Stigma and Health

Intersectional Stigma as a Fundamental Cause of Health Disparities: A Case Study of How Drug Use Stigma Intersecting With Racism and Xenophobia Creates Health Inequities for Black and Hispanic Persons Who Use Drugs Over Time

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Abstract

Recent evidence points to racial and ethnic disparities in drug-related deaths and health conditions. Informed by stigma, intersectionality, intersectional stigma, and fundamental cause theories, we aimed to explore whether intersectional stigma was a fundamental cause of health. We document key events and policies over time and find that when progress is made new mechanisms emerge that negatively affect health outcomes for Black and Hispanic persons. We then focus on intersectional stigma targeting Black and Hispanic persons who use drugs. We document that when a person, or group of people, occupy multiple stigmatized identities the processes of stigmatization and scapegoating are particularly persistent and pernicious since people and groups can be stigmatized and scapegoated on varying intersections. We propose that an intersectional stigma framework allows for a better understanding of observed patterns over time, thereby providing a better guide for policies and interventions designed to reduce disparities. As a framework, intersectional stigma aims to recognize that when different sources of stigma collide, a new set of circumstances is created for those who reside in the intersection. We conclude that intersectional stigma is a fundamental cause of health inequities and provide policy recommendations aimed at dismantling intersectional stigma processes and mitigating the effects of intersectional stigmas to ultimately promote better health outcomes for Black and Hispanic persons who use drugs.

Key words (up to 5): race and ethnicity, drug use, intersectional stigma, fundamental cause

"One can study the elements of an oppressive structure with great care and good will without seeing the structure as a whole, and hence without seeing or being able to understand that one is looking at a cage and that there are people there who are caged, whose motion and mobility are restricted, whose lives are shaped and reduced." – Marilyn Frye (1983)

Racial and ethnic disparities in drug-related deaths and health conditions point to a stark set of circumstances that demand a unique lens for understanding and addressing these disparities. We propose that an intersectional stigma framework allows for a better understanding of patterned health disparities over time, thereby providing a better guide for policies and interventions designed to reduce disparities. As a framework, intersectional stigma aims to recognize that when different sources of stigma collide, a new set of circumstances is created for those who reside in the intersection (Berger, 2010).

The complex set of circumstances that have transpired as the opioid and stimulant epidemics have unfolded require multiple lenses to push toward a more complete understanding of how drug use, race, and ethnicity interact to create unique experiences for Black and Hispanic[1] persons who use drugs. One prominent element amidst the complexity is deeply rooted enduring inequities. To understand these inequities, we propose an intersectional stigma lens that incorporates the following concepts and theories from the social sciences: 1) stigma, 2) intersectionality, 3) intersectional stigma, and 4) fundamental cause theory. We ultimately argue that intersectional stigma is a fundamental cause of health inequities over time.

[1] Most research that we reviewed referred to non-Hispanic Black persons, non-Hispanic white persons, and Hispanic persons and consequently we adopted this categorization ourselves. In doing this the intersection of Black and Hispanic is not explicitly explored – an outcome that should be addressed in future research.

We begin by defining stigma and describe what drug use and racial stigma research has contributed to our understanding of health disparities. We then discuss the importance of intersectionality and intersectional stigma. We follow with a definition of fundamental cause theory and describe why fundamental cause theory is a useful tool for understanding the devastating impacts of stigma and intersectional stigma. After describing the theoretical advantages of combining these concepts, we present a case study of stigma due to race and ethnicity as a fundamental cause.

The examples given elucidate how health disparities are perpetuated over time through changing mechanisms (i.e., pathways to health outcomes such as policies, ideologies, etc.; Hatzenbuehler et al., 2013) that disadvantage Black and Hispanic persons. We then apply an intersectional stigma lens, using the four tenets of fundamental cause theory. We discuss how intersectional stigma due to drug use, race, and ethnicity contributes to inequities for Black and Hispanic persons who use drugs over time. Although intersectional stigma affects many different racial and ethnic minority groups, we focus on Black and Hispanic populations in order to provide concrete examples and delve into this issue in depth.

Key to the intersectional stigma framework is the notion that when people occupy more than one stigmatized status, they can be scapegoated on either one or all of these statuses, and societal mechanisms can be employed similarly; that is, drug use stigma, race and ethnicity stigma, or some combination can be employed at any time. Life at the intersection is a unique oppression that is reinforced and reproduced via flexible mechanisms that change over time, and thus, intersectional stigma is a fundamental cause.

Stigma

The construct of stigma was elaborated by Erving Goffman, who defined stigma as an attribute (physical marker on the body), behavior, or a reputation that placed a person outside of the "norm" in society. Goffman's conception of stigma focused mostly on stigma in interpersonal contexts, however, there were some notions of how larger organizations and structures also played a role (Goffman, 2009). Since then, researchers have expanded the stigma construct to macrosocial forms of stigma which have been termed structural stigma (Hatzenbuehler & Link, 2014). Structural stigma has its origins in the related concept of institutional racism (Carmichael et al., 1992; Feagin et al., 2020; Williams & Williams-Morris, 2000), which recognizes the important roles that institutions (e.g., governments) and cultural ideologies play in perpetuating racism and disadvantaging people of color. We take a "systems approach," which accounts for stigma processes at the micro, meso, and macro level and how systems of oppression are interconnected (Ezell, Ompad, & Walters, 2021; Ezell, Walters, Friedman, et al., 2021;Pescosolido & Martin, 2015).

