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Résumé de l'article

Les personnes racialisées subissent des dommages excessifs et évitables liés à la consommation de substances, ce qui soulève des questions sur la manière dont la justice doit être recherchée par le biais des politiques de santé. Cette étude de cas vise à montrer comment les perspectives bioéthiques peuvent contribuer à éclairer les approches de la justice raciale dans la prise de décision en matière de politique de santé publique concernant la consommation de substances psychoactives.

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ÉTUDE DE CAS / CASE STUDY

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Résumé
Les personnes racialisées subissent des dommages excessifs et évitables liés à la consommation de substances, ce qui soulève des questions sur la manière dont la justice doit être recherchée par le biais des politiques de santé. Cette étude de cas vise à montrer comment les perspectives bioéthiques peuvent contribuer à éclairer les approches de la justice raciale dans la prise de décision en matière de politique de santé publique concernant la consommation de substances psychoactives.

Mots-clés
analgésiques, opioïdes, benzodiazépines, méthamphétamine, réduction des méfaits, racisme, antiracisme, éthique, équité en matière de santé

Abstract
Racialized people experience excess and preventable harm from substance use, raising questions about how justice ought to be pursued via health policy. This case study is intended to surface how bioethical perspectives may contribute to informing approaches to racial justice in public health policy decision-making about substance use.

Keywords
analgesics, opioid, benzodiazepines, methamphetamine, harm reduction, racism, antiracism, ethics, health equity

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INTRODUCTION

Substance use is a public health crisis in Canada (1); and racism is a key factor shaping how racialized people experience the harms of substance use (2). Within and outside of health care, racism is deeply embedded in the design and implementation of laws, policies, practices, and norms related to substance use (institutional racism) (3) and how racialized people who use substances are treated by service providers (interpersonal racism) (3). Racism leads to disparities in morbidity and mortality and social and economic costs that constrain the health and well-being of racialized people (4). In the context of substance use, racism causes Black and Indigenous people to be more likely to be blamed, arrested, and imprisoned for substance use and to suffer fatal and non-fatal overdose compared to White people who use substances (2,5-7). One of the locations where racism occurs is in harm reduction and treatment services, which are a main source of care for people who use substances. Harm reduction services have not been equitably accessible for racialized groups and these services have lacked cultural safety (8,9). This contributes to racialized groups experiencing high rates of morbidity and mortality from substance use.

Previous work has stated the need for antiracist and culturally responsive harm reduction and treatment services that centre and respond to the lived experiences, needs, social contexts, and values of racialized groups (8,9). Bioethics research and practice have contributed significantly to debates about harm reduction and the decisions of policymakers to implement supervised consumption sites as a matter of health equity; however, relatively less attention has been given to racism (10). The urgency of a bioethical perspective is magnified in the current polysubstance era, where combinations of opioids and other synthetic substances further increase the risk of death compared to the use of opioids (11) and are poised to deepen existing patterns of harm along racialized lines.

Substance use has been defined as the use and bodily absorption of selected substances that may lead to dependence and other harmful effects (12). Substance use continues to accelerate in Canada (13), transitioning from a crisis of overdose and death due to opioids only, to a crisis of even higher risks of overdose and death due to combined uses of synthetic opioids with stimulants and benzodiazipines (11). In this current polysubstance era, people who use substances include growing numbers of diverse racialized people. Treatment and harm reduction services are key for mitigating the health effects of substance use but may be of limited effectiveness for polysubstance use since they were developed for opioids only (11).

This case is an invitation to engage with the question of how public health policy ought to approach substance use in racialized communities in Canada in the current polysubstance era. It was developed for teaching in a graduate course on racism, intersectionality, and health equity in a Canadian school of public health (MP). It was informed by published evidence about substance use patterns and services in Canada, our identities and experiences as members of racialized communities, and our background in public health ethics and policy research (MP) and providing substance use care oriented to the needs of Indigenous communities (CM).

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CASE

Opioid use is a priority public health issue in a mid-sized Canadian city rapidly growing in population size and sociodemographic diversity. The city's public health unit operates one supervised consumption site located where opioid use is concentrated. Service users do not need to provide health insurance or personal identification to access free treatment and harm reduction services at this site.

To help inform the renewal of federal and provincial funding for the site, the city's public health unit conducted a quantitative study of opioid overdose and a qualitative study of emerging issues in the city. Key findings were that incidence rates of opioid overdose were increasing overall with the highest rates found among males employed in high-income construction work. There were no available quantitative data by ethnicity. However, in the qualitative study, supervised consumption site service providers reported a surge in polysubstance use, including among racialized young men who are newcomers and international students. Service providers also reported that these sites are beyond capacity, ill-equipped to treat and reduce the harms of polysubstance use, and that there is an urgent need for epidemiologic evidence and services tailored to racialized communities (14).

Based on this study, the city's public health unit wants to request renewed funding for the existing supervised consumption site with additional funding to develop, implement, and evaluate antiracist and culturally responsive polysubstance treatment and harm reduction services. However, media reports have found a low level of public support for renewed funding. There is also public debate about whether antiracist and culturally adapted services are warranted and the need for funding for competing health issues affecting racialized communities in the city.

ETHICAL ANALYSIS

This case study presents a familiar ethical dilemma in public health, which is how to allocate limited public resources to improve the health of populations. At a coarse level, there is the question of whether to allocate resources toward substance use treatment and harm reduction, or other health issues that are important according to racialized people in this jurisdiction – health issues that are likely less stigmatized, well-documented in research, and more prevalent than substance use. At a more granular level, that is somewhat implicit in this case study, is the consideration of all potential pathways for public health to address polysubstance use in racialized communities; specifically, how much resources to allocate to social and political determinants versus treatment and harm reduction services. At an even more refined level – and what distinguishes this case study as a justice issue – is the question of whether antiracist and culturally adapted services are warranted. The key stakeholders in this case seem to agree that this is a resource allocation issue but have competing conceptions about which specific resource allocation issue is at stake and a lack of consensus about the justice dimension. Thus, the public health unit has two tasks: first, to justify their reasoning for their request to allocate resources for more treatment and harm reduction services versus other health issues and the determinants of polysubstance use, overdose, and mortality in racialized communities, and second, to justify why investment in antiracist and culturally responsive approaches is needed.

DISCUSSION QUESTIONS

1. Antiracist and culturally responsive care require institutions and service providers to effectively address power imbalances and provide safe and respectful care. What might this look like for racialized people in harm reduction and treatment services, and who should decide?
2. Racism intersects with other forms of discrimination salient to polysubstance use, such as gender discrimination (15). How should intersectionality be considered when developing and implementing polysubstance treatment and harm reduction services for racialized communities?
3. There is conflicting evidence about whether culturally and ethnically concordant health care promotes racial justice. What is the premise of culturally and ethnically concordant care, and should it be applied in this situation?
4. Racial justice is often challenged by the lack of health evidence for specific racialized and ethnic groups in Canada. How do normative assessments about the value of quantitative and qualitative research influence public health policymaking about polysubstance use? What should be done by public health practitioners to uphold epistemic justice for racialized communities in policy decision-making?

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