Lessons for the Opioid Crisis—Integrating Social Determinants of Health Into Clinical Care

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Overdose deaths accelerated with the emergence of COVID-19, and this acceleration was fastest among Black, Latinx, and Native Americans, whose overdose rates had already increased before COVID-19.[1,2] COVID-19 led to limits on access to medications for opioid use disorder and harm-reduction services, exacerbating low treatment and retention rates,[3–5] in the face of toxic drug supplies laced with high-potency synthetic opioids.[6] Disproportionate deaths from substance use disorders (SUDs) and from COVID-19 among low-income people marginalized by race, ethnicity, and migrant status have similar upstream causes of exposure, including unstable and crowded housing, high-risk employment or unemployment, and high levels of policing and incarceration, combined with low levels of access to health care and preventive measures. SUD and COVID-19 require health care systems to intervene in social determinants of health (SDOH), where the health care system itself is an intermediary social–structural determinant.[7] We examine determinants of SUDs and social–structural interventions that promise to stem SUD-related deaths accelerated by COVID-19.

SOCIAL–STRUCTURAL DETERMINANTS

Physical, sexual, and emotional trauma, including adverse childhood events, are associated with substance use,[8] as are discrimination based on race, ethnicity, LGBTQ (lesbian, gay, bisexual, transgender/-sexual, queer) status, and gender, and the intersection of trauma with discrimination further increases the risk of SUD. The stigma itself of having a SUD is a barrier to treatment and harm reduction.[9] Collective support and positive social environments, such as those fostered in cultural centers or faith organizations, can prevent and mitigate SUDs.

Punitive drug law enforcement discourages help seeking and treatment and leads to unstable drug supplies that are contaminated with fentanyl and other high-potency synthetic opioids that heighten overdose risk.[10] Incarcerated people are at an elevated risk of drug overdose in the weeks following release,[11] and communities with high incarceration rates have higher mortality.[12] Drug courts disproportionately cite low-income people of color for infractions, leading to imprisonment rather than treatment.[13]

Economic precarity and unstable housing disrupt the social networks that sustain health and prevent overdose.[14] Urban planners often displace residents of Black and Latinx neighborhoods, leaving them exposed to narcotic trade and HIV.[15] The child welfare system disproportionately removes low-income Black, Latinx, and Indigenous children from families affected by SUDs, and children raised in foster care are at high risk for SUDs.[16,17] Therefore, reducing SUD-related deaths and disability requires the redress of discriminatory public policies.

LESSONS FROM AIDS ACTIVISM

HIV and SUDs are both stigmatized in popular discourse as owing to bad choices, and those most affected are socially marginalized. Yet, today many people with HIV are living longer than ever before, with most deaths from non-HIV–related illnesses. Likely reasons include 1980s and 1990s AIDS activism that addressed SDOH, such as the AIDS Coalition to Unleash Power, a grassroots organization with many leaders who were publicly HIV positive. They addressed HIV stigma and promoted mutual aid and self-advocacy (http://tcleadership.org/act-up). This enabled community dissemination of safer sex and safer injection information, community advocate members on

scientific review committees and policy advisory boards, and, ultimately, the federal HIV budget, which includes billions of dollars to address prevention and treatment, cash and housing assistance, research, and racial and ethnic inequality.[18]

A key component was the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which led to the largest federal program focused on providing HIV care and treatment services. The act requires local planning councils made up of community leaders, including those with HIV, along with providers of health and social services and focuses on SDOH.

Community-based organizations providing harm reduction—including safe syringe exchange and safe injection and safer sex supplies and education; onsite clinical testing and treatment of SUD, HIV, and hepatitis C; and social services[19]—are critical in reducing HIV transmission. Yet many forms of harm reduction are illegal or ineligible for public funds in most states.[20]

INTERVENTION EXAMPLES

Applying lessons from AIDS activism regarding the value of community mobilization, peer support, and integration of social services with systems of health care, we have outlined local initiatives that demonstrate what a SDOH approach to SUD might entail.

