

Exploration of Health Trends: Are Systematic Injustice and Disparities Causing Unequal Consequences?

Sarah Mukkuzhi

Walpole High School

ABSTRACT

While most of the world holds a heavy dependence on drug use, addiction affects society's most vulnerable in an unbalanced manner. Although addicts are dismissed for not taking advantage of resources around them to succeed, it is not widely known how disadvantaged communities are predisposed to fail in the United States from the very moment they are born. America possesses deep, horrifying roots of systematic injustice concerning substance use, seen evidently during the crack cocaine epidemic. It is a common notion that substance addictions lead to one being impoverished; however, historical lack of opportunities and no education leads to poverty, which in turn will lead to addiction. Prevalent mental health illnesses can be associated with drug use used for coping mechanisms when individuals are presented with a lack of better alternatives or education. Creating more accessible resources and education to those who are struggling is one of the first steps in correcting existing disparities caused by historical injustices. Minorities are found to disproportionately have worse mental and physical health, a trend mirrored by history. New models of proactive care have to be implemented to address the growing health gap in our country to prevent the growing problem, most importantly at a young age before individuals follow the trend of society which predetermined some to live unhealthier lives based on social conditions.

Eligibility Criteria

Inclusion of sources are experiments built with proper randomization to control for confounding variables, well-conducted observational studies, and primary and secondary sources. Exclusion of sources will occur for studies not based in America, studies conducted after the year 2000, and material not peer-reviewed.

Concept A: Historical Racial Injustice and Socioeconomic Status

The Crack epidemic skyrocketed in the 1970's-1980's in America's urban population. Users of crack cocaine typically were poor, racial minorities compared to the middle class population who preferred powder cocaine. Despite the similarities in the drugs, the Anti Drug Abuse Act of 1986 created an incarceration policy where the minimum penalty for one gram of crack was equivalent to the punishment for one hundred grams of powder cocaine. There is heavy speculation the severe incarceration was a facade in order to target black communities; consequences were that there is a profuse amount of low-income minorities who have been incarcerated for crack cocaine use (Chappell & Maggard, 2007). Compared to other countries' drug policies, the U.S. showed no remorse to struggling minorities and no mandatory rehabilitation to those addicted and used addiction, which psychologically affects the brain, as an excuse to throw poor minorities in prison. Discriminatory policies are not exclusively recent nor adhering to our country's beliefs of equality and opportunity. Similarly, low-class

minorities face discrimination in improving their drug habits. A recent study demonstrated that among American adults over the age of eighteen, 7.7% reported substance use. The report did not find a substantially higher amount of substance use among racial and ethnic minority groups; however, minorities were found to be less likely to receive treatment services. There was discrimination regarding living conditions and work environments which leads to worse health conditions generally among people of color (McKnight-eily et al., 2021). Therefore, it can be deduced that while minority groups might not be using substances at a higher frequency compared to other groups, the effects and consequences that follow statistically hit them harder. Black communities, as proved in an alternative study, actually have greater levels of poor health compared to white ones and on average showed more discontent when measuring levels of life satisfaction. In the U.S. individuals advantaged socioeconomically possess better levels of health. Interestingly, as immigrants moved to America and assimilated, they had increased use of cigarettes, alcohol, and illegal drugs. (House & Williams, 2000). These disadvantaged minorities not having overall good health is directly linked to their socioeconomic status, and potentially caused by lack of better healthcare access. It is questionable whether these communities do not have any access to resources to get better or whether they do not wish to, possibly due to a lack of better education. Statistics show African-American smokers had higher attempts at quitting compared to their racial counterparts; contrastingly, these attempts in many cases did not lead to cessation of smoking. (Keeler et al., 2017). These failures to cease smoking implies the latter, not wishing to get help, is a false theory. As mentioned prior, typical users of cracks tend to fall under urban and low income populations. Despite many being impoverished, an addiction to crack cocaine can cost up to \$82,125 per year (Bezruczyk, 2023). One possibility is that addiction can lead to being impoverished. However, this contradicts the fact that many employed individuals (as stated above), prefer powder cocaine; therefore, in order for an addiction to so drastically change their economic status, it most likely would not be crack cocaine that originally enticed them and led to a crippling addiction. Another factor leading to addiction is access to low-quality education or even choosing not to complete education. Prescription opioid use and poverty rates were greater among adults with less than a high school education (Pear et al., 2019). An arising follow-up question is prior to dropping out of high school where they are not educated on dangers of drug use? It cannot be determined whether any other factors or cultures around them lead to many dropping out of high school; one theory could be that education of those schools were not of very high value, caused by the fact they are being funded by impoverished communities. This supposedly low-quality education could in turn mean students were not well taught about the dangers of drugs, causing more opioid abuse. Another article speaks of this 2019 opioid abuse study supports the above theory, claiming systematic injustice directly leads to worse conditions where an individual is born based on the distribution of money and resources nationally and locally, meaning low education levels and quality. Addiction will arise as a result of unemployment, homelessness, poverty, after-effects of incarceration (which are many times disproportionality unjust toward people of color), making relapse easier (Grinspoon, 2021). Directly addressing this structural violence will make a substantial difference.

