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00:00 Hi, everyone. This is Ashley Cooper. Welcome back to another episode of the Antiracism in Medicine series of The Clinical Problem Solvers podcast. As always, our goal in this podcast is to equip our listeners at all levels of training with a consciousness and tools to practice anti-racism in their health professions careers. I am thrilled to be hosting this episode today with team members, Sud and Gillette. Gillette is new to our team, so I have the honor of introducing her today.

00:25 Kiersten TaLeigh Gillette-Pierce, she/they is currently a student at Johns Hopkins School of Public Health, pursuing a Master of Science in public health with a double concentration in maternal, fetal, and perinatal health in women, sexual, and reproductive health. As an academic researcher, they focus on transnational, racial, ethnic, and gender disparities in pregnancy-related, sexual, and reproductive health outcomes for all persons with gynecologic organs with a specific interest in people of African descent. She has published in the Journal of Advanced Nursing and Medicine Science and Law. Gillette has also published work with Rewire News Group and the Center for American Progress, focusing on reproductive health and rights policy, reproductive justice, and health outcomes for Black birthing persons. Welcome, Gillette. On today's episode, we are discussing racial health disparities in addiction treatment. During the episode, we will unpack how the criminalization and racialization of substance use informs the present-day opioid epidemic and inequities in care. We will also discuss how harm reduction can be employed as a public health model to prevent drug-related fatalities. Sud and Gillette, I'll hand it over to you both to introduce our incredible guests for today.

01:36 Thank you, Ashley. And welcome to the team, Gillette. I am very excited to introduce Dr. Jessica Isom. Dr. Jessica Isom is a board-certified community psychiatrist and faculty leader in the Yale Department of Psychiatry's Social Justice and Health Equity Curriculum. She primarily works in Boston as an attending psychiatrist at Codman Square Health Center, where she is leading a grant effort to infuse anti-racism in opioid use disorder services. She is a nationally recognized expert on racial equity and justice in psychiatry with a focus on workforce development and organizational transformation. Her professional interests include working towards eradicating racial and ethnic mental health disparities, mitigating the impact of implicit racial bias on clinical care and the use of a community centered population health approach in psychiatric practice. She serves on multiple advisory

boards and is a consultant, curriculum developer, and presenter to a variety of organizations, including Fortune 500 companies and medical societies through her company, Vision for Equity, LLC. Dr. Isom received her MD from the University of North Carolina School of Medicine and completed her residency at Yale University. Thank you so much for being here with us today, Dr. Isom.

02:59 Thanks, Sud. Now I'm going to introduce Dr. Jordan. Dr. Ayana Jordan is an endowed Barbara Wilson associate professor in the department of psychiatry, addiction psychiatrist and associate professor in the Department of Population Health at New York University, Grossman School of Medicine. She also serves as pillar co-lead for community engagement at NYU Langone's Institute for Excellence in Health Equity. As principal investigator for the Jordan Wellness Collaborative, she leads a research, education, and clinical program that partners with community members to provide optimal access to evidence-based treatments for racial and ethnic minoritized patients with mental health disorders. Through her multifaceted work, she provides addiction treatment in faith settings, studies health outcomes for people with treatment in faith settings and studies health outcomes for people with opioid use disorder in the cultural system and trans addiction specialists to provide culturally informed treatment. Dr. Jordan is dedicated to creating spaces and opportunities for people of color, specifically black women in academia who are vastly underrepresented. She has numerous peer-reviewed publications, has been featured at international conferences, and is the proud recipient of various clinical and research awards. The fundamental message of equity and inclusion has informed her research, clinical work, and leadership duties at NYU and beyond. Thanks for being here today, Dr. Jordan.

04:14 Thank you. I am excited to be with you all and most importantly, my friend, Dr. Isom.

04:21 Wonderful. Thank you, Gillette and Sud. And with that, I'll start us off for today. I first wanted to provide a bit of contextualization for today's episode. There is an extended historical legacy undergirding the opioid epidemic, which we find ourselves enmeshed in today. We know that over the past two decades, national overdose deaths involving opioids have continually risen. In 2021 alone, over 100,000 people died from drug-related overdose, and over 75,000 of those deaths were attributed to opioids. Further, we know that the opioid epidemic has brought a disproportionate mortality toll on marginalized communities. Since 1999, racial health disparities in drug overdose deaths have been noted. As of 2015, opioid overdose fatalities have escalated most rapidly amongst black, indigenous, and Latinx communities. Between 2007 to 2019, black individuals experienced a higher death rate for opioid overdose deaths than any other racial or ethnic group. And in 2020, indigenous communities experienced the highest drug overdose deaths of any racial or ethnic group. With the advent of the opioid epidemic, the racialization of substance use has become strikingly apparent. While substance use has been medicalized as a public health crisis for predominantly white groups through terms such as the opioid epidemic, substance

use has contrastingly been historically stigmatized and criminalized for marginalized communities. For our listeners who are just beginning to learn about this history, Dr. Isom and Dr. Jordan, would you both be able to provide a brief background on the historical criminalization of substance use and the racialization of addiction treatment?

05:54 Sure. So if it's okay, Jessica, I'll go ahead and get started. I think it's really important when we're talking about the criminalization and racialization of people with substance use disorders and people who use drugs, we have to really look at our own history, right? Our history in the United States. And it's really been a long-standing history, really beginning in the 1920s, with the US government's response to how people who use drugs that are racialized differently were viewed as kind of criminals versus what's happening really in the early 2000s looking at the opioid crisis when it was really viewed as a medical condition. So the way in which racialization has impacted outcome is nothing new. And I think it's important for the listeners to understand that from Chinese populations really being subjected to opium dens and black people really being controlled through opioid treatment programs in terms of seeing this as a way to drive down crime and as a way to get back law and order in different neighborhoods, that's very different than what we're seeing now with people being viewed as having a medical condition if they're using substances. And so what we have to understand is that there is a very real kind of bifurcation of how people think about substance use because of this racialization. And one of the things that I always like to point out is the ways in which the academic institutions have participated in the racialization of substance use.

