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Addiction, Race, and the Structurally Vulnerable

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CONTEXT

Structural vulnerability is a social science construct that describes the situation of an individual's risk for negative health outcomes due to their interactions with "socioeconomic, political, and cultural or normative hierarchies."[1,2] This concept underscores the impact of social determinants of health (SDoH) that are known to exert a significant influence on the individual's health and ability to assess and benefit from reasonable, affordable, and quality health care. Unfortunately, the prevailing traditional culture of medicine and particularly in the field of addictions appear to tacitly condone the stigma and discrimination faced by patients with substance use disorders (SUD), based on societal attitudes that suggest that the source of vulnerability and suffering is predicated only on personal choices.[1,3] This societal ambivalence may have created the unintended consequence that perpetuates frustration, adverse outcomes, and suffering experienced by patients and their families. This also leaves organized medicine to grapple with a revolving door of hospital readmissions, poor treatment retention, escalating health care costs as well as worsening physical and emotional burden of patients who are already facing the toll of chronic mental illness and (often comorbid) substance use disorders. The clinician's understanding of the influence of structural vulnerability on patients' health and health outcomes presents an opportunity for a robust and holistic dialogue on the subject and better care. At the public heath level, keen attention to structural vulnerability represents a paradigm shift in advocacy, as we refine models of care to reflect addressing societal structures as the source of vulnerability, suffering, and inequalities, which worsen the overall health outcomes in underrepresented minority communities.

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HEALTH DISPARITY AND RACE

According to Braveman, health disparities describe the differences in health that could potentially be shaped by policies. These health differences are rooted in the social and lived experiences of disadvantaged peoples who have consistently been the subject of systematic and systemic socioeconomic disadvantage and discrimination.[4] Consequently, these populations suffer greater vulnerabilities, risks, structural violence, and worse health outcomes compared to other "privileged" and socially advantaged groups.[4] Margaret Whitehead noted that health disparities are, in fact, differences that "are not only unnecessary and avoidable but, are considered unfair and unjust." She further defined equity in health care "as equal access to available care for equal need, equal utilization for equal need, equal quality of care for all".[5] The Institute of Medicine (IOM) of the National Academy of Sciences described health disparities as "racial and ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention".[6] Health disparities in the African American communities has been a subject of much study and debate over the last several years.[6-12] This increased scholastic interest has generated findings such as African Americans receiving less treatment for postoperative pain and myocardial infarction, increased likelihood of being diagnosed with psychotic disorders,[7] and living in poor segregated neighborhoods where the built environment accentuates the obesity epidemic, among other health issues. This disparity also underlie the conclusive empirical evidence comparing the differences in the structural societal, political, and legislative responses to the "crack" epidemic with so-called "drug war" of the 1970s and 1980s and the robust response to the ongoing opioid epidemic.[13-15] Furthermore, a recent study of "buprenorphine treatment divide by race/ethnicity", Lagisetty and colleagues reported a clear discordance in buprenorphine treatment by race and wealth and a concentration of buprenorphine treatment among White persons and those with private insurance or those who could pay for treatment. According to their study, between 2012 and 2015, Whites had significantly more buprenorphine prescription visits than other races/ethnicities, 12.7 million vs

363 000. They concluded that African American patients had statistically significantly lower odds of receiving buprenorphine prescription at their scheduled office visits (adjusted odds ratio, 0.23; 95% confidence interval, 0.13-0.44).[16] Similar findings of disparities were also reported by Hansen et al[17] and Marsh.[18]

CLINICAL ASSESSMENT OF STRUCTURAL VULNERABILITY

African Americans and other underrepresented minorities report more significant barriers to accessing health care, lower utilization, and higher dropout rates from treatment in the face of disproportionate incarceration, stigma, and consequential poorer health outcomes.[3,18,19] Wells and others have also reported a significant unmet need for African Americans who were more likely to have no access to treatments for substance use disorders.[19]

The Structural Vulnerability Tool (SVAT), as originally described, is a qualitative measure of social and structural factors that may limit access to care.[2] The SVAT is an observational guide for screening patients' level of health risk "imposed by societal forces in order to organize a comprehensive health treatment plan that mobilizes supportive resources both inside and outside the clinical setting".[2] As described by Bourgois et al,[2] the SVAT contains eight domains including financial security, residence, risk environments, food access, social network, legal status, education, and discrimination. A quantitative adaptation of this tool is currently being utilized by the author in an ongoing REACH (Recognizing and Eliminating Addiction through a Culturally informed Healthcare) program scholarly project titled: structural vulnerability, perceived barriers and discrimination among African Americans with SUD.[2,20]

