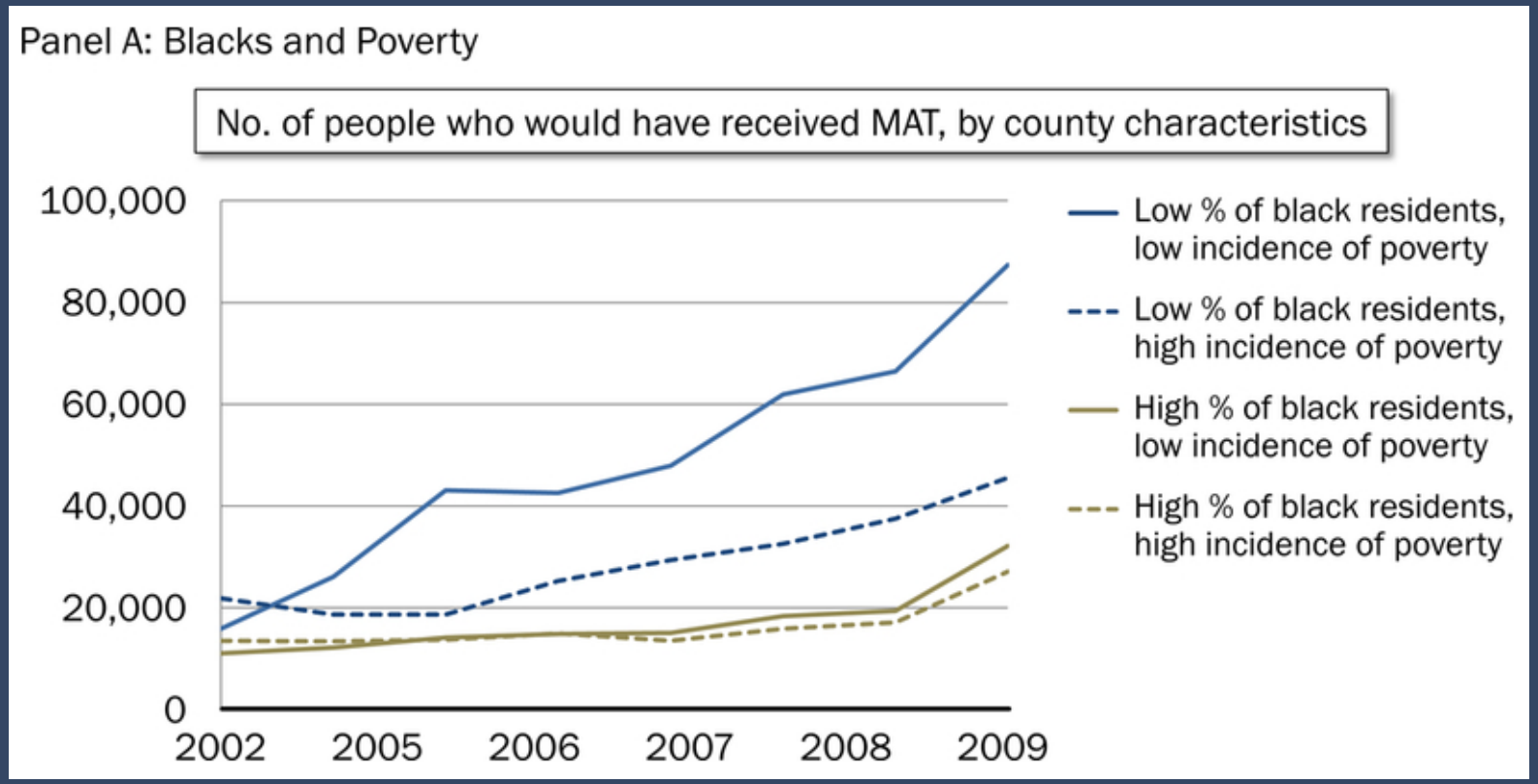
Separate and unequal treatment options

Among Medicaid enrollees in 14 states, **receipt of MOUD increased** at a much higher rate for residents of counties with **lower poverty rates and lower concentrations of Black and Hispanic individuals**



