# *RACIAL INEQUITIES IN OUD TREATMENT*

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**Part 1: The Harms of Resources That Help Alleviate the Burdens of Opioid Use Disorder Being Less Accessible to People of Color**

The opioid crisis has grown to a point where one in three American families say it is a problem for them and their loved ones (Coady). The crisis has permeated across America since the late 1990s killing over a million people (Coady). It is killing more people under fifty than guns or car accidents and more people are dying from opioids than HIV at its height (Coady). So how can we slow such a far-reaching problem? The answer to preventing deaths from this epidemic seem to lay in a two-pronged approach—harm reduction programs and medically assisted treatment therapies. The harm reduction programs are a first step approach to addressing the issue of Opioid Use Disorders. harm reduction programs “meet people where they are at” meaning their goal is not necessarily recovery, rather, it is to eliminate harms associated with Opioid Use Disorder or OUD. These programs can provide valuable resources for safe use practices like clean needles—to prevent the spread of Hepatitis and HIV—and Naloxone—an opioid antagonist that can save someone from an overdose by binding pain receptors and knocking off the opioids. The medically assisted treatments or MATs are an effective recovery plan. MAT treatments are a less powerful narcotic that can offset the withdraw effects from more powerful opioids. Typically combined with counseling and behavioral therapy, MATs are demonstrated to be the most effect means of long-term recovery from opioid addiction. Studies have shown patients on MAT have a decreased chance of relapsing, contracting HIV, and overdosing compared to other treatment options (Sheridan). These two combatants of the many harms associated with OUD have seen a rapid rise in their availability over the past several years. While the growth in these two programs is positive for many people affected by the opioid

crisis, access to these resources has been heavily limited for minority patients compared to White patients.

**Harm Reduction Programs**

Let's start by discussing by discussing some of the racialized inequalities currently seen in harm reduction programs. In my own experience working at a harm reduction program in Huntington, WV I found that the population we served was overwhelming White. The data collected by the program during in-take reflected this as well. While data is admittedly limited across the country, the problem isn't centralized to the specific program I worked at or the state of West Virginia. A study of the demographics of harm reduction programs in Kentucky showed that White people utilized their harm reduction programs around 70% of the time compared to only 2% of the time compared to people identifying as non-White (28% of the study chose not to identify their race) (Bhargava). The data was collected by the Kentucky Department of Public Health REDCAP database which captures data from people the first they enter the program (Bhargava). Another study that examined patients across six treatment facilities in Massachusetts and two in Rhode Island found that during the COVID-19 pandemic people self-identifying as from a racial/ ethnic minority group were 8 to 10 times more likely than their White counterparts to have their access to harm reduction programs interrupted (Rosales et al.). The study utilized a cluster randomized trial and enrolled 188 who patients across sociodemographic and severity of opioid use (Rosales et al.).

When evaluating harms one of the best approaches for analysis is Martha Nussbaum's Human Development Approach. This approach, also called the Capabilities Approach, is defined as "an approach to comparative quality-of-life assessment and to theorizing about basic social justice" (Nussbaum). Nussbaum takes this concept and creates a list of ten fundamental

capabilities that she deems necessary to a dignified and just life. We judge the harms associated with limiting access to harm reduction programs and MAT programs by the extent to which these harms limit the central capabilities outlined by Nussbaum. The central capabilities include: Life, Bodily Health, Body Integrity, Emotions, Practical Reason, Affiliation, Other Species, Play, Control Over One's Environment, and finally, Senses, Thought, and Imagination (Arcidiacono and Di Martino).

The obvious harm to a limited access to these facilities is that people of color with opioid use disorder are less likely to be able to use as safely as their White counterparts. This harm comes directly in conflict with Nussbaum's capability of life as a lack of Naloxone can cause someone to lose their life if they were to overdose without it present. It also makes them more at risk for life alerting diseases such as HIV or various strains of Hepatitis due to their lack of access to clean needles which obviously effects their capability of bodily health. Further, programs can provide vaccinations against certain strains of Hepatitis and provide free PrEP—a drug taken to prevent HIV in at-risk populations. In addition to the health-related harms in preventing access to these programs, there are also social ones. harm reduction programs tend to have workers in place that meet a variety of social needs. They can have religious leaders, social workers, and other community leaders. Over the course of my internship, I heard from a number of people that they were hesitant to enter locations like the church, public agencies, and other community agencies. They communicated that it was due to the judgement or stigma they feel when entering such locations. By placing these professionals in the harm reduction programs—an environment free of stigma and directly created for people with OUD—there is a better chance people with OUD actually engage with these people in meaningful ways. These people and their organizations can provide the feeling of affiliation, can provide meaningful interactions

with other people, and can help them illicit more control over their own environment. Additionally, the people working daily in the program typically have social capital with programs that intersect with the needs of people with OUD. For example, the harm reduction Program I worked at had connections to the local homeless shelter so if participants in the program were in need of a place to sleep that night more often than not the program workers were able to facilitate a connection. They also had connections to local food banks, clothing drives, and other programs. Being sent to these locations by people within the program seemingly gave participants more confidence in actually utilizing their resources. Further, harm reduction programs tend to be a steppingstone to recovery. People who go to a harm reduction programs are five times more likely to enter treatment (Coady). This implies that another harm from a limited access to harm reduction programs is a lessened likelihood of entering a recovery program. Thus, in limiting the capabilities of minority peoples with OUD to accessing these resources, people are causing them harms on a variety of levels.

