Understanding and addressing racial and ethnic disparities in substance use disorder care: Perspectives from overdose survivors and healthcare providers

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BACKGROUND

The opioid-related overdose death rate in Massachusetts reached an all-time high in 2022, with growing racial and ethnic disparities [1]. Despite strong evidence showing the effectiveness of using methadone or buprenorphine for treatment of opioid use disorder, there is a significant treatment gap, especially for communities of color. In Massachusetts, studies have shown racial and ethnic disparities in access to any substance use disorder (SUD) treatment post-overdose, use of buprenorphine, and retention in buprenorphine treatment [2-4].

REFERENCES: 1) "Opioid-Related Overdose Deaths, All Intents, MA Residents – Demographic Data Highlights", Massachusetts Department of Public Health, 2023; **2)** Dooley, "Accessing Treatment Post-Opioid Overdose: A Health Equity Study", Boston Public Health Commission, 2019; **3)** Schiff et al., "Assessment of Racial and Ethnic Disparities in the Use of Medication to Treat Opioid Use Disorder Among Pregnant Women in Massachusetts", JAMA Network Open 3(5), 2020; **4)** Wakeman et al., "Trends in Buprenorphine Treatment Disparities during the COVID Pandemic in Massachusetts", Substance Abuse 43(1), 2022

METHODS

- Semi-structured interviews with **59 recent opioid overdose survivors** who were living in Boston and identified as Black (18, 31%), Hispanic/Latinx (23, 39%), or White (18, 31%)
- Semi-structured interviews with **29 care providers** working in a variety of roles at Mass General Brigham (MGB) hospitals and clinics, including MDs, nurses, Advanced Practice Providers, recovery coaches and other peer support staff, psychologists, social workers, medical assistants, front desk staff, and administrative staff
- Interviews explored participants' experiences with and perspectives on SUD treatment access and equity. Transcripts were coded and analyzed to identify themes relevant to healthcare providers and institutions, and themes from the two data sets were triangulated

QUALITATIVE FINDINGS & RECOMMENDATIONS

1 BIAS, STIGMA, LACK OF TRUST

FINDINGS: OVERDOSE SURVIVORS

Overdose survivors described common experiences of bias, stigma, and disrespect in healthcare settings, which left them feeling dehumanized and deterred care-seeking. Survivors commonly attributed their mistreatment to stigma against drug use and addiction, though some also referenced anti-homeless stigma and/or racism (intersectional stigma).

"[Medical staff] all know I'm a junkie. I get treated with disgust, like they don't want to get close to me, and they talk about my look. They say, I'm dirty, and I stink" […] "most [providers] here are racists" […] "they don't like to hear me speaking Spanish".
– Overdose survivor (Latino male)

FINDINGS: CARE PROVIDERS

Providers observed stigma in some medical settings resulting in differential responses to substance use compared with other medical conditions. Providers also noted that communities of color may not trust healthcare institutions in general, and that rebuilding this trust requires broad, intentional efforts to improve access and quality of care across departments and services.

"I had a patient, PCP's been with them you know, for over 10 years, and [the patient] had an issue with opioids, it was after some knee surgery or something happened, and he was […] [getting] a pill here and there, and he really wanted to stop. And when he finally told his PCP, the PCP, since they were giving them pain meds on and off, was sort of like "Oh, well you used me".
– MGB care provider

RECOMMENDATIONS

Center trust-building in all patient interactions and institutional processes/policies with strategies such as:
1. Hiring and supporting peer staff (especially people who have lived/living experience with SUD intersecting with other minoritized or marginalized identities)
2. Having a consistent presence in the community to meet people where they are

2 IMPORTANCE OF HARM REDUCTION APPROACH AND PEER STAFF

Survivors expressed a preference for working with staff who share lived experiences with the communities served, emphasizing lived experience with addiction. They also felt most cared for and respected when receiving services at harm reduction programs.

"[Programs should hire] people that are recovering, yeah, because you can read a book on it all you want, but you still never walked in those shoes. […] if there was one person who had eight years clean or there's somebody else who has a PhD […] I'm still gonna listen to the person that has years clean because they've been in my shoes"
– Overdose survivor (Black male)

"[Staff at a harm reduction program] really care. You don't just ask them a question and they just answer it. No, they engage. […] They would stop their own job to make sure that you got what you need."
– Overdose survivor (Latina female)

Providers expressed general support for a harm reduction approach to SUD but noted this approach is not consistently implemented by all staff. Not all providers understand treatment/progress from a harm reduction perspective.

"You don't have to be abstinent for me to take care of you. And that is in direct contradiction to the belief of a lot of the PCPs in the community…For me, I give you [medication] and you cut [your use] down…that's a win. You know, I'm celebrating that with you, and we'll tweak the plan as we go to meet your goals. But, to [another provider], that was a failure. And that reinforced that sense of failure in the patient's own brain."
– MGB care provider

Adopt and institutionalize a harm reduction approach across roles and departments, including:
1. Centering patient goals and priorities in care planning
2. Implementing trainings and other strategies to build awareness around substance use disorders and harm reduction across roles and departments

3 PROCESS GAPS

Some survivors shared negative experiences of receiving acute overdose care from a medical professional who offered insufficient or no support around connecting to further SUD treatment or services. This was more common for Black and Latino/a/x survivors.

"The [hospital staff] didn't offer me no treatment at all; they didn't offer me no detox, none of that."
– Overdose survivor (Black female)

Care providers highlighted that although low-barrier evidence-based treatment is widely available at MGB, there are gaps and inconsistencies in SUD identification and referral processes across the system. Increasingly, primary care providers are integrating SUD care into their practice, but there is still more to be done.

"…if [the SUD services are] depending on other people to refer patients in, I think, I'm only as strong as the PCP willing to ask those questions, right? So if the patients aren't being asked the questions by the PCP, or if they don't feel like they can disclose that information without being stigmatized, then they're not going to [get connected to care]"
– MGB care provider

Build upon existing resources and strengths by:
1. Developing processes to leverage existing touchpoints with patients to make connections to care
2. Monitoring gaps with a racial equity lens and identifying process improvements
3. Integrating care across departments to create more access points

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