07:52 And one of the best examples I can give in addition to the opioid crisis is how people with cocaine use disorder were treated and are still treated. So I don't know if people understand this, but there was a paper that was published in the New England Journal of Medicine, which is still heralded today as one of the most prestigious noble journals that you can publish in, right? They published a paper on September 12th, 1985, looking at cocaine use in pregnancy. The point of why I'm going back that far is because we have to understand that that paper in itself really brought forth the notion of this differing type of presentation amongst women who were using cocaine. And this really led to what we know as crack babies, which is a heavily kind of racialized stereotype way of viewing people, especially black mothers who give birth to baby who were deemed as being less smart, not being as capable, and really being seen as a problem because of their cocaine use. And so you have all of these negative thoughts of people being called a crackhead, you seeing media representation of usually black mothers not taking care of their children or being out of control or being inherently violent when we know that regardless of if you use powdered cocaine or crack cocaine, there's no difference in the presentation. And this whole narrative of having crack babies was indeed false.

09:46 However, the ways in which we think about who uses substances today, which one is vilified, which one is seen as a medical illness is

very much informed by these narratives. So the point is that the way in which academia, the media participate in a racialization of substance use is important. And that there's still a reason today while when you're thinking of somebody with a cocaine use disorder, you might go to these images, particularly of black people smoking crack or this narrative of crack babies and crack mothers being identified with one racial group, whereas you think about having a medical illness, usually cocaine use disorder doesn't come to mind, you're thinking of a white person, who's middle aged, with an opiate use disorder. And that's very much based in how our systems have propagated these narratives. So I want Jessica to get in here. I think that there's more to say, especially about how our laws starting in the 1970s really did disproportionately affect Latin and black and indigenous communities. But I think just understanding how media and the institution of academia and medicine itself participates in a racialization of substance use is important, for sure.

11:14

Yeah. I appreciate that download, Dr. Jordan. And I think it's important to highlight the intentionality behind these processes. We're using language like racialization, which is describing a process, which means the process is coordinated by groups that hold power and can influence public opinion. They can create narratives that are consumed by the public, which drives behaviors by not only individual citizens who, for example, can vote for against a policy, but also decision makers, legislative policymakers for example, and also those who are members of the healthcare profession who are informing the kind of policies that are developed. So that racialization process where you assign that racial meeting to something that was previously not in any way associated with race is a very powerful way of driving public narrative, driving the kinds of policies that are supported or not, and then really leading to some terrible consequences for those who are classified as racial others, racially minoritized folks. And that's in contrast to another type of process, which is medicalization, which Dr. Jordan was referencing, where you put an aspect of the human experience underneath the purview of the medical profession? And one example of this outside of this conversation would be pregnancy. In the west, we think about pregnancy, we think about doctors and nurses and medical assistants, whereas in other geographic areas, that's not something that folks think of. They might think of doulas or midwives. There's not really a medical connotation to it.

12:54

The same thing goes for how we've evolved in our appreciation of some of the underlying contributions to our relationship with drugs and for those who develop substance use disorders so that the brain being a focus of research and conversation in the public as this biological element to conversations around persons who use drugs and then incorporates medicalized solutions like coming to get pharmacotherapy, for example, at least stigmatized way, or seeking psychotherapy or other things. So medicalization can, in some ways, really support a distancing from what the other consequences can be of criminalization where instead you're labeled as a criminal committing a criminal act that, of course, warrants some kind of

consequences, including incarceration. So I wanted to underline some of those things again and reinforce there's an intentionality here, which means that that it's a process that can be I don't want to say reversed, but addressed. [laughter] A process that can be addressed in ways that prevent those consequences from occurring in the future.

14:01 Yeah, absolutely. Thank you both for that real quick history lesson on kind of the process that was intentionally came about and something that needs to be addressed. And I know, Dr. Isom, you started to touch on this slightly, but both of you have described that the face of addiction within the popular imagination has changed several times over the course of the 19th, 20th, and 21st centuries. And I was wondering if you could tell us a little bit about how this changing face of addiction is informed, what drug policy has been enacted over the past several decades.

14:44 Yes. I am thinking about how to develop an anti-racist praxis. One of the important components of that is developing common sense racial knowledge that is counter to dominant ways of understanding the world. So common sense racial knowledge would mean a person driving down the street who's a black, let's say man, for example, recognizes that when the police lights come on, there's going to be a very particular type of experience informed by this person's race, their gender, and other characteristics, maybe their class, or their wealth status. The thing with common sense racial knowledge and its dominant form in the United States is that it doesn't at all often acknowledge that there are racialized experiences. And one way to actually detect that is to look at how the media portrays folks that use drugs and might have a substance abuse disorder. So there have been studies out there that have basically examined media in the form of articles or even TV news media to see what kind of language, what kind of emotional tone, what kind of contextual factors were or were not provided. And that reveals some pretty interesting stuff, which I'm sure we'll get into. But again, sticking with this theme of intentionality, if you go back to the late 19th century, early 20th century, you'll see as those early drug policies are being developed, that there is a racialization of certain substances associated with some very unfavorable characteristics, which again was intended to drive public opinion, including public sentiments in ways that would support policies that were often punitive.

16:31 So one example of that is in the west to California, there was a very complicated relationship between the United States and other nations around opium. And what had happened in the west is that Chinese immigrants and also Chinese Americans had been providing labor in ways that was supportive of the west. And that led to some positive interracial relationships. Once that labor need was mostly addressed, you saw an increase in anti-Chinese sentiments. And one thing that you saw as far as associations was this association of Chinese persons with references to being gamblers or prostitutes or criminals and also specifically being opium themes. And there's a part of this formula that's consistent as well, where that association between a racial or ethnic group and a substance is tied to a threat

to the most valued demographic in America, at least in rhetoric, which is white women and children. So these opium themes, for example, were depicted in this play where there were white women, white damsels in distress being provided the opium and then being subject to the advances of Chinese men. And what it really is reinforcing here is that some people's relationships with substances is worthy of interrogation in a way that results in criminalization. Because everybody was using opium. [laughter] Back then it was not just Chinese Americans and Chinese immigrants.

18:00 Exactly. Yeah.

18:02 So they're even having these primary sources examples of how on one side there's this anti-Chinese rhetoric around their opium use, and then they'll be advertising opium to other people. So basically what they did in San Francisco specifically was create this ordinance that banned opium smoking and opium dance, which allowed them to prosecute Chinese people, essentially, using that ordinance. And then there's similar threats with cocaine in the late 20th century or in the early-- sorry, yes, in the early 1900s, there was an association between southern black men and cocaine use and specifically tied to black men's perceived [inaudible] for raping white women. So they were described as these cocaine themes. There were similar rhetoric in the 1980s as well around black folks use of cocaine and how it led to and fueled criminality and violence of different forms. The last one I'll offer is with Mexican immigrants in the early 1900s. Their use of marijuana and others use of marijuana was just a thing at the time, but there became this association between marijuana, Mexican immigrants, and again, these unfavorable characteristics.