Stein, et al, *Subst Abus*, 2018

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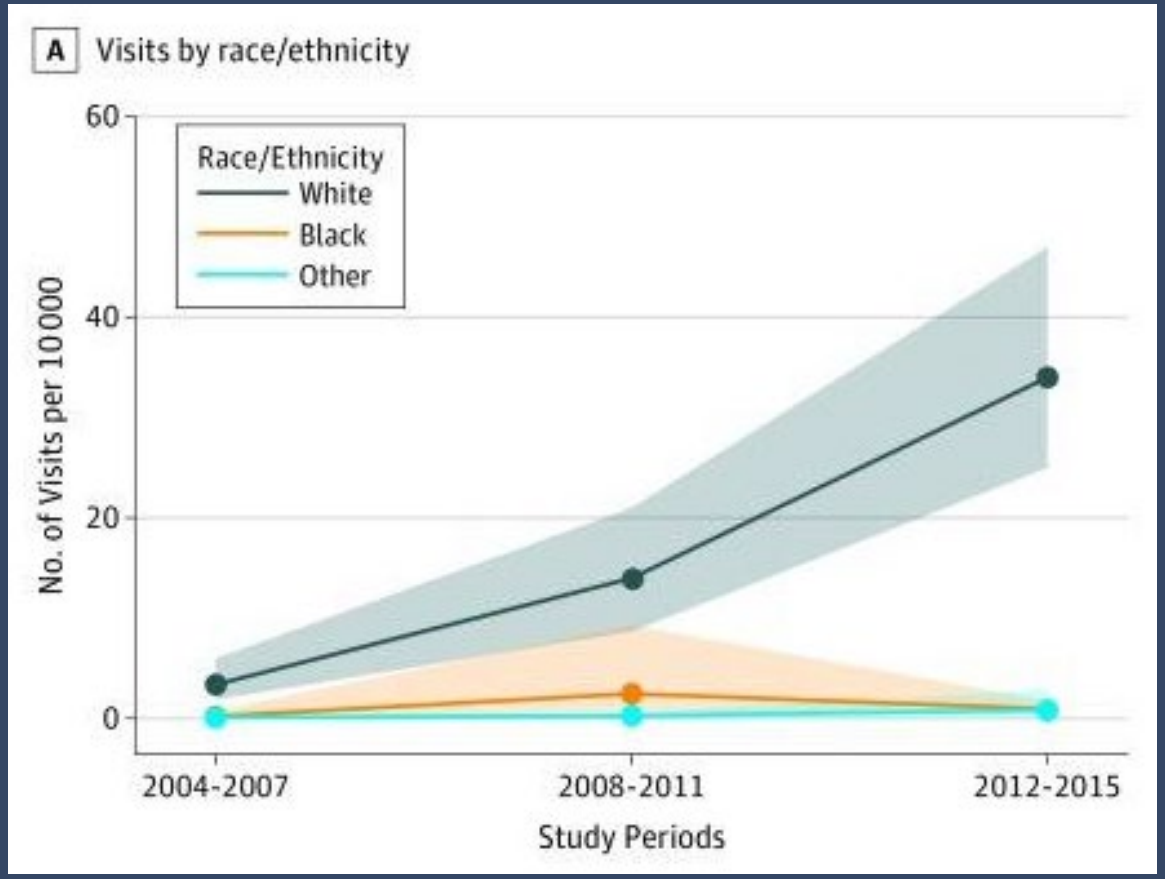
Separate and unequal treatment options

Among individuals with buprenorphine-related visits, **Blacks/African Americans were less likely to receive buprenorphine compared to Whites**



Lagisetty, et al, *JAMA Psych,* 2019

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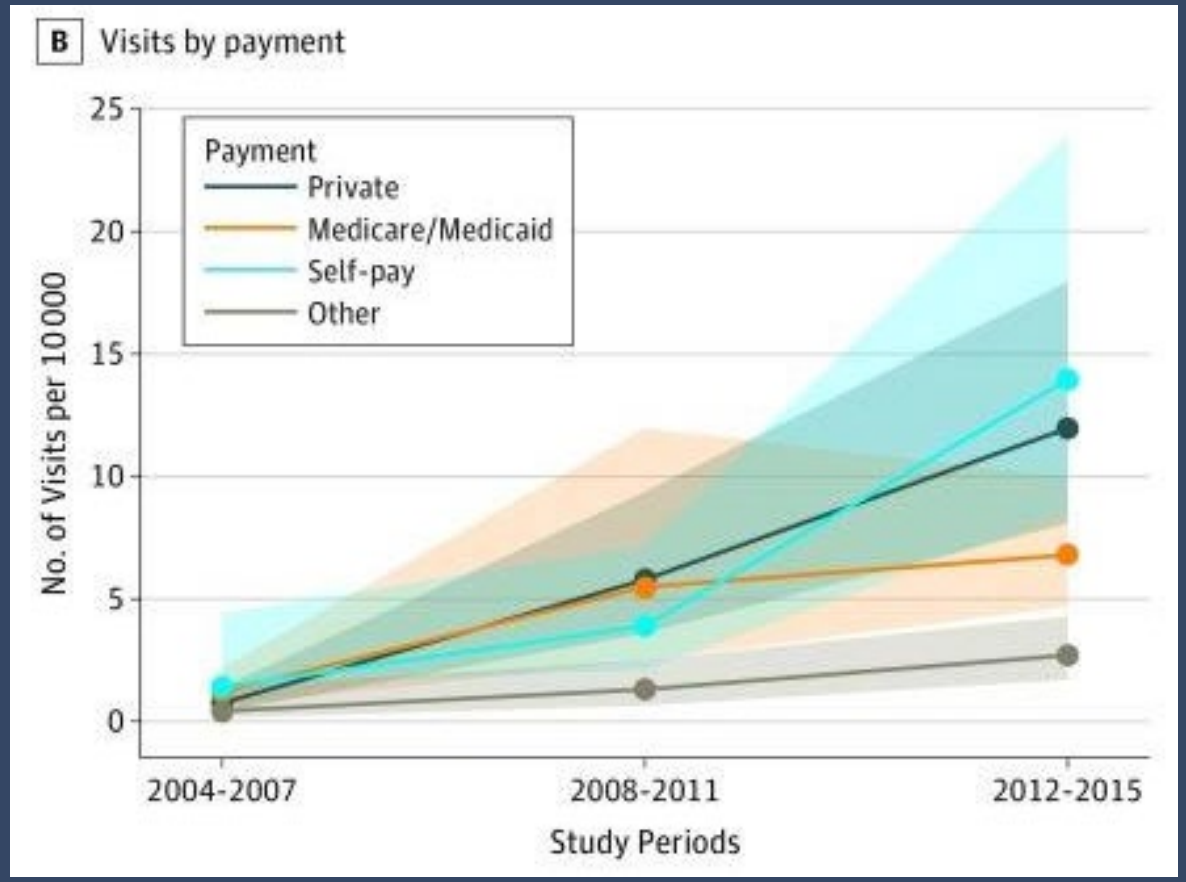
Separate and unequal treatment options

Of those who received buprenorphine, nearly **40% self-paid and 34% had private insurance**



Lagisetty, et al, *JAMA Psych,* 2019

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Do these disparities exist for special populations?