Criminal Justice System–Clinical Care

The Criminal Justice Continuum of Care for Opioid Users at risk for Overdose, launched in Rhode Island and grounded in the sequential intercept model, institutes the following in law enforcement interactions, courts, jails and prisons, community reentry, parole, and probation: (1) screening for OUD and overdose risk, (2) treatment and diversion, and (3) overdose prevention that includes naloxone. The intervention emphasizes medications for opioid use disorder, given that only a minority of drug courts and carceral facilities offer medications for opioid use disorder.[21]

Culturally Resonant Approaches

Native American communities in the United States have integrated traditional healing methods and incorporated Indigenous views of addiction and recovery into biomedical approaches. Studies of integration of buprenorphine maintenance with organized healing sessions, fishing, hunting, and community gardening in Canadian First Nations communities have shown high rates of treatment retention (74%) at 18 months,[22] and healing sessions combined with buprenorphine have had high levels of treatment participation, community-level reductions in criminal charges and child protection measures, increased school attendance, and increased flu vaccination.[23]

Faith-Based Organizations as Partners

Imani Breakthrough is a culturally informed approach based on a partnership of Yale University Department of Psychiatry clinicians with Black and Latinx churches. The Imani framework includes the citizenship model, based on the 5Rs—rights, roles, responsibilities, resources, and relationships—necessary to establish recovery from substances, while also addressing SDOH and emphasizing how spirituality can be a central aspect of recovery. Peer recovery coaches and spiritual facilitators work with participants to enhance dimensions of wellness identified by the Substance Abuse and Mental Health Services Administration. Imani increases referral rates for addiction treatment.[24]

Housing and Harm-Reduction Support

Atira Women's Resource Society of British Columbia offers housing with substance treatment, round-the-clock childcare services, educational enrichment, and parenting support for women regardless of their drug use status. Atira has arranged with child protective authorities to allow women to keep custody of their children without requiring abstinence from drugs. This breaks the cycle of state-sponsored child removal in which generations of poor and First Nations children have been separated from their parents because of substance use, thereby elevating their own risk of substance use and of losing custody of their children. Atira also runs women-only syringe exchange and medically supervised safe consumption sites (https://atira.bc.ca/who-we-are), 40 housing programs, two community daycares, and several support programs (https://www.housingpartnership.ca/atira).

Housing First

Housing First provides immediate housing with supports and case management, without requiring SUD treatment. The US Substance Abuse and Mental Health Services Administration and Housing and Urban Development recognize it as a best practice. Individuals served by Housing First are more likely to continue medications for

opioid use disorder for at least three years and are less likely to use substances nonmedically than are those required to have treatment as a condition of housing (https://www.pathwayshousingfirst.org).

CONCLUSIONS

Clinicians can use their symbolic capital to advocate policies that address SDOH and collaborate with community organizations and nonhealth sectors to identify and act on institutional barriers to their patients' health, such as through a structural competency approach.[25]

Health systems must engage communities, destigmatize SUD, and link to social services with locally controlled, adaptable funds akin to the Ryan White CARE Act to build community-based infrastructure: accessible, trusted services including in cultural, faith-based, and harm-reduction organizations as well as local businesses such as pharmacies. Only by addressing SDOH can health care systems stem overdose-related deaths and comorbidities, including COVID-19. AJPH

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PUBLICATION INFORMATION

Full Citation: Hansen H, Jordan A, Plough A, Alegria M, Cunningham C, Ostrovsky A. Lessons for the opioid crisis—integrating social determinants of health into clinical care. *Am J Public Health*. 2022; 112(S2):S109–S111.

Acceptance Date: November 30, 2021.

DOI: https://doi.org/10.2105/AJPH.2021.306651

ACKNOWLEDGMENTS

The authors wish to thank the National Academy of Medicine Opioid Collaborative and its officers Aisha Salman and Elizabeth Finkelman for making this editorial possible. The authors received in-kind administrative, editorial, and communications support from the National Academy of Medicine, although the opinions expressed are solely those of the authors.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