**MAT Programs**

Moving from harm reduction programs and into a certain type of treatment program, we will start to look at the racial discrepancies in MAT treatment programs. Though there are several types of treatment programs that don't involve MAT, the MAT programs tend to have an increased likelihood of getting people into long term recovery (Coady). Since long term recovery eliminates many of the harms associated with active drug disorder, it's even more important to consider the racialized inequalities in these programs. When examining MAT programs, it is important to note that two similar, but different types of drugs are mostly utilized. The two main FDA approved MAT medications for treating OUD are Buprenorphine and Methadone (Newsome and Valentine). Buprenorphine and Methadone work by blocking brain opioid

receptors and reducing both cravings and withdraw symptoms (Newsome and Valentine). Both of these two medications have their own sets of varying inequalities in minority communities compared to White ones.

Starting with Buprenorphine, the more widely used medication between the two, we see some pretty large discrepancies in who is getting prescribed it. One first-hand account from John Woodyear, an addiction treatment specialist who prescribes Buprenorphine in Troy, North Carolina, exemplifies this disparity. Woodyear's town is seeing increasingly high rates of overdoses in the Black and Native American populations, yet he claims his patients are still 90% percent White (Newsome and Valentine). This seems to be a reoccurring theme across the nation. A national study from 2012 to 2015 laid out how of the 13.4 million ambulatory visits for Buprenorphine in the United States 12.7 million of the visits were accounted for by patients identifying as White (Lagisetty et al.). That means around 95% of patients on Buprenorphine are White (Lagisetty et al.).This inequality was only perpetuated by the pandemic as prescription fills fell in all populations but particularly in Black, Hispanic, and Asian patients (Nguyen et al.). Buprenorphine fills for Black Medicaid patients decreased by 10% compared to only 3.5% for White people. While refills for Black cash-paying patients decreased by 20% and decreased by 15% for White patients (Nguyen et al.). The inequities in the decrease of both cash-paying and Medicaid patients seem to imply that the issues driving these differences while likely also driven by the social determinants of health, have some sort of racialized component to them.

The next drug we will examine is Methadone which tends to be more utilized in minority groups than the previously mentioned Buprenorphine (Goedel et al.). Around 16% of the total Methadone prescriptions in 2017 were prescribed to Black people (D'Aunno et al.). It has also been reported that Methadone clinics are usually located in poor communities of color

(Newsome and Valentine). When one compares the prescription rates of Buprenorphine for people of color to Methadone prescription for people of color, the inequality begins to become apparent. Using this these two studies, we are able to hypothesize that there are inequalities in access to Buprenorphine treatment because people of color are able to access Methadone but not the Buprenorphine. Now that we have established the potential difference in access to methadone and Buprenorphine, we can explore the differences between the two drugs. Methadone compared to Buprenorphine is *more* lethal in overdose potential if used incorrectly. Further, Methadone does not tend to contain the opiate antagonist Naloxone whereas its counterpart Buprenorphine does. This increases the chances for abuse of the Methadone due to those receptors not being blocked. So, despite seeing that Methadone is a more readily accessible to minority patients than Buprenorphine, it may not be as effective of a drug in preventing relapse. There also currently exists a potential inequity in the way Methadone doses get distributed when comparing people of color and White people. A consistently higher dose of Methadone has been linked to better outcomes for recovery (D'Aunno et al.). One study found that when analyzing the dosage of Methadone utilized at a neighborhood level, it was found that areas with higher proportions of African American patients were more likely to under-dose Methadone than predominately White neighborhood (D'Aunno et al.). The inequality here shows that even when minority patients get medication in a manner close to equity through MAT programs, the actual level of that treatment and ultimately its chances of being successful, are often inequitable.

The harms associated with not getting treatment or getting inadequate treatment are vast. Assuming the majority of people who do not receive treatment remain on drugs, they are potentially suffering big picture health related harms such as death or disease. These two harms would obviously contradict Nussbaum's capabilities of life and bodily health. People who

remain on drugs are also more likely struggle to acquire a job than someone who has gone through recovery. This can lead to housing instability or outright homelessness (Daley). Factors associated with homelessness can create threats to nearly every aspect of the ten capabilities. In addition, people who do not receive treatment can suffer from socially and family related harms related harms. People may have problems maintaining relationships due to high rates of tension and conflict surrounding their substance use (Daley). People with substance use disorders area also more likely to have family instability driven by abuse or violence, family separation, divorce, or the direct removal of children by child protective services (Daley). Thus, remaining on drugs can affect people's ability to maintain affiliations—yet another Nussbaum's capability (Nussbaum). Finally, people with OUD are also more likely to get imprisoned due to the laws surrounding substance use, a harm that has a vast umbrella of downstream harms similar to homelessness that can harm arguably every capability.

**Part 2: How Social Structures Limit Access to Harm Reduction Programs and MAT Programs For People of Color**

When examining the harms associated with inequalities in harm reduction and treatment access, it is essential to examine the social structures driving the inequities. Identification of the social structures perpetuating inequalities is an essential part of the process of figuring out if there is an inequity occurring. If there truly are no barriers in place to access and the reality is that people of color are just choosing to not access harm reduction program under their own volition then there may not be a true inequity occurring. However, if there is an inequity occurring, the identification of social structures can tell us how that inequity is being carried out. Ultimately, identifying the social structures driving an inequity gives us a natural starting point in a policy that may address the inequity. Eastwood describes social structures as "durable,

individual-spanning phenomena that enable and constrain our choices and that are themselves made of our independent choices" (Eastwood). Eastwood further elaborates to say that social structures are made up of an interacting relationship between what he refers to as the three R's: rules, representations, and relationships. Eastwood defines rules as "shared prescriptions and proscriptions" (Eastwood). He defines representations as "shared schemes or categorization" (Eastwood). Lastly, he defines relationships as "a sustained interaction between individuals" (Eastwood). Examining the identified inequities from this perspective will help us understand how they are occurring.