- Reviewed data set of pregnant women with OUD who delivered an infant in MA between 2011–2015
- Reviewed receipt of medication for OUD prior to delivery

Schiff, et al, *JAMA Netw Open,* 2020

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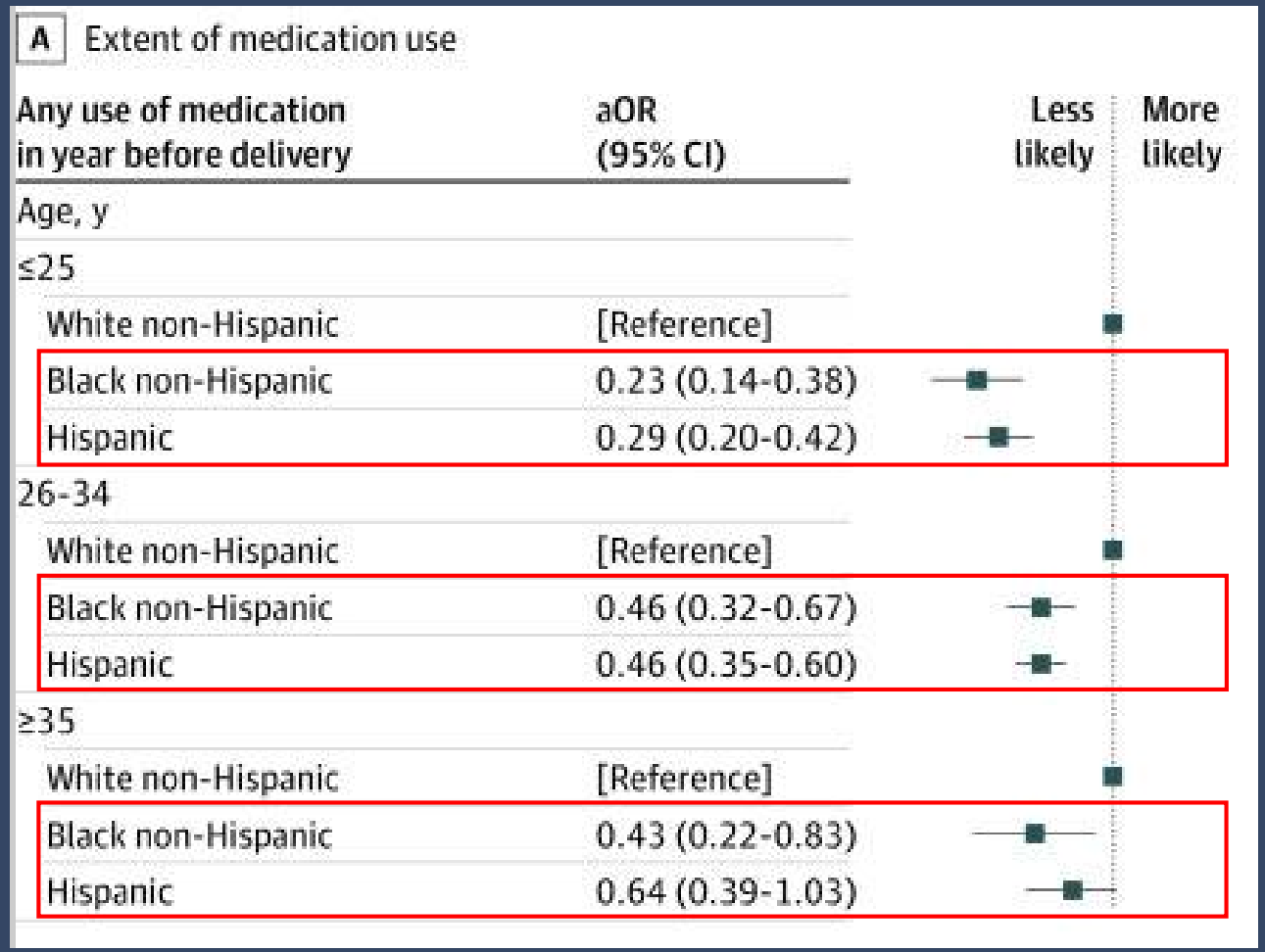
Do these disparities exist for special populations?

Black non -Hispanic and Hispanic women had a substantially lower likelihood of receiving any medication for the treatment of OUD



A Extent of medication use

Any use of medication in year before delivery	aOR (95% CI)
Age, y	
≤25	
White non-Hispanic	[Reference]
Black non-Hispanic	0.23 (0.14-0.38)
Hispanic	0.29 (0.20-0.42)
26-34	
White non-Hispanic	[Reference]
Black non-Hispanic	0.46 (0.32-0.67)
Hispanic	0.46 (0.35-0.60)
≥35	
White non-Hispanic	[Reference]
Black non-Hispanic	0.43 (0.22-0.83)
Hispanic	0.64 (0.39-1.03)