Stigma upholds systems of oppression by "keeping people down, in and/or away" (Phelan et al., 2008). "Keeping people down" refers to systems of exploitation and domination, and racism is an example of "keeping people down." The US economy thrives because of unpaid, or low paid, labor of Black and Hispanic people (Robinson, 2020), and such racial capitalism leads to health inequities (Laster Pirtle, 2020). Stigma reinforces economically-driven societal hierarchies, creates an "us" versus "them" mentality (Link & Phelan, 2001), and facilitates divide-and-rule politics (Friedman, Williams, Guarino et al., 2021; Friedman et al., 2022). In many cases, this allows for those in power to increase their profit margins (Keefe, 2021).

"Keeping people in" refers to stigma that functions to advance cultural dictates and enforce social norms. Drug use stigma is an example of "keeping people in" (Phelan et al., 2008). Cultural dominance upholds systems of oppression by privileging some behaviors, tastes, etc. and penalizes others, and sometimes these larger societal dictates are believed to be just (Bourdieu, 2011; Gramsci, 2011). Lastly, "keeping people away" refers to stigma that functions to promote disease avoidance. Furthermore, stigma processes are supported by scapegoating. People in power are able to maintain the status quo by blaming individuals and groups for their suffering (Gilmore & Somerville, 1994), thereby upholding systems of oppression that keep people "down, in, and/or away."

Drug Use, Racism, and Social Determinants of Health

Drug Use

Rarely has research on drug use stigma applied an intersectional stigma lens, which we argue is necessary to capture the complexities of stigma experiences and outcomes (Walters, Frank, Van Ham et al., 2021). Drug use research has focused on associations with poor health outcomes (Ahern et al., 2007; Latkin et al., 2013), differences in stigma by drug type (Ahern et al., 2007; Luoma et al., 2007), and how stigma experiences structure people's lives and access to resources, such as employment (Richardson et al., 2019), housing (Arum et al., 2021), and food (Schmitz et al., 2016). Research has also explored associations between stigma and health "risks", such as increased syringe and injection equipment sharing and condomless sex (Flom et al., 2001; Surratt et al., 2021).

Drug use stigma can lead to perceptions of persons who use drugs as dangerous, and as a result people may want to distance themselves from people who use drugs (Ledford et al., 2021).

Compared to other forms of stigma, the stigma of drug use has been found to be greater than stigma against smoking, obesity, or mental illness (Barry et al., 2014; Phillips & Shaw, 2013). This is particularly challenging for people who use crack cocaine and/or inject drugs as those forms of drug use are more stigmatized than other groups who use drugs (Ahern et al., 2007; Luoma et al., 2007).

Drug use research has also explored stigma in healthcare settings, which not only impacts health outcomes, but also deters from future healthcare use (Ellis et al., 2020; Smith et al., 2016). As such, people who use drugs are disproportionately affected by many life-threatening diseases that are amendable to health intervention such as hepatitis and human immunodeficiency virus (HIV) (Hagan & Jarlais, 2000), endocarditis (Wurcel et al., 2016), diabetes (Rouhani et al., 2021), and cancer (Smith et al., 2015), to name a few. More so, people who are in drug treatment continue to carry the mark of stigma, which impacts health outcomes even after cessation of active illicit drug use (Earnshaw et al., 2013).

As noted above, drug use stigma serves the societal purpose of enforcing social norms, by attempting to extract conformity to norms surrounding "appropriate" drug use and labeling those who do not conform as deviant or immoral (Phelan et al., 2008). It can also serve as a method of oppression, "keeping down" those who do not meet social norms (Phelan et al., 2008). For example, many forms of drug use are criminalized and once a person enters the criminal legal system and obtains a criminal record their job opportunities decrease. Persons with a criminal record usually enter low paid jobs that can be seen as dehumanizing (Slade & Alleyne, 2021). Drug use stigma is a means to socially and economically disadvantage people and groups who do not conform.

When Racism intersects with Drug Use

According to 2019 data from the National Survey on Drug Use and Health, similar percentages of white[2] (21.7%), Black (21.9%), and Hispanic (19.1%) individuals reported past-year drug use (in the civilian, non-institutionalized population ages 12 and older; Substance Abuse and Mental Health Services Administration, n.d.). Despite such similar rates of drug use overall, racial/ethnic groups differ in terms of risk factors for drug use disorders (Molina et al., 2012), use of specific drug types (Kacha-Ochana et al., 2022; Schuler, Schell, et al., 2021), trajectories of use (Chen & Jacobson, 2012; Vasilenko et al., 2017), and entry points for treatment and types of services received (Mulvaney-Day et al., 2012; Perron et al., 2009). Many of these differences may be linked to differential stigmatization of drug use by race. For example, racial differences in the types of drugs most frequently used represent a symptom of racial stigma, as medical biases result in greater availability of prescription opioids for white than Black or Hispanic individuals (Meghani et al., 2012). Racial drug use stigma further compounds as media avenues depict "sympathetic" narratives of white prescription opioid use, contrasted with "criminalized" Black or Hispanic drug use (Netherland & Hansen, 2016, p. 664). Results from experimental research indicate stronger implicit biases for the punishment of Hispanic, compared to white, individuals who inject drugs (Kulesza et al., 2016).

In addition to stigma attributed to drug use (Latkin et al., 2013), Black and Hispanic people who use drugs experience stigma attributed to race and ethnicity (Strathdee et al., 2020). This includes both interpersonal and structural stigmas (e.g., racial segregation, policing, and

[2] Given our intention to center anti-racism, we capitalize Black and Hispanic but not white. Please see the following articles for greater discussion on this topic. Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford law review*, 1241-1299.; Dumas, M. J. (2016). Against the Dark: Antiblackness in Education Policy and Discourse. *Theory Into Practice*, *55*(1), 11-19. https://doi.org/10.1080/00405841.2016.1116852; Pérez Huber, L. (2010). Using Latina/o Critical Race Theory (LatCrit) and racist nativism to explore intersectionality in the educational experiences of undocumented Chicana college students. *Educational Foundations*, *24*, 77-96.

criminal legal involvement) (Frankenfeld & Leslie, 2019; Kerr & Jackson, 2016; Williams & Collins, 2002), which limit access to resources that can be harnessed for better health outcomes.