Concept B: Economic Status and Racial Disparities Associated with Mental Illness

A fifteen year study proved that as unemployment fluctuates, poor mental health follows in a directly proportional relationship. More notably, unemployment induced mental illness was more prevalent for blacks in comparison to their white counterparts, especially during a recession in 2007-2011 (Lo and Chong, 2014). Furthermore; unemployment can many times mean a lack of wealth, leading to probable speculation that those struggling do not have abundant access to mental health help, resources, or even quality education. It has been established that systematic injustice has been known to create poverty and structural injustice, yet there is now

also another added layer with the correlation to poor mental health. An observational study found 70% of subjects, ranging twelve to twenty-five, reported using a substance recently and 30% possess health, social, financial, and legal issues (Gao et al., 2023). It can be speculated that such overlapping could mean these mental health stressors can lead to substance use as a coping mechanism; nevertheless, there remains a possibility that substance use causes other issues or even that mental health and socioeconomic status have no causation or connection beyond correlation.

Concept C: Lack of Resources for Low-Income Individuals and Attainable Solutions

There have been expansions to provide more health care to American citizens, one seen in 2014 when 26+ states expanded their Medicaid eligibility to include more low-income individuals. Low income residents were found to be more at risk for substance use disorders as well as not obtaining health insurance. With the expansion, there was an increase in Medicaid coverage and decline in uninsured adults with substance use disorders; despite these strides, it has merely led to an expansion of insurance not treatment. The proportion of U.S. adults not related remained the same, even. With insurance levels growing (Olfson et al., 2018). More easily accessible treatment is clearly missing among individuals who use substances; as they are usually not in a situation to afford proper help, their care should be given with the same level of quality as a wealthier struggling citizen might receive. Another approach would be educating early, before addiction issues arise. One experiment, based in sixteen middle schools, gave students the chance to participate in CHOICE, a voluntary after school program. It was estimated at schools with CHOICE as an option. One in fifteen students were successfully prevented from participating in alcohol use at the time. It was suggested that overall alcohol intake was lower at these selected schools, but without strong evidence to suggest the latter claim as the p-value was 0.20 and not statistically significant (D'Amico, et al., 2012). Nevertheless, to some extent this proactive approach in educating children was effective in preventing some substance use among young students. The access to healthcare dropped significantly following the COVID-19 pandemic, yet it definitely did not do so equally. A study found trends of being uninsured, delayed medical care, and delayed mental health treatments were all higher for adults with an income less than \$25,000 (Lee & Singh 2021). While the pandemic overall led to less treatment for those with cases not surrounding the virus, there is a noticeable treatment gap related to the income of the person needing medical care. While not being able to receive care when seeking for it leads to poorer health, bad experiences with healthcare workers is another barrier that can stop a patient from returning. It was repeatedly reported that patients with mental illnesses felt they were excluded from decisions, forced to wait unbearably long for treatment, not being fully informed on their options or illness, and being spoken to in a condescending manner. These interactions were seen systematically and not just in a few outlier facilities. It was also realized by many healthcare workers that they did not understand the small ways their own stigmas can bleed into patient care until receiving anti-stigma courses. All of the above experiences have led to patients stopping care, delaying returning to treatment, feeling unsafe, and receiving worse quality mental and physical care (Knaak et al., 2017). It is important to be aware of how subtle behaviors can stop patients from returning to care. While physical and structural barriers are needed to help low-income individuals get better resources it is important to understand the hidden, mental barriers that exist.

Conclusions

Deducing from the literature, systematic injustice does in fact cause worse education opportunities, high unemployment rates, and increased addiction issues for marginalized groups. Minorities face the worst of the repercussions that arise from systematic injustice, a pattern repeated throughout history; moreover, unemployment

itself is associated with worse mental health. Similarly, marginalized communities often face worse physical health conditions due to low-income populations being hit the hardest by drug use; Our governments declared a ‘war on drugs’ and instilled such harsh punishments for those struggling, under a mask of seeking justice, in order to target these hurting minority groups. Our mission should be, to first and foremost, have more empathy. Empathy for the situation our society puts marginalized groups in. Empathy to not enforce such strict laws that lead to the abundant and unjust incarceration of minorities. We need to advocate for kinder models that allow redemption, education, and rehabilitation. Without aid, recovery is not always an available option since many low income groups are correlated with less available care and more barriers preventing seeking help. There is an unbalanced prevalence of delayed health care