REFERENCES

1. Friedman J, Mann NC, Hansen H, et al. Racial/ethnic, social, and geographic trends in overdose-associated cardiac arrests observed by US Emergency Medical Services during the COVID-19 pandemic. *JAMA Psychiatry*. 2021;78(8):886–895. https://doi.org/10.1001/jamapsychiatry.2021.0967
2. Furr-Holden D, Milam AJ, Wang L, Sadler R. African Americans now outpace Whites in opioid-involved overdose deaths: a comparison of temporal trends from 1999 to 2018. *Addiction*. 2021;116(3):677–683. https://doi.org/10.1111/add.15233
3. Khatri UG, Perrone J. Opioid use disorder and COVID-19: crashing of the crises. *J Addict Med*. 2020;14(4):e6–e7. https://doi.org/10.1097/ADM.0000000000000684
4. O'Brien PL, Schrader K, Waddell A, Mulvaney-Day N. Models for medication-assisted treatment for opioid use disorder, retention, and continuity of care. Appendix 1: literature review. July 8, 2020. Available at: https://aspe.hhs.gov/reports/models-medication-assisted-treatment-opioid-use-disorder-retention-continuity-care-0. Accessed February 4, 2022.
5. Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine treatment divide by race/ethnicity and payment. *JAMA Psychiatry*. 2019;76(9):979–981. https://doi.org/10.1001/jamapsychiatry.2019.0876
6. Becker WC, Fiellin DA. When epidemics collide: coronavirus disease 2019 (COVID-19) and the opioid crisis. *Ann Intern Med*. 2020;173(1):59–60. https://doi.org/10.7326/M20-1210
7. Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper 2 (policy and practice). 2010. Available at: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf. Accessed February 4, 2022.
8. Prangnell A, Imtiaz S, Karamouzian M, Hayashi K. Childhood abuse as a risk factor for injection drug use: a systematic review of observational studies. *Drug Alcohol Rev*. 2020;39(1):71–82. https://doi.org/10.1111/dar.13001
9. Tsai AC, Kiang MV, Barnett ML, et al. Stigma as a fundamental hindrance to the United States opioid overdose crisis response. *PLoS Med*. 2019; 16(11):e1002969. https://doi.org/10.1371/journal.pmed.1002969
10. Ciccarone D. The triple wave epidemic: supply and demand drivers of the US opioid overdose crisis. *Int J Drug Policy*. 2019;71:183–188. https://doi.org/10.1016/j.drugpo.2019.01.010
11. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157–165. https://doi.org/10.1056/NEJMsa064115
12. Drucker E. *A Plague of Prisons: The Epidemiology of Mass Incarceration in America*. New York, NY: New Press; 2013.
13. Kaye K. Review of enforcing freedom: drug courts, therapeutic communities, and the intimacies of the state. *Soc Forces*. 2020;99(2):e1–e3. https://doi.org/10.1093/sf/soaa069
14. Zoorob MJ, Salemi JL. Bowling alone, dying together: the role of social capital in mitigating the drug overdose epidemic in the United States. *Drug Alcohol Depend*. 2017;173:1–9. https://doi.org/10.1016/j.drugalcdep.2016.12.011
15. Fullilove MT. *Root Shock: How Tearing Up City Neighborhoods Hurts America, and What We Can Do About It*. Oakland, CA: New Village Press; 2016. https://doi.org/10.2307/j.ctt21pxmmc
16. Roberts DE. *Shattered Bonds: The Color of Child Welfare*. New York, NY: Basic Books; 2009.
17. McKenzie HA, Dell CA, Fornssler B. Understanding addictions among Indigenous people through social determinants of health frameworks and strength-based approaches: a review of the research literature from 2013 to 2016. *Curr Addict Rep*. 2016;3:378–386. https://doi.org/10.1007/s40429-016-0116-9
18. US Health Resources and Services Administration. New 2020 Ryan White HIV/AIDS program data. 2020. Available at: https://ryanwhite.hrsa.gov. Accessed February 22, 2022.
19. Campbell ANC, Tross S, Calsyn DA. Substance use disorders and HIV/AIDS prevention and treatment intervention: research and practice considerations. *Soc Work Public Health*. 2013; 28(3–4):333–348. https://doi.org/10.1080/19371918.2013.774665
20. Nadelmann E, LaSalle L. Two steps forward, one step back: current harm reduction policy and politics in the United States. *Harm Reduct J*. 2017;14(1):37. https://doi.org/10.1186/s12954-017-0157-y
21. Brinkley-Rubinstein L, Zaller N, Martino S, et al. Criminal justice continuum for opioid users at risk of overdose. *Addict Behav*. 2018;86:104–110. https://doi.org/10.1016/j.addbeh.2018.02.024
22. Mamakwa S, Kahan M, Kanate D, et al. Evaluation of 6 remote First Nations community-based buprenorphine programs in northwestern Ontario: retrospective study. *Can Fam Physician*. 2017;63(2):137–145.
23. Kanate D, Folk D, Cirone S, et al. Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence: evaluating outpatient buprenorphine–naloxone substitution therapy in the context of a First Nations healing program. *Can Fam Physician*. 2015;61(2):160–165.
24. Bruce L. IMANI breakthrough honored for transformational work in community. Yale School of Medicine. December 16, 2019. Available at: https://medicine.yale.edu/news-article/imani-breakthrough-honored-for-transformational-work-in-community. Accessed February 4, 2022.
25. Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med*. 2014;103:126–133. https://doi.org/10.1016/j.socscimed.2013.06.032