Schiff, et al, *JAMA Netw Open,* 2020

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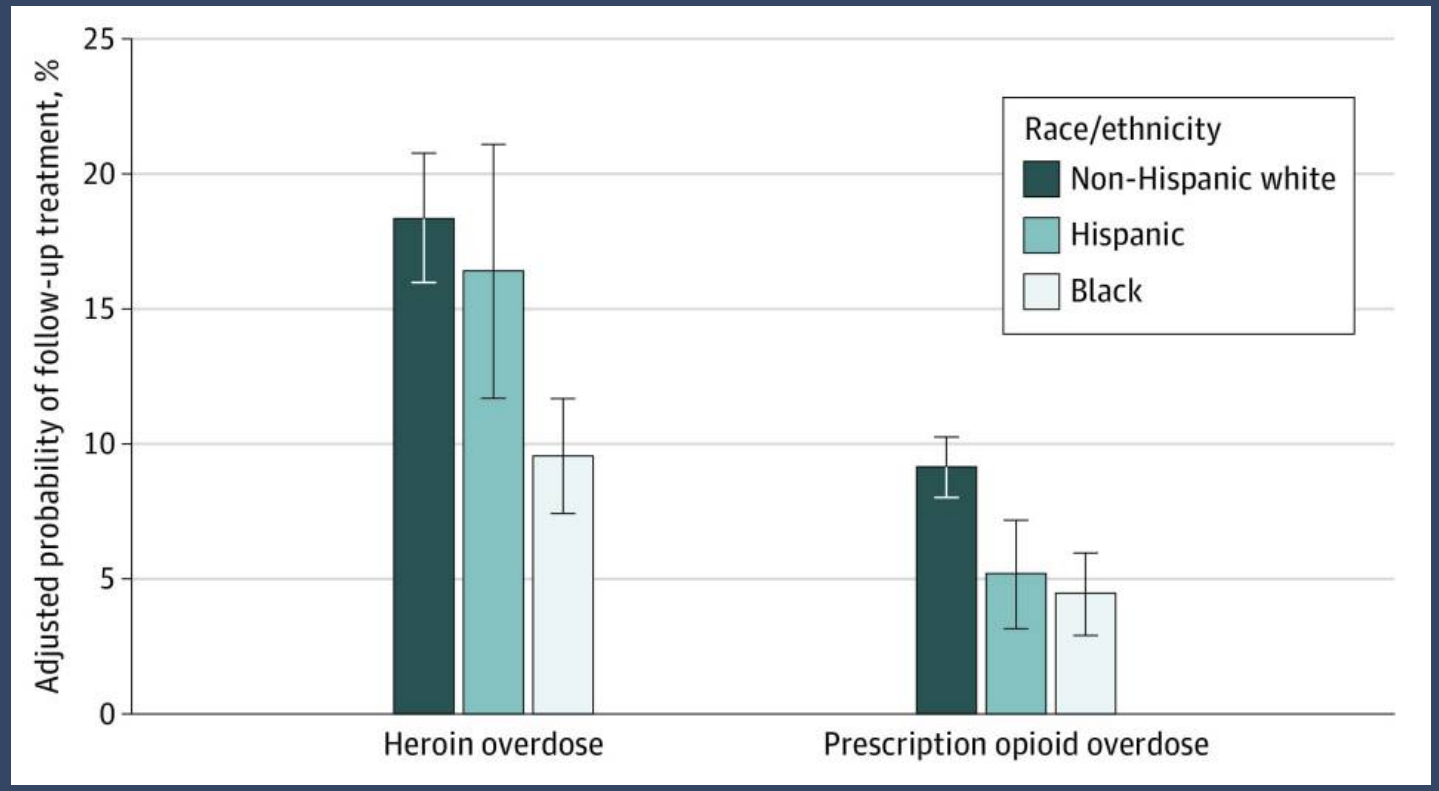
What about in the emergency room?

- Reviewed administrative claims data from 2011 – 2016
- Measured follow-up treatment in 90 days after an overdose
- Treatment = receipt of buprenorphine or naltrexone

Kilaru, et al, *JAMA Netw Open,* 2020

What about in the emergency room?

Blacks and Hispanics are less likely to receive MOUD within 90 days of discharge



Kilaru, et al, *JAMA Netw Open,* 2020

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Why do treatment disparities continue?

Stigma

Drug use has been treated as a moral weakness that should be overcome with **willpower rather than medical treatment** , which often results in **blaming patients for their disease**

Why do treatment disparities continue?

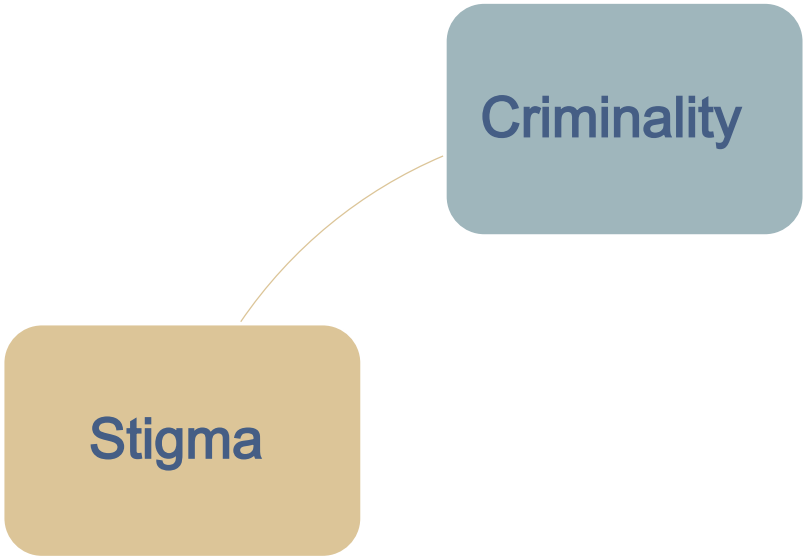
Stigma

Different groups may view mental illness and its treatment in different ways:

- Minorities are less likely to want to treatment than their white counterparts due to internalized stigma[1,2]
- Hispanic/Latinos report believing that people with mental illness are out of control, dangerous, and suffer from an incurable disease[3]
- Black/African Americans are more likely to view mental illness as a weakness and that problems will improve on their own[4]

1. Nadeem, et al, *Psychiatr Serv,* 2007
2. Clement, et al, *Cambridge University Press,* 2015
3. Caplan, *Hisp Health Care Int,* 2019
4. Conner, et al, *Am J of Ger Pscyhiatry,* 2010

Why do treatment disparities continue?



