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Building Outreach and Diversity in the Field of Addictions

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THE CASE FOR DIVERSITY, EQUITY, AND INCLUSION IN THE FIELD OF ADDICTIONS

Deliberate actions to promote racial and ethnic diversity among addiction researchers and providers is increasingly being recognized as a necessary step in the effort to mitigate worsening health disparities in the field. The urgency in focusing on a diverse workforce can readily be appreciated in the face of a deepening opioid crisis, where a changing ethnodemographic population is weighted toward underrepresented minorities (URM) and requires a direct need for culturally informed researchers and providers from racial and ethnic URM backgrounds.

The purpose of this paper is to reinforce the immediate need for diversity, equity, and inclusion (DEI) in the field of addictions, and to define these terms for a shared understanding of what these concepts entail. In this article, we describe the lack of racial and ethnic diversity in research and the existing medical workforce and make the case that DEI infrastructure is necessary to improve patient outcomes. We provide examples of programmatic efforts within the field of addiction that are dedicated to increasing the number of racial and ethnic URM researchers, clinical providers, and faculty. An overview of deliberate recruitment strategies is provided to highlight the importance of directed outreach. We conclude with a discussion of how DEI efforts can be measured to accurately track progress.

DEI can take several forms, but for purposes of this article we specifically highlight the benefits of increasing people from racial and ethnic URM backgrounds in the field of addiction. A review of the pertinent literature highlights three main areas where a DEI lens is useful and applicable to addiction. (a) DEI allows for the development of researchers and providers who more closely represent the heterogeneous population of patients served and can help to create, disseminate, and evaluate culturally tailored prevention and treatment interventions.[1] (b) DEI improves initiation and retention rates of patients from diverse populations who are more likely to seek treatment from URM providers.[2] (c) DEI can lead to improved health outcomes with improved adherence to treatment recommendations, and in which patients report greater satisfaction with racial or ethnically matched providers.[1,2]

To establish a shared language and understanding of the nuances involved in DEI, we provide clear definitions of each concept. *Diversity* describes the degree to which institutions and organizations represent the compositional heterogeneity of individual characteristics within the workforce.[3] People who are participating in decision-making, leadership, and any other areas necessary for informed addiction care most ideally should reflect the demographics of those affected by addiction, including gender, sexual orientation, and varied racial and ethnic backgrounds. *Equity* means that everyone has access to what is necessary in order to be successful. What is "necessary" may or may not look the same for everyone, and oftentimes URM groups require a different set of resources, skills, or support. Equity is different from equality, which allows for everyone to have the same resources, but which does not always equate to success. Employing an equity framework shifts systems and conditions to allow for those who have been excluded or oppressed to benefit and become invested change agents.[3] *Inclusion* exists when barriers are eliminated and when people are valued and appreciated as themselves, and then become willing and able to fully be involved in decision-making. People in an inclusive environment feel empowered, appreciated, and heard, regardless of their racial or ethnic background.

Taken together, upholding fidelity to a DEI framework is more likely to promote fairness for all and result in a state of health attainment, regardless of individual characteristics, such as race, ethnicity, sexual identity, cultural practices, language, religion, or gender. DEI efforts which are directed, focused, and ongoing can help minority groups leverage power in predominately White institutions, where those who belong to the majority culture benefit from innate privilege. This creates a space of inclusiveness in which researchers and

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TABLE 1. Race/ethnicity profile of current addiction psychiatry and addiction medicine subspecialty trainees in 2018

Ethnicity	Addiction psychiatry, *N* (%)	Addiction medicine, *N* (%)
White non-Hispanic	46 (55.4)	23 (59.0)
Asian/Pacific Islander	18 (21.7)	4 (0.10)
Hispanic/Latino	4 (0.05)	4 (0.10)
Black/African American	3 (0.04)	0 (0)
Native American/Alaskan	1 (0.01)	0 (0)
Other	7 (0.08)	2 (0.05)
Unknown	4 (0.05)	6 (0.15)

Source: ACGME data resource book 2018/2019.

providers from diverse backgrounds have an opportunity to equally collaborate and contribute toward improving outcomes for all people. DEI ensures and bolsters the scaffolding needed to develop and maintain a fully functional, cooperative, and diverse workforce equipped to sustain and promote the diversity of differing viewpoints working toward the common good of all people.