19:21 So things like rape, sexual violence is a broader category, but also just threatening the goodness of white women and children. And that contributes to this concept of this moral panic, where there's this identified threat that reinforces really negative public sentiments towards the target group that leads to support of a policy that typically is punitive in nature. So things like, for example, the Harrison Narcotics Act, way back in the 1930s and then more recent drug policies like the War on Drugs, the Antidrug Abuse Act of 1986. Those are all partially contributed to by these really intentional associations of racially minoritized groups with unfavorable characteristics that need to be tamped down on with the power of the law. Again while ignoring that drug use is pretty similar across racial and ethnic groups.

20:21 Yeah. I mean, I think Dr. Isom, you're just dropping gems, and I'm like, "Yes, yes, yes," over here in the amen corner. But I want to kind of go back or to just lift up some of the things you said regarding the criminalization of substance use around the nondominant group, right? And so I think just understanding very clearly that there is this ideal identity in the United States that is very avert, even if people don't want to speak it out loud, is this kind of cisgender, heterosexual white male, and anything that is different from that comes away from the ideal identity. So thinking about who's closer to that cisgender, heterosexual white male is the white woman, da

da da da da. But the further you get away from that, if we're thinking about Chinese immigrants, Mexican Americans, transgender, black women, etc., they're no longer the protected or ideal identity. And so how can we subordinate them or criminalize their substance use to further other them because they can't be like us, right? Despite their substance use being very equivocal and certain instances or certain substances actually using substances less than the dominant group. But how can we criminalize them in a way that punishes them for their substance use and further minimizes their identity? And I think that one of the ways that we have to understand that the US has been complicit in othering minoritized people is through policy.

22:13

So we can't talk about treatment or why we have disparities in substance use disorder outcomes if we don't understand that the policies that exist create these differential outcomes, right? So going back to the War on Drugs, understanding that Nixon wanted to be elected, right? And so he had to have an intentional-- going back to what Dr. Isom is saying, the intentionality of saying, "I need a campaign platform that's going to get me elected." Very similar to Trump and MAGA. And what I need to do here is create other minoritized identity that I can heavily criminalize to make the dominant group feel safer, i.e., white people and get me elected. And that's exactly what happened with the War on Drugs. And Nixon championed methadone clinics what we call opioid treatment programs because he saw that as a way to control namely inner city black bodies so that they can drive down crime. Then in the '80s with Dr. Isom already mentioned, Reagan came down and doubled down with the Antidrug Abuse Act, both in the '86 and '88, which said that if you use crack cocaine, which was the predominant type or form of cocaine use amongst minoritized communities compared to powder cocaine, which was the preferred form in the majority or the dominant group, you actually have to have one gram of crack cocaine to a 100 grams of powder cocaine, but you still get the same sentence.

24:09

So can you imagine we know that there's no differential effect of how cocaine interacts with the body, but because we understood in this nation that racially minoritized people were more likely to have access to crack cocaine versus powder cocaine, they introduced this 1 to 100 sentencing that led to single handedly an over representation of black and brown bodies in the carceral system. And so when you look at the prison population around the '80s after the introduction of the Antidrug Abuse Act, it skyrocketed, and it's not because black and brown people are using substances anymore, it's because of the legislation. But then people are so baffled, and they're like, "Why do we have these disparities?" Well, if you're in prison [laughter] because of your substance use as opposed to out in the community getting treatment, of course, you're going to have differential outcomes. Or if you can't get a job because you have a history of being involved in a legal system because you were sent to prison instead of getting treatment, of course, we'll have these disparities. So I think we have to really understand how US history has propagated what we're seeing now. And even when we're

introducing policies that try and rectify it, the Fair Sentencing Act in 2010 tried to rectify the over representation of black and Latinx people that were sent to jail. We still have this overwhelming disparity. And so I know we're going to get the solutions, but we have to think about investment in communities that have been disproportionately impacted by these racist drug policies. There's no way in addressing the disparity that exists now without understanding how the US has to be implicit in making sure people get reparations for these racist policies.

26:17 Thanks. So I love the fact that we're talking about the ways in which racially minoritized folks are seen in the court of law because something that goes hand in hand is the court of public opinion. So we want to get to talking about shifting social attitudes here. I want to know if you both could tell us a bit about how the historical racialization of substance use has informed the ways in which we societally view drug use and substance use disorders. Also want to ask how does stigmatizing language inform these social attitudes?

26:47 Yeah. It's is a great question. I think for folks who are trying to hone their lens in a way that allows them to be more effective in providing care, the culturally responsive, and historically informed, one can google and look at how we describe persons who make use of drugs and those who have substance use disorders and really think about in these media narratives things such as tone and context. So one example of this might be when we're describing a Latino man's use of opioids, are we focusing on that individual and their relationship with the drug and not focusing on their context? For example, are we bringing in other factors such as wealth status, such as availability of resources, for example, having access to insurance? Are we bringing in generational differences? Are we talking about the current drug policies at the time that might influence their relationship with access to services or the availability of that particular drug in their community? When we have that expanded contextual and really sympathetic tone and descriptors, it's typically not associated with that type of drug user. It's often associated with those who have the power and multiple spaces to reduce the amount of stigma associated with a particular behavior.

28:16 So the important thing about thinking about stigma is that you already stigmatized by being a racialized minority. And then there's another stigma added in your relationship with use of drugs, especially those that have substance use disorders. And overcoming those two stigmas is very, very, very difficult. So when there's an intentional racialization, when there's an association of a particular substance with a racial group, you're essentially creating the perfect recipe for a lack of sympathetic regard toward that particular demographic and their struggle. You saw the opposite of that with the current opioid epidemic, you said media to really bring it home, that these are people. These are human beings. These are your brothers, your sisters, your uncles, your aunties, except they just look white, [laughter] right? So in these stories, I mean, I can even find myself connecting with these people who, of course, are humans, right, but they don't typically represent the people, for

example, I work with, in my community, as far as visually in their histories. But I'm connecting with them because media is just kind of expertly crafting a narrative that touches my heart. And that helps with stigma. So there's even this social media graphic I've used in presentations that shows how that narrative pivot to more sympathetic, contextually informed representation has influenced the level of stigma experienced by folks with substance use disorders.

