Placing Racial Equity at the Center of Substance Use Research: Lessons From the HEALing Communities Study

Avik Chatterjee, MD, MPH, LaShawn Glasgow, DrPH, Mackenzie Bullard, MPH, Mariah Sabir, MPH, Greer Hamilton, MSW, Deborah Chassler, MSW, Danelle J. Stevens-Watkins, PhD, Dawn Goddard-Eckrich, EdD, Emma Rodgers, MS, Joan Chaya, MA, Sandra Rodriguez, MPH, Damara N. Gutnick, MD, Emmanuel A. Oga, MD, MPH, Pamela Salsberry, PhD, and Linda Sprague Martinez, PhD

ABOUT THE AUTHORS

Avik Chatterjee is with Boston University School of Medicine and Boston Medical Center, Boston, MA. LaShawn Glasgow and Emmanuel A. Oga are with RTI International, Research Triangle Park, NC. Mackenzie Bullard is with Boston University School of Medicine. At the time of study, Mariah Sabir was with Boston University School of Medicine. Greer Hamilton, Deborah Chassler, and Linda Sprague Martinez are with the Boston University School of Social Work. Danelle Stevens-Watkins is with the University of Kentucky College of Education, Lexington. Dawn Goddard-Eckrich, Emma Rodgers, and Sandra Rodriguez are with the Columbia University School of Social Work, New York, NY. Joan Chaya is with the Montefiore Medical Center, Bronx, NY. Damara N. Gutnick is with the Albert Einstein College of Medicine, Bronx, NY. Pamela Salsberry is with The Ohio State University College of Public Health, Columbus.

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Structural racism, "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice," is pervasive in the United States, impacting all systems including addiction treatment.[1(p1453)] This article describes efforts to center racial equity in the Helping to End Addiction Long-Term (HEALing) Communities Study (HCS), a multisite implementation research study sponsored by the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration to reduce opioid overdose deaths in highly affected communities.[2] Guided by what Public Health Critical Race Praxis (a framework to help researchers understand and challenge the power hierarchies that buttress health inequities) terms "disciplinary self-critique,"[3] we share lessons and opportunities that we hope will resonate with researchers and funders in the addiction field and help us all better center racial equity in our work.

THE HEALing COMMUNITIES STUDY

The HCS aims to reduce opioid-related overdose fatalities by 40% over two years through the Communities That HEAL (Helping to End Addiction Long-Term) intervention (CTH).[2] CTH is a community-engaged, data-driven intervention designed to support the adoption of evidence-based practices for addressing opioid use disorder (OUD) in 67 highly affected communities (defined as counties or cities or towns in HCS) across Kentucky, Massachusetts, New York, and Ohio.

Community engagement (i.e., "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people")[4(p.xv)] is a core element of CTH, and communities consider how to reach high-risk and underserved populations. However, there is no explicit racial equity study aim. Given the pervasiveness of structural racism in the United States, addiction initiatives that lack an intentional focus on racial equity from the start risk perpetuating inequities.[5]

STRUCTURAL RACISM AND THE US OPIOID EPIDEMIC

Structural racism is evident in the US response to OUD. OUD among Black and Latinx people has long been addressed through punitive, rather than treatment-based, measures (e.g., the "War on Drugs").[6] Scholars note that federal methadone regulations, formed when OUD predominantly affected people of color,[7,8] including daily observed dosing and low thresholds for discharge, were racialized (i.e., created differently because of the race of individuals receiving treatment) and grounded in social control[8] (e.g., "liquid handcuffs.")[9]

The growth of prescription opioid use among suburban, middle-income White people ushered in a framing of OUD as a public health concern, rather than a moral or criminal issue.[10] The racialization of addiction treatment has contributed to a de facto segregated system.[11,12] Black patients have 77% lower odds of receiving buprenorphine—a treatment for OUD associated with decreased mortalty[13]—than White patients.[12]

OUR JOURNEY AND LESSONS LEARNED

Because HCS began without an explicit approach for centering racial equity, efforts emerged organically at each site, which evolved into midcourse study-wide efforts, though not to its incorporation as a study aim. We are sharing selected real-world insights from our ongoing journey to help equip other researchers to center racial equity in similar work (Box 1).