In addition to utilizing Eastwood's three R's in an analysis of social structure, I will also utilize ideas from Patricia Collins. Collins' work specifically analyzes the oppressive components of social structures—an appropriate lens by which to examine racialized differences in access to OUD resources. Collins calls us to consider the institution dimension, the symbolic dimension, and the individual dimension. The intuitional dimension refers to specific organizations like schools, businesses, or hospitals. Collins defines the symbolic dimension as "widespread, societally-sanctioned ideologies used to justify relations of domination and subordination" (Collins). Lastly, she defines the individual dimension as "the multiple ways in which our race, class, and gender as categories of analysis frame our individual biographies" (Collins).

**Harm Reduction Social Structures**

The first social structure I will examine concerns the policing of drug paraphernalia. Most states have direct laws—or rules for the context of our social structure discussion—that prevent the possession of drugs or items that could be used for drug use. The punishment for this in most states seems to be a monetary fine, but in some it can include prison time. These laws date back

to 1979 when the DEA drafted a Model Drug Paraphernalia Act for states to incorporate into their own legislature (*Drug Paraphernalia: Summary of State Laws*). These drug laws still exist today in every state except Alaska (Singer and Heimowitz). This law essentially prohibits the work harm reduction program agencies are attempting to carryout. Since many harm reduction programs contain needle exchanges these programs can inherently violate this law since exchanges are bringing in and dispersing drug paraphernalia. While the needle exchange portion of harm reduction programs is legal in many states, even with their drug paraphernalia laws, there are still underlying effects of the law that limits how these programs can function. An example of this conflict occurred at the Harm Reduction Program I worked at when police officers would camp outside the health department and arrest the participants for their possession of drug paraphernalia. Since the officers were confiscating either the old needles they were bringing in—which were required in order to receive new ones—or the new ones they had just received, the goals of protecting the health of these people were not able to be fully met. Though my individual experience is limited to just Huntington, this phenomenon has been documented in harm reduction programs in other areas of the country. A 2022 study carried out in seven sites operated by the North Carolina Harm Reduction Coalition examined the effect of policing on participants attempting to access the program. The study utilized a survey and interview methodology for collecting data. The study survey sample was made up of 414 participants and was 53% female, 64.9% White, 22% Black, and 4.7% Hispanic by demographics (Morrissey et al.). Nearly 1 in 5 respondents reported that an officer confiscated their syringes that they obtained from a harm reduction program (Morrissey et al.). This seems to show that the confiscation of syringes at least occurs in parts of the country other than Huntington. Admittedly, published research studies into this specific phenomena were limited. I was, however, able to

gather some more qualitative data about the issue from interviews. In an interview conducted with Claudia Dambra, we get a description of the psychological effects of policing on people's willingness to access harm reduction programs. Dambra runs a harm reduction program in Texas—a state with strict laws around drug paraphernalia. When asked about the effects of policing on people with OUD in her area Dambra said, "The criminalization and the general thought of criminalization is causing people to hurt themselves. It's causing them to not seek help if they need it. It's causing them to think that this is what they deserve, when you're living your life in fear of even having a sterile syringe or sterile pipe, your quality of life is just so low" (Dey). Though data is limited on just how widespread the issue of policing specific to harm reduction programs across the country actually is, the testimony of Dambra shows just how harmful criminalization can be on people with OUD. Even if the police officers aren't camping outside of the programs like in Huntington, the mere presence of the laws has a negative effect on people's willingness to utilize these programs.

The Dambra quote starts to move us from the rule portion of social structure and into the representation portion. When examining the representation portion there are several aspects to consider. Dambra gives us a look at how the law makes people with OUD view themselves or how the rule effects their representation of self. In this sense, the rule seems to be driving the representation. There are also representations that drove the production of the law in the first place. These representations villainized drug use. Many representation also framed drug addiction as more of a minority problem than any other group. The laws around paraphernalia originate from a long history of stigmatization of drug use—starting in the 1970s with Nixon's campaign for the "War on Drugs". This movement politicized drug use and created a negative representation of people using drugs that mostly targeted Black and Latino communities

(Levins). When discussing the Nixon motivation for carrying out the "War on Drugs" John Ehrlichman, a White House Counselor and assistant to the president, said, "The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and Black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or Black, but by getting the public to associate the hippies with marijuana and Blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did" (Baum). The public support for many of these drug laws around drug paraphernalia were driven by the representation of drug users created by the Nixon administration. When unpacking this quote, we should not only consider how the basis for the rule we are examined was based on the manipulation on the public's representation of drug users, but also how this representation would be even more damaging to people of color. There would go onto be further movements throughout the 80s and 90s that increased the strictness of laws surrounding drug use and possession. Many of these laws specifically targeted Black and Latino communities (Levins).