For example, Black people identified as having a criminal legal history are less likely to receive call-backs for job announcements compared to white people with a criminal legal history (Pager, 2003). Low paid jobs that Black and Hispanic people are pushed into are essential for society to function and therefore benefit others, including the profits of those in power. Furthermore, incarcerated people's labor is often exploited to provide goods and services for the larger society. For example, incarcerated people engage in agricultural work, manufacturing, and firefighting, and may receive less than minimum wage for their efforts (DelSesto, 2021).

Of importance for this study is how drug use and race and ethnicity intersect, and how the criminal legal system is used as a mechanism to "keep people down." Exploring these intersections is necessary for understanding how and why Black and Hispanic people who use drugs have different experiences and health outcomes when compared to white people.

Intersectionality and Developing an Intersectional Stigma Framework

The concept of intersectionality was developed in revolutionary struggles led by women of color. For example, Vietnamese women freedom fighters laid forth the idea of "triple jeopardy" to describe the interlocking oppression caused by systems of sexism, racism, and capitalism (Aguilar, 2012). In 1969, Frances M. Beal published a pamphlet outlining the intersecting oppressions experienced by "Third World Women" (Beal, 2008) and in 1977 the Combahee River Collective Statement noted that there are systems of oppression that interlock (Combahee River Collective, 1983). In 1989 Kimberlé Crenshaw coined the term

intersectionality to explain how Black women's experiences differed "because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated" (Crenshaw, 1989, p. 140). Then, in 2010, Michele Tracey Berger coined the term "intersectional stigma" in the book Workable Sisterhood, which explored the lives of HIV-positive women of color (Berger, 2010).

Intersectional Stigma

Intersectional stigma is the "total synchronistic influence of various forms of oppression which combine and overlap to form a *distinct positionality*" (Berger, 2010, p. 4). Although we may think of intersection stigma at the individual level, Berger did not see this in individualistic terms, rather like Crenshaw (1989), Berger (2010) referred to interlocking structures such as race, class, and gender. We follow this tradition, and consistent with Bowleg (2022), we agree it is "the historical legacy of interlocking structural oppression based on those intersections" that cause health inequities (Bowleg, 2022). Thus, when we refer to intersectional stigma, we account for power relations, similar to Link and Phelan (2001).

Intersectional stigma is multidimensional, multilevel, and multidirectional (Earnshaw et al., 2022). Intersectional stigma is *multidimensional* in that it includes varying forms of oppressions, such as racism, xenophobia, and drug use stigma. It is *multilevel* in that it operates at structural levels, as described above, as well as community, interpersonal, and individual levels. Finally, intersectional stigma is *multidirectional*. It involves reciprocal influence across levels in that stigma operating at one level reinforces and shapes stigma at other levels.

Intersectional stigma allows us to identify qualitative differences between groups within a larger stigmatized group and recognize how within stigmatized groups other stigmas may exist that create unique experiences (Berger, 2022).

Key to our argument is that when a person, or group of people, occupy multiple stigmatized statuses the processes of stigmatization and scapegoating are particularly persistent and pernicious since people and groups can be stigmatized and scapegoated based on varying intersections. Furthermore, experiences and outcomes differ at varying intersections (Crenshaw, 1991). We focus on stigma due to drug use and race and ethnicity to demonstrate how intersectional stigma operates as a fundamental cause.

Past research focusing on drug use stigma has demonstrated inequities in health supports and healthcare (Frank et al., 2021; Jaiswal et al., 2021; Muncan et al., 2020), social and behavioral conditions that impact risk for infectious diseases such as HIV and hepatitis C (Walters, Braksmajer, Coston et al., 2020; Walters, Platt, Anakaraonye et al., 2021; Walters et al., 2018), and ultimately negative mental and physical health outcomes (Ahern et al., 2007; Latkin et al., 2019). Research has identified the racialized aspect of the War on Drugs, and how drug policies have disproportionately affected communities of color (Alexander, 2020). We build on these studies by exploring how the intersections of drug use and race and ethnicity stigmas allow for communities of color, using Black and Hispanic communities as our example, to be scapegoated and stigmatized at higher rates than white communities. Stigma experiences at this intersection are not additive, and they reflect social inequities and power systems in society (Bowleg, 2008; Hill Collins, 2001).

Fundamental Cause Theory

Intersectional stigma is a fundamental cause of health. To elucidate how stigma and intersectional stigma operate and disadvantage populations via limited opportunities and resources, we turn to fundamental cause theory. Fundamental causes have four central features. They (1) influence multiple disease outcomes through (2) multiple risk factors, (3) involve access to resources since resources determine a person's ability to manage their health, and (4) reproduce over time via the replacement of intervening mechanisms (Phelan & Link, 2013). It has been argued that stigma and racism are fundamental causes (Link et al., 2017). We add to this body of literature by integrating an intersectional framework and ultimately arguing that intersectional stigma is a fundamental cause of health.

We first begin by using stigma due to race and ethnicity as an example of a fundamental cause. We describe how racism and anti-immigration sentiments are fundamental causes of inequities for Black and Hispanic persons in the US (Phelan & Link, 2015). A key feature of fundamental cause theory is the replacement of mechanisms linking a fundamental cause to disease outcomes. It follows that if racism and anti-immigration stigmatization are fundamental causes, we should see a historical replacement of mechanisms over time.