29:47 And there's a racialization to that. And there's a graph in this article that shows that there's more stigma experienced by racially and ethnically minoritized persons who make use of drugs relative to their white counterparts. And I think that's largely connected to, again, goes really sympathetic, contextual representations in media that drive public opinion and feelings. I'll also say as we become more kind in our regard for specifically those who make use of opioids, not necessarily those who make use of other substances like cocaine or alcohol, but in that particular space, you have seen a pivot in how we use language. So I think, unfortunately-- and I know Dr. Jordan can speak to this, too. I think the more recent focus on how we talk about persons who make use of drugs, for example, or persons with substance use disorders has largely been driven by a hyper focus on white people and their relationship with substances. I think if the primary group being discussed at this time was stigmatized in the way that racially and ethnically minoritized people are, that we probably wouldn't be focusing so much on how we talk about people that make use of drugs or have substance use disorders. So I think that's a thing that could benefit all, but not equally. As far as how the language has shifted, we're focusing more on reducing how language contributes to stigma, but I don't think those benefits will be spread equally across the board.

31:22 No, absolutely. And I think to that point, Dr. Isom, we don't have to guess, right? We can look and see what has already been done. So we know that when there was a large focus on people who were using cocaine, it wasn't persons with cocaine use disorder or people in need of treatment or people in need of help. It was crack babies and crack mamas and crackheads, and you smoked the TV. [laughter] All of these representations of kind of deranged, inherently violent folks, whereas we've seen that when there was a disproportionate increase of white people who were being impacted by opioid use, there were actual headlines about the changing face of addiction, right? The new face of substance use. And so we already know that, again, when you come for the most protected identity in America, which is the dominant group, white people, there is a compassion and an empathy that's created in the media that forces us to use kinder language in a way that was just not kind for other groups.

32:50 Thank you both so much for your insights on this racialization of substance use. And I really appreciate how you both elucidated that there's a bifurcation in the way society views substance use dependent upon a person's social group membership, like you both said, Dr. Jordan and Dr. Isom, dependent on if you're in the dominant group or in a minoritized group. And I'm wondering about this

specifically in terms of racial health inequities in opioid addiction treatment and also thinking about how we can begin to rectify them because, as you said, Dr. Isom, because it's a racialization, it's a process that means there's room for amelioration.

33:21 So Dr. Jordan and Dr. Isom, we know that buprenorphine and methadone alike are both FDA-approved prescriptions for treating opioid addiction, and they possess a comparable pharmacology. Yet research elucidates that black individuals in the United States are disproportionately prescribed methadone. A drug that requires patients to line up daily to receive doses under observation at treatment facilities, whereas white patients are far more likely to be prescribed buprenorphine, which can be prescribed from the privacy of a physician's office and taken for a month interval at one's own home. Can you tell us a bit more about why black patients have been historically under prescribed buprenorphine, the consequences of the historical trend, and how we may begin to rectify these racial health inequities in opioid addiction treatment?

34:06 I'll start, Dr. Isom, if that's okay. I mean, we've talked about it a little earlier in the podcast, but just really thinking about that connection to the War on Drugs in terms of really seeing methadone clinics and methadone, in particular, as a way to control black people who use substances and also drive down crime. We know that that's false, right? [laughter] That there was not a significant impact in terms of violence related to substance use. However, there's still this legacy that people who use substances are inherently more dangerous, especially people who need to go to methadone clinics. And so they have to be isolated and somehow controlled. And so we're seeing, even till this day, ways in which minoritized bodies are subject to carceral practice, like lining up, like having to provide a urine every single day, actually having observed urine. So people watching you urinate in order to make sure that you're giving a "clean specimen," making sure that people have to come and get their medications every single day, and actually opening their mouth and having to check to make sure they're swallowed. This is very intimately linked to that historical reference of needing to control people to keep them in line to make sure that they're doing okay, right? And so it's not happened since that more racially minoritized people, not just black people, are shunted to opioid treatment programs, even to today.

36:05 And so one of the things that we have to ask ourselves and the medical institution is, first of all, is there a need to have methadone clinics in the first place? Methadone is the most studied medication for opioid use disorder, inherently safe. In other industrialized countries, pharmacists give it out, from primary care clinics, with really good effect. So why do we have these clinics in the first place? That's one of the things. Is it even necessary? COVID has shown us - and this has been published recently - that people who have increased access to their methadone dosing, meaning that they don't have to come every day, that they can come twice a month or once a month, are able to keep themselves safe and do very well and have no unintentional overdoses. So why are we subjecting people

to these very inhumane systems? I would argue it's because they won, use substances, which is a minoritized identity in and of itself, where Dr. Isom already touched on, right? It's very intentional, but also when you're thinking about what group doesn't have access to alternative methods of care because of racist practices. You are further othering this group because you know that people from racial and ethnic minoritized backgrounds are more likely to access care here because they don't have other options. So again, how can we reimagine, which is what's happening with the Opioid Treatment Access Act so that we're able to provide more autonomy to people who go to opioid treatment programs so that they don't have to come and be subjected to these practices.

37:58

But moreover, can we be even more "radical," but it's not radical at all because it's been done in many other countries, where we eliminate the need for these clinics altogether. And we're already doing that, like you mentioned, with buprenorphine, right? So it's been a wonderful recent decision to totally get rid of the X waiver, which is what you needed initially to be able to prescribe buprenorphine. So now that has been totally eliminated. So what I'm hoping is that more physicians and other providers will actually be able to feel empowered to provide this medication what's given in office-based clinics so that it can be more readily available to racial and ethnic minoritized groups. But what we see in that, it's already happened, which is just because you have the policy doesn't mean it's going to be rolled out on an equitable manner, is that white people are more likely to benefit from buprenorphine because, one, they don't have to worry about insurance status, that most of the providers who give buprenorphine are white, right, and they're in areas that don't have high racial and ethnic minoritized populations. So again, we have to think strategically just because we have these medications that are actually lifesaving, what are ways that we can actually make sure that everyone, regardless of their racialized identity has access. And I think one of the ways that we have to do that is make it available to everyone, not just some, but also provide incentives for people who are taking care of folks from racial and ethnic minoritized groups to actually want to provide this medication. So whether it's in the form of bonuses or actually providing more resources so that people in these areas can be able to provide this medication.

40:14

Yeah. That's a powerful share. One thing that came to mind, Dr. Jordan, which has been a thread throughout this conversation has been this concept of deservingness and how access to deservingness really does dictate your experience. So this deservingness concept basically just means that you deserve to be treated in a particular sort of way. And there's this concept of control that you mentioned that really does speak to a lack of recognition for the full humanity of particularly black folks on methadone who have been pleased since their arrival in this country in very specific ways and experience that oppressive relationship with their choice of treatment in ways that they're conscious of that shapes probably how they interact with other available treatments. But I'll say this, I think we often think

that if we build it, they will come. And I'll say it from my own experience at my health center, I work in a catchment area that's predominantly black and African American and representative of the entire African Diaspora. One thing that is really important for those listening here is that there's the data in papers, and there's the data in your own sphere of influence. And one thing that we don't often do in places that offer buprenorphine is look at our data in a racially disaggregated way. One of the things that health center I'm familiar with did was look at their Suboxone recipients or different varieties of buprenorphine recipients by race, ethnicity, and language.

