



RESEARCH REPORT

# Recommendations for Programs and Funders Who Serve People Who Use Substances

## Disrupting Structural Racism's Impact on Health and Well-Being

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# Executive Summary

**Structural racism has long been a part of systems and structures in the United States, including substance use treatment and prevention services. Implicit and explicit discrimination in national and local policies, practices, programs, leadership, and access to resources including wealth, health, and education have had a profound and harmful effect on people who use drugs. This is particularly true for Black, Indigenous, Latinx, and other historically and structurally excluded people. In our research, we have found that substance use service models led for and by people of color were relatively small, underfunded, and often unrecognized by public and private health care payers (Clemans-Cope et al., forthcoming). Yet these programs had important potential to dismantle structural racism related to people in communities of color who use substances.**

This study aims to highlight when and how communities of color counter historical structural racism and continued oppression by creating culturally effective community-based programming that promotes equitable outcomes for people who use drugs. In the introduction, we present examples of how white supremacy has affected programs and services for people of color who use drugs or have substance use disorders. In the environmental scan of published research for the current study, we found a dearth of research and tools that could be used to identify and characterize these types of asset-based substance use service models, particularly those that address structural racism and are led for and by people of color.

We then present findings from key informant interviews with discussants from nine community and other relevant organizations to examine the ways programs and organizations support and provide services that interrupt structural racism as it relates to substance use. We focused particularly on how these organizations operationalize dismantling structural racism affecting people who use drugs. The following key recommendations emerged that may serve to mitigate structural and institutional racism in the substance use treatment and prevention paradigm:

1. Provide holistic care using a racial justice frame, which focuses on dismantling and redistributing resources from structurally racist systems.

2. Support client-centered care while navigating the interwoven goals of dismantling racism and keeping people who use drugs alive, in part by ensuring leaders adopt an antiracist framework in the provision of care.
3. Choose and support staff with high emotional intelligence who are committed to holistic, empathetic care and reflect the community.
4. Build trust with clients through culturally effective care including alternative therapies not funded by health insurance, which may lead to improved wellness and later engagement in medical therapies, such as PrEP for HIV prevention.
5. Form participant advisory boards consisting of clients who can identify respectful and culturally effective care in the community.
6. Encourage these unique, racism-dismantling community-based programs to build their own in-house research capabilities.

The following key recommendations emerged from these discussions with key informants on principles and changes needed in funding organizations to dismantle structural racism that harms people who use substances.

1. Focus on racial justice work:
  - a. Large private funders can take a larger role in funding scalable racial justice work related to people who use drugs.
  - b. Small private funders are well positioned to support local racial justice work and local capacity building.
  - c. Funders need to help build and sustain community capacity related to nonpunitive and antiracist services for people who use drugs.
  - d. Funders need to support efforts that break the link between health and the criminal legal and other punitive systems for people who use drugs.
2. Focus on community:
  - a. Funders need to focus on the importance of building community trust, especially through transparency in institutional goals that may conflict with those of grantee organizations.
  - b. Funders need to prioritize grantees' community-based research agendas.
  - c. Funders need to expand community involvement in grantmaking and oversight.
3. Focus on external factors:

- a. Private funders need to use their influence on policymakers and government research agendas to bring antiracist services and health care for people who use drugs to scale, as these services are often underfunded and inaccessible.
- b. Funders should better support community organizers working to advance effective political advocacy strategies in response to harmful policy changes that disrupt access to clients (e.g., abortion restrictions) and backlash against recent racial justice initiatives.
- c. Funders should communicate and engage with media to support those doing the most progressive justice-involved work.

Ultimately, racism embedded in health, social, and drug policy programs, practices, and procedures means that many substance use programs exist without visibility, recognition, or financial support. Nevertheless, they have been involved in creating services that communities need. We sought to identify and elevate the work, concerns, and recommendations of these organizations to help changemakers and policymakers think about how and why they should fund such efforts. If society seeks to dismantle structural racism, we must partner with these leaders and others like them in the field to rethink the way research, policies, and services are defined, implemented, analyzed, and evaluated for equitable well-being outcomes.



# Recommendations for Programs and Funders Who Serve People Who Use Substances

## Background

Structural racism<sup>1</sup> has long been a part of systems and structures in the United States (Braveman et al. 2022; Darity and Mullen 2020; Dunbar-Ortiz 2015; Hannah-Jones et al. 2021; Katznelson 2005; Kendi 2016; Rothstein 2017; Takaki 2008), including within the systems and structures that address substance use. Racist policies, including implicit and explicit discrimination in national and local policies, practices, programs, leadership, and access to resources such as wealth, health, and education, have had a profound and harmful effect on people who use drugs. This is particularly true for Black, Indigenous, Latinx, and other historically and structurally excluded people. The development of racist and punitive policies over hundreds of years “produced and normalized” racist tropes and stereotypes (Kendi 2019), including those related to drug use.<sup>2</sup> Since early colonial times, laws and regulations related to alcohol and drug use were a means to wield economic and political power over targeted populations (Dunbar-Ortiz 2015; Holton 2015). This punitive criminal legal frame for drug use also restricted the development of nonpunitive health and social services systems for those with substance use disorders (SUDs).<sup>3</sup>

Historically, the health care system in the United States has not provided substance-related care for those with SUD,<sup>4</sup> as these services were primarily funded through grants such as federal block grants to separate treatment systems (Bailey 2018). Recently, SUD care is slowly being integrated into health care and public health systems, including Medicaid and Medicare, through legislation (Wen et al. 2013),<sup>5</sup> yet inequitable access to high-quality health care and resulting inequitable health outcomes stem from a long history of structural racism in health services and systems (IOM 2003). Since the health system has been slow to address substance use, it is naïve to assume it will provide equitable, nonpunitive, culturally effective substance use services with strong mechanisms for accountability, training, and monitoring.

Against the backdrop of criminalization and racism, communities and people who use drugs, including people with SUD, have developed expertise and infrastructure for providing culturally effective care, and these can serve as guides for building a just future. A diversity of providers works to provide culturally and linguistically effective services for people who use drugs across race, ethnicity, sexual orientation, age, gender, parenting status, ability, and other intersectional identities.

To cultivate holistic wellness and positive, meaningful outcomes for people who use drugs, particularly for Black, Indigenous, Latinx, and other historically and structurally excluded people, all health and social systems need to be involved, including physical and behavioral health care systems and payers, social services and supports, child welfare, and education (Clemans-Cope et al., forthcoming). To support the best possible outcomes, these systems would work with community expertise and people who use drugs to re-envision their care and social supports to develop, implement, and evaluate nonpunitive, culturally and linguistically effective, evidence-informed services—and keep reworking these systems until inequities are eliminated. This will require dismantling structures that have been implemented in the past and continue to harm people who use drugs.

In this research, we recognize the role of structural racism and seek to move beyond the traditional focus on communities' deficits and challenges related to substance use. We posit that this framework has limited policymakers' thinking about goals for change. We contend that it is critical to recognize and embrace the collective and historical wisdom and social capital, such as mutually respectful relationships, connectedness, and trustworthiness among people (University of Wisconsin Population Health Institute 2019),<sup>6</sup> that communities of color built *despite* systematic oppression. We believe this framework can better support aspirational thinking, productive collaboration, and effective solutions to address substance use and SUDs.

In our research, we sought to identify and learn from community-based programs and organizations that provide nonpunitive, culturally and linguistically effective substance use services aimed at improving outcomes *and* interrupting structural racism and systematic oppression among people of color. The study addresses the following research questions:

- How have previous studies, assessments, and tools identified and characterized services in the community that address structural racism and the needs of people who use substances, especially services not sufficiently financed to bring to scale?
- In a small sample of community and other relevant organizations, how do programs and organizations support and provide services that interrupt structural racism as it relates to substance use?

In this report, we first provide a brief background on the role of structural racism in both historical and more recent drug policy. We then describe the methodological approach and conceptual frameworks used in this research. Next, we present key findings from the environmental scan, followed by six recommendations from key informants on principles and changes required in organizations and programs to dismantle structural racism affecting people who use substances. We also share 10 recommendations for ways funders can support work to dismantle structural racism affecting people who use substances. We end with a synthesis and discussion of findings.