Proof of the effects of these representations still existing today can be seen in the incarceration rates for people of color. In a 2013 study by the Drug Policy Alliance, it was found that despite only representing 13 percent of the US population, Black people made up 30% of those arrested for drug law violations (*The Drug War, Mass Incarceration, and Race*). Additionally, they represented 40% of those incarcerated for drug law violations. The study also found disproportionate arrests and incarcerations for Latino people. Latino people represent 17 percent of the US population but comprise 20 percent of the people in state prisons for drugs offenses and 37 percent of people in federal prisons (*The Drug War, Mass Incarceration, and*

*Race*). There are limitations in applying this study from ten years ago—mostly that there could've been considerable changes to the demographics of those imprisoned over a ten-year period—to present day, but the study represents the most recent data available. Another limitation of the study is that it does not specify the type of drug people were arrested for possessing.

We can see these specific representation manifest specifically for people with OUD when looking at the study surrounding a harm reduction programs in North Carolina. That study doesn't necessarily give us proof of the occurrence across the country, but it does show that the villainized representation police officers may hold toward people with general substance use disorder can manifest for people with OUD specifically. The study North Carolina study found that 55.1% of Black participants reported having at least one negative interaction with law enforcement in the past year, compared to 50.1% for White participants (Morrissey et al.). Though a notable difference at first glance, a chi-square analysis conducted by the study showed this was *not* a significant difference. What the study did find was that some areas in North Caroline had significant differences in the ways Black people in the harm reduction programs were policed compared to White participants (Morrissey et al.). In Durham County for example, it was found that police officers were significantly more likely to doubt a Black person's ownership of an SSP card [1]compared to a non-Black person. They found that 20.3% of the Black population in the study reported this experience compared to only 14.3% for non-Black participants (Morrissey et al.). This was compared to an analysis of harm reduction programs in counties outside of Durham which found that 10.3% of Black participants had their SSP card doubted compared to 7.5% of non-Black participants. An example of how large of a burden

[1] The SSP card is given out by some harm reduction programs to signify that you are a member of their program.

having your SSP card question can be is shared from the testimony of a woman in one of the interviews (Morrissey et al.). The interview reads, "I don't think the law takes the cards and stuff as seriously…Not me personally, but people I've been with... basically [would] get arrested anyway. And of course, it gets dropped when it goes to court, but it's the process of getting there. And if you don't have anybody to bond you out, you know, sometimes North Carolina takes their time…It [could] be anywhere between a week to 30 days depending on if they're pushing off your court date or whatever. And sometimes they do it just to fuck with you, simply. You know? They know it's gonna get dropped" (Morrissey et al.). This testimony shows how big of a burden the police can create in situations regarding drug paraphernalia. As a whole, this study seems to show that there can be enhanced suspicious for Black people's SSP cards compared to White people and that the frequency of these suspicions can vary by area.

The knowledge of how an institution may treat people differently based on their race plays into Collins Individual dimension of oppression. Essentially, because Black people are more likely to not trust police and to view them as treating them unfairly, this is going to play a role in their individual biographies. That understanding of their individual identity may lead them to avoid an institution they see as biased against them. Due to the fact that the drug paraphernalia law can increase police presence around harm reduction programs, it is reasonable that the knowledge of this keeps some Black people away. It is also possible that this type of thinking keeps other minority people away, though most research seems to highlight how it effects Black people.

**MAT Social Structures**

Another important social structure worth analyzing centers around Buprenorphine. In order to prescribe Buprenorphine, there were several structural rules a physician had to follow.

They had to submit a notification of intent to prescribe the drug to the Substance Use and Mental Health Services Administration or SAMSA, hold an active medical license, have a current DEA registration number and obtain an additional certification in addiction through an approved eight-hour training course (Healy et al.). These requirements have been around since the Drug Addiction Treatment Act in 2000 (Hurt). This certification, labeled an X-Waiver, was the only way a physician could prescribe Buprenorphine. This led to only 8% of physician being able to prescribe Buprenorphine (Davies). Further, a provider could only prescribe the drug to 30 patients at any given time during the first year of service. After the first year, they could go through an application process to get that number up to 100 (Healy et al.). Finally, after two years, they could get up to 275 patients—where they we seemingly capped. As of the first of January, X-Waivers are no longer required to treat patients with Buprenorphine (Healy et al.). Nonetheless, the waiver's existence since the inception of the drug has implications on what groups have long been able to access it and the capabilities for communities of color to access it in the future. A system that has been around for over twenty years is no doubt going to have some structures in place that take time to dismantle. Historically, this policy was a response to the very thing that started the crisis which was over prescription of Opioids in "Pill Mills" across the country. In these "Pill Mills" doctors would hold hundreds of patients at a time. Many times, they wouldn't even see the patients and would instead have already signed prescriptions for nurses to just hand out Opioids if the patients could pay—normally in cash. Since Buprenorphine is an opioid, the DEA seems to have suggested these regulations to prevent the same things from happening with Buprenorphine. Regardless of why the regulations occurred, the strong regulations on Buprenorphine made it a highly limited resource in doctors' offices across the country. The rule, however, is not in itself racialized. It would explain why more people receive

Methadone, a less regulated drug, but not why Black people and other people of color were provided less access to Buprenorphine compared to White people.