Make Racial Equity a Required Component

In Massachusetts, calls to formally center racial equity in the study came early on. For example, staff raised concerns about lack of diversity among coalition and community advisory board membership. Some staff also questioned the prominent representation of law enforcement on coalitions and the tendency to focus on buprenorphine without addressing accessibility barriers for Black, Indigenous, and other people of color (BIPOC). Massachusetts established a Racial Equity and Social Justice (RESJ) committee to help formalize a focus on racial equity. The RESJ committee drafted a charter defining structures and strategies for integrating a racial equity lens in that site's work, which later helped to inform the adoption of a study-wide statement of commitment to racial equity.[15]

Expect Resistance to Antiracist Change

The development of the Massachusetts RESJ committee charter—an iterative process requiring several drafts back and forth between the committee and research site leadership—involved difficult conversations around racial equity concepts, such as "White supremacy culture" (i.e., the idea that the actions, thoughts, and beliefs of White people are superior to those of other races, especially the Black race),[16] that were unfamiliar or discomforting for some White team members. Such discomfort has been termed "White fragility."[17] To facilitate difficult but necessary conversations, the RESJ committee convened affinity groups—groups of individuals with similar backgrounds who teach each other about racial equity.[18] Conversations informed charter enhancements, including the addition of racial equity references. References to scientific literature added credibility to the

BOX 1— Insights on Centering Racial Equity in Addiction Research and Practical Examples

Insight	Practical Example
Formalize the integration of a racial equity lens early; make it an explicit and required component of the study.	Include an explicit aim related to assessing and achieving racial equity as part of the research study.
Expect resistance to antiracist change; difficult conversations are necessary to advance the work.	Establish affinity groups within study teams to provide a safe space for researchers and staff to discuss structural racism, health inequities, and racial equity principles.
Commit to assessing and advancing diversity and inclusion.	Disseminate job postings for study positions to historically Black colleges and universities and BIPOC-owned and professional organizations, engage BIPOC team members in recruitment activities and hiring decisions, and ensure a living wage for all study staff.[14]
Provide ongoing education on racial equity.	Provide trainings on racial equity topics, including the links between structural racism and health inequities, to researchers, staff, and community partners over the course of the study.
Meet communities where they are.	Tailor racial equity work to communities' starting points, learning from community experts when possible and promoting community-led equity work through study newsletters and learning collaboratives.
Dedicate resources to ensure communications materials—visual and written—resonate with BIPOC.	Dedicate resources early to translation and community engagement to support the timely development of culturally relevant materials.
Invest in data infrastructure.	Allocate resources for assessing relevant data infrastructure and building relationships and protocols necessary to fill data gaps so that racial and ethnic inequities can be identified and monitored and can inform interventions over the course of the study.

Note. BIPOC = Black, Indigenous, and other people of color.

charter and were resources that helped RESJ committee members understand and respond to senior study staff. Being able to contextualize the resistance to the charter and questions around equity work allowed RESJ committee members to persist when confronted with resistance.

Commit to Advancing Diversity and Inclusion

During the CTH planning phase, the New York team visited all 16 of their HCS communities and noticed few BIPOC coalition members. Majority-White research teams, community advisory boards, and coalitions can exclude or overshadow voices of "outsiders within" (e.g., BIPOC within majority-White organizations) who are in a unique position to point out the study's gaps in equity and help increase the team's understanding of the lived experiences of BIPOC, which leads to a more-thorough examination of the problems and to more culturally responsive solutions.[19]

Although diverse research teams alone do not ensure that racial equity is centered in research—as noted in Public Health Critical Race Praxis, power sharing and amplifying BIPOC voices is also needed—it is an essential step.[19] All four research sites are increasing the diversity of their teams and coalition partnerships. Key strategies include supporting research opportunities for underrepresented minority scholars and contracting with BIPOC-owned businesses. Some sites recruited existing coalitions for the study, so they had little influence over membership. In these cases, education was a key strategy for encouraging diversification. To date, methods of assessing study staff and coalition diversity have been informal; conversations on how best to formally assess staff and coalition make-up are ongoing.

Provide Ongoing Racial Equity Education

Addressing racial inequities in health requires raising awareness of inequities and building support to address them.[20] Thus, providing training and education on the link between structural racism and health inequities has been an important part of our efforts to center racial equity in the study. For example, Kentucky's community-facing staff are required, and lead researchers encouraged, to complete interactive trainings about unconscious bias and cross-cultural communication. The Kentucky team also recently partnered with Voices of Hope, a community-based recovery support nonprofit, to host a virtual town hall for researchers to connect with community members and learn firsthand about the barriers to care and recovery BIPOC face. Research sites continue to provide education as one component in a multipronged strategy for centering racial equity in HCS. Understanding the optimal types and topics of education is an ongoing process, guided by Public Health Critical Race Praxis and issues encountered by community-facing teams and other study staff.

