Racial Disparities in Treatment for Pain and Opioid Use Disorder

How did we get here and where are we going?

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No conflicts of interest
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

1970

“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

1971

1973

1974

National Institute for Drug Abuse (NIDA) established

Narcotic Addict Treatment Act: regulated methadone clinics for treatment
Controlled Substances Act: drug schedule
Richard Nixon declares War on Drugs
Drug Enforcement Administration created
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/amounts 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.
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

Unequal Criminalization

Persons Incarcerated for Drug Offenses by Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Incarcerated Persons per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>20</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>100</td>
</tr>
<tr>
<td>Black</td>
<td>250</td>
</tr>
</tbody>
</table>

Carson & Sabol, 2012
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
2000s: A Shift Toward Treatment

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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
Why was the waiver put in place?

- 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
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

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.

- 71,125 people died from drug overdoses in 2019.

Peak HIV deaths (1995)

A treatment gap remains

People with OUD

NSDUH, 2019
A treatment gap remains

20% received treatment

People with OUD
A treatment gap remains

35% received evidence based treatment

People with OUD
A treatment gap remains

< 43% engaged in treatment for 1 year

People with OUD
Who does this epidemic affect?

10 million people with chronic pain are prescribed opioids

1.6 million people had an opioid use disorder in 2019
Treatment for Pain
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
Less likely to receive an opioid for pain

% of ER Visits Resulting in Opioid Prescription, by Race, 1993 - 2005

- White: 31.0%
- Black/African American: 23.0%
- Hispanic/Latino: 24.0%

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.
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\(^2\)

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Why does this happen?

Racial and ethnic minorities more likely to experience **miscommunication** or **misinterpretation** about pain with medical providers.
Some doctors still choose to believe that pain levels are lower for Blacks than Whites or that minorities are ‘drug seekers’.
Physicians are more likely to underestimate the amount of pain that African American are experiencing.
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?

Pain

10 million people with chronic pain are prescribed opioids

Addiction

1.6 million people had an opioid use disorder in 2019

NSDUH, 2019
How common is opioid use and misuse?

- 49.5 Million received at least 1 opioid Rx (15% of US pop)
- 10.3 Million misused opioids (heroin + Rx) (3.7% of US pop)
- 2.0 Million had an OUD (.7% of US pop)

Does misuse differ by race?

Little Difference in Opioid Misuse by Race/Ethnicity

- White: 4.0%
- Black/African American: 3.7%
- Hispanic/Latino: 3.6%

National Average = 3.7%

2018 National Survey on Drug Use and Health: Detailed Tables
Overdose rates by Race/Ethnicity

Rate per 100,000 of All Opioid Overdose Deaths, by Race/Ethnicity, 2017

National Average = 14.9%

- 19.4% White
- 12.9% Black/African American
- 6.8% Hispanic/Latino

2018 CDC Annual Surveillance Report of Drug-Related Risks and Outcomes
Individual who are Black and Hispanic are experiencing a faster increase in rates of drug overdose deaths involving opioids.
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
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
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
Separate and unequal treatment options

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

Separate and unequal treatment options

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

Schiff, et al, JAMA Netw Open, 2020
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
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
Why do treatment disparities continue?

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?

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\(^4\)

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.
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
Ensuring legalization is equitable


How will past harms to minority communities be repaired?
Although Blacks and Whites use illicit drugs at the same rates, Blacks are 6-10 times more likely to be incarcerated for drug offenses.

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.
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
Why do treatment disparities continue?

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

• 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?

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

We thought we knew drug addiction. Then our nephew died in our house.

The opioid crisis exposed in photos from a hard-hit neighborhood.

Photographer David Guttenfelder has documented horrors around the world, but he was shocked by what he saw on a Philadelphia street.
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
• 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?

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