One factor that might be driving this difference in prescription preference by race is implicit bias in physician. The NIH defines implicit bias as "a form of bias that occurs automatically and unintentionally, that nevertheless affects, judgments, decision, and behaviors" (*Implicit Bias*). A 2015 study examining fifteen studies across the country centered in racial bias in medical processes found that in all but one there was low to moderate implicit racial/ethnic bias against Black, Hispanic/Latino/Latino, and dark-skinned people compared to White people (Hall et al.). The study found that implicit bias was significantly related to patient-provider interactions, treatment decision, treatment adherence, and patient health outcomes. An example of this bias manifesting was shared by a Black man in a Pew research study. They described their interaction with a physician by saying, "My mom, and I can't think of it specifically, she has complained to me about being at the hospital and feeling as though they were treating her like she was a drug addict. When they would have to give her pain medication, or she would need something for pain – having her fill out forms, only allotting a certain amount, or cutting it, when her pain is… she goes through pain more times a day, they'll cut it to less. Less than what she needs to get through the day and not be in pain" (Funk). Here we see how implicit bias toward the man's mother provided a barrier in the physician-patient relationship that didn't allow for treatment that the patient was satisfied with and eliminated their pain. This quote serves as representation of the most apparent way that implicit bias fits into the three R's—its effects on the physician-patient relationship. If patients of color feel they are being treated differently than White people they are less likely to trust White physicians. In fact, studies show this to be true. A survey by NORC with over 2,000 participants and an oversampling for Black, Hispanic, and

Asian respondents found that White patients trusted physicians 86% of the time compared to 76% of the time for Black patients and 77% for Hispanic patients (Mensik). This distrust can lead to patients being less likely to follow doctors' recommendations and it makes patients less likely to return to the physician's office for subsequent treatment. When you combine the consequences of distrust with the fact that for MAT treatment to be successful you need to regularly return for treatment, one can see how with a limited ability to prescribe Buprenorphine, doctors would want to provide it to people they viewed as likely to return for treatment. These types of interactions and their consequences fall under Young's symbolic dimension. The widespread ideology among physicians, even if subconscious, that people of color are less likely to return creates a system that further perpetuates distrust between medical providers and patients of color and the whole process will continue to repeat. While there are likely other factors relating to the social determinants of health effecting people of colors ability to return, implicit bias and the way it impacts relationships within the social structure is playing some sort of role here.

**Final Thoughts on Social Structure**

Though I have only explored two specific rules driving social structures around Harm Reduction Programs and MAT treatment, there are greater implications behind the factors driving both of them. The laws around drug paraphernalia raises a bigger questions of how historic laws built to prevent drug use and ultimately protect people, can now be used as weapons that harm people—especially people of color. Further, the analysis forces us to consider how the over policing of people with OUD can be harmful for both people with OUD and for the communities around them. If people didn't feel comfortable bringing their syringes back to the program, where were they most likely to continue ending up? The X-Waiver policy forced us to

consider the implicit bias's that exist within health care as a whole institution. Even with the X-Waiver no longer in place, it will be important to see how implicit bias continue to manifest for people with OUD as they engage with health care systems.

**Establishing Inequities in Access to Harm Reduction Programs**

In order to claim an inequity has occurred, I must first define an inequity. I will define an inequity as an unjust inequality. How we gauge the unjust component of this definition comes from our defined central capabilities approach. If people do not have access to a resource that would ensure their central capabilities are met, this would be considered unjust. Additionally, if people are unable to access resources that might allow them to achieve their central capabilities due to social structures driving these resources away from groups based on what should be irrelevant characteristics for the given situation. These irrelevant characteristics could include things like race, gender, religion, sexual orientation, etc. A clear-cut example of this would be the federal government refusing to give welfare to people who qualify just because they were within a given group. This would be an unjust inequity. A more nuanced example would be if the federal government had no direct laws in place to prevent a given group from accessing welfare but in order to access welfare you had to go to a local agency to get approved. Let's say the majority of the agencies are not placed in neighborhoods where predominately people of that group reside and even further let's say that there is no public transportation to the agency. Even though there is no law in place preventing people of this group from accessing welfare, because rules like the placement of the agency and having to go in person to get the resource, the social structures could lead to an inequity that prevents people from accessing a resource that uplifts their central capabilities. We would also consider this an unjust inequity.

In part one, we established that there are inequalities related to people of colors ability to access harm reduction programs compared to White people. We saw this through data provided by the state of Kentucky, a study conducted in harm reduction programs in Massachusetts and Rhode Island, and through my experience working in a HRP in Huntington, WV. There is still uncertainty into how widespread the inequality actually is across the nation, but we know with relative confidence it is occurring in these places. When we add in part two's social structural analysis we see that there are laws around paraphernalia that could be perpetuating this inequality. Through a first-hand account, we see that just the placement of these laws can have psychological impacts on people's willingness to access harm reduction resources. Further, we see through empirical data that these laws typically are enforced at higher rates among people of color when compared to White people. These factors seem to show that the social structures in place lower the capability of people of color to access these programs when compared to White people and that moves this occurrence from an inequality to an unjustifiable inequity. So, while there is no direct law creating an unjust inequality, there are social structure in place that limit people of colors capabilities to access this resource. Due to this, I would define this occurrence as an inequity.

**Establishing an Inequity in Buprenorphine Accessibility for People of Color**

In part one, we saw an inequality in people of colors ability to access Buprenorphine MAT treatment as opposed to Methadone. Black people were only being prescribed Buprenorphine 2.5%of the time compared to Methadone where they were prescribed around 16% of the total prescriptions. When we examined the social structures involved with Buprenorphine prescriptions, we saw that doctors were limited by both how much Buprenorphine they could prescribe to a patient and the number of patients they were able to

carry at any one time. When we considered this rule in relation with what we know about how implicit bias against people of color can manifest in health care setting, we begin to see how an inequity may be appearing. If this rule limits the amount of the resource the physician can prescribe it is only further feeding into those tendencies of implicit bias. The result of this is that people of color tend to be prescribed Methadone, a less effective drug. The fact that Methadone was being prescribed at significantly higher rates tells that an inequality exists, but the fact that there were structures in place that limited the amount of the Buprenorphine (the better drug) being prescribed to people of color shows that an inequity exists.