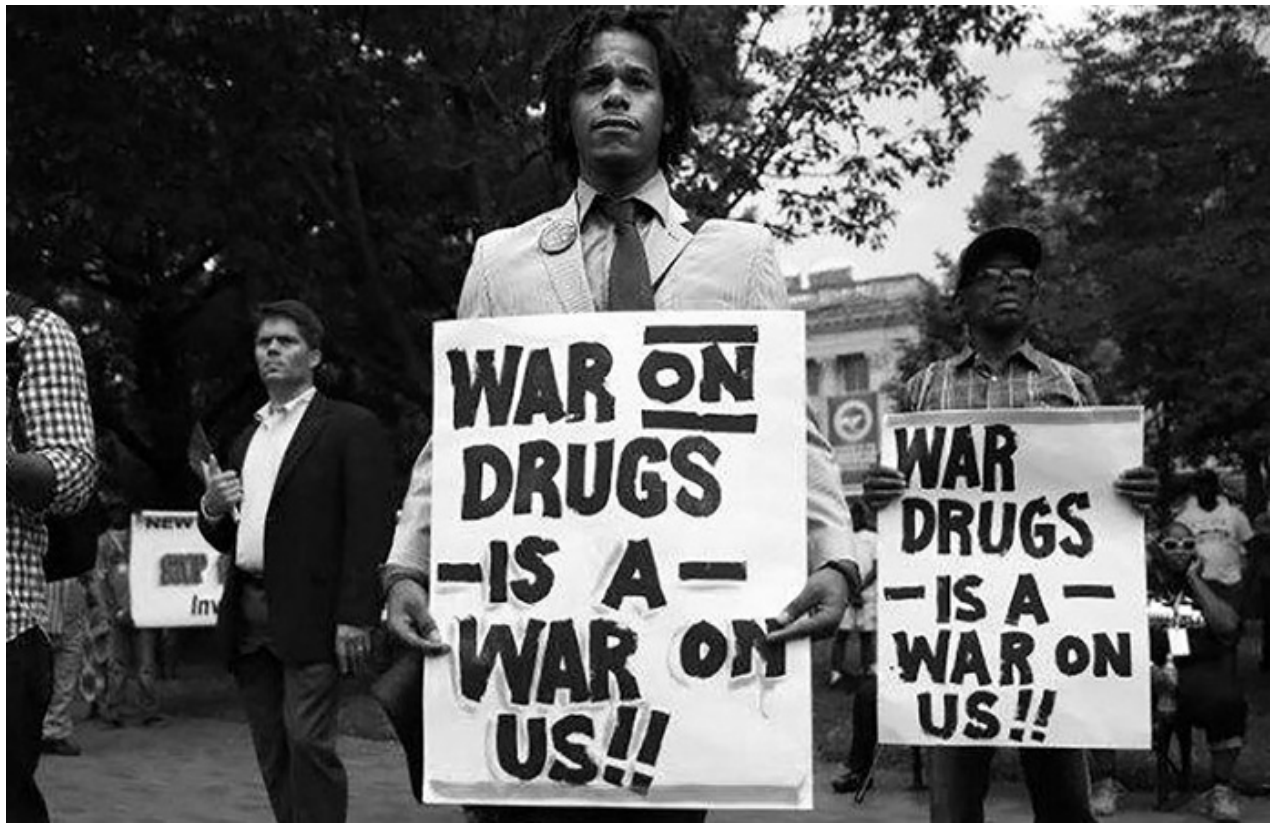
"The Nixon White House…had two enemies: the antiwar left and black people…by getting the public to associate the **hippies with marijuana** and **blacks with heroin** and then criminalizing both heavily, we could disrupt those communities… **Did we know we were lying about the drugs? Of course we did.** "

John Ehrlichman
Domestic Policy Chief, Nixon Administration

Why do treatment disparities continue?

Criminality

Stigma



Although individuals who are Black and Whites use illicit drugs at the same rates, people who are Black are 6 -10 times more likely to be incarcerated for drug offenses

Netherland & Hansen, *Cult Med Psychiatry,* 2016

Michigan drug policy still punitive

Possession of Schedule I or II drug

- Prison time of 4 yrs to life
- Fines of $25k - $1M

Ecstasy and Meth

- Prison time up to 10 yrs
- Fines of up to $15k

Sweeping legislative change

2020 election:

- Oregon voted to decriminalize all drugs
- Five additional states legalized marijuana either recreationally or medicinally