Mechanisms continue to change because of inequities, which allow people who occupy higher power positions to use flexible resources (e.g., money, cultural and social capital) to obtain better health outcomes, while these resources are not available to other groups (Clouston & Link, 2021). Guided by this notion, we explored historic events and policies to see whether stigma mechanisms changed over time targeting Black persons, Hispanic persons, and at the intersection of race, ethnicity, and drug use. Our review suggests that, indeed, mechanisms changed over time. Figures 1 and 2 display key events in the US that have affected Black and

Hispanic persons, respectively. They show that when progress is made, new stigma mechanisms emerge, keeping Black and Hispanic persons "down, in, or away" (Phelan et al., 2008).

When we apply an intersectional stigma lens (Figure 3) we discover how mechanisms become more flexible, making it easier to stigmatize people living in the intersections and further exacerbating health disparities. These timelines are not meant to be exhaustive but instead focus on key events and legislation (i.e., mechanisms) in the areas of housing and education as these play a critical role in access to resources and the development of generational wealth, which are impactful for individual and community health outcomes (Phelan & Link, 2005; Williams & Collins, 2001).

Key to the intersectional stigma framework is that one stigma process, and the associated systems of oppression, are reinforced by others when people and groups are living in the intersection. Fundamental cause theory has come to conceptualize the use of stigma by powerful groups as a flexible means to obtain desired ends. That is, if powerful groups are blocked in their goal of keeping others "down, in, or away," they replace mechanisms to find another way to achieve their goal (Link & Phelan, 2001). Intersectional stigma allows us to see that the powerful can use multiple intersecting stigmas in this process, thus increasing the already "many ways in which such discrimination can be achieved" (Link & Phelan, 2001). Therefore, the intersection(s) allow for even more flexible resources and the intersections reinforce each other (see Figure 3). These resources and mechanisms can be strategically deployed to achieve desired ends of the powerful. Fundamental cause theory points to the construction of intersectional stigma in the actions of those who benefit by stigmatizing others.

Racial and Ethnic Stigmatization Leads to Mechanism Replacement Across Time and Place

Before incorporating an intersectional lens, we focus on racial and ethnic stigma, which has had long term and contemporary consequences and has endured through the replacement of mechanisms over time. Black and Hispanic persons in the US have consistently experienced various inequities. Structural racism aimed at Black persons, much of which also impacts Hispanic, Indigenous, and other people of color (Bailey et al., 2017), is at the root of inequities.

In Figure 1 we trace the history of mechanism replacement by showing when one mechanism changes or is abolished new mechanisms emerge to oppress Black people in the US. We begin historically with slavery and show the new mechanisms that merged once slavery was abolished (Feagin & Ducey, 2018). Following legislation such as the Emancipation Proclamation in 1863 (Emancipation Proclamation, 1963), the 14th amendment in 1868 (U.S. Const. amend. XIV), which granted citizenship, and the 15th amendment in 1870 (U.S. Const. amend. XV), which granted Black men the right to vote, oppositional mechanisms arose. The Ku Klux Klan grew in prominence and lynchings increased (Wade, 1998). Racial violence (Tolnay & Beck, 1990), as well as lack of economic opportunities (Fligstein, 2013), sparked the "great migration" of the early 1900's when Black people moved from southern to northern states.

As more rights were afforded to Black people, mechanisms changed that limited resources and excluded Black people from key societal positions. Using housing as an example, the 1930's redlining created situations where Black persons were virtually unable to buy homes, and thus unable to have assets to pass down to future generations (Bailey et al., 2021). The Shelley v. Kraemer (1948) ruling allowed homes to be sold to Black people. Yet, Black people were more likely to pay inflated housing prices (Mehlhorn, 1998; Rothstein, 2017).

Policies focusing on urban renewal used eminent domain laws and allowed for the removal of racial and ethnic minority groups from areas, stripping them from their assets and

paying less than market value for their homes (Carpenter & Ross, 2009; DiMento & Ellis, 2012; Gotham, 2001; Pritchett, 2003). The same year that Brown v. Board of Education (1954) ruled that separate was not equal, Berman v. Parker (1954) ruled urban renewal constitutional. In fact, throughout the civil rights movement while many gains toward equality were made, there were also mechanism changes aimed to oppress Black people. There was increased violence towards Black people and segregation, as white people fled to live in suburbs and Black people became clustered in urban settings (Farley et al., 1978; Gans, 1982). Discriminatory lending, also known as mortgage redlining, became prevalent (Wyly & Holloway, 1999). Experiences such as these have isolated Black persons living in the US, marginalized them economically, and limited employment and educational opportunities (Williams & Collins, 2001). We mention education because quality of education is highly correlated with where someone lives in the US.

Although most research has focused on Black persons, Hispanic persons have also faced discrimination and stigma in housing via these mechanisms (Williams & Collins, 2001; Yinger, 1995). In 1968 the Fair Housing Act banned racial and ethnic discrimination; however, in practice this was rarely enforced. Moreover, the law did not target mortgage lending (Massey, 2015) and racial segregation continued to persist for both Black and Hispanic communities (Rugh & Massey, 2014).

A study exploring housing discrimination between 1989 - 2000 found that Black and Hispanic persons still faced discrimination in renting and purchasing homes (Ross & Turner, 2005). For Hispanic persons who are immigrants, housing opportunities may be even more limited as states have passed anti-illegal immigrant legislation that restricts housing, employment, and other benefits (Allen, 2020; Esses, 2021; Oliveri, 2009), which limit access to resources and create health disparities (Cabral & Cuevas, 2020).