Another recently developed tool that can be readily utilized in clinical settings is the Neighborhood Navigator Tool developed by the American Academy of Family Physicians in order to provide physicians with education and resources to address SDoH.[21] Other tools that may be utilized include the Barriers to Access to Care Evaluation (BACE v3) created by Clement et al,[22] which is a 30-item scale with subscales of stigma, attitudinal, and instrumental domains that may be useful in clinical settings to identify key barriers to care that patients face. In conclusion, the assessment of structural vulnerability could represent a paradigm shift in the practice of medicine and addiction psychiatry in particular. During individual patient encounters, assessments of social vulnerability should be considered standard of care and best practice. Physicians should be at the vanguard of advocating for pedagogical interventions that reorient medical education and training toward attending to the multidirectional interface around addictions, race, and the structurally vulnerable.

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REFERENCES

1. Holmes SM. Structural vulnerability and hierarchies of ethnicity and citizenship on the farm. *Med Anthropol*. 2011;30:425-449.
2. Bourgois P, Holmes SM, Sue K, et al. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. *Acad Med*. 2017;92:299-307.
3. Mennis J, Stahler GJ. Racial and ethnic disparities in outpatient substance use disorder treatment episode completion for different substances. *J Subst Abuse Treat*. 2016;63:25-33.
4. Braveman P. Health disparities and health equity: concepts and measurement. *Annu Rev Public Health*. 2006;27:167-194.
5. Whitehead M. The concepts and principles of equity and health. *Health Promot Int*. 1991;6:217-228.
6. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003.
7. Schwartz RC, Blankenship DM. Racial disparities in psychotic disorder diagnosis: a review of empirical literature. *World J Psychiatry*. 2014;4:133-140.
8. Anderson KO, Green CR, Payne R. Racial and ethnic disparities in pain: causes and consequences of unequal care. *J Pain*. 2009;10:1187-1204.
9. Cintron A, Morrison RS. Pain and ethnicity in the United States: a systematic review. *J Palliat Med*. 2006;9:1454-1473.
10. Edwards CL, Fillingim RB, Keefe F. Race, ethnicity and pain. *Pain*. 2001;94:133-137.
11. Green CR, Anderson KO, Baker TA, et al. The unequal burden of pain: confronting racial and ethnic disparities in pain. *Pain Med*. 2003;4:277-294.
12. Lopez L, Wilper AP, Cervantes MC, et al. Racial and sex differences in emergency department triage assessment and test ordering for chest pain, 1997-2006. *Acad Emerg Med*. 2010;17:801-808.
13. Santoro TN, Santoro JD. Racial bias in the US opioid epidemic: a review of the history of systemic bias and implications for care. *Cureus*. 2018;10:e3733.
14. Netherland J, Hansen HB. The war on drugs that wasn't: wasted whiteness, "dirty doctors," and race in media coverage of prescription opioid misuse. *Cult Med Psychiatry*. 2016;40:664-686.
15. Pouget ER, Fong C, Rosenblum A. Racial/ethnic differences in prevalence trends for heroin use and non-medical use of prescription opioids among entrants to opioid treatment programs, 2005-2016. *Subst Use Misuse*. 2018;53:290-300.
16. Lagisetty PA, Ross R, Bohnert A, et al. Buprenorphine treatment divide by race/ethnicity and payment. *JAMA Psychiatry*. 2019.
17. Hansen H, Siegel C, Wanderling J, et al. Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City. *Drug Alcohol Depend*. 2016;164:14-21.
18. Marsh JC, Cao D, Guerrero E, Shin HC. Need-service matching in substance abuse treatment: racial/ethnic differences. *Eval Program Plann*. 2009;32:43-51.
19. Wells K, Klap R, Koike A, et al. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *Am J Psychiatry*. 2001;158:2027-2032.
20. REACH. Recognizing and eliminating addiction through culturally informed healthcare. https://medicine.yale.edu/psychiatry/education/reach/reach/. Accessed 29 October 2019.
21. Sherin K, Adebanjo T, Jani A. Social determinants of health: family physicians' leadership role. *Am Fam Physician*. 2019;99:476-477.
22. Clement S, Brohan E, Jeffery D, et al. Development and psychometric properties the Barriers to Access to Care Evaluation scale (BACE) related to people with mental ill health. *BMC Psychiatry*. 2012;12:36.