DIVERSITY: THE CURRENT STATE OF AFFAIRS

It is important to understand the current landscape of racial and ethnic diversity within the discipline of addiction. Addiction, like all of medicine has the hierarchical structure and culture of influence, which still looks predominantly and overwhelmingly White, thus leaving little or no room for the URM voice to be heard or even expressed. Medicine has lagged other organizations in improving the composition of its workforce. The statistics could not be starker, as medical school admissions and graduate medical education tell the story of a healthcare industry in a diversity crisis. In 2018, according to the Association of American Medical Colleges (AAMC) few matriculants to medical school identified themselves as Black/African American (7.1%), Hispanic, Latino, or Spanish origin (6.2%), or American Indian or Alaska Native (0.2%).[4] In psychiatry, the 2018 Resident Census demonstrated that White and Asian people makeup nearly three-fourths of all Post-Graduate (PGY)-1 psychiatry residency positions (52.1% White and 24.7% Asian), while less than 1% of residents identified as American Indian/Alaskan Native or Native Hawaiian/Other Pacific Islander, 8.1% identified as Black/African American, and 8.9% identified as Hispanic/Latino/Spanish Origin.[5] Table 1 shows the racial and ethnic breakdown of addiction psychiatry and addiction medicine fellows in 2018, in which all URM populations contributed less than 0.1% to the pool of addiction fellows.[5] In 2019, among practicing psychiatrists in the United States, 69% identified as Caucasian, 9% as Asian/Indian, 7% as Hispanic/Latino, 3% as Black/African American, 3% as Chinese, 2% as Asian (other), and 2% as Filipino.[6] Specifically, among practicing addiction psychiatrists in the United States (shown in Table 2), 62% identify as White, 16.1% Asian, 6.4% Hispanic/Latino, 6.9% Black/African American, and 0.25% Native American/Alaskan.

This lack of racial and ethnic diversity also extends into the research arena, where members of URM groups are vastly underrepresented among researchers funded by the National Institute of Health (NIH). For example, Black/African Americans, Hispanics/Latinos, and Native Americans comprise 30% of the United States population; however, in 2010 these groups received very little funding for addiction research from the National Institute on Drug Abuse (NIDA); where 2% were Black/African American, 4% Hispanic, and less than 1% Native American.[7] The implications of these disproportionate funding portfolios are significant with potentially far-reaching consequences since researchers from racial and ethnic URM backgrounds are more likely to pursue and conduct research that directly impacts URM communities. The "Building Diversity in Addiction Research" section of this article provides a brief discussion of an NIDA-funded programming that is committed to improving the number of addiction researchers from URM backgrounds.[7]

DEI AND HEALTH OUTCOMES: DECONSTRUCTING GAPS IN ADDICTION TREATMENT

Improving and managing DEI efforts is imperative in medicine, as this has been empirically shown to improve health outcomes among URM communities.[1,2,8] A prime

TABLE 2. Race/ethnicity profile of practicing addiction psychiatrists as of January 2020

Ethnicity	Addiction psychiatrists, *N* (%)
White non-Hispanic	992 (62.0)
Asian	258 (16.1)
Hispanic/Latino	102 (6.4)
Black/African American	110 (6.9)
Native American/Alaskan	4 (0.25)
Other	130 (8.1)

Source: American Academy of Addiction Psychiatrists (AAAP), personal communication (based on information provided by 1599 out of 1800 AAAP members).

example of this is the work by Venner et al at the University of New Mexico. Applying a culturally appropriate lens to evidence-based interventions such as Motivational Interviewing, this group has improved accessibility and acceptability of medication for addiction treatment (MAT) for addressing the disproportionate impact of substance use related health disparities in American Indian/Alaska Natives.[9,10] Further, within the ongoing opioid crisis, there continues to be decreased initiation and engagement of Black, Latinx, and Native American populations in medication treatment for opioid use disorder (MOUD), while all of these groups have increasing rates of opioid overdose deaths.[11] In this context, DEI efforts are crucial in understanding how racial and ethnic URM groups are systematically excluded from the existing treatment options, and what changes can be made to repair the lack of attention given to URM communities deserving culturally affirming addiction treatment. Lagisetty[12] demonstrated that those who accessed MOUD were limited to individuals with higher income and in predominantly White communities. Racial and ethnic URM communities with OUD continue to be excluded from evidenced-based treatments, despite having access to care through health insurance.[12] This draws attention to a greater question of why racial and ethnic URM groups are not being adequately served by the existing addiction treatment system. DEI efforts alone will not suffice, but DEI will surely create the existing workforce needed to tackle these complex issues like institutionalized racism manifesting as structural vulnerability, socioeconomic and political exclusion, and attrition of racial and ethnic URM providers and researchers.