In Figure 2 we historically trace changing stigma mechanisms targeting Hispanic people. For Hispanic people in the US, anti-immigrant stigma and the ties between the criminal and immigration systems perpetuate fear that prevents some undocumented Hispanic people from accessing any health services that are available to them (Martinez et al., 2015). Historically, Hispanic immigrants have been excluded from accessing public services (Faber, 2019) and been deported (Varsanyi, 2020). Laws were passed to ensure that immigrants could not legally be employed (Calavita, 1989). Hispanic persons have also experienced violence (Chiodo, 2013).

As gains were made, such as the DREAM ACT in 2002 which granted legal status to undocumented persons who immigrated as children to the US (Chavez, 2020), we also saw reactive policies to maintain the status quo and keep Hispanic people, especially Hispanic immigrants, socially disenfranchised and inhibited from relocation opportunities. In 2010 the US had the largest immigration detention centers in the world (Hernández, 2006). In 2012 the Deferred Action for Childhood Arrivals (DACA) was passed to temporarily relieve people from deportation. In 2014 DACA was expanded, and the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) was passed (American Immigration Council, 2016). However, in 2017 DAPA was rescinded, a border wall was funded between the US and Mexico, and deportations increased (National Archives, 2017).

In 2020 the COVID-19 pandemic began and as time has gone by disparities in infection and outcomes are increasing. Black and Hispanic persons have experienced higher rates of COVID-19 infection and are more likely to have severe infection and death (Bassett et al., 2020). This is because of living conditions, economic disenfranchisement, and more limited access to resources that promote health, all consequences of the stigma process (Friedman, Williams, Guarino et al., 2021).

COVID-19 is clustering in low socio-economic areas that are more likely to be overcrowded and where higher percentages of Black and Hispanic persons live (Chen & Krieger, 2020). The lower access to resources among Black and Hispanic persons can be attributed to historical processes of stigma that maintain contemporary impact (e.g. housing discrimination, American apartheid, redlining) or remain perpetuated today (e.g. informal discriminatory hiring practices (Petersen et al., 2000) or housing discrimination (Roscigno et al., 2009), as previously described. These are rooted in stigma processes such as racial capitalism (Laster Pirtle, 2020) and structural racism and violence (Bluthenthal, 2021; Reskin, 2012).

These processes have historically limited access to resources for Black and Hispanic persons, exploited their labor, and continue to exploit labor for the economic benefits of a few (Cedric, 2021). Persons who are not documented may face additional challenges related to immigration status. They may lack health insurance and access to healthcare as well as experience language barriers for non-English speakers, which can decrease access to medical services (Cleaveland & Waslin, 2021; Macias Gil et al., 2020).

In this section we have outlined how mechanisms have changed to keep Black and Hispanic people oppressed. These changes were motivated by racial and ethnic stigma, persisted over time, and operate as a fundamental cause of health disparities. Below, we explore how the intersections of race, ethnicity and drug use allow for more flexible mechanisms targeting race, ethnicity, drug use, or some combination.

Intersectional Stigma as a Fundamental Cause: a case study of racial, ethnic, and drug use stigma

Intersectional Stigmas Reduce Access to Resources

The intersectional effect of drug use, race and ethnicity stigma, and how these statuses intersect with larger structures to create oppressions, is better understood, and measured using an intersectional stigma lens. Access to resources, such as money, education, employment, neighborhood options for living, green space, and social capital, are paramount to fundamental cause theory, as these are associated with health outcomes (Link & Phelan, 1995). Those with limited access to resources bear the brunt of diseases and experience poorer health outcomes over time.

Black and Hispanic persons who use drugs experience disproportionate arrest rates and criminal penalties for drug-related charges (Alexander, 2020). This is particularly damaging because criminal legal involvement limits access to resources such as employment opportunities, housing, and public assistance programs, due to stigmatizing policies which render individuals with drug convictions ineligible (Lundgren et al., 2010).

In Figure 3 we trace the criminalization of drugs and show how incarceration due to drug use disproportionately burdened Black and Hispanic persons over time. Drug policies have historically been racist and xenophobic, with the first anti-opium laws targeting Chinese immigrants in 1870 (Musto, 1987). In the 1960s narcotic prescriptions soared among white people (Herzberg, 2017). Since these were legally prescribed, white people who used drugs did not face the threat of incarceration. Then in 1973 Rockefeller laws targeted communities of color and incarcerated people on drug charges. These laws were passed despite the Prettyman commission's recommendation for drug treatment (Musto & Korsmeyer, 2008).

Racial and ethnic disparities in drug treatment (Lagisetty et al., 2019) are of importance to note because access to resources, such as drug treatment, have life and death consequences;

persons who are on medications for opioid use disorder have reduced risk of overdose (Sordo et al., 2017) and infectious diseases, such as HIV and hepatitis C (Corsi et al., 2009; Krebs et al., 2021). Intersectional stigma due to drug use, race, and ethnicity limits access to these medications overall, including limited access while incarcerated for Black and Hispanic persons who use drugs (Brezel et al., 2020).

Intersectional stigma shapes which medications for opioid use disorder are received, if any. Black and Hispanic persons with opioid use disorders are more frequently prescribed methadone, which is administered in highly-monitored and stigmatized settings (Frank et al., 2021), while white or higher-income patients more frequently receive buprenorphine, which is available via a prescription and can be self-administered without direct supervision (Andraka-Christou, 2021). Both national and regional data document greater availability and growth of buprenorphine distribution in high-income areas with primarily white residents (Schuler, Dick, et al., 2021). As indicated in fundamental cause theory, resources are limited for Black and Hispanic persons who use drugs due to the larger systems of discrimination and stigma outlined above.