41:54

And what they found is that there were no patients receiving that medication, that treatment, that's vocation Creole, which is a popular language in our catchment area. There was an over representation of white patients who were receiving that treatment as opposed to the majority racial group in the area. What that represents is that white people were coming outside of this area to receive [laughter] Suboxone. They were traveling sometimes an hour or more to access this treatment in this place where there were people in the surrounding neighborhood who were not accessing it at all. So one thing about having this real equity orientation to the work that we do is to, one, disaggregate the data and then start asking questions. So if we build it and they don't come, then that really speaks to the work of Dr. Jordan and also here in Massachusetts with the rise grant that's asking, "How do we infuse anti-racism in our provision of these services to those who have opened use disorders?" We have to start asking what about what we built is aversive to those around us.

43:07

And so a large part of what I've been doing and others who've received funding in the Boston area, including the Grayken Addiction Center at Boston Medical Center and others. It's really just asking questions and listening to why folks are not coming and what their experiences are like when they do come and how those are aversive as well. The last thing I'll say is that there is a lot of control in paternalism and how we offer treatments culturally as healthcare professionals, and a part of not receiving access to equitably is what we offer people when they're right in front of us. So there's definitely some interpersonal level factors there such as do we represent the full spectrum of available treatments? Are we formally X waver, for example, but also are we talking about the full spectrum available treatments with our patients or are we filtering our treatment plans based on the person sitting in front of us? That's in addition to the structural factors such as the geographic location of folks that hand out Suboxone and also the distribution of access to insurance and also wealth, because private pay gets you access to buprenorphine products as well.

44:20

One of the things you said, Dr. Isom, that just really hit me in my core is really that if you build it, will they come? And probably not, especially for racial and ethnic minoritized people because the people who are developing the interventions themselves are totally out of touch with the group because there's no representation of the group itself, but also thinking about how do you consider treatment

alternatives that do not center the dominant group. And I want to bring in Dr. Camilla [Vinter's?] work in thinking about dealing with indigenous people with opiate use disorder. What she found was to increase access to buprenorphine, it had to not replicate the one-on-one system of doctor-patient, doctor-patient, right? That people from indigenous communities were more likely to initiate and engage in buprenorphine treatment if they did it in a group setting. They weren't concerned about their peer knowing or someone from their neighborhood knowing that they had opiate use disorder, but felt more empowered to talk about their substance use, ways to initiate a recovery, and actually were more likely to engage in the medication if they did so in a group setting. So I think really having to reject a lot of what we were even taught about ways in which people receive care to center cultural values so that people will be more likely to engage with things that we know work is really, really important.

46:01 And I love this disaggregation of data point. I have to lift that up because we see both for black, indigenous, and Latinx communities that there have been an increase in the amount of overdose deaths, unintentional, due to the influx of fentanyl and now Xylazine. But the point is when we disaggregate the data, especially amongst Latinx communities, what we see is that the main driver of that is people of Mexican descent. So we have to even break it down by ethnicity, right? It's not okay to just lock everybody together, that we have to see what are the particular patterns amongst different ethnic populations so that we can tailor interventions to that particular group. So this whole one size fits most is not going to work. And then this country, when we're thinking about traditional ways in which we provide care, traditional usually means white, right? And it totally ignores entire identities of people who will not benefit.

47:22 And the last thing I'll say is, a lot of times, I get it. Taking care of many people who are racial ethnic minorities, I get why they don't want to interact with our system because it's inherently violent and racist. The ways in which they have to enter into a place that is not reflective of who they are, oftentimes, they are not greeted or seen by medical providers or support staff that look like them, that talk like them, that understand their language, that understand their cultural dialect, there's no representation of who they are on the wall. And then the ways in which they are policed or sometimes told on, we know that people who come into the medical facility, especially if you are birthing person, you're more likely to be sent to CYF or some type of agency as opposed to being sent for help. So there's real reasons for them not to engage in traditional settings of care because it can be harmful. And so I think that there has to be a real interrogation and intentionality, backed up with Dr. Isom saying, how do we provide care and what are ways in which we can dismantle what we're doing in our clinics to be more helpful as to not just continually centering the dominant group?

48:48 Thanks so much, Dr. Jordan and Dr. Isom. I'm actually glad that you said that because you kind of let us into our next question on harm reduction. So both of you have written vastly on the importance of

employing a harm reduction approach to address the current opioid epidemic. Given your extensive experience dispersing care through a harm reduction lens, would you both be able to elucidate what employing a comprehensive harm reduction approach looks like on a practical level, kind of what you already have done, but maybe we can do a deeper dive. How can clinicians translate this theoretical understandings of the racialization and criminalization of the opioid epidemic into practices through their work?

49:23 Yeah. I love this question because I practice in an FQHC. And I have appreciated growing, [laughter] particularly in relationship with Dr. Jordan as an addiction psychiatrist and really making use of harm reduction in my work with patients. And it actually feels better. [laughter] It feels more caring to be approaching the care in that way. And I think it does actually inform the relationship. Before I talk about specifics, though, I want to be transparent about the connection between what we were talking about earlier. This racialization concept. One thing in the Boston area that you've probably seen in the media is this real hyper focus on this intersection of mass and cast. It's a street intersection that's in the area where Boston medical center is. There are lots of unhoused folks there and lots and lots and lots of drug use. When you see Mass and Cass in the media, it's often a van driving down the street with a camera, and you'll see a lot of faces, but lots of specifically white faces. Again, in the chosen shots that are put in the media, not necessarily saying that there aren't other folks there. So one thing that was interesting for me is that in my conceptualization of the Boston opioid epidemic issue was Mass and Cass, Mass and Cass white faces. So one thing that happened a few months ago is we were provided data that showed the absolute drug overdose rate by zip code. And lo and behold, over the past three years, the highest absolute drug overdose rate for opioids was where my clinic is located.