Marijuana policy by state

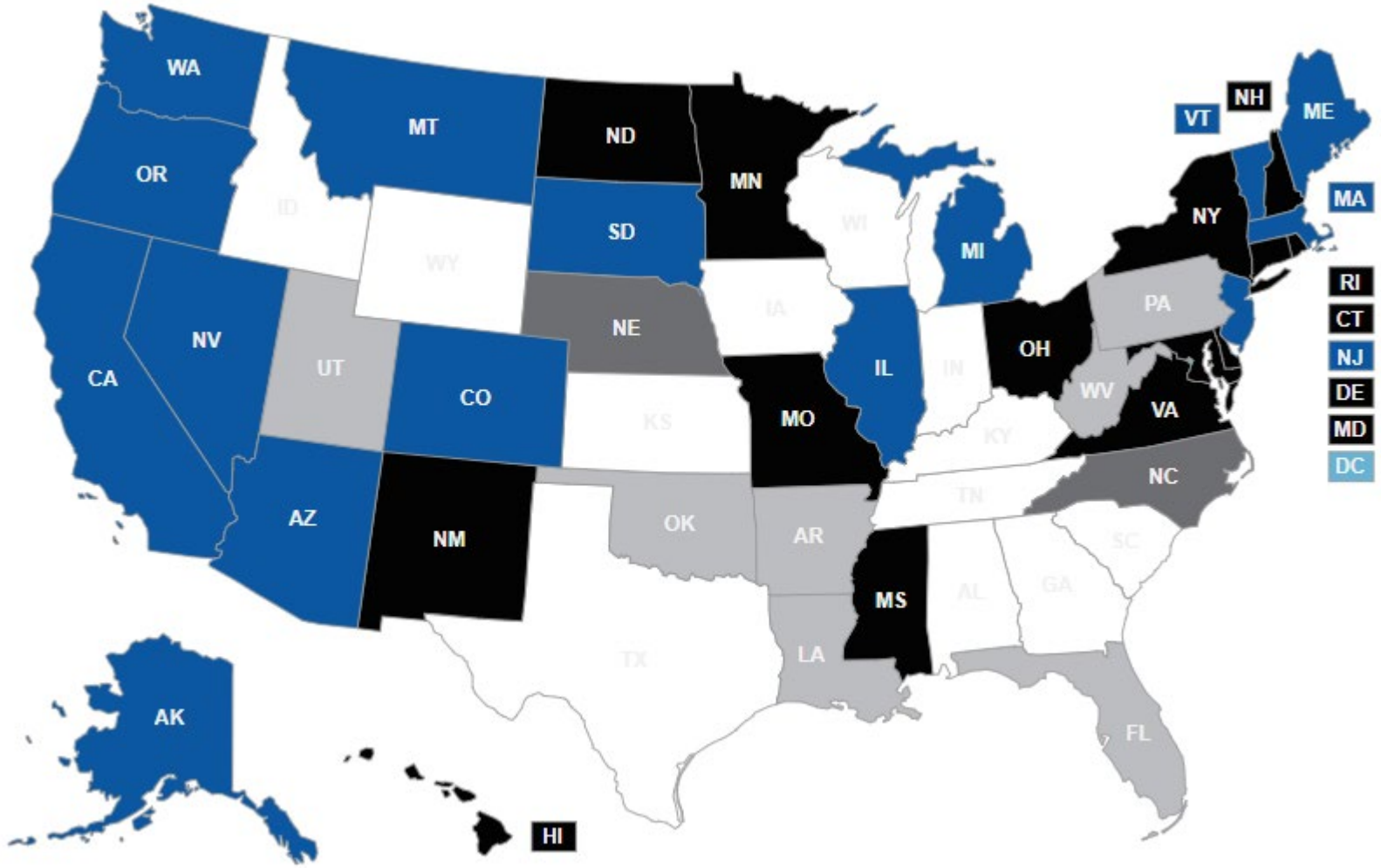
States with medical marijuana laws

States that have removed jail time for possessing small amounts of marijuana

States that have both a medical marijuana law and have removed jail time for possessing small amounts of marijuana

Marijuana is legal for adults and is taxed and regulated similar to alcohol; state also has a medical marijuana law

Marijuana is legal for adults (no sales); medical marijuana law



Marijuana Policy Project

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Ensuring legalization is equitable

▲ Jesce Horton, a young entrepreneur who wants to see more black business owners enter the cannabis industry. Photograph: Jesce Horton

Inequality and opportunity in America

A billion-dollar industry, a racist legacy: being black and growing pot in America

How will past harms to minority communities be repaired?

Hackman. *The Guardian,* 2017

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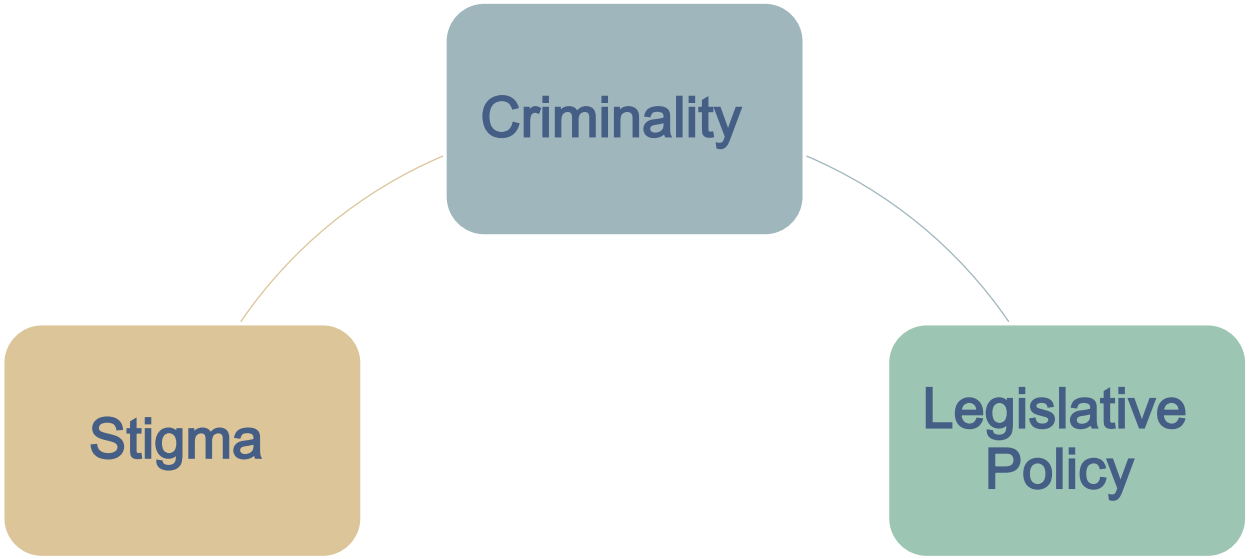
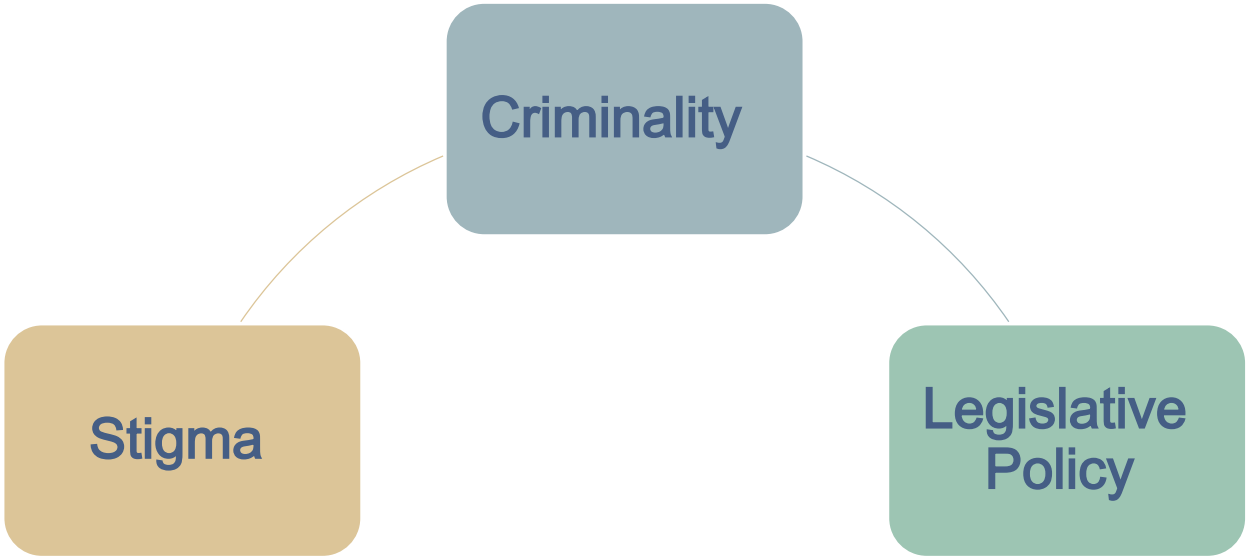
Why do disparities continue?