Intersectional Stigmas Influence Multiple Diseases via Multiple Risk Factors

Diseases often cluster in communities because of fundamental social causes, not because people are more susceptible to multiple diseases biologically. For example, overdose, HCV, and HIV tend to cluster among communities that use drugs (Perlman & Jordan, 2018; Singer & Clair, 2003). Stigmatizing policies that criminalize drug use have made it more challenging for persons who use drugs to access health supports and harm reduction as well as to secure and maintain

stable well-paying jobs, both of which impact health outcomes (Walters, Kral, Lamb et al., 2021).

Black and Hispanic persons who use drugs must contend with intersectional stigma that includes racial and ethnic discrimination as well as drug related discrimination. The intersection of these two statuses is qualitatively different than, for example, people who use drugs who are white. One important disparity to highlight is the criminal legal system, which disproportionately incarcerates Black and Hispanic persons who use drugs (Alexander, 2020; Western, 2006). Incarceration is associated with loss or lack of resources and multiple negative health outcomes as described in the Drug Use, Racism, and Social Determinants of Health section and the resources section above.

COVID-19 infection is yet another disease that is disproportionately affecting marginalized communities, such as persons who use drugs, Black and Hispanic persons, and the intersections of both in the US (Horton, 2020; Wang et al., 2021). Since the pandemic Black and Hispanic persons who use drugs have experienced higher rates of economic instability, COVID-19 infection, and increased mental health conditions (Mistler et al., 2021). COVID-19 has also destabilized housing conditions, particularly among Black and Hispanic persons who faced evictions (Benfer et al., 2021). Homelessness and housing instability has been associated with multiple health outcomes such as COVID-19 (Rozenfeld et al., 2020), HIV (Aidala et al., 2005), HCV (Arum et al., 2021), and overdose (Van Draanen et al., 2020).

Given the higher prevalence of poverty, housing instability, unemployment, and incarceration (Bourgois et al., 2017; Cooper, 2015), Black and Hispanic persons who use drugs are at increased risk for COVID-19 infection (Ralli et al., 2021; Seal, 2020). This includes

increased risk for severe COVID-19 outcomes due to comorbidities, stigma, socio-economic status, and housing insecurity (Jenkins et al., 2020; Walters, Seal, Stopka et al., 2020)).

COVID-19 has disrupted drug markets (Bolinski et al., 2022; Walters et al., 2022), has been associated with increased overdoses (Morin et al., 2021), and altered drug-related and sexual risk behaviors that place people who use drugs at risk for infectious diseases (Stephenson et al., 2020), while simultaneously decreasing access to health services (Strathdee et al., 2006). COVID-19 disruptions may be particularly challenging for Black and Hispanic PWUD, who prior to the pandemic, experienced increases in overdose mortality (Cano, 2021) and higher rates of HIV (Bartholomew et al., 2020; Crepaz et al., 2018), and HCV (Backus et al., 2014).

In line with fundamental cause theory, we have discussed how intersectional stigmas influence multiple diseases via multiple risk factors due to lack of resources afforded to stigmatized populations, and how COVID-19 is becoming another disproportionately distributed disease.

Intersectional Stigmas Contribute to Poor Health Over Time

If intersectional stigma is a fundamental cause, it follows that people who use drugs who are Black and/or Hispanic will experience poor health over time. Drug use and accompanying stigma has been racialized in media narratives and formalized in legal frameworks through disproportionate application of policing, disparate prosecutorial charging, and harsher sentencing of drug laws for racialized communities (Alexander, 2020).

Presentations of early 20th century narcotic uptake (opium, heroin, and marijuana) invoked imagery of non-white groups and the exaggeration of these substances' impact. This, coupled with the suppression of science on health effects of drug use, helped foster public

hysteria (Hari, 2015). Media presentations may have also helped cultivate sentiment translating into some of the earliest narcotic control laws (Rosino & Hughey, 2018). In the late 20th century, newspaper coverage of the crack epidemic included implicit and explicit cues highlighting drug use among people of color and emphasized drug use activity under the specter of a criminal legal frame (McCubbins, 2020).

National and statewide approaches to addressing illicit drug use in the 1980s and 1990s emphasized robust media campaigns (e.g. "Just say no") coupled with policies that incentivized more aggressive policing for drug crimes and harsher penalties for drug possession (Hari, 2015). The most used example of the discrimination inherent in the War on Drugs policies was the differential sentencing of powder cocaine (predominantly used by white persons) to crack (predominantly used by Black persons; Sklansky, 1995).

Figure 3 traces key legislation that criminalized drug use for Black and Hispanic persons and other people of color, while medicalizing it for white people. As legislation passed criminalizing drugs and creating minimum sentences in the 1900s, some people, mostly white middle aged and middle class, were able to access drugs legally by obtaining prescriptions. (Herzberg, 2020). In 1987 the American Medical Association defined addiction as a disease (Nathan et al., 2016). This further widened health disparities between Black and Hispanic versus white people who used drugs. In 1992 legislation that accelerated Food and Drug Administration approval process was passed (Herzberg, 2020) and in 1995 the American Pain Society introduced pain as the fifth vital sign (Morone & Weiner, 2013). With pain being the fifth vital sign doctors were able to prescribe opioids to treat pain. The ability to prescribe coupled with direct-to-consumer marketing in the US contributed to the increase in use of prescription pain medications (Nathan et al., 2016).

Beginning in 1999 rates of opioid overdoses began rising in the United States. This increase was attributed to prescription opioid pain relievers and impacted mostly white individuals who had access to prescribers (Centers for Disease Control & Prevention, 2011; Om, 2018). Given the racial difference in impact, discourse of the modern opioid "crisis" is more likely to highlight white drug use and emphasize the epidemic as a public health concern (McCubbins, 2020), despite the most recent increase in Black and Hispanic overdose deaths. While contemporary media discourse of the War on Drugs most frequently highlights its failures and inability to reduce crime (Rosino & Hughey, 2018), modern media coverage has been criticized on the grounds of continued projection of criminality upon racialized minorities despite the adoption of "color blind" framing (as this approach precludes needed discourse on explicit racism within the criminal legal system; Netherland & Hansen, 2016). The confluence of stigmatizing ideologies at the intersection of drug use and race and ethnicity perpetuated by the media and policies over time has contributed to poor health for Black and Hispanic people who use drugs.