51:13 And again, I'm located in a zip code 02124 that has a very, very, very large population of racially minoritized folks. And specifically folks who are non-English-speaking, for example, the two most common languages are Haitian Creole and also Spanish. So for my clinic and our conceptualization of who needs harm reduction, the fact that we're constantly exposed to this really narrow focus and representation of who is affected by the opioid epidemic likely has affected how much we're using harm reduction with folks who are actually more vulnerable by absolute numbers than other folks, particularly those in the Mass and Cass area. So for me, that data really-- and I encourage others to do the same. It really opened my eyes to what is the reality of the area around me that the patients I serve and how should that inform my approach to care. So one example of this is not just thinking about use of heroin, but thinking about use of cocaine, crack cocaine laced with fentanyl. There's a lot of patients who are succumbing to overdoses and deaths from their use of crack cocaine. So one of the things that we've done at the health center through a couple of grants is we have fentanyl strips. And we offer those fentanyl strips not just to patient who make use

of heroin or other opioids, but those who are making use of cocaine and specifically crack cocaine.

52:39 And the really powerful story that comes to mind for me late last year was working with a patient, and it's a black man who has schizophrenia and also cocaine use disorder. And I was handing him these fentanyl strips and trying to support his transition into being more preparatory for accessing detox. And I told him about the statistics. I said, "In our area code where we exist, we're dying. And we are dying. Black people are dying. And specifically black people who make use of crack cocaine." And the emotional reaction that he had to that share, that piece of information, I think is the emotional reaction we often don't have because there's such an empathy gap with his experience, right? So much of an empathy gap that he didn't even see himself in this conversation about the opioid epidemic and potentials for overdoses. So I say all that to say that data can be a way of highlighting the reality in ways that connect us to adopting harm reduction approaches with all of the people who need harm reduction approaches. So that's my own transparency around how data illuminated for me and need to really be thinking about harm reduction with patients that I had not been trained to think about harm reduction with. So I'll stop there and pass to Dr. Jordan for some specific ones, and I'm happy to offer that, too. But I really want to underline the power of data and challenging the hegemonic narratives around who is vulnerable to overdoses and deaths from opioids.

54:19 Yeah, I mean, honestly, Dr. Isom, I [laughter] just have to take a beat because I got so emotionally impacted by that share. Yeah. I mean, the empathy gap is a real thing, right? And I think sometimes-- and it's a mature defense mechanism to be able to do the work that we do. There has to be a level of intellectualization because that allows you to deal with the real trauma of seeing people who look like you and other minoritized people die unnecessarily, but yet you have to go on. So I think that one of the real things that harm reduction narrative or approach allows me to do is provide a sense of understanding and love out loud to people who are being ignored by the healthcare system, quite honestly. And so when I think about harm reduction, I have to understand, again, the historical context as to why many racial and ethnic minoritized people are left out. And so in the African principle of Sankofa, looking back to understand how to move forward, many of the groups in the harm reduction organizations are predominantly white, organized, and orchestrated by white people.

56:01 And so there is a reality to why there is not a myopic focus on how we can integrate or adapt harm reduction principles to people who are not part of the dominant group because they have not been involved in the leadership or the rolling out of harm reduction in the first place. And so part of what my group and others are doing is really elevating people from racial and ethnic minoritized backgrounds who have been leading harm reduction in those areas. So I just want to lift up St. Ann's Corner for Harm Reduction. It is a all-Latino-run organization that's led by Joyce Rivera, a badass Latinx

woman who has been working in the South Bronx and does not get her due, because she said, "My folks are dying. The data is not being reported in the major media in the way that people dying from opioids have been. Yet I am going to do something." And so her group and others have been out with mobile vans literally supplying clean syringes, clean cotton, and water so that people are less likely to die from infectious diseases, right? To decrease hepatitis B, hepatitis C, giving out Narcan for free, which in this country that's a for-profit system can be really costly. And making sure that if people accidentally overdose, they're able to still be alive. Giving out what Dr. Isom mentioned, fentanyl strips, in her particular area.

58:01

I also want to lift up a black-lead organization, Mark Jenkins, who works with the CT Greater Harm Reduction Coalition because, again, he's one of the few black people in the space that have been running harm reduction mobile intervention that works specifically with black communities. Why haven't these groups been covered in a national way, especially given the groups that are the mostly impacted right now in the current opioid crisis? And so I think when we're talking about how these narratives lead to an empathy gap, it is important to understand that that really does affect how resources are being spent, where money goes. With all these opioid sediment funds, if people knew about this organization, that would be one way to really shut money towards these coalitions that are working in the areas that are most disproportionately impacted. But yet, they're trying to provide resources on a shoestring budget. It doesn't make any sense, right? And so when we're thinking about practical ways in which harm reduction saves lives, it literally is meeting people where they're at and optimizing safety. I love that different way of looking at harm reduction. Alex Wally offered that to me. It's not just about reducing harm because there can be real euphoria and good that comes from using substances, right? When we think about alcohol use and other substance use, there can be real pleasurable effects that come from using substances. So instead of thinking about always harm reduction, how can we think about optimizing safety?

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And if we're able to reduce the amount of people that have HIV AIDS, reduce the amount of people who have hepatitis B, hepatitis C, reduce the amount of people who die unintentionally, then we are allowing people the chance to make a decision that works the best for them. And that's what I love about the movement. So one of the things that we're doing with the Jordan Wellness Collaborative that I'm really excited about is we just got a grant and the new heal initiative to look at ways in which we can study what we're calling an integrated harm reduction intervention, which means that we are employing people who use drugs from the communities that are most adversely affected, black and Latinx folks, and we're saying, "We want you to go out into the barrios, the neighborhood, the hood, wherever folks are using drugs, and offer education back to what Dr. Isom was saying of just letting folks know that we are the ones that are dying right now. And if you're interested in getting help or doing something about it, we can bring those resources to you." So it's an eight-week intervention. The first four weeks is just

providing education around safe substance use. What supplies are available? Really giving out safe supply, but also letting them know how to protect themselves. Know your rights when you get pulled over by police because we know that police are more likely to be in areas of racial and ethnic-minoritized population. Not because you're doing anything wrong, but because that is what happens as a result of being other than a society. So we provide education around these general harm reduction practices.