**Part 3: How to Start to Overcoming Inequalities in Access to OUD Resources: Decriminalization, Increased Funding, and Targeted Placement of OUD Treatment Programs**

Now that we've discussed the social structures in place driving these inequities, we can begin to explore possible policy solutions to attempt to lessen their harms. The plan in which I would recommend employing would call for two major policy recommendations. The first would increase federal funding for MAT and harm reduction programs across the country. This would be an attempt to increase the total number of resources accessible for people across the board. Placed within that increased funding would be financial incentives for prioritizing MAT and harm reduction programs in communities of color. This would seek to address many of the problems in accessibility of the programs for these people. The policy would also seek to improve employment of people of color in these programs—a potential remedy for some of the implicit bias's we pointed to as a problem in social structure.

The second policy recommendation would be the outright decriminalization of drugs. We would do this in a way that still has legal consequences for those dealing or distributing currently

illegal drugs but wouldn't punish the user. This would hopefully eliminate some of the stigma that prevents people from accessing MAT or harm reduction resources. It would also attempt to change the way police officers interact with people with OUD. Instead of potentially imprisoning people with OUD or giving them monetary fines, officers would share information about nearby harm reduction and MAT programs. The goals of this policy recommendation are to not only level up access to harm reduction resources and MAT programs for communities of color, but also to level up access to these resources for all people with OUD.

**Policy Recommendation: Decriminalization**

Before we have established the moral permissibility of these polices we will begin by discussing how we should carry out the policy and some of the consideration for this process. We will start with that decriminalization component. In theory, decriminalization of drugs without any of the other aspects associated with my recommended policy, would reduce stigma, reduce negative police interactions with people with OUD, and would allow access to resources that protect those with OUD to become more readily available. To be clear, what I am suggesting is a full scale-nationwide legalization of a certain amount of all drugs. One country that can serve as a model for decriminalizing drug use is Portugal (Bajekal). Portugal issued Law no 30/2000 which Decriminalized the public and private use, acquisition, and possession of all illegal drugs for personal use (Rego et al.). The main goal of the policy was to widen social and public health protections for drug users. Under the law, it was still illegal to deal drugs but anyone with less than a 10-day supply of the drug was sent to a local commission. This agency is completely independent from the police and its main goal is "Encouraging adherence to treatment, or the decision to abstain from drug use" (Rego et al.). This commission consists of a doctor, a lawyer, and a social worker where they are taught about treatment options and available medical services

(Bajekal). While I don't necessarily think the United States has the infrastructure to create a whole commission for people with OUD, the framework of all the types of people involved in the Portuguese commission could be incorporated into harm reduction programs in the United States. I believe that's outside the scope of my current recommendation, but I think it is an important aspect to consider. The results of these policies have been overwhelmingly positive with Portugal's Drug Czar Dr. Joao Goulao declaring, "The biggest effect [of decriminalization] has been to allow the stigma of drug addiction to fall, to let people speak clearly and to pursue professional help without fear" (*It's Time for the U.S. to Decriminalize Drug Use and Possession*). This statement is supported by the fact that the number of people in drug treatment increased by more than 60 percent between 1998 and 2011 in Portugal (*It's Time for the U.S. to Decriminalize Drug Use and Possession*). Our policy would follow many of the ideas incorporated by Portugal. We would have nation-wide legalization combined with increased capacity to serve people with OUD. This policy would alleviate some of the barriers for people of color to access OUD resources like the psychological feeling of unworthiness related to the presence of the laws and the types of negative interactions they might have with police as a consequence for accessing these programs.

Some might argue that Portugal and the US are drastically different countries with different people and different problems around drug use. This is a valid claim, but the counterfactual of not incorporating this policy would continue to negatively affect people of color with OUD. What we can learn from this statement though is that there will be differences in how the US might have a successful decriminalization policy and how Portugal has it. To examine some of these differences we can look at decriminalization in Oregon. Oregon instituted a policy around decriminalization combined with an increase in funding for harm reduction

programs in 2020 and have had many failures in the goals they hoped to accomplish. The Oregon policy saw less than 1% of people entered treatment two years after the law had passed (Hochman). The reason for this seems to be because the state was slow to channel funds into many of the programs. People from the programs meant to serve people with OUD testified to the Oregon lawmakers that they didn't have the staff or funding to meet the demands of people entering the program (Hochman). The case in Oregon raises legitimate concerns about how the policy recommendation I make will be carried out. I don't believe it's a strong enough argument to do away with the recommendation altogether, but I do believe it makes even more important the efficiency of giving out funding for these programs must be for the policy to be successful.