## The Role of Structural Racism in Historical Drug Policy

Institutions and disciplines that create drug policy and address substance use have a long history of creating or perpetuating policies, practices, and programs that, by design or consequence, ensure racially inequitable outcomes. Policymakers have intentionally used racism against structurally excluded populations to hinder their economic advancement as far back as the 1760s, when white colonists used alcohol to trick Native Americans into signing fraudulent land deeds (Dunbar-Ortiz 2015; Holton 2015). In 1875, policymakers in San Francisco sought to vilify and target Chinese residents by criminalizing opium dens and opium smoking—the types of opium consumption traditionally used by Chinese communities—in part as a response to white residents’ fear of losing jobs to Chinese laborers (Ahmad 2000; McCaffrey 2019). Racist policies have also characterized the war on drugs; this policy, started during the Nixon administration in 1971, funded police forces to become increasingly militarized, targeting Black/African American and Latinx populations (Cooper 2015). These policies criminalizing certain types of substance use explicitly targeted racialized populations (Mauer and King 2007),<sup>7</sup> with a top Nixon adviser admitting in 1994 that Black people were the White House’s enemy. This adviser confirmed that if they could “associate...Blacks with heroin, and then criminalize [it] heavily, we could disrupt [Black] communities.”<sup>8</sup> Likewise, the 1986 Anti-Drug Abuse Act and related legislation established a 100-to-1 sentencing disparity between crack and powder cocaine, as well as mandatory minimum sentencing for crack cocaine possession, with racially disparate consequences. These were amplified by increased funding to the carceral system.<sup>9</sup> The proliferation of laws criminalizing substance use specifically targeted racialized populations (Mauer and King 2007).<sup>10</sup>

The punitive focus and racist elements of drug policy extend beyond the criminal legal system to immigration, education, child welfare, employment, housing, and social supports (Drug Policy Alliance 2021a, 2021b, 2021c, 2021d),<sup>11</sup> even extending to foreign policy.<sup>12</sup> Despite this, structurally marginalized communities affected by punitive and carceral drug policies have cared about and for each other—and, in lieu of governmental and mainstream support, have developed their own resources and

infrastructures. These communities were broad; they included people of different races, ethnicities, sexual orientations, gender identities, socioeconomic statuses, and other intersectional identities that have always been most affected by systemic punitive drug policies. Among the earliest examples of these community-led efforts is the work of the Black Panther Party and Young Lords, who jointly founded a drug treatment program in the South Bronx that used acupuncture with methadone treatment for opioid use disorder (Meng 2021), as well as harm reduction programs (Hassan 2022). This kind of work gained more media attention during the HIV epidemic; when the Reagan administration and prior administrations politicized and defunded research and public education regarding SUD, many people who used intravenous drugs and were at high risk for HIV formed unsanctioned syringe exchange programs as acts of civil disobedience, especially in New York and San Francisco. From this reality rose the harm reduction philosophies and practices we see today (Anderson 1991).<sup>13</sup>

Yet, until the late 1990s, the drug policy status quo focused on interdiction rather than prevention or treatment.<sup>14</sup> This justified enormous resources for law enforcement efforts to reduce drug supply,<sup>15</sup> supported by “not in my back yard” attitudes of the general public toward the need for treatment clinics, as well as punitive laws and “out of sight, out of mind” stances of policymakers. Moreover, the law enforcement expenditures aimed at reducing the drug supply were sometimes—or often—corrupt.<sup>16</sup>

## **The Role of Structural Racism in Recent Drug Policy (1990s and Later)**

Drug policy advocates and communities have long called for an antiracist public health response to substance use for decades, largely in vain. One example of the role of structural racism in recent drug policy was the prescription opioid crisis, which motivated policymakers and the health system to shift the frame of SUD to public health and to provide health and social services for SUD (Netherland and Hansen 2017). Research found that racially disparate representational strategies in the media shaped responses from policymakers and the public, which likely bolstered support for racially inequitable drug policies, exacerbating racial disparities in access to health care and in the criminal justice system (Netherland and Hansen 2016).<sup>17</sup> A 2011 study of media coverage of opioid use across the United States found that published stories humanized “white opioid addiction as a tragedy of wasted potential, rather than a violent threat,” compared with stories centering criminality for Black and Latinx people who use drugs (Netherland and Hansen 2016). By the end of 2015, a nascent public health response began to take shape. But uneven distribution of treatment—driven in part by experts’ claims that buprenorphine treatment was more suitable for suburban populations than methadone treatment—resulted in disproportionately easy access to buprenorphine treatment in predominantly white neighborhoods (Hansen and Netherland 2016; Netherland and Hansen 2017). This is a clear example of

policies, practices, and programs combining to mount a public health–related response that nevertheless perpetuates racially disparate access to treatment because of the absence of a racial equity lens.

During this same period in the 2010s, state and federal policy responses emphasized decreasing access to prescription opioids through inflexible opioid prescribing guidelines (Dowell, Haegerich, and Chou 2016) and policies targeting so-called “pill mills” (Lyapustina et al. 2016; Rutkow et al. 2015). As predicted by substance use experts, starting around 2015 on the East Coast, people with opioid use disorders related to prescription opioids shifted to heroin and fentanyl, causing extremely high overdose mortality (Ciccarone 2021; Ciccarone et al. 2016). The restrictive approaches to opioid prescribing may also have contributed to a shift toward injection drug use and increased morbidity such as hepatitis C and HIV infection (Broz et al. 2021; Gray et al. 2018).<sup>18</sup> Despite these trends, policymakers were unwilling to embrace proven harm reduction strategies such as syringe access and even closed some syringe programs.<sup>19</sup> Fortunately, some recognized the threat and promoted these public health measures (Knopf 2021). Nevertheless, three factors significantly contributed to higher rates of overdose among people—most notably people of color—who use drugs: (1) low support and funding for proven harm reduction strategies, (2) introduction of fentanyl into the illicit drug supply, and (3) an increase in the number of people who previously used prescription opioids turning to street drugs (AHRQ 2020; Kiang et al. 2021).<sup>20</sup> These trends have been exacerbated by racial inequities in access to high-quality treatment for SUD (Dunphy et al. 2022; Hollander et al. 2021; Tiako 2020).

Throughout this narrative, we aim to uplift significant scholarship that highlights the pervasiveness of structural racism in our nation’s drug policy. More scholars and activists have also proposed solutions to disrupting structural racism in drug policy on a large scale, including decriminalization of drug possession and the provision of culturally effective care for SUD (Farahmand, Arshed, and Bradley 2020; Matsuzaka and Knapp 2019).<sup>21</sup> While harm reduction interventions are effective and have been working in Black and Brown communities for decades (Hassan 2022), scant scholarly work has focused on the issues unique to communities of color and the ways that structural racism affects how substance use is addressed. Scholarly work is also missing a focus on community assets, strengths, and successes in marginalized communities, which can stimulate aspirational thinking about substance use.

## Methods and Conceptual Framework

We launched this project in the spring of 2022. At the outset, the team conducted an environmental scan to examine how previous studies, assessments, and tools have identified assets and services in the

community that address the needs of people who use substances. In the environmental scan, we examined published and grey literature released after 2000, producing a synthesis summarized below. We also conducted an interview with the primary author of the study that most closely addressed this research question to ensure we understood the processes that were used (Collinson 2022). While we first focused on asset-based services, based on findings from our environmental scan, which showed a dearth of research on asset-based services within historically and structurally excluded populations that use drugs, we reoriented to include a broader range of services that have the potential to disrupt the adverse effects of structural racism on people who use substances.

Between June and August 2022, we conducted key informant interviews to identify the ways that programs and organizations can support and provide services that interrupt structural racism as it relates to substance use. We developed an interview protocol that included content on the development, implementation, and evaluation of culturally effective services; how institutions support and build on client strengths; funders' current financial and political support for culturally and linguistically effective nonpunitive services; recommendations for funder support and suggestions about private and governmental funder roles in supporting asset-framed substance use services; challenges related to political contexts; and other questions that addressed knowledge gaps identified through the environmental scan. The project team, Urban project advisers (Rekha Balu, Tracie Gardner, and Brian Smedley), and the study's consultant, Monique Tula, former president of the National Harm Reduction Coalition, reviewed the interview protocol (appendix A).