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And for those who are interested in getting more help with housing or mental health treatment or wanting to be placed on buprenorphine or methadone, then we allow that community health worker to stay with the person and shepherd them through the very circuitous healthcare system. And we think by having this integrated harm reduction initiative that we will be able to reduce the amount of people who are dying versus what's being offered now. So I hope you guys invite us back to talk about that. But that's just one way of a culturally relevant harm reduction service where we're saying we're going to do it ourselves, and we're going to employ people that intimately have an understanding of the drug-using networks in their community. I get so angry, similar to Dr. Isom, where I see the data was just released in New York City where I work. Again, the most impacted population in terms of unintentional opioid overdoses or overdoses involving opioids were amongst black people. Why isn't that being covered by CNN, The New Yorker, MSNBC in the same way that the opioid crisis in the early 2000s was covered in the white community? It's upsetting, and it's leading to this empathy gap that Dr. Isom was talking about that is so violent that even when you are a part of that group, you forget that your own people have been impacted. And so why do I go so hard because what other choice do I have, right? Understanding that those who understand culturally aware interventions, those who directly identify with a minoritized group have to be involved in the conversation, because if we don't, who will?

01:03:58

Yes. Absolutely. Thank you so much, both of you, for sharing those insights and thoughts, especially about the need to render minoritized communities visible in this data around opioid epidemic, which unfortunately does not often happen both in media representation and even data analyses and what's actually communicated through health journalism. And that leads into the next question actually that I was wanting to ask, which is as both of you have illuminated leading with the harm reduction approach to addiction treatment is of paramount importance when attempting to rectify the racial inequities, which beleaguered minoritized patients grappling with addiction. And I'm wondering how we may translate this clinical approach to addiction care into larger policy measures designed to structurally combat the opioid epidemic. And Dr. Isom, I know that in your article, Nothing About Us Without Us, you describe a model in which patients can and should be included in the creation and implementation of drug policy. And I'm wondering what do you envision such a model looking like? And can you speak to

how this policy model may help ameliorate racial health inequities in opioid addiction treatment?

01:05:02 Yeah. I think a place to see where this pivot to really centering those most impacted and their expertise is by following the money. And I'm in Boston. I'm in Massachusetts more broadly. We are getting millions of dollars to do things. And I put it that way because the people who are getting access to these funds are deciding what things they want to do. And their approach to developing an intervention may be the status quo of doing a bit of literature review, seeing what others have done, and implementing those interventions. And what we've typically done is not really considered at all that there is value from those who've been impacted the most. And come with that lived expertise. I'm really curious to see how some of the grants that actually do emphasize incorporation of community engagement approach maybe not necessarily fully engaged, [laughter] like the work that Dr. Jordan is doing, but some engagement is being expected in some grants. And I'm curious to see the kinds of interventions that those goals come up with because I think it might be quite different from what we would naturally imagine ourselves just as purely healthcare professionals and others offering services to this demographic. I think with this nothing about us without us commitment, there would be an expansion of imagination and Dr. Jordan has shared some examples of that going out there talking to people giving them information where they live, where they work, where they play, and then inviting them in ways that are culturally informed to access services, hopefully, that are flexibly available.

01:06:52 That's a whole lot different than what I'm hired to do, which is sit in my office and wait for people to come to me, right? Which is why I do other things, because that is insufficient as a way of addressing racial health. It's not enough. So I see a model similar to what the Reagan Center for Addiction did. I was invited as an expert after they'd done all this research with people from all across the experience. Those who provide services, receive services to just get a foundational understanding of how black people experience use of drugs and addiction treatment. They did all that work for a year and a half, and then invited myself and a bunch of others, including folks with lived and learned experience to just talk as equals in a space about different factors that impact the experiences of black people who have substance use disorders. So I was present for two convenings. The first was focused on patient-level factors, the second on provider-level factors.

01:07:56 And it's so humbling to sit in a room where you have an expertise to offer and a whole lot of ignorance that you're carrying around with you. And that you as me. So I was there offering my expertise, which might be some language describing things such as what is institutional betrayal, what's institutional neglect? How does that shape experience as a black person's who have substance use disorders? But I've learned so much from just listening to people. These are peers. These are folks who worked in a treatment center who themselves that lived experience. These were mental health

professionals. People who had so much memory from the community going decades back and have seen how things have evolved. And that spirit of a bunch of people sitting in a room, titles not being the thing that we're focusing on, but are different types of expertise being offered into the space. I see that as the future, and that can produce the kind of imagination that creates the solutions that could actually turn the tide on the inequities that we're still talking about centuries later.

01:08:59

That is really powerful, Dr. Isom. I appreciate that. It's so interesting to-- I think with many physicians and other healthcare providers, it's difficult for us to just speak truth to power about what we can do and what we can't do. And understand that in order to really change the outcome, we have to know what we don't-- know what we know and then understand what we don't know and get that expertise in another form to help us in the conversations and really develop policy, which I'm glad that many organizations are starting to understand. But I think that is not adequately compensated, right? So we want people to be on community advisory boards and influence policy decisions. But not pay them at the same rate that others are being paid. And so there is a superficial engagement. And so I think when we're really considering policy development, there has to be a real commitment to what you're saying about financial investment in the experts that we choose, but also really being comprehensive and understanding that there's expertise outside of formal education. But I'd like to offer some policy recommendations that my group and others have really published or talked about in different forums because I do think it is a way forward, right? The ways in which we think about this are really fourfold. I think one is really taking a look at our methadone regulations federally in this country. That's one big bucket. Really focusing on social or reparative justice. That's another big bucket. Financial restructuring with Dr. Isom has already talked about and then really investing in harm reduction or safety optimization in a way that our country has never done before.

01:11:06

So really starting with that federal methadone regulation is knowing and seeing that the methadone take-home doses that were extended during COVID have to be memorialized. They have to be-- or not even memorialize. They have to be instituted broadly and made permanent, right? And so there's no reason for us to go back to people coming into clinic every single day needing to provide urine, needing to have people look into their mouths in order to get their medication. We've seen and my group and others have studied that there is ability to still access safety with people getting access to their medication for extended periods of time. So number one in policy is increasing methadone, take-home doses, and making sure that that's permanent. Another thing that I discussed earlier, but really looking at methadone availability in additional settings. So not just making it through methadone clinics, but thinking about how can we get it to people in the street like we do for buprenorphine, people who cannot come or do not feel comfortable coming to clinic settings, how can we dispense it through pharmacies? There was a

paper that just published. And so that there was actually increased patient acceptability of getting their methadone in pharmacies as opposed to clinics. That's important. Methadone federal regulation. Another thing is looking at social and reparative justice, that second bucket. We have to de-emphasize policing in how we provide substance use. So I was actually at an institution where you couldn't even access mental health treatment unless you were greeted by a police officer. That's unacceptable.