BUILDING DIVERSITY IN ADDICTION RESEARCH

It is imperative to focus on efforts to increase the training, recruitment, and development of racial and ethnic URM providers and researchers within addiction. One strategy is through direct programming to support racial and ethnic URM individuals who have already identified an interest in the field. Recognizing and Eliminating disparities in Addiction through Culturally informed Healthcare (REACH) is an educational 5-year training grant funded by the Substance Abuse and Mental Health Administration to the American Academy of Addiction Psychiatry. This REACH grant has two main goals: (a) it aims to increase the number of addiction specialists adequately trained to work with URM patients who have substance use disorders, and (2) to increase the overall number of URM addiction specialists in the Addiction Psychiatry/Addiction Medicine workforce. In the first year, REACH recruited 19 scholars comprised of 7 fellows and 12 trainees (ie, a combination of medical students, residents, and advanced health professional students). All of them completed a 1-week intensive course and received 37.5 hours of in-person training at Yale University School of Medicine, which focused on a core curriculum of providing culturally informed addiction treatment and important considerations therein. Following the 1-week intensive course, REACH scholars conducted a scholarly project aimed at improving health outcomes for racial and ethnic URM with SUD and participated in continuing medical education through 1-hour monthly training webinars, for a total of 11 webinars over the course of the year. See Table 3 for a list of the webinars.

The Learning for Early Careers in Addiction and Diversity (LEAD) training program was developed to increase the number of researchers from racial and ethnic minority backgrounds and to support efforts in receiving funding from the NIH, to become independent scientists.[7] The LEAD Program is embedded within a community of treatment researchers and community-based service providers across the United States drawn from the larger NIDA Clinical Trials Network (CTN). These providers are committed to creating new treatment options and optimizing evidence-based addiction treatment in community-level clinical practice. The LEAD Program uses a team-mentoring approach in which every LEAD scholar works with three types of mentors: (a) a CTN primary mentor from anywhere in the United States, (b) a local University of California San Francisco (UCSF) mentor through a program held each summer, and (c) a nationally regarded advisor from a racial

TABLE 3. Schedule and topics of REACH webinars for the year 2019-2020

Month	Webinar topic	Speaker
August	How to Conduct a "Grey (unpublished) Literature" Search	Melissa Funaro and Kenya Flash, Yale
September	Social Media Advocacy	Dr Michael Sinha, Harvard
October	Harm Reduction	Dr Kim Sue, Harm Reduction Coalition, NYC
November	Qualitative Research Method	Dr Emily Arnold, UCSF
December	Social Medicine	Dr Ruth Shim, UCSD
January	Implicit Bias	Dr Lilanthi Balasuriya, Yale
February	Self-Care and Provide Wellness	Dr Jennifer Best, University of Washington
March	How to be a Change Agent	Dr José A. Bauermeister, UPenn
April	Trauma-Informed Care	Rosalind De Lisser, NP, UCSF
May	Late Breaking Research Programs	Dr Latrice Montgomery, University of Cincinnati
June	Bio/Psycho/Socio/Spiritual/Cultural Formulation	Dr Yusuf Ransome, Yale

or ethnic URM background.[7] The LEAD training program includes a funded 4-week intensive program at UCSF each summer, where scholars have the ability to network with other racial and ethnic URM researchers, and also to participate in grant writing and manuscript development workshops to help obtain grant funding.[7]

Beyond DEI educational and research programming another important strategy to increase the number of racial and ethnic minorities in addiction is the deliberate recruitment and outreach to institutions with substantially higher racial and ethnic URM populations. These include connections with Historically Black Colleges and Universities (HBCUs) in the United States, which include Meharry Medical College, Morehouse School of Medicine, Howard University School of Medicine, and Charles R. Drew University of Medicine. The majority of physicians in the United States who identify as Black/African American, have attended an HBCU either for undergraduate or graduate training. Another effective strategy is recruiting scholars from geographic areas with high racial and ethnic URM populations. These include places like New Mexico, Texas, California, Nevada, Utah, and Puerto Rico, which are all states or a territory with high concentrations of individuals of Hispanic or Latino origin. Other places can specifically recruit Hawaiian/Pacific Islander populations including Hawaii, California, Washington, Texas, New York, Florida, Utah, Nevada, Oregon, and Arizona. Places to recruit Black/African American populations include Maryland, Virginia, Louisiana, Alabama, Georgia, Michigan, and the District of Columbia. Finally, places to recruit Native American populations include South Dakota, New York, Alaska, Washington, Texas, North Carolina, New Mexico, and Arizona.

Other considerations beyond geography include financial considerations and culturally progressive environments that can intentionally support racial and ethnic URM trainees. It is important to think comprehensively about all the factors that can unintentionally favor the majority culture. Therefore, a deliberate focus on ways to eliminate barriers that can prevent people from racial and ethnic URM communities from accessing and pursuing further training in addiction is paramount. One idea is to purposefully create scholarships or develop systems where people can interview for positions remotely, which removes the weight of travel-related expenses. To promote inclusion, programs could also purposefully incorporate an antiracism framework in all areas of teaching, training, research, and work. Deliberate mentorship and support can also help many racial and ethnic URM researchers and providers cope with the psychological stress of living and performing in predominately White environments. Many White colleagues fail to realize that working within a majority context can feel particularly isolating and distressing for some minorities.