We selected interview participants after identifying organizations that have brought a racial justice lens (which focuses on dismantling and redistributing resources from structurally racist systems) to their work and that had a long history of providing culturally effective substance use services. We collaborated with Monique Tula to identify and connect with interviewees at organizations that met these criteria. We selected participants from organizations led for and by people of color that are directly providing or supporting provision of nonpunitive, culturally effective community-based services. In total, we conducted eight interviews with nine people, the majority of whom work directly in, or adjacent to, the substance use field. Appendix B contains a full list of interview participants, organizations, websites, and program descriptions. The team reviewed the environmental scan and interview notes to identify areas of agreement and common approaches, strategies, and recommendations—as well as areas of disagreement and areas where further study is needed and desired.

## Conceptual Frameworks

This project used a historical, systemic, and administrative framework to account for the role of structural racism in drug policy and in structural barriers that disproportionately affect people of color who use drugs, specifically related to housing, employment, access to health care, social determinants of health (Artiga and Hinton 2018), and health equity (Gee 2016; Gee and Ford 2011). Ample evidence demonstrates that society and government have implicitly and explicitly advanced and embraced punitive responses to drug use. This study aims to highlight when and how communities of color counter historical structural racism and continued oppression by creating culturally effective community-based programming that promotes equitable outcomes for people who use drugs. The legacy of racism in all areas, including research, meant that these programs and practices, led by people of color, have rarely received research attention and funding. Chen and colleagues further explore these concepts, identifying white supremacist practices in the public health funding cascade and explicating how they affect female researchers of color (Chen et al. 2022). This is an example of how white supremacy has affected programs and services for people of color who use drugs or have SUD: culturally effective care for these populations seldom aligns with evidence-based medicine and best practices based on systematic reviews of the traditional medical literature (Matsuzaka and Knapp 2019). With the exclusion of these programs and services from research and scholarship, the question of what is in fact “evidence based” must be questioned. We see this embedded bias result in the exclusion of these programs from public and private funding needed to sustain them, much less bring the work to the scale needed in the community.

The use of these structural racism frameworks in public health research was critical to the approach and implementation of this research project (Ford and Airhihenbuwa 2010), including a critical assessment of the literature and gaps in the literature, the construction of the interview protocol, the approach used to identify interviewees (described below), financial compensation for interviewees’ time, and our responses to interviewees’ identification of structural racism within the interview protocol.

## Limitations

This study has several limitations, including its short timeline, which required us to choose interviewees with whom one of our study team had a relationship; the time constraint meant we were only able to conduct interviews with eight organizations and that our key informants were not very diverse in terms of the communities they serve—most served largely Black clients and communities. Thus, the findings

reported here may not represent a comprehensive assessment based on interviews with a broader set of individuals and organizations.

## Findings

In this section, we first report findings from the environmental scan of published literature on research and tools that could be used to identify and characterize asset-based substance use service models that address structural racism and are led for and by people of color. We then present findings from the key informant interviews with discussants from nine community and other organizations to examine the ways programs and organizations support people who use substances and provide services that interrupt structural racism related to substance use. We present recommendations that emerged from these discussions that may serve to mitigate structural and institutional racism in the substance use treatment and prevention paradigm. We follow with recommendations that emerged on principles and changes needed in funding organizations to dismantle structural racism that harms people who use substances.

### **Environmental Scan of Efforts to Address Structural Racism Facing People Who Use Substances**

In the environmental scan, we found a lack of approaches and tools to identify and characterize interventions and solutions to disrupt structural racism related to substance use in communities. The scan revealed limitations in previous definitions of community assets and needs related to substance use, with few or no models that demonstrated asset-framed substance use services led by and for communities of color and that offered culturally and linguistically effective, nonpunitive, comprehensive care.<sup>22</sup> Previous approaches used for community asset mapping and needs assessments, such as community health needs assessments (Cevasco 2020), health impact assessments,<sup>23</sup> and community asset mapping (Green 2014; Lazarus, Taliep, and Naidoo 2017),<sup>24</sup> have been largely government funded and led by hospital staff or researchers who may not be from the community. Community-driven responses to substance use needs are essential to ensure needs are addressed and programs and services are accessible, safe, respectful, and effective (El-Bassel et al. 2021; Delman et al. 2019; Harrison et al. 2020).

As revealed in our review of the literature, these efforts have usually excluded people who use drugs and other marginalized groups. The literature lacked a focus on these populations and their well-

being; given the racialized framing of drug use in the US, the exclusion of these groups is a form of structural racism. Traditional government- or researcher-led approaches have not been designed to support efforts to disrupt structural racism related to substance use in communities, which especially harms historically excluded populations, such as Black people, transgender people, HIV-positive people, and sex workers, that use substances.

Community assets, as defined by past research, are generally limited to community resources such as programs, services, individuals, institutions, and, in some cases, associations between community members and social resources. Among the techniques that map associations between people and resources are community asset mapping and asset-based community development and its extension, asset-based community engagement (Collinson and Best 1993; Kretzmann and McKnight 1993). Past assessments have not recognized the importance of identifying and centering community assets and services that are culturally effective, and they have generally not identified disrupters and change agents. In part, this is because most of those who develop and administer these assessments—with some exceptions (Collinson 2022; Collinson and Best 2019)—do not typically have community relationships that support finding the right people, asking the right questions, and getting full and meaningful responses that move beyond the typical deficit frame.

Structural racism embedded in the research process and a societal disapproval of people who use drugs likely affect how many researchers think about, construct, and implement substance use–related research. This is because the dominant frame for drug use in this country is punitive and informed by the war on drugs, which scholars have long linked to racism (Cooper 2015; Gunja 2003; Mauer and King 2007; Nunn 2002; Tonry 1994). Programs led by and for the community that provide culturally effective care for substance use receive little research focus or health system funding. Thus, the field is generally lacking documentation of approaches and tools to identify and characterize interventions and solutions that disrupt structural racism related to substance use in communities.

## **Recommendations from Key Informants on Principles and Changes Required in Organizations and Programs to Dismantle Structural Racism Affecting People Who Use Substances**

In our conversations with interviewees, we asked them to describe principles and changes required for organizations to support asset-framed substance use services that disrupt structural racism. Responses covered the provision of holistic care, leadership and staff characteristics, trust building with clients,

participant advisory boards, and in-house research capabilities. The six recommendations were as follows.

**1. PROVIDE HOLISTIC CARE USING A RACIAL JUSTICE FRAME, WHICH FOCUSES ON DISMANTLING AND REDISTRIBUTING RESOURCES FROM STRUCTURALLY RACIST SYSTEMS.**

In describing care that uses asset framing and is led for and by communities of color, most key informants highlighted the need for using a racial justice frame. As described in more detail below, discussants explained that racial justice is about dismantling and redistributing resources from structurally racist systems (and contrasted this with racial equity, which focuses on reforming existing systems to give people what they need). Discussants wanted us to understand that the effects of racism on people who use drugs cannot be dismantled by focusing on a small silo of services. As discussants explained, services provided to people who use drugs in overpoliced and marginalized communities must address the country's punitive, racist history and its consequences and be provided in partnership with community members and clients. The organizations we spoke with sought to address health, not just health care services, and emphasized the importance of addressing social determinants to improve well-being.

For example, one interviewee expressed that harm reduction organizations, although considered “ahead of the curve” on providing holistic care for people who use drugs, have by and large not adopted explicit antiracist framings. Discussants posited that, if safe injection sites were legalized in the United States, Black and Brown people would not use the services at the site because that would put them at risk for contact with law enforcement. This is an example of the difference between racial equity framing and racial justice framing in policy solutions and the greater effectiveness of the latter in addressing structural racism.

A program serving Black communities referenced by one of our discussants described the connectedness of health and broad racial justice work: “Black wellness and healing work can only progress if this work is done while addressing economic reform, inequities in the criminal legal system, HIV/AIDS, transphobia, homophobia, racism, misogynoir, reproductive justice, intimate partner violence, and other issues that challenge the wellness of Black communities.”<sup>25</sup>

## 2. SUPPORT CLIENT-CENTERED CARE WHILE NAVIGATING THE INTERWOVEN GOALS OF DISMANTLING RACISM AND KEEPING PEOPLE WHO USE DRUGS ALIVE, IN PART BY ENSURING LEADERS ADOPT AN ANTIRACIST FRAMEWORK IN THE PROVISION OF CARE.