**Policy Recommendation: Increased Funding and Prioritization of Communities of Color**

We will now move into the logistics of expanded funding portions of our policy and the targeting of MAT and harm reduction programs in neighborhoods of color with OUD. The ways in which we will invest those increased funds will be directly into the amount of MAT medications facilities can supply. We will give MAT facilities more money for both Buprenorphine and Methadone. We will give harm reduction programs more money for Naloxone and supplies like Fentanyl test kits or syringes. Additionally, we will invest in improved salaries for staff positions and increase the number of staff positions. This consideration would address some of the problems identified in Oregon. Finally, in terms of creating a plan to address the needs of communities of color, we would work with community partners from communities we have identified as higher risk for OUD and see what they believed the needs are in the area before allocating funding. Working in partnership with these leaders would allow us to gauge the severity of the problem in the area before granting funding and would allow us to maximize efficiency of the resources allocated. It also gives the people who

are most familiar with how to help the problems in their area, a seat at the table for decision making. The total amount of money required to carry out the program effectively on a national level would be around 15 billion dollars. We gather this number from the total amount invested in all areas of OUD in 2018—7.5 billion dollars—and doubling it (*Tracking Federal Funding to Combat the Opioid Crisis*). This amount accounted for how much government insurance paid for MAT treatments, non-MAT related treatment programs, harm reduction programs, drug security, drug prevention programs, and more (*Tracking Federal Funding to Combat the Opioid Crisis*). Now, that might sound like a large sum of money to invest in OUD treatments, and it is, but when we consider that the total US spending budget for 2018 was 4.1 trillion it becomes only a fractional rise (*The Federal Budget in 2018: An Infographic*). Total spending on OUD goes from .18% of the budget to a whopping .36% of the budget. This seems like a justifiable investment for a phenomenon that is in some way affecting one in three American families.

Transitioning to the actual carrying out of the policy, one large aspect to consider for all programs we aim to fund are the demographics of people staffed within them. People of color tend to benefit from having doctors or health care providers who are also people of color (Huerto). Specifically, evidence shows that when doctors and patients share the same race or ethnicity there are improvements in the time spent with the patient, the patient's adherence to medication, shared decision making, wait times for treatments, and patient perception of their treatment decisions (Huerto). Knowing this, the goals of my proposed policy of improving funding and placing these programs in low-income neighborhoods of color may fall short if these programs aren't actually staffed with people of color. I would argue that knowing this fact, it would make sense to allocate some of that improved funding for these programs to financially incentivizing physicians or health care worker of color to receive added bonuses for coming to

work in these facilities. This initiative is in line with a recommendation from the Foundation for Opioid Response. Their policy suggestion is to "offer training and financial incentives for physicians and other prescribers, particularly those who treat Medicaid beneficiaries, to offer MOUD as the standard of care" (*Promoting Equity in Access to Opioid Use Disorder Treatment and Supports: A Focus on Black Communities*). Additional recommendations from the Foundation for Opioid Response that I believe we should also incorporate are utilizing the plan to increase funding toward the peer recovery support work force working within communities of color. We would also invest in outreach campaigns that specifically target communities of color and make it clear what resources are available to them, their effectiveness and where they are located (*Promoting Equity in Access to Opioid Use Disorder Treatment and Supports: A Focus on Black Communities*).

The carrying out of this race-based method of targeting for funding would be controversial. Many people would argue that the distribution of these resources should just be targeted to neighborhoods with high overdose rates regardless of racial demographics of the area. This is not a baseless claim, but it discounts the fact that most harm reduction clinics and MAT treatment facilities are already located in predominately White neighborhoods. It's also not as though this recommendation will *only* benefit people of color. The decriminalization component would make stigma and incarceration rates go down for all people with OUD. The increased funding for MAT programs and harm reduction programs in general will also raise the number of resources for people across the board. The initiatives for diversifying the people serving within these programs will also only offer more perspectives, something that could be beneficial for people regardless of their race. Finally, the targeting of new programs in neighborhoods of color will not only serve people of color in that area, they will be open to all people. It's likely this

would improve the access to all people in the area with OUD, not just those people of color. The design featured within my policy recommendation is racially conscious, but it also meant to improve the accessibility of resources that eliminate harm for *all* people with OUD.

**Moral Justification**

These presented policy proposals convey various benefits and burdens to different individual stakeholders. We will now consider the moral permissibility of each action. The moral principle by which I will examine each aspect of this policy is contractualism. According to Elizabeth Ashford, this moral theory is based around the claim that each person's moral status is grounded in their fundamental equality (Ashford). It says that an action is right if and only if a reasonable person could not reject them. There are two criteria for rejecting an action. The first states that the only reasons for judging for or against a principle are 'single individuals' reasons for objecting the principles and its alternatives. This means the principle cannot be compared against the net utility of a whole group, rather the pros and cons for a single individual against another must be weighed (Ashford). The second reason for a rejection depends on the comparative strength of different actor's reasons for or against the principle.

I chose contractualism because it is the policy that most considers the needs of those "worst off" in society. When examining the population with OUD, they are likely to have multiple intersecting identities that would put them in the category of "worst off" in society. This consideration of the "worst off" is the reason I chose contractualism over a moral principle like utilitarianism. Utilitarianism attempts to maximize the most utility possible in a society. This consideration can harm vulnerable populations and prioritizes the whole over the individual. We see how these moral principles can play out in the Mr. Jones and the machine example from Thomas Scanlon (Ashford). In this example, a soccer game is playing worldwide for over a

billion people. There is one machine allowing the game to broadcast. Somehow, Mr. Jones gets tangled in the machine and becomes stuck. Mr. Jones is clearly in immense pain as the machine is pressing on his body and crushing him while simultaneously electrocuting him. In order to get Mr. Jones out of the machine, the other workers must momentarily turn off the machine which would stop the broadcast of the game for a short amount of time. The utilitarian might say that we should leave Mr. Jones in the machine to suffer and ultimately die as the cost of his individual life would not outweigh the minor cost to over a billion people being deprived of the game for some time. The contractualist would say that we unplug the machine and get Mr. Jones out because the harms he is suffering individually outweigh the harms any individual who would be inconvenienced by the game being temporarily turned off would suffer. This example illustrates the difference in the two moral theories. I would much rather live in a society that considers the immense suffering of an individual over the minor inconvenience to many.