- As rates of opioid use rose among whites in the 90s and 00s, much of the 'blame' for addiction was transferred from patients to physicians
- Policy began favoring treatment over incarceration for Rx opioid use among whites

Netherland & Hansen, *Biosocieties,* 2017

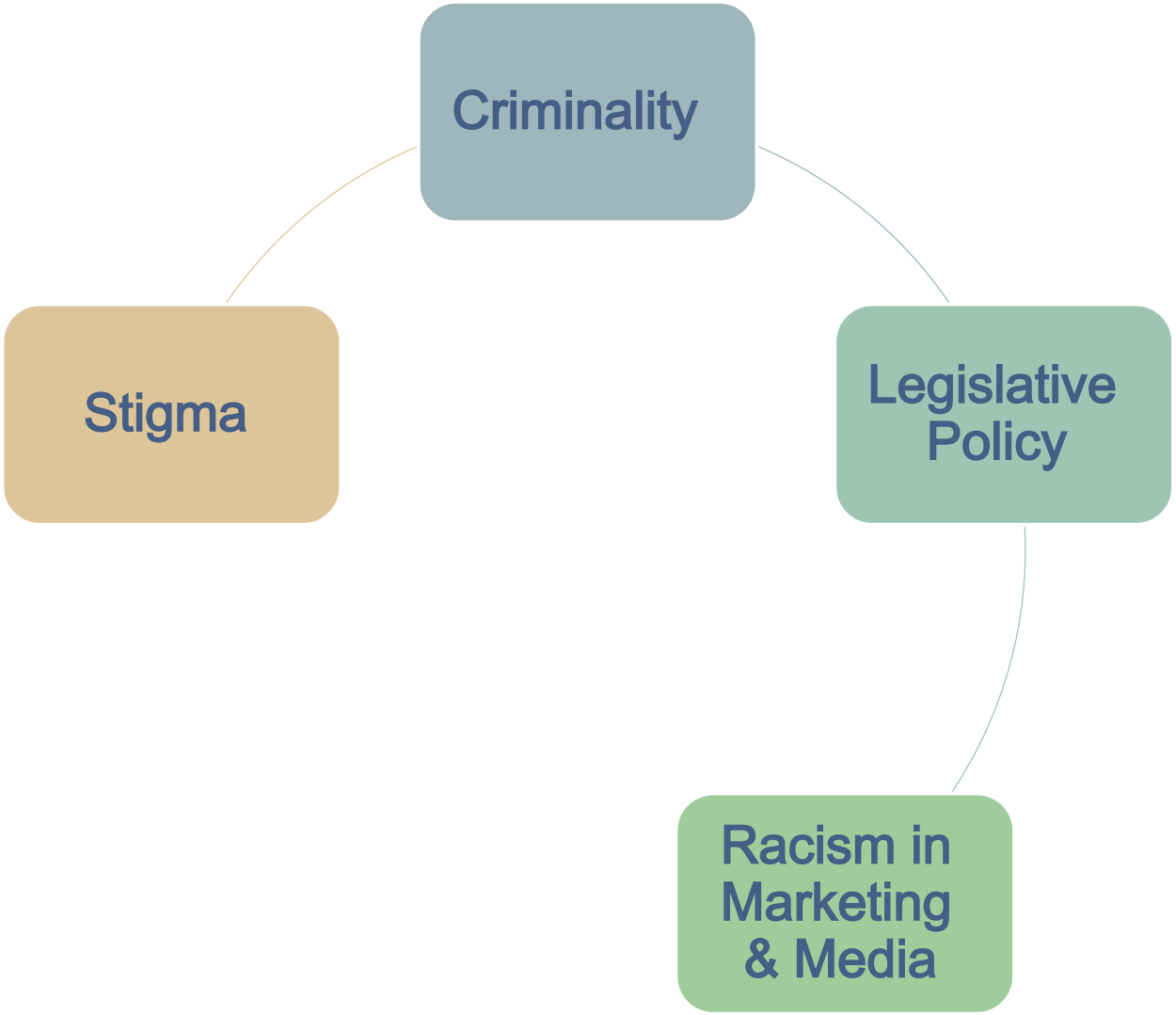
Why do disparities continue?