Respondents noted that leadership matters greatly; the work, vision, and outcomes of an organization are significantly shaped by leadership's vision. Leaders often work with small budgets, volunteer their time, and often must navigate interwoven goals: working toward a larger vision that dismantles racism and its effects while doing the difficult, short-term work of keeping people who use drugs alive. These leaders adopt an antiracist framework in the provision of care. For example, these organizations develop and offer culturally and linguistically effective patient-centered services that are client driven and voluntary, drawing on the organization's established experience that led to improved health outcomes and strengthened, shared decisionmaking between patients and providers. One interviewee described the many barriers to traveling to a clinic outside their community for care and cited their organization's use of Assertive Community Treatment, a wraparound modality that emphasizes engaging people within their communities as a strategy for overcoming these barriers to care (Penzenstadler et al. 2019).

## 3. CHOOSE AND SUPPORT STAFF WITH HIGH EMOTIONAL INTELLIGENCE WHO ARE COMMITTED TO HOLISTIC, EMPATHETIC CARE, AND REFLECT THE COMMUNITY.

Another key finding from these organizations was that they have to find the right people to work in these systems. The right kind of staff have high emotional intelligence, are passionate, energized, and empathetic, and want to work with people who use drugs in a respectful manner. Additionally, these staff must be committed to holistic care and support, even when the mainstream public and private health systems push back and reject this approach. Finally, they must be committed to working with patients with the perspective that they are "in it together." One interviewee said they wanted to find like-minded people who "fit into the puzzle of someone's recovery." It follows that one staff member alone is not going to suit every potential client, so leaders of these programs want to have a diverse staff that will meet diverse needs and be able to provide services that are as tailored to the individual as possible.

Beyond screening for basic credentials, recruitment and onboarding processes should be intentionally crafted to assess these soft skills, which also requires valuing knowledge not traditionally valued in white supremacy culture (e.g., lived experience). One discussant reported that "academic credentials are rarely an indicator of a person's 'readiness' to do this type of work, and may, in fact, be a hinderance, as the preparation is limited to theory as opposed to practice—unless the person has an extensive history providing services or lived experience." Discussants described peer support

counselors—including those who do not have credentials and degrees but have used substances—and patient navigators with these characteristics. An informant shared that staff, especially front-facing staff, should reflect the community being served, because these staff may already have relationships with community members. Existing relationships can facilitate trust with potential clients, giving a mutual feeling of “these are our people,” as one interviewee said. One discussant observed that “the most effective teams are those that combine people with lived experience with people who have the theoretical framing that can support interventions. The two perspectives complement one another, and teams [and their] programs are richer for the diversity of perspectives.”

In return, the organization’s leadership and other staff acknowledge the emotionally difficult elements of community work and prioritize wellness programs for those providing direct services so that staff are assured that self-care is supported and valued. Interviewees recognized that organizations must also support their staff with ongoing, adaptive education and other resources.

#### 4. BUILD TRUST WITH CLIENTS THROUGH CULTURALLY EFFECTIVE CARE, INCLUDING ALTERNATIVE THERAPIES NOT FUNDED BY HEALTH INSURANCE, WHICH MAY LEAD TO IMPROVED WELLNESS AND LATER ENGAGEMENT IN MEDICAL THERAPIES, SUCH AS PREP FOR HIV PREVENTION.

Interviewees expressed a desire for health care systems and professionals to recognize and fund culturally effective alternative medicine strategies for people who use drugs as a necessary component of a racial justice framing. Several interviewees stressed the importance of the trust-building and engagement stages with clients, and that this key element of care is generally poorly funded or not funded. Discussants described how holistic care is deprioritized and even disdained by the traditional health care system, and how dismantling systems that dehumanize Black people and other people of color begins with centering holistic, therapeutic practices and community-based systems of care that alleviate harm and trauma for present and future generations. Further, as explained by a program referenced by one of our discussants, “community-based systems of care must integrate into current practices in Black life and build upon current traditions and norms in Black communities in order to be sustainable.”<sup>26</sup>

One interviewee mentioned the importance of building trusting, therapeutic relationships with clients who are sex workers who use drugs and are not ready to change their drug-using behavior but want to be well. The interviewee pays for mental health and wellness strategies from her own pocket because this culturally effective engagement work is not funded or billable under available medical avenues. These nonstandard therapies can include dancing, mindfulness, essential oils, crystal energy

therapy, prayer circles, visioning sessions, and journaling workshops. The strong therapeutic bonds that she develops may result in later engagement with traditional medical care and social services that benefit both the client and the community, such as medications to prevent HIV. However, the interviewee reported that clients often decline such mainstream health care medications, particularly at the beginning of the therapeutic relationship, because they lack trust in the medical system and because of the history of racism within their communities. She told us that she wished there were more support and evaluation of the front-end work to potentially demonstrate its value and lead to funding. As described in more detail below, funding and evaluation for programs and partners outside of the mainstream, typical grantees—including programs that build trusting therapeutic relationships with clients who use drugs through spiritual connections and alternative, culturally effective, nonstandard therapies—are critical for disrupting racism.

#### **5. FORM PARTICIPANT ADVISORY BOARDS CONSISTING OF CLIENTS WHO CAN IDENTIFY RESPECTFUL AND CULTURALLY EFFECTIVE CARE IN THE COMMUNITY.**

Many interviewees use or recommended participant advisory boards who are paid for their time and expertise to guide community organizations. These interviewees partner with and compensate clients and community members to conduct community asset mapping, which draws on community member expertise to judge which programs and services are respectful and provide culturally effective care. An interviewee from one organization reported that their participant advisory board helps develop guides (e.g., to rate syringe services programs) similar to *The Negro Motorist Green Book*, created in the Jim Crow era to list businesses that would safely serve Black travelers, so that others may know programs that are identified as respectful and effective by those who have interacted with them (Green 1936).

#### **6. ENCOURAGE THESE UNIQUE, RACISM-DISMANTLING COMMUNITY-BASED PROGRAMS TO BUILD THEIR OWN IN-HOUSE RESEARCH CAPABILITIES.**

Developing the in-house research capabilities of racism-dismantling, community-based programs helps ensure community needs are addressed and research and evaluation are safe, respectful, culturally effective, and valued by the community. An interviewee from one of the organizations we spoke to described how their organization developed their own research capabilities. To improve the impact of their work, the organization first gathered information by listening to what the community felt should be researched and then looked for funding to support the work. Over time, they developed in-house researchers who often partner with a university or other large research institution for grant funding, with research codesigned by program staff. In addition to improving services, the data were used to advocate for better services throughout the system overall.

## Key Recommendations for Ways Funders Can Support Work to Dismantle Structural Racism Affecting People Who Use Substances

In our conversations with interviewees, we asked for suggestions about private and governmental funder roles in supporting asset-framed substance use services that disrupt structural racism. Several interviewees supported the idea of funders understanding their respective roles in supporting efforts by and for the communities and felt it was important to create a division of labor for funders of different sizes. Ten recommendations emerged.

### 1. LARGE PRIVATE FUNDERS CAN TAKE A LARGER ROLE IN FUNDING SCALABLE RACIAL JUSTICE WORK RELATED TO PEOPLE WHO USE DRUGS.

Informants emphasized the importance of philanthropy supporting efforts to dismantle structural racism. They doubted that scalable racial justice work could be accomplished by governments and expressed that more progressive and community-involved racial justice work would likely require unprecedented leadership and funding from foundations, universities, and health systems. As the discussants noted, *racial equity* is about reforming existing systems to give people what they need, and *racial justice* is about dismantling and redistributing resources from structurally racist systems, such as the criminal legal system, thereby giving people what they are owed. Informants explained that if private philanthropy were to focus on racial equity rather than racial justice, the racial justice work would largely go unfunded. This would result in a loss for all, but the loss would be disproportionately impactful for people who use drugs.

Some interviewees explained that an important role for large private funders is funding scalable racial justice work, including established services with a deep evidence base like syringe, reproductive justice, and sexual health services for people who use drugs. And this work could expand to more politically sensitive yet effective services such as safe injection facilities, decriminalization of drug possession, and abortion services. For example, only a few larger private funders fund research related to the decriminalization of drug possession in Oregon,<sup>27</sup> although this policy has the potential to disrupt structural racism and is a critical innovation in nonpunitive services for people who use drugs.

In addition, larger funders can expand funding to reproductive justice programs that work at the intersection of structural racism and reproductive and sexual health rights, as these programs recognize that punitive responses to reproductive health issues disproportionately affect people who use drugs. For example, in Tennessee, SisterReach uses a four-pronged strategy to promote reproductive justice through education, policy and advocacy, culture change, and harm reduction. In Georgia, SisterLove

uses a five-pronged strategy to promote sexual and reproductive health through their research program along with education, prevention, support, and human rights advocacy.