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Why, when someone is going through a substance use exacerbation or mental health crisis, do we call 911, especially for racial and ethnic minoritized group where that interaction can be deadly? We published a paper on this in Lancet Psychiatry. And so we have to look at different models like cahoots where we take policing out of the interaction with people who use substances. And remove police from acute mental health and addiction crisis settings, and that can be part of federal regulation. The third bucket is in financial restructuring, right? So there has to be a way in which we do not hold financial incentives for people to come into the clinic. Can we incentivize people's outcomes as opposed to how many times they come in for care? Is there a way to really invest in community programming or investing in a social determinants of health as opposed to how many times people come into clinic? So really working with the economists to understand ways in which our existing clinic can be reorganized so that there is financial incentives, not for people to come always in the clinic, but for people to stay healthy and actually have better outcomes when we look at the social determinants.

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And then finally, in that last bucket, for really investing in safety optimization. So making it very easy to have free access to sterile syringes and fentanyl strips and Narcan. And there's been these vending machines that have worked brilliantly looking at how we can just freely give people access to condoms and syringes and Narcan so that there is not even a barrier to people having to go anywhere per se to get it, or being able to check their drugs at different drug-checking supplies around the nation and around different neighborhoods where there's increased substance use so that people will know that there's a high level of fentanyl or Xylazine, and it's not safe to use. And then finally, really establishing medically safe supervised consumption sites or drug overdose prevention sites. We have the data, but we need to really get serious about operationalizing some of these policy recommendations.

01:15:44

Thank you both so much for providing those really critical policy insights and really illuminating how we can incorporate individuals who have lived experience into the policy making process and why that's such a pivotal action to do. I just had one last question for you both. For our listeners who will finish this episode and return to their healthcare professions, I'm wondering what are some practical applications that they can interweave into their work to help combat racial health inequities and addiction treatment?

01:16:11 Yeah. I would say, for this, there's a way of practicing as healthcare professionals that's what I would call equity ignorant. And that's changing. In medical education, particularly for undergraduate medical education, there's been more of a focus on reducing equity ignorance, really helping folks to understand that being egalitarian is not the way to be a competent physician. So there's this concept from the education space called equity mindedness that I adapted for healthcare professionals as a way of really offering some concrete handles to prepare yourself to be a fully competent position. And an equity minded physician as opposed to an equity ignorant physician or healthcare professional more broadly is one that has an awareness that racial identities exist, they possess one, and that there are differential histories associated with racial group memberships. Of course, that varies globally, but specifically here in the United States, there's a very specific history with some slight geographic differences. It's also a type of healthcare professional that really values disaggregating data so that they're having an informed approach to their work and not just operating off of, for example, the imagery that they're exposed to about who has or does not have a particular health problem.

01:17:38 The third component is that they're reflective, and they really are critical of the things that we just do all the time and take for granted that actually do have consequences. So if I left my training and just did what I was told to do when I'm prescribing medication, I would not be successful in offering the full spectrum of supports to my patients that I'm successful at offering now because I've adapted my approach to prescribing in ways that honors the history and is culturally responsive. So folks can make an informed decision that's not corrupted by just really being clumsy in my approach to having that conversation with them. The fourth part is that you see yourself as someone who has some kind of agency as it relates to addressing racial inequities. So you are a part of the solution. So you're not figuring out if I'm going to do something, you're figuring out what you're going to do. What's your lane? And then, finally, it's really applying a sense of racialized experiences to not only out there with what our patients and their families and communities are experiencing, but also our actual workplaces in our clinical settings. So in these places that we inhabit, they are racialized spaces. I need to check myself for how that is impacting, how I show up, and how others experience me. And the same goes for others in the space around me. So I would prescribe equity mindedness to folks who are listening. And again, this is a way of combating equity ignorance, which is pretty pervasive in the helping professions.

01:19:12 And I'll just quickly add to that. I mean, I really think Dr. Isom kind of covered a much of what you can do. I think I'll just add just some practical applications of our discussion so far. And this is really thinking about-- Dr. Isom, that really changed me this awake working paradox that-- not even paradox, but model that you put forth in terms of how do you move along the spectrum? So I think first of all, is like understanding that there is a real issue, and you can't just dig your head in the sand and ignore it. And so one of the things that

you have to do is part of your CME is understand what is the scope of the issue, right? Oh, it's not just another lecture about anti-racism, but increase your knowledge so you know ways in which you can implement this knowledge in your everyday clinical care. So it's not okay to not educate yourself. We are very smart people, and it is our responsibility to get access to education. The other thing I will say with that education is you have to do something. So part of it is that you actually have to use a assessment to ask people about their substance use, regardless of what they look like, their housing status, and it's so interesting because we see this amongst racial and ethnic minoritized people who have mood disorders. They're less likely to be asked about their mood disorders and more likely to be diagnosed with a psychotic illness. A lot of it is just because of personally mediated racism.

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And so part of it is just having a way in which you literally have a subjective tool-- excuse me, an objective tool to be able to ask everyone that comes in front of you about their substance use. Doesn't mean you have to treat it, but you have to ask about it so that you can refer them to the appropriate care. And this is important because I come across so many people that are not even asked about their substance use, right? And so that's important. And then, lastly, really in the spirit of Helena Hansen and Jonathan Metzl is this concept of practicing structural competency and understanding that there's only so much that you can do as a healthcare professional and really making the connections with community organizations, especially in the area of housing, legal, food insecurity, mental health treatment is key because you're going to have to assess for what else is happening beyond the clinical problem that they came into you for so that you can have those connections and be able to expertly refer folks to the care that they need, because a lot of times you'll be chasing your tail only focusing on the medical "problem" if the person is about to be evicted or the person doesn't have access to food, etc., etc.

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And so you have to be able to do the upfront work, whether with the social worker or hospital administration or clinical administration to say, "How do we form these strategic partnerships so that when I see that there is a vulnerability in the patient that came to see me in these areas that I actually asked about, I can do something?" And that might seem onerous, but what the literature is showing us that healthcare providers are more likely to express satisfaction and less likely to get burned out when they have better outcomes for their patients. And that's one way to do it.

01:23:12

Thank you so much, Dr. Isom and Dr. Jordan. This has been an incredibly enriching conversation, and we really appreciate the work that you do and for taking the time to equip us and our listeners to be better advocates. I know that I'll be returning to this conversation often, and we just really appreciate having you both here.

01:23:31

It's been so good. It's such a pleasure. I learn from Dr. Isom all of the time. And what a wonderful way to spend the last 90 minutes together, for sure.

01:23:42 Yes. It's been lovely. You throw back to residency where [laughter] Dr. Jordan was my attending. I learned a lot from you as well. And thank you all for inviting us for this conversation.