Another very important, yet rarely appreciated and often overlooked factor, is the rich and diverse set of experiences researchers from racial and URM backgrounds can add to the understanding of addiction and functioning. For example, as famed neuroscientist Carl Hart posited in his book *High Price*,[13] problematic substance use can be linked to a lack of access to alternate pathways to success, and not from a sense of moral inaptitude. Dr Hart goes on to describe that his limited use of cocaine and his current success are deeply connected to the opportunities afforded him. Otherwise, he may have seen a life filled with cocaine as a viable option. This deeper lens for nuance and for discovering who succeeds is seen again in the work of Dr Blacksher,[14] who wrote about the moral self and "feeling poor in the midst of poverty." Here, Dr Blacksher[14] discusses poignantly the damaging effects poverty can have on ego strength, thus serving as an unconscious or perceived barrier to success. The intimate understanding of these often varying perspectives of racial and ethnic minority researchers can provide a different lens to view the meaning and interpretation of addiction, which may be overlooked or not readily understood by White researchers.

DIVERSITY, INCLUSION, AND EQUITY METRICS

Racial and ethnic diversity, equity, and inclusion is a dynamic, deliberative, and ongoing process, rather than a static utopian endpoint. As such, developing specific metrics geared toward identifying, measuring, and tracking progress is the key. In healthcare, the process of developing these benchmarks is nuanced and directly affects patient health outcomes. Ferdman[3] asserts that organizations must have a "clear approach to inclusion which is translated into specific strategies, policies, and practices that can be observed and assessed." One such approach, is to develop Specific, Measurable, Achievable, Realistic, and Time-bound (SMART) goals[15] that are periodically reviewed with leadership. The development of how to track progress of these SMART goals must include systematic engagement of existing racial and ethnic URM providers and researchers with lived experience in being marginalized and minoritized. Collaborations with these important stakeholders have the potential to yield culturally sensitive systems that can better inform benchmarks and evaluation tools conducive to increased URM representation. Two examples of DEI benchmarks are (a) deliberate reporting and tracking of the recruitment, matriculation, and retention rates of racial and ethnic URM addiction providers, and (b) collection of data through exit interviews. Jointly, these benchmarks provide a framework for elucidating the reasons why racial and ethnic URM providers or researchers have left, are planning to leave, or feel isolated within an institution or organization. The Inclusion Assessment Matrix developed by Ferdman,[3] may prove useful as a DEI metric, since it involves the identification of salient dimensions of inclusion, which can help an organization to personalize and define the elements necessary to promote equity and inclusion across relevant systems or functions of an organization.

DISCUSSION

An addiction workforce that delivers care or conducts research must operate within a culturally informed framework, focused on diversity, equity, and inclusion. The urgency in which action must occur is captured in the current dismal state of DEI in medicine. This sentiment is echoed in a recent report by the AAMC, according to which, progress remains minimal and inequitable, despite over a decade of efforts to improve physician workforce diversity.[5] This apparent paradox underscores the need for a shift from a diversity-only focus to one that equally implements all arms of the triad: diversity, equity, and inclusion. Only then can we truly expect to see impactful, long-lasting change.

Organizations and institutions must understand the need to foster a sense of belonging, where value and meaning is placed on the point of view garnered by a more diverse group, not simply a select few. The understanding and operationalization of the concepts discussed have structural implications, as recruiting and developing a workforce of racially, ethnically, and linguistically matched individuals will translate into a higher likelihood of culturally informed treatment approaches and research discoveries.[2] A more racially and ethnically matched workforce are not only more likely to work and conduct research pertaining to URM populations, but can help to minimize disparities, while also designing and delivering culturally targeted preventative programming.[1,2]

In summary, diversity, equity, and inclusion can make a lasting impact in three areas. (a) DEI can improve the deliberate recruitment of providers and researchers from racial and ethnic URM backgrounds. (b) DEI can improve initiation and retention rates of people accessing addiction treatment from racial and ethnic URM populations. (c) DEI can improve treatment adherence, given people from URM backgrounds express a higher satisfaction with addiction care provided by racial and ethnic URM providers. However, even though DEI efforts are necessary to promote a more heterogeneous workforce, which is representative of all people, this approach will not be sufficient to eliminate health disparities in addiction. Further research and more attention must be devoted to the contribution of racism and vulnerabilities in the social determinants of health as significant contributors to the quality and timeliness of treatment, and to access clinical trials of new treatments. DEI within addiction must, therefore, continue to promote equitable inclusion and representation from all populations to ensure that effective solutions exist and are accessible for all, not just a selected few.

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Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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