## 2. SMALL PRIVATE FUNDERS ARE WELL POSITIONED TO SUPPORT LOCAL RACIAL JUSTICE WORK AND LOCAL CAPACITY BUILDING.

Interviewees saw smaller private funders, who they viewed as nimbler and more progressive, as best suited to support racial justice work that requires local investment, local relationships, long-term community organizing, and a commitment to local capacity building. Discussants felt that smaller private funders were more likely to let grantees do what they determine is needed for their organization and work, not just in harm reduction but in other needed supports and services.

Interviewees explained that when large funders support services such as syringe access, the demands of metrics to meet the funders' goals may not align with the grantee's or client's needs, goals, or preferences. Some interviewees felt it was unlikely that large funders would fund innovative racial justice work or racial justice education, in part because these funders often place unrealistic requirements on the funded work and require the work to become immediately sustainable through insurance reimbursements or other types of reliable and repeatable government funding. They reported that this type of pay-for-services "sustainability" frame, as opposed to sustainable funding for investments in movements and client overall well-being, works neither with racial justice movements nor in the drug policy movement, which has a long history of racism that will take a long time to eradicate.

In addition, interviewees thought small private funders are more committed to long-term funding and more transparent about funding decisions and the end of funding than are larger funders. Funders of all sizes seemed to recognize that the end of funding often leaves massive gaps in needed community services, but discussants thought neither small nor large funders responded adequately to these gaps. Interviewees noted that larger private funders, including the Open Society Foundations, the Ford Foundation, and the Robert Wood Johnson Foundation, have reduced funding in critically important substance use-related areas.

## 3. FUNDERS NEED TO HELP BUILD AND SUSTAIN COMMUNITY CAPACITY RELATED TO NONPUNITIVE AND ANTIRACIST SERVICES FOR PEOPLE WHO USE DRUGS.

Interviewees reported that funders can use their relationships with one another and their grantees to help build and sustain community organizations. This means supporting leadership development, advocacy work, capacity development, and community organizing from the community lens. Virtually all

interviewees argued that successfully building community capacity for providing services to people who use drugs requires ongoing examination and critique of the country's structurally racist health care system infrastructure and other social service infrastructures.

As described above, the construction of drug policy and the linked substance use system were intentionally built to be racist. Interviewees observed that it will take time for these systems to be trusted and competent enough to serve clients and produce equitable outcomes. Interviewees report that communities' needs include building the capacity of local organizations to enforce accountability in local systems for equitable outcomes. Interviewees note that this is especially important in more rural areas. One of the interviewees spoke about the need for dissemination of harm reduction strategies to Appalachia; funders can play a critical role in facilitating and disseminating models and best practices. Moreover, funders are especially well suited to provide convening and collaboration spaces in states where harm reduction services are in their infancy to meet with veteran advocates and service providers; these are valuable opportunities to help build community expertise in policy advocacy. Some interviewees prioritized funding and supporting community organizing around elections with a focus on racial justice to help shift the political climate and policy, and some supported nonelectoral work such as political education and mutual aid. In addition, interviewees suggested connecting community programs to politically savvy individuals and organizations to learn effective political advocacy strategies to advance communities' goals.

As mentioned above (in recommendation number 6 for programs), supporting the in-house research capabilities of racism-dismantling community-based programs is another important feature of community capacity building. This includes support for evaluations of organizations that are providing culturally effective and holistic services, including alternative practices that effectively engage and support client overall health and well-being. Such evaluations will require the development of different community- and system-resonant outcome measures. In the longer term, investments in this type of research capability could transform research and the type of evidence available.

#### **4. FUNDERS NEED TO SUPPORT EFFORTS THAT BREAK THE LINK BETWEEN HEALTH AND THE CRIMINAL LEGAL AND OTHER PUNITIVE SYSTEMS FOR PEOPLE WHO USE DRUGS.**

To reduce the adverse effects of structural racism in the lives of people who use drugs, discussants recommended that funders focus on supporting efforts that break the link between health and the criminal legal system. This will require reducing contacts between people who use drugs and the criminal legal system, including through policing and diversion programs, prosecution, courts and drug courts, and corrections. Additionally, this would require funding organizations and their organizing

efforts to prioritize people of color and those from other structurally marginalized populations, using racial justice-informed, health equity-achieving, nonpunitive, and holistic approaches to support people who use drugs. This kind of philanthropic investment will advance equitable access, opportunity, and outcomes related to high-quality health care, education, employment, housing, neighborhoods and the built environment, and other social and community supports. One strategy to disrupt structural racism among those who use drugs that our discussants reported is supporting organizations working to decriminalize drug possession and increase equitable access to and outcomes from a full continuum of substance use services, including harm reduction, treatment, and other health and social supports—as in Oregon, for example.<sup>28</sup>

#### **5. FUNDERS NEED TO FOCUS ON THE IMPORTANCE OF BUILDING COMMUNITY TRUST, ESPECIALLY THROUGH TRANSPARENCY IN INSTITUTIONAL GOALS THAT MAY CONFLICT WITH THOSE OF GRANTEE ORGANIZATIONS.**

Almost all interviewees noted that for funders to work in the substance use field, they should try to build trusting spaces for community partners. Interviewees reported that grantees seek the ability to share with one another about organizational needs and struggles. They need to talk about the negative consequences of racism for their clients and their organizations, including structural racism within funding structures, and this can only happen in an environment of honest conversations and listening sessions where the funder will not penalize grantees. Grantees want funders to be transparent about their goals and any underlying agendas that may conflict with grantees' and partners' goals and motives.

Funders can do more to build relationships with culturally relevant community programs and providers. The goal is to become a trusted funder by building long-standing relationships with people and communities, particularly among programs and providers that serve and are staffed by marginalized populations and provide care and services that are not reimbursed by traditional funders.

#### **6. FUNDERS NEED TO PRIORITIZE GRANTEE'S COMMUNITY-BASED RESEARCH AGENDAS.**

Interviewees expressed that an important part of building and sustaining community capacity related to nonpunitive and antiracist services for people who use drugs is for funders to embrace community-based research agendas, not their own research agendas. One organization had an internal research group and noted the importance of receiving private funding to support their research agenda that helped change the status quo in provider practice and funding strategies.

Some programs wanted their own research capacity to demonstrate the efficacy of their work for applications for government funding to support successful approaches that they have observed, such as

the use of alternative medicine, wellness practice, and other more holistic care services. Others sought research into whether and how programs that address social determinants of health—like different forms of universal basic income and housing-first models—can be assessed, improved, promoted, and scaled for specific client populations. Some programs felt that community-level research was needed to identify the drug-related policies that trap people who use drugs in a cycle of negative outcomes. In addition, some programs reported a desire to frame their work and research agenda through a racial reparations framework, and one interviewee wanted to draw attention to the history of stolen labor and the framework for providing true reparations to descendants of enslaved people in the United States. To properly value and fund these avenues of research, funders must first develop and clarify the antiracist frameworks they are using to evaluate proposals. Funders must also have the knowledge and accompanying humility that they are only scratching the surface of the kind of work that has been taking place in historically marginalized and excluded communities for decades.

#### **7. FUNDERS NEED TO EXPAND COMMUNITY INVOLVEMENT IN GRANTMAKING AND OVERSIGHT.**

Many programs were looking for funders to democratize decisionmaking, such as by including community members on community advisory boards that can make funding decisions and by funding staff hiring committees. Interviewees urged funders to include people who use drugs, not just those in recovery, in decisions about where substance use funding should go. They observed that funders can share outcomes and other data related to people who use drugs with community members and leaders and can work with the community to develop solutions when inequitable outcomes are identified.

#### **8. PRIVATE FUNDERS NEED TO USE THEIR INFLUENCE ON POLICYMAKERS AND GOVERNMENT RESEARCH AGENDAS TO BRING ANTIRACIST SERVICES AND HEALTH CARE FOR PEOPLE WHO USE DRUGS TO SCALE, AS THESE SERVICES ARE OFTEN UNDERFUNDED AND INACCESSIBLE.**

Influencing government funders is an area interviewees identified where large philanthropic institutions and those in public-private partnerships can do more to shape government frames and funding related to people who use drugs. For example, interviewees pointed to the opportunity for foundations to influence public-sector expansions of funding and reimbursement for culturally effective engagement, harm reduction service, alternative healers and therapies, and other services that improve patient-provider trust and partnered care.