Medical interventions exacerbate inequities: fatal overdose and naloxone as a case study

One key element of fundamental cause theory is that when interventions are created, eventually unequal access to life saving supports will cluster among stigmatized populations. At the intersection of drug use and race and ethnicity, we use overdose as an example. A recent publication analyzed opioid overdose death trends over a 20-year period and found that white individuals had a higher prevalence which continued to increase from 1999-2016 (Furr-Holden et al., 2021). During 1999-2016, in contrast to the white population, the Black population did not

have a statistically significant increase; in 2016-2018 the white population had a statistically significant decrease, while Black overdose deaths accelerated (Furr-Holden et al., 2021).

During 2020, the first year of the COVID-19 pandemic, drug overdose mortality rates in the Non-Hispanic Black population surpassed rates in the Non-Hispanic white population for the first time in the twenty-first century (Friedman, Mann, Hansen et al., 2021). Although the Hispanic population overall experiences lower rates of drug overdose deaths, Hispanic overdose deaths have also recently accelerated (Cano, 2021), and Hispanics of Puerto Rican heritage die of overdoses at higher rates than Non-Hispanic white individuals (Cano, 2020).

Research suggests that racial disparities in drug overdose mortality cannot be solely attributed to differences in the prevalence of drug use; for example, Black individuals die of cocaine-involved overdoses at a rate twice as high as white individuals, even though past-year cocaine use is equally as prevalent in white adults as Black adults (Cano et al., 2020; Kariisa et al., 2021). Thus, disparities in overdose mortality are more likely explained using intersectional stigma as a fundamental cause lens.

Black and Hispanic populations face disproportionate exposure to risk factors for negative outcomes from drug use, as socioeconomic deprivation, homelessness, and incarceration have been identified as social determinants of health particularly salient for individuals who use drugs (Galea & Vlahov, 2002). In addition, racial discrimination, arguably a fundamental cause (Phelan & Link, 2015), is associated with greater substance use (Gibbons et al., 2010). Racial discrimination has created and perpetuated inequalities in income and education, stress, residential context, and access to high quality medical care (Williams & Jackson, 2006), all of which contribute to a variety of health disparities for individuals who use drugs. A recent Morbidity and Mortality Weekly Report found a significant increase in overdose

rates in counties with high income inequality, most prominent for Black populations (Kariisa et al., 2022). Black people were also less likely to have previous substance use treatment (e.g., lack of resources) compared to white people (Kariisa et al., 2022).

The lens of intersectional stigma as a fundamental cause also applies to differential access to resources for preventing fatal overdose (Dayton et al., 2020). The time periods of increasing overdose mortality in Black and Hispanic populations coincide with the availability of naloxone, a biomedical intervention that can reverse opioid overdoses. Naloxone was approved by the Food and Drug Administration in 1971 for medical use; however, individuals did not have access unless it was prescribed to them, and thus naloxone was underutilized in non-medical settings (Davis & Carr, 2015). Recently states have begun to enact laws that support access and use of naloxone.

The first types of laws make naloxone more available, sometimes by not requiring prescriptions and allowing either pharmacies or community-based organizations to dispense naloxone. The second type of laws are Good Samaritan Laws that protect people who call emergency services for someone who is overdosing from prosecution from criminal behavior such as illegal drug use (Davis et al., 2013). Only four of the 50 states and the District of Columbia (DC) had enacted such laws in 2010. By 2015, 43 states and DC enacted them (Davis & Carr, 2015) and, as of 2017, all states and DC enacted some type of law aimed at increasing access to naloxone (Lieberman & Davis, 2021).

These laws are important as they are associated with a decrease in fatal overdoses (Smart et al., 2021). Yet, there is variation by state in how much protections are offered to Good Samaritans. Some states provide protections for probation or parole violations when others do not. Some laws protect people from prosecution if violating drug paraphernalia laws, and others

do not. For example, legislation passed in Texas (H.B. No. 1694) in 2021 provides exceptions to penalties for drug possession and use. However, people who are the first to contact emergency services for a suspected overdose are not protected if they have had an incident in which they called 911 for an overdose in the past 18 months, have been convicted of a felony or have used this same protection when calling for a previous overdose.

Regional studies suggest that Black individuals who use opioids are less likely than white individuals to be familiar with the protections of Good Samaritan Laws (Evans et al., 2016; Schneider et al., 2020). Moreover, fear of police, which is particularly salient among Black and Hispanic individuals in disadvantaged and minoritized communities (Schuck et al., 2008), often persists as a barrier to calling emergency services for overdose response, even when Good Samaritan Laws are in place (Wagner et al., 2019). Thus, the intersectional stigma embodied by racial disparities in policing and police violence due to drug use (Johnson et al., 2019; Mitchell & Caudy, 2015) may also increase vulnerability to fatal overdose for Black and Hispanic persons who use drugs. Data from regional and clinical samples also indicate that Black and Hispanic individuals who use opioids are less likely than white individuals to report naloxone access and training (Jones et al., 2021), and thus are less likely than their white peers to receive naloxone (Kinnard et al., 2021). Within racial and ethnic minority communities, naloxone availability may not suffice to mitigate barriers to carrying naloxone, as documented among Puerto Rican migrants who inject drugs in New York City (Gelpí-Acosta et al., 2019).