Meet Communities Where They Are

Stark demographic contrasts across Ohio's HCS communities add to the complexity of racial equity work. In some of Ohio's urban communities, BIPOC comprise approximately 40% of the population, but they are less than 5% of the population in some rural communities. Some of Ohio's most-diverse HCS communities were already racial equity champions and innovators, which created an opportunity for the study team to learn from communities. HCS study staff in Ohio learned about existing community approaches to equity via coalition meetings, one-on-one meetings with key stakeholders, and conversations with existing racial equity groups. To meet all HCS communities where they are, the Ohio team drafted a health equity plan that acknowledges that structural barriers influence outcomes for marginalized populations (including not only BIPOC but also transitional-age youths and people in rural communities), that each Ohio HCS community has its own health equity priorities, and that each community is starting from a different place regarding understanding inequities. Meeting each community where they are has been an ongoing endeavor for the Ohio team, one that requires engagement to determine each community's understanding of OUD-related inequities. It also requires understanding the challenges communities face that can limit their racial equity work, such as data gaps and workforce shortages.

Ensure Communications Materials Resonate

Health communication campaigns were integrated into the CTH to help drive demand for evidence-based practices and reduce stigma.[21] To ramp up the campaign quickly, a workgroup reviewed stock photography for draft campaign materials. BIPOC are under- and misrepresented in the images available through the largest stock imagery companies.[22] The workgroup

had always planned to provide a more diverse set of images for the campaigns and to support communities in using their own images, and those plans were fulfilled in time. However, when relying on stock images in initial message-testing materials, researchers must be mindful of how the lack of BIPOC representation can reinforce the marginalization of racial and ethnic minorities in our nation's response to OUD.

Beyond the development of culturally relevant resources, centering racial equity in HCS demands thoughtful distribution of materials, in languages appropriate for each community, so they are frequently seen and heard by BIPOC.[23] This is resource-intensive work, but dedicating the necessary time and funding to creating inclusive materials and distribution strategies is vital to advancing equity.

Invest in Data Infrastructure

Disaggregated data on treatment and overdoses can help raise awareness of inequities in treatment measures and outcomes and inform equitable evidence-based practice implementation. In response to communities' data needs, the HCS data team expedited estimates for 2018 and 2019 data on opioid overdose deaths in advance of state-level reports. Stratified data revealed disparate trends in overdose deaths among Blacks and Hispanics compared with Whites.[24] These data prompted action to better reach BIPOC; for example, a Massachusetts coalition hired a bilingual, bicultural outreach worker to dispense naloxone to individuals whom existing efforts were missing.

For other outcomes, the availability of stratified data is limited. For example, the state Prescription Drug Monitoring Program in Massachusetts does not contain stratified data, making analysis of initiation and retention on buprenorphine by race/ethnicity impossible. HCS is partnering with community organizations and state agencies to assess existing data sets and eliminate critical gaps.

CONCLUSIONS

HCS has vast potential to save lives and promote racial equity. Although HCS is focused on OUD, we believe these insights apply broadly to addiction research because of the way health care and society's response to addiction are shaped by racism. To realize this promise in HCS and similar studies to save lives but also promote racial equity (or at the very least, not worsen inequities), funders and researchers must intentionally and explicitly center racial equity from the start.[25] We also acknowledge that the pervasiveness of structural racism and inequities in social determinants of health demand far more than study-level improvements. As a research community, we need to critically examine and strengthen our methods of inquiry, intervention approaches, and funding practices to advance equity; this includes centering BIPOC voices in decision-making and investment in adapting evidence-based practices to ensure they reach, resonate with, and improve outcomes among BIPOC and other groups who have been excluded from the evidence-generating process.[26]

Based on the conversations this work has initiated, study leadership has expressed a commitment to examining and publishing on racial equity implications of HCS. Sharing lessons from our ongoing journey is one way to hold ourselves accountable; we hope that our insights will promote the centering of racial equity in addiction research. AJPH

CORRESPONDENCE

Correspondence should be sent to Avik Chatterjee, MD, MPH, 801 Massachusetts Ave, 4th Floor, Boston, MA 02118 (e-mail: avc031@mail.harvard.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

HUMAN PARTICIPANT PROTECTION

This study protocol (Pro00038088) was approved by Advarra Inc, the HEALing Communities Study Single institutional review board. The ClinicalTrials.gov identifier for the study is NCT04111939.

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