Interviewees noted that private funders can also influence government research agendas and funding to support existing or novel culturally effective services and approaches and policies that

address social determinants of health and evaluate if those approaches and policies are promoting equitable outcomes. One interviewee also described the role of large private funders in influencing local governments to fund established services such as syringe services. They explained that advocating for these types of services requires meeting state and local policymakers “where they are.” It also requires cultivating empathy and emotional intelligence through regular communication to support these programs for the long term. As the interviewee said, “The person who needs these services is your kid, your parent—have empathy for what they are going through.” The discussant described this strategy as “culturally effective” outreach from large funders to policymakers.

One interviewee also pointed out the need for funders to influence policymakers to pay policy and regulatory attention to the equity impacts of the high cost of prescription drugs that people who use illicit drugs need. For example, discussants encouraged support for organizations that center people who use drugs when evaluating access to high-cost prescription medications that people who use drugs may need for well-being and health. Health care for people who use drugs should include affordable access to prescription medications such as PrEP for HIV prevention, naloxone for overdose reversal, buprenorphine for treatment of opioid use disorder, and other high-cost medications. Studies that evaluate policies and regulations seeking to decrease drug costs should ensure equitable access to prescription drugs for people who use drugs and people with SUD (Farrow 2022).

#### 9. FUNDERS SHOULD BETTER SUPPORT COMMUNITY ORGANIZERS WORKING TO ADVANCE EFFECTIVE POLITICAL ADVOCACY STRATEGIES IN RESPONSE TO HARMFUL POLICY CHANGES THAT DISRUPT CARE ACCESS (E.G., ABORTION RESTRICTIONS) AND BACKLASH AGAINST RECENT RACIAL JUSTICE INITIATIVES.

We also asked interviewees about the political context of their work and whether they have developed strategies to respond to (1) policy changes that may disrupt services or limit options for clients (e.g., abortion restrictions) and (2) backlash against recent racial justice initiatives. There is an acknowledgment that people who use drugs have always faced challenges in both “red” and “blue” states—struggle is the norm, not something new. Interviewees felt that it was time for myth busting and to elevate wellness as a goal for people who use drugs. Some interviewees prioritized their funding toward electoral community organizing with a focus on racial justice to help shift the political climate and policy in their communities. Some supported nonelectoral work such as community education and provided mutual aid. In addition, interviewees suggested that funders could be useful in connecting community programs to politically savvy individuals and organizations to learn effective political advocacy strategies.

## 10. FUNDERS SHOULD COMMUNICATE AND ENGAGE WITH MEDIA TO SUPPORT THOSE DOING THE MOST PROGRESSIVE JUSTICE-INVOLVED WORK.

Interviewees also identified a role for private funders in using their authority to communicate about racial justice and racial equity issues, regardless of political backlash. Interviewees point out that this backup is particularly needed in areas where policymakers and media continue to apply a punitive frame to drug users instead of a health-based frame. Along with funding the work of the grantees who work in these spaces, particularly those doing the most progressive justice-involved work, the visible support from funders in media could have an outsized impact. Interviewees expressed that funders who are justice driven are less responsive to negative media attention than government funders, providing a safe space for harm reduction and other initiatives that are effective in dismantling racism.

## Discussion

In our research, we have found that substance use service models led for and by people of color were relatively small, underfunded, and often unrecognized by public and private health care payers (Clemans-Cope et al., forthcoming). While difficult to identify, these programs had important potential to dismantle structural racism related to people of color who use substances. In the research described in this report, the project team originally sought to use and expand on existing studies, assessments, and tools created to identify asset-based substance use service models, particularly those that address structural racism and are led for and by people of color. We found a lack of tools that could serve as a frame to support community definitions of asset-based, culturally effective wellness models for people who use drugs. The dearth of research and tools in this space likely stems from structural racism and the drug use stigma woven throughout research and government institutions, which shape research agendas, funding, the diversity of grantees and their collaborators across identities and experiences, and the policy conclusions drawn from studies.

The team shifted focus to identifying and learning from organizations and community programs that improve health and well-being for historically and systematically excluded populations who use drugs. We focused particularly on how these organizations operationalize dismantling structural racism affecting people who use drugs. Interviewees suggest these organizations and programs **focus on racial justice work** and offered the following recommendations to mitigate structural and institution racism in the substance use treatment and prevention paradigm:

1. Provide holistic care using a racial justice frame, which focuses on dismantling and redistributing resources from structurally racist systems.

2. Support client-centered care while navigating the interwoven goals of dismantling racism and keeping people who use drugs alive, in part by ensuring leaders adopt an antiracist framework in the provision of care.
3. Choose and support staff with high emotional intelligence who are committed to holistic, empathetic care and reflect the community.
4. Build trust with clients through culturally effective care, including alternative therapies not funded by health insurance, which may lead to improved wellness and later engagement in medical therapies, such as PrEP for HIV prevention.
5. Form participant advisory boards consisting of clients who identify respectful and culturally effective care in the community.
6. Encourage these unique, racism-dismantling community-based programs to build their own in-house research capabilities.

The following key recommendations emerged from the discussions with key informants on **principles and changes needed** in funding organizations to dismantle structural racism that harms people who use substances:

1. Large private funders can take a larger role in funding scalable racial justice work related to people who use drugs.
2. Small private funders are well positioned to support local racial justice work and local capacity building.
3. Funders need to help build and sustain community capacity related to nonpunitive and antiracist services for people who use drugs.
4. Funders need to support efforts that break the link between health and the criminal legal and other punitive systems for people who use drugs.

In addition, funders should **focus on community**:

1. Funders need to focus on the importance of building community trust, especially through transparency in institutional goals that may conflict with those of grantee organizations.
2. Funders need to prioritize grantees' community-based research agendas.
3. Funders need to expand community involvement in grantmaking and oversight.

Lastly, funders should **focus on external factors**:

1. Private funders need to use their influence on policymakers and government research agendas to bring antiracist services and health care for people who use drugs to scale, as these services are often underfunded and inaccessible.
2. Funders should better support community organizers working to advance effective political advocacy strategies in response to harmful policy changes that clients' care access (e.g., abortion restrictions) and backlash against recent racial justice initiatives.
3. Funders should communicate and engage with media to support those doing the most progressive justice-involved work.

Given the paucity of scholarship in the field, future research could take a vast number of directions. More scholarship is needed to explore facilitators, barriers, and structures for mutually beneficial partnerships between funders and community organizations that serve people of color who use drugs. Further, given our project's eventual focus on anti-Black structural racism, we recognize the need for more research on culturally effective care for people who use drugs that centers other nonwhite communities, such as specific groups within the Latinx and Asian communities. The literature assessing potential limitations and biases of the existing research on community organizations that serve people who use drugs and are affected by structural racism is limited; this gap is notable given that the risks of data collection for stigmatized and criminalized behaviors intersect with the oppression and social control of Black people, Indigenous people, and other people of color within medical and public health programs. Future research could also address the recommendations above aimed at expanding attention and funding for programs that serve people who use drugs and explicitly focus on structural racism.

Ultimately, the racism embedded in health, social, and drug policy programs, practices, and procedures means many substance use programs exist without visibility, recognition, or financial support. Nevertheless, they have been involved in creating services that communities need. We sought to identify and elevate these organizations' work to help changemakers and policymakers think about how and why they should fund such efforts. If society seeks to dismantle structural racism, we must partner with these leaders and others like them in the field to rethink the way research, policies, and services are defined, implemented, analyzed, and evaluated for equitable well-being outcomes.

# Appendix A. Interview Protocol

## Introductory and Consent Language

Thank you for making time to speak with us today. As we explained in our email, we are researchers from the Urban Institute assessing the potential for collecting information from community leaders on services that are meeting the needs of historically and systemically excluded people who use substances but are not financed or reimbursed to adequately scale up to meet the need of the community at large, that is, to eliminate racial and ethnic differences in access and outcomes. The project, supported by the Robert Wood Johnson Foundation, will help to guide them on grant making strategies that will help to end long standing policies, practices and programs that reinforce racism. The Urban Institute is undertaking this work independently. Funders do not determine research findings or the insights and recommendations of Urban experts.

During this interview, we'd like to talk about community programs, policies, resources, and infrastructure that exist or are needed to support these types of services for historically excluded populations, including but not limited to people of color. The insights that you provide will be combined with those of other stakeholders to help us develop recommendations to understand the current context, strengths, and gaps and develop community-based recommendations for identifying culturally relevant community strengths related to providing culturally effective services for people who bore the brunt of past punitive drug policies as systems shift towards a more health-based approach. Ultimately, we'll be producing a report on our findings which may be made publicly available.

Your participation in this discussion is voluntary. If you prefer not to answer, or don't know the answer to, any specific questions, please let us know and we will move on.

We believe that participation in this interview poses minimal risks to you, and every effort will be made to protect your confidentiality. While we may use some quotations in reports, we will not attribute quotations to an individual or his or her organization. [If the interview is taking place via Zoom videoconference add: Since this is a videoconference, we encourage you to participate in a private setting. Also, while we are employing the appropriate security measures during this virtual interview, it is important that you know that no system such as Zoom is 100 percent secure.]

Finally, we would like to record our conversation today just for use as back up to our notes. The audio recording will only be available to the research team and will be destroyed when the project is completed.

Do you have any questions for us before we get started?

Do you consent to participate in the interview?

Do you consent to this interview being recorded [not a requirement to continue]?

## Interview Questions

1. Please describe your role at your organization, and the populations your organization serves.
2. How do you tailor the services you offer or the way you provide these services *in a culturally effective way* to meet the needs of your clients who use substances?
3. For historically excluded populations, *which of your services are most important* to meet client's needs, promote improved health and wellbeing, and interrupt the effects of structural racism?
  - a. How did you identify and develop these services?
4. How are these services financed? (e.g., Medicaid, block grant, foundation, etc.; note: differential scaling)
5. What efforts, if any, have government or foundations made to identify and support under-resourced services? If yes, how? If not, why not?
6. What resources and relationships with other culturally relevant community programs (like health, social services, social supports) support your clients' wellbeing? How did you build these relationships?
  - a. How do you link clients to these programs? Warm hand-offs, or something else? How often?
7. How do you *assess and leverage your client's strengths or community assets* to facilitate engagement with your organization or other community organizations?
  - a. What support does your program need to better leverage client's strengths or address barriers?

### Establishing Holistic, Inclusive Programs to Disrupt Structural Racism

As you think of your ideal vision of a successful program designed to eliminate the effects of racism related to drug policy and substance use in communities:

1. What role can private funders play in acceptance, development, operations, expansion and sustainability of programs that provide a culturally relevant and effective continuum of services to historically excluded populations?
  - a. How could private funders support the education and training needed to fully scale and staff such programs?
2. What role do you think government should play in recognizing and funding more programs that provide culturally effective non-punitive services to historically excluded populations?
  - a. Have you seen any local or state legislative, health department, Medicaid or other policy efforts to address racial differences in health or social outcomes for people who use drugs? Where do the efforts sit in the government?
  - b. If government has not done this, what needs to change?
  - c. If government has funded these services, was the financing through block grants, Medicaid, a combination or something else?
3. Are there roles that health systems, universities, and individual program leadership can play to expand equitable access to and outcomes from culturally effective care?
  - a. Prompt (if necessary): Are there champions in advocacy or government pushing for examination of racial or ethnic disparities in outcomes or past racist or punitive policies related to substance use?

## Political Context

Next, we'd like to learn a bit more about the political dynamics and policy context AND where there is more work to be done to advance equity at the local and state levels.

1. In responding to backlash against affirmative action and racial justice initiatives, are there tools or strategies you are using to minimize the effects of this backlash on your program and your client's access to your services? Ex. Legal strategies, outreach, relationship building, etc.
2. What other political or policy factors impact access to and outcomes from culturally effective substance use programming from prevention, harm reduction, treatment or recovery areas?

## Wrap-Up

1. Lastly, can you give us any recommendations of other people in the field – funders, workforce

experts, program leadership, etc. who could speak to these issues?

## **Thank You**

Thank you so much for taking the time to speak with us. Your insights, thoughts and perspectives are crucial as we work with RWJF to identify programs that are most effective in supporting services to disrupt racism related to substance use in communities. We realize that this set of questions was just a starting point; if you have additional thoughts, please feel free to e-mail or call us. Thanks again, we will be sure to share our findings with you once the study is completed.

# Appendix B. Details on Interview Participants

TABLE B.1

Interview Participants List (Interviews Conducted between June and August 2022)

Interviewee and title	Organization name and website	Organization description
Dr. Orisha Bowers, BFA, MA, MEd, PhD, CEO	<a href="#">Orixa Healing Arts, Wellness, and Spiritual Centre</a>	Orixa Healing Arts, Wellness, and Spiritual Centre is a healing and wellness practice that provides education and creative interdisciplinary tools to businesses, nonprofit organizations, faith institutions, and individuals.
Chris Richardson, director of the Support Team Assisted Response (STAR) Program	<a href="#">WellPower</a>	WellPower is a place for recovery, resilience, and well-being, known locally and nationally as a model for innovative and effective community behavioral health care. Through multiple community sites, mental health providers in several Denver public schools, collaborations with community partnerships, and home-based outreach, WellPower provides treatment, prevention, outreach, and crisis services to children, families, and adults.
Indya Hairston, MPH, Community-Based Research Program manager	<a href="#">SisterLove</a>	SisterLove, Inc., was founded as a volunteer organization in 1989 to educate African American women in Atlanta, Georgia, about HIV/AIDS prevention, self-help, and safer-sex techniques. The organization's mission has been to eradicate the adverse impact of HIV/AIDS and reproductive health challenges upon women and their families through education, prevention, support, and human rights advocacy in the United States and around the world.
Dr. Vignetta Charles, PhD, CEO Dr. Michael Everett, EdD, chief people & culture officer	<a href="#">ETR (Education, Training, and Research)</a>	ETR is a behavioral health nonprofit devoted to providing science-based programs and services, driven by their mission to advance health and opportunities for youth, families, and communities. They seek to promote equity and justice through first understanding and then addressing the ways health and education outcomes are influenced by the complex interactions between people and their environment.
Tiffany West, director, Advancing Black Equity and Community Engagement	<a href="#">Gilead Sciences</a>	Gilead Sciences, Inc. is a research-based biopharmaceutical company that discovers, develops, and commercializes innovative medicines in areas of unmet medical need. With each new discovery and investigational drug candidate, they seek to improve the care of patients living with life-threatening diseases around the world. Gilead's therapeutic areas of focus include HIV/AIDS, liver diseases, hematology and oncology, inflammatory and respiratory diseases, and cardiovascular conditions.
Cherisse Scott, founder and CEO	<a href="#">SisterReach</a>	Located in Memphis, Tennessee, SisterReach empowers the people they serve to lead healthy lives, raise healthy families, and live in healthy and sustainable communities

Interviewee and title	Organization name and website	Organization description
Monique Tula, portfolio manager	<a href="#">Facente Consulting</a>	<p>by using a four-pronged strategy of education, policy and advocacy, culture change, and harm reduction.</p> <p>Facente Consulting is a woman-owned consulting firm headquartered in the San Francisco Bay Area, specializing in providing public health-related professional services to health departments, other government agencies, nonprofits, universities, coalitions, and philanthropies. Their team is passionate about public health, values the wisdom of communities, and applies their wealth of skills and experience to advancing health equity for people affected by HIV and hepatitis C, people who use drugs, and other populations who have been historically and are currently neglected and harmed by our society.</p>
Kenyon Farrow	<a href="#">PrEP4All</a>	<p>PrEP4All works with community members to identify the most pressing public health concerns impeding access to HIV care across the country. Then they collaborate with public health experts from around the world to craft rigorous policy solutions to these problems. They use those solutions to pressure the federal government to act and ensure that everyone gets the HIV care they need.</p>

**Note:** Descriptions are direct quotations from organizations' websites and other materials.

# Notes

- 1 As described by Paula Braveman, “Systemic and structural racism are forms of racism that are pervasively and deeply embedded in systems, laws, written or unwritten policies, and entrenched practices and beliefs that produce, condone, and perpetuate widespread unfair treatment and oppression of people of color, with adverse health consequences. ... Systemic racism emphasizes the involvement of whole systems, and often all systems—for example, political, legal, economic, health care, school, and criminal justice systems—including the structures that uphold the systems. Structural racism emphasizes the role of the structures (laws, policies, institutional practices, and entrenched norms) that are the systems’ scaffolding.” (Braveman et al. 2022).
- 2 The development of racist and punitive drug policies was similar to the development of racist policies such as residential segregation; as Kendi writes, racist ideas grow out of discriminatory policies, rather than the reverse (Kendi 2019). This point is not well-understood in the research and policy analysis (Brown et al. 2019).
- 3 People who use substance are not the same as those with SUD, which is characterized by symptoms in the following categories: impaired control over substance use, social problems at work, school or home related to substance use, substance use in risky settings or use despite known problems, and physical dependence, related to the use of specific substances that relate to SUD, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or DSM-5, developed by the American Psychiatric Association. See “What Is a Substance Use Disorder?” American Psychiatric Association, accessed December 6, 2022, <https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder>.
- 4 While Dr. Benjamin Rush, a signer of the Declaration of Independence, described what would later be called alcohol use disorder as a disease in the late 1700s (Smith 2011), treating SUD as a chronic health condition, rather than a moral failing or psychopathology was not common in the past. The framing of SUD as a health condition gained acceptance in the 20th century, as part of the Alcoholics Anonymous program, which started in 1935 (Caravella 2019), and the identification of SUD as a primary mental health disorder in the 1980 version of the *Diagnostic and Statistical Manual of Mental Disorders* (Robinson and Adinoff 2016).
- 5 “The Mental Health Parity and Addiction Equity Act (MHPAEA),” Centers for Medicare & Medicaid Services, accessed December 6, 2022, [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea\\_factsheet](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet); and “Substance Abuse and the Affordable Care Act,” the White House of President Barack Obama, Office of National Drug Control Policy, accessed December 6, 2022, <https://obamawhitehouse.archives.gov/ondcp/healthcare>.
- 6 Jody Horntvedt, “‘Social Capital’ Makes Communities Better Places to Live,” University of Minnesota Extension, reviewed in 2012, <https://extension.umn.edu/building-trust-communities/social-capital-makes-communities-better-places-live>.
- 7 Dan Baum, “Legalize It All: How to Win the War on Drugs.” *Harper’s Magazine*, April 1, 2016, <https://harpers.org/archive/2016/04/legalize-it-all/>; and Tom LoBianco, “Report: Aide Says Nixon’s War on Drugs Targeted Blacks, Hippies,” CNN, March 23, 2016. <https://www.cnn.com/2016/03/23/politics/john-ehrllichman-richard-nixon-drug-war-blacks-hippie/index.html>.
- 8 “Drug War Confessional,” Vera Institute of Justice, accessed December 6, 2022, <https://www.vera.org/reimagining-prison-webumentary/the-past-is-never-dead/drug-war-confessional>.
- 9 “Reagan’s National Drug Strategy Crackdown: Policing Detroit through the War on Crime, Drugs, and Youth,” Policing and Social Justice HistoryLab, accessed December 6, 2022, <https://policing.umhistorylabs.lsa.umich.edu/s/crackdowndetroit/page/reagan-s-national-drug-strategy>.
- 10 Baum, “Legalize It All”; and LoBianco, “Aide Says Nixon’s War on Drugs Targeted Blacks, Hippies.”

- <sup>11</sup> Tamar Chukrun, Julian Xie, Donna Biederman, and Trisha Dalapati, “By Perpetuating Substance Use Disorder Stigma, Public Housing Policy Causes Harm,” *Health Affairs Forefront*, July 2022, <https://www.healthaffairs.org/doi/10.1377/forefront.20220720.195224>; and “Privacy in America: Workplace Drug Testing,” American Civil Liberties Union, accessed December 6, 2022, <https://www.aclu.org/other/workplace-drug-testing>.
- <sup>12</sup> The US Central Intelligence Agency (CIA) involved itself in international drug trafficking as early as the 1930s in Central and South America for the purpose of advancing antileft power structures (Blum 1996). For example, in the 1980s, the Reagan administration’s CIA used sales of crack cocaine in South Central Los Angeles from Colombia to fund a proxy war against Nicaragua’s leftist government through the Contras (see “The Contras, Cocaine, and Covert Operations,” National Security Archive Electronic Briefing Book No. 2, accessed December 6, 2022, <https://nsarchive2.gwu.edu/NSAEBB/NSAEBB2/index.html>), despite serious human rights violations (Human Rights Watch 1990). This history reveals the interwovenness of the United States’ drug policy strategy that both criminalized and leveraged drug use and possession, systematically harming non-White communities abroad and at home.
- <sup>13</sup> “History of Health: Needle Exchange in San Francisco,” San Francisco AIDS Foundation, accessed December 6, 2022, <https://www.sfaf.org/resource-library/needle-exchange-in-san-francisco/>.
- <sup>14</sup> Arthur Robin Williams, “Pivoting from Carceral to Compassionate Drug Policy Approaches,” *Health Affairs Forefront*, June 1, 2022, <https://www.healthaffairs.org/doi/10.1377/forefront.20220531.200494/full/>.
- <sup>15</sup> Nathaniel Lee, “America Has Spent over a Trillion Dollars Fighting the War on Drugs. 50 Year Later, Drug Use in the U.S. Is Climbing Again,” CNBC, June 17, 2021, <https://www.cnbc.com/2021/06/17/the-us-has-spent-over-a-trillion-dollars-fighting-war-on-drugs.html>.
- <sup>16</sup> Jim Mustian and Joshua Goodman, “DEA’s Most Corrupt Agent: Parties, Sex amid ‘Unwinnable War,’” *AP News*, November 14, 2022. <https://apnews.com/article/soccer-sports-la-liga-money-laundering-puerto-rico-38aed2da8cd0ac237aca28aa39321105>.
- <sup>17</sup> For example, during the 2010s, Staten Island, New York City, experienced a high rate of overdose death among suburban white opioid users. Media coverage shaped a “sympathetic narrative,” describing “the victimization of ‘unlikely users’ as casualties of deceitful pharmaceutical companies or corrupt doctors, and later, as users made a switch to heroin, opportunistic drug dealers” (Mendoza, Rivera, Hansen 2019).
- <sup>18</sup> Centers for Disease Control and Prevention, “Increase in Hepatitis C Infections Linked to Worsening Opioid Crisis,” news release, December 21, 2017, <https://www.cdc.gov/nchhstp/newsroom/2017/hepatitis-c-and-opioid-injection.html>.
- <sup>19</sup> Tarihya McClain, “Why Communities in Most Need of Syringe Exchange Programs Are Eliminating Them Despite Proven Success,” Georgetown Law, O’Neill Institute for National and Global Health, September 23, 2021, <https://live-oneil-new.pantheonsite.io/why-communities-in-most-need-of-syringe-exchange-programs-are-eliminating-them-despite-proven-success/>.
- <sup>20</sup> Alexander Lekhtman, “How Overdose Surged for Black People as It Held Steady for Whites,” *Filter*, September 15, 2021, <https://filtermag.org/black-americans-opioid-overdose/>.
- <sup>21</sup> Health Justice Recovery Alliance, “Drug Decriminalization in Oregon—One Year Later: Thousands of Arrests Averted; Over 16,000 People Served,” news release, February 1, 2022, <https://healthjusticerecovery.org/news-and-updates/febdecrimanniversary/>.
- <sup>22</sup> Comprehensive care includes the availability of abstinence-based care as one component, as some patients desire such care.
- <sup>23</sup> “Health Impact Assessment,” Centers for Disease Control and Prevention, accessed December 6, 2022, <https://www.cdc.gov/healthyplaces/hia.htm>.

- <sup>24</sup> Linda Baird and Marlon Peterson, “Introduction to Community Asset Mapping,” Center for Court Innovation, accessed December 6, 2022, [https://www.courtinnovation.org/sites/default/files/documents/asset\\_mapping.pdf](https://www.courtinnovation.org/sites/default/files/documents/asset_mapping.pdf).
- <sup>25</sup> “About – BEAM,” BEAM, accessed December 6, 2022, <https://beam.community/about/>.
- <sup>26</sup> “About – BEAM,” BEAM.
- <sup>27</sup> Health Justice Recovery Alliance, “Drug Decriminalization in Oregon.”
- <sup>28</sup> Health Justice Recovery Alliance, “Drug Decriminalization in Oregon.”

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## STATEMENT OF INDEPENDENCE

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