- Buprenorphine was approved as an option for the ‘new’ ‘suburban’ Rx opioid user
- While methadone was appropriate for the ‘urban’ ‘hardcore’ heroin user

Netherland & Hansen, *Biosocieties,* 2017

Why do treatment disparities continue?



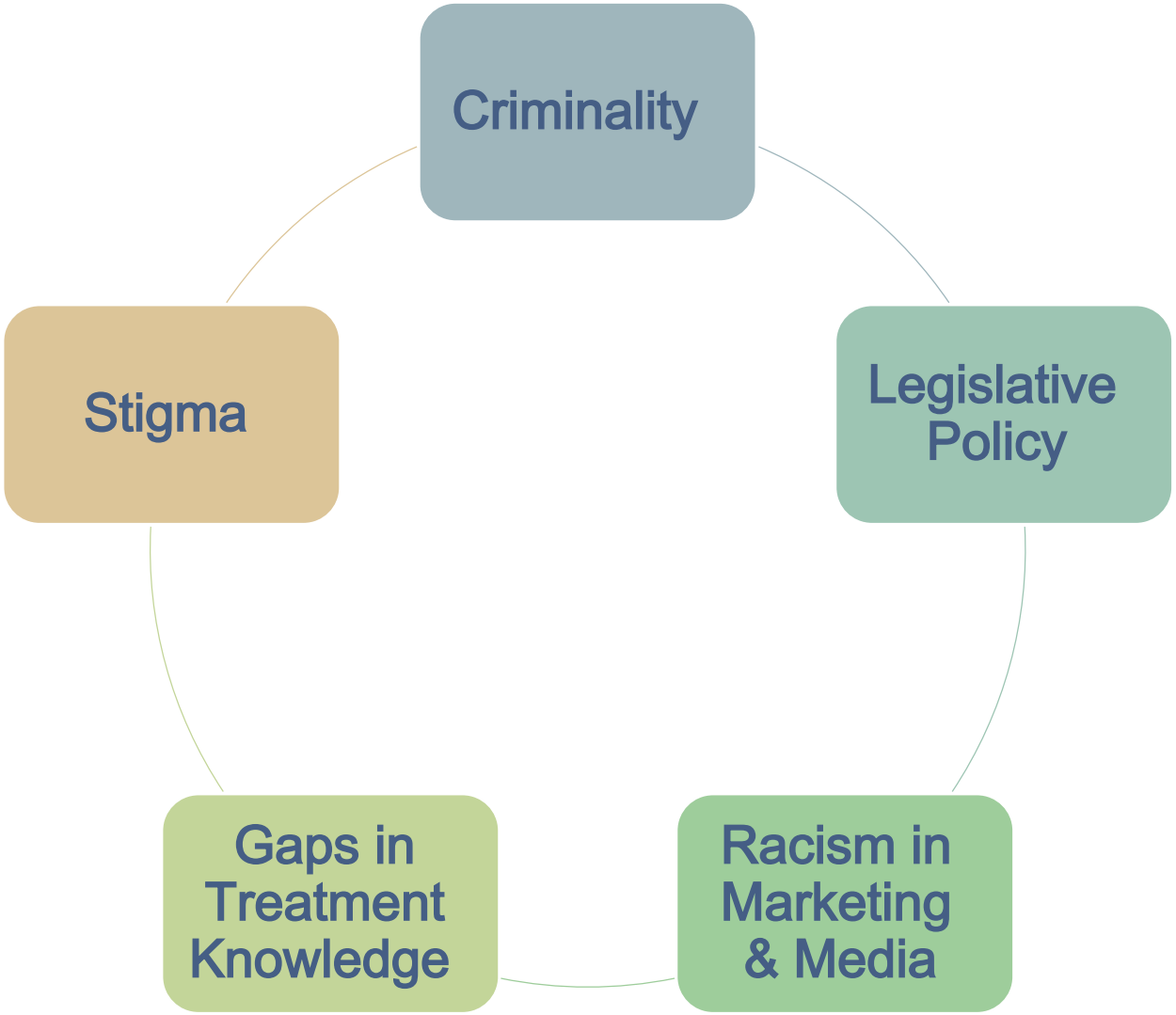
- Both OxyContin and buprenorphine were marketed toward doctors in white suburban areas

- Media often show white opioid users sympathetically and racial minorities as criminal, homeless, impoverished

Why do treatment disparities continue?

- Criminality
- Stigma
- Legislative Policy
- Racism in Marketing & Media

Why do treatment disparities continue?



Little research has been done to understand how these disparities have affected treatment knowledge gaps or preferences across races

What can we, as providers, do?

Multiple approaches to addressing structural racism

Within ourselves:

Acknowledge and understand our own biases by completing implicit bias training:

http://kirwaninstitute.osu.edu/implicit-bias-training/

With our patients:

- Build trust with all patients you encounter by being non-judgmental
- Use non-stigmatizing, person-first language (‘addict’ vs ‘person with addiction’)

In our institutions:

- Change recruitment and retention practices to increase numbers of minority students, staff, and faculty[1]
- Standardize evaluation & treatment protocols to minimize bias

1 Yousif, Ayogu & Bell. *NEJM.* 2020

To increase engagement among patients, providers and communities, solutions must be multi-faceted and public health focused

Thank You!
Questions?

lagiset@med.umich.edu
@poojalagisetty

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