**Contractualism as Justification for Increased Funding and Targeting of Resources in Neighborhoods of color**

The principle of contractualism asks us to weigh the probability of harms along with the severity of harms. We will particularly examine the increases in funding and targeting of neighborhoods of color with higher rates of OUD as we justify the policy through contractualism. In terms of the people who could reasonable object this policy or would be negatively affected by its alternatives, our main stakeholders are the people of color with OUD who currently have many barriers to accessing MAT and harm reduction services, the general taxpayers, the people of the neighborhoods where the new programs would be located, and the White people with OUD living in predominately White neighborhoods who wouldn't necessarily be targeted for the additional harm reduction and MAT program.

When we examine the harms of *not* instituting this policy for people of color with OUD we see that there is an increased risk for death. This is as severe a situation as we can have in a scenario. In this scenario, the affluent taxpayer would lose not money due to their taxes remaining the same. Counter to this scenario, if we did institute the expanded investment in funding for MAT and harm reduction programs, we would likely protect people of color with OUD from death. Meanwhile, the affluent taxpayer is going to suffer by losing a slightly larger portion of their money to taxes. When valuing the severity of the situation between these two actors, the person of color clearly wins based off the severity of the situation for them if we do nothing.

The argument for people in the neighborhood where the harm reduction and MAT programs would be placed may be that placing these programs here will raise the number of people with OUD in their neighborhood which may increase the chances that they come into contact with violent crime or even murder. The severity of both parties claims in this situation would be equal. Both the people of color with OUD and a property owner in one of these areas could claim the action that would benefit the other group could harm them to the point of death. The difference in these claims comes down to probability. It is far more likely the person of color with OUD would die from not receiving a resource like Naloxone as opposed to the probability the property owner experiences a violent crime just because one of these programs is in their neighborhood.

Finally, we compare the circumstances between targeting these resources specifically to neighborhoods of color as opposed to just targeting them to the areas with the greatest need regardless of color. The severity of outcomes is equal in both situation—the possibility of death if the resources are inaccessible. We would justify these by the fact that it is more probable for a

White person to be able to access MAT and harm reduction programs than it is for a person of color. Due to the fact that it is less probable for a person of color to be able to access these resources, we are morally justified in targeting them. Some people that might say we're already giving 7.5 billion to OUD, why do we need to give more? I would counter with the fact that of the 7.5-billion-dollar budget, only about 50 percent of that budget goes toward treatment and recovery (*Tracking Federal Funding to Combat the Opioid Crisis*). This simply isn't enough to fund the resources necessary for an epidemic effecting millions of people. Additionally, there are few initiatives being federally funded to address the growing rates of overdose in communities of color. This policy addresses both of those concerns all while only raising the total national budget by a fraction of a percent.

**Contractualism as Justification for Decriminalization**

There would be two main stakeholders in the contractualist argument for decriminalization. The first would be a person of color with OUD who has been arrested for possession of a substance or paraphernalia. This could also just be an someone of color with OUD who has been harassed or had a negative interaction with the police because of their substance use. Their literal ability to access live saving resources can be impeded upon by these laws. Additionally, these laws can be part of the reason they don't believe they deserve these resources. Another stakeholder would be someone living in a neighborhood where there is a high prevalence of discarded drug paraphernalia in public places. This person wants criminalization to remain in place because they believe it discourages the discarding of used drug paraphernalia. The fear from this person is that someone may accidentally come across one of these used pieces of drug paraphernalia and receive a harm. These harms could be a puncture from a syringe or the transmission of a lifelong disease like HIV or various strains of Hepatitis.

Both individual stakeholders have legitimate claims. If we do not legalize, it seems like that could cause a serious threat of death to someone with OUD. This is the most severe harm possible. If we do legalize, the person in an area with higher amounts of discarded drug paraphernalia could have increased chance of contracting a life altering disease. When we weigh death against life altering disease, death is still the worse harm. Even if we were to weigh the two equally, the probability that death due to an inability to access these resources would occur would be significantly higher than the probability that someone contracted a disease by accidently getting punctured by left-out drug paraphernalia—the chances of catching a disease from a single needle stick are 1 in 300 (Ellis). The chances of dying due to an overdose without Naloxone present is essentially a hundred percent. Due to this consideration, we can justify the policy of decriminalization under contractualism.

**Concluding thoughts**

The racial differences across harm reduction programs and MAT treatments are an inequity that is deserving of people attention. The inequity was created by political policies enacted by the Nixon administration in terms of the targeting of minorities for drug use imprisonment. It was further carried out by the doubling down of the "War on Drugs" throughout the 80s, 90s, and early 2000s. This has continued into the present with laws around drug paraphernalia that are still enforced today. America has so long criminalized drug use—specifically for people of color—that it has led people to believe they aren't deserving of care or treatment. If we are to end this harmful representation, it starts with these policies. We must provide funding for programs that specifically meet people of color "where they're at". We must increase the number of people of color working within these programs so that people may get treatment without implicit bias'. We must end laws that not only make people with OUD feel

unworthy of treatment, but also decreases their interactions with law enforcement—a system that many people of color see as discriminatory. These policies represent a *start* to addressing several inequities associated with OUD.

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