Researchers have pointed out that naloxone distribution programs are, understandably, designed for individuals who use opioids, yet individuals who use non-opioid drugs or engage in polydrug use are also at risk of a fatal opioid overdose due to fentanyl (Gladden et al., 2019; Nolan et al., 2019). Fentanyl is approximately 50 times more potent than heroin (Jones et al.,

2018) and people may be unaware that fentanyl is in the local drug supply (Rouhani et al., 2019). For Black individuals in some communities, cocaine contaminated with fentanyl appears to represent a severe threat (Ray et al., 2020). Considering that cocaine-involved overdose mortality is disproportionately high among Black (Cano et al., 2020) and Puerto Rican persons (Cano & Gelpí-Acosta, 2021), continuing to center funding and innovations almost exclusively on opioids may widen disparities as technological advances are developed and implemented which benefit white communities more than racial and ethnic marginalized communities.

Policy Implications

Using the case study of intersectional stigma due to drug use, race, and ethnicity, we see how policies have reflected societal stigmas and become tools that perpetuate inequities. Thus, we have several policy recommendations. First, we recommend abolishing the criminalization of drug use and immigration. The mark of a criminal record, and non-citizenship, greatly influences health outcomes and access to resources (Pager, 2003). Drug criminalization has facilitated a range of negative outcomes in the US in general and for Black and Hispanic people in particular. The considerable public investment in criminalization has not translated into desired declines in drug availability or use (Mitchell, 2009); it has, however, exacerbated criminal legal inequities and redirected valuable resources from public health approaches that could reduce disease transmission, prevent overdose, and address mental health of people who use drugs. Thus, legislators should consider repeal of punitive drug laws and adoption of evidence-based strategies that can reduce health risks.

Second, we recommend prioritizing funding for, and building of social infrastructures that can be used to support health and reduce stigma along the intersections of drug use and race and ethnicity. Of particular importance is the funding and scaling up of syringe service programs (SSPs). SSPs provide stigma free care, a space for social supports and networks to develop, and are associated with better health outcomes (Walters, Coston, Neaigus et al., 2020; Walters, Reilly, Neaigus et al., 2017). Moreover, syringe exchange programs demonstrate cost-effectiveness (Ruiz et al., 2019).

Another important social infrastructure for drug using populations is overdose prevention centers, also called safe consumption sites. Safe consumption sites provide stigma free settings where people can use drugs under medical supervision. They also provide a variety of harm reduction resources, decrease the odds of infectious disease transmission, and reduce overdose deaths (Duncan et al., 2021). Safe consumption sites are also cost-effective. States and municipalities should consider them for large scale implementation even if just from fiscal standpoints (Pinkerton, 2010). These are universal programs with benefits across racial lines, offering individuals who use drugs the opportunity to access a variety of services, including treatment referrals, while respecting client self-determination. Future research should explore how experiences at SSPs, and safe consumption sites differ, if at all, by race and ethnicity, and if and how new spaces and programs can be erected to promote health equity among groups who use drugs.

As drug laws and their execution have disproportionately affected racial and ethnic minoritized communities, reparative policies and investments can be valuable for remediating their effects. Black and Hispanic people living in the US have accumulated much less wealth than white people living in the US. The accumulation of wealth, such as homes, stocks, and other

assets, allow for access to more flexible resources (Keister, 2000). One possible reparation would be homeownership programs that counter the years of policies that made home ownership either illegal or very difficult (Shapiro, 2006). There could also be monetary payments, college tuition or loan forgiveness, and/or business grants (Ray & Perry, 2020). Business licenses and grants might be particularly helpful along the intersection of race and ethnicity and drug use. As we described above, the disproportionate impact of the War on Drugs has negatively affected Black and Hispanic communities. Given that many states have legalized marijuana, this could be an opportunity to give back to those communities (Vitiello, 2019), provide direct economic stimulus to communities disproportionately affected by the War on Drugs, and create policies to increase opportunities for marijuana entrepreneurship for Black and Hispanic people. Thus, reparative policies may increase capital in Black and Hispanic communities and thus have downstream effects on employment and housing. To understand how best to apply reparations and create restorative policies, we should work with communities most impacted and center them in all aspects (Kerr et al., 2022).

Since there is a paucity of literature examining interventions to address intersectional stigma, expansive evaluations of existing interventions to observe shifts in stigma across socioecological levels may help guide development of strategies to address intersectional stigma (Kerr et al., 2022). Policies to address underlying social and economic inequities may translate into reducing social and economic marginalization for Black and Hispanic people, but this warrants further investigation.

Conclusion

An intersectional stigma framework is needed to understand the various ways groups and sub-groups of people are constrained and oppressed in society. This perspective allows for an understanding of how interlocking systems operate to subordinate and exploit varying groups of people, and how those systems create health inequities. The case study of intersectional stigma due to drug use, race and ethnicity provides an example of how intersectional stigma operates as a fundamental cause to health outcomes and how mechanisms change over time, which continue to create and reinforce inequities.

People and groups that occupy intersections of stigmatized statuses can be scapegoated on those varying intersections, creating particularly harmful health outcomes. In this paper we have described some of the unique experiences of Black and Hispanic people who use drugs and how their health outcomes cannot be explained by looking solely at stigma due to race and ethnicity nor stigma due to drug use. Instead, it is the intersection of these stigmas, and the interlocking social structural systems that have historically discriminated against people and groups (Bowleg, 2022). These interlocking social structural systems that we refer to when we discuss intersectional stigma have adapted over time and remain a fundamental cause of health inequities. Furthermore, intersectional stigma allows for more mechanisms to oppress groups and for the oppressive systems to be used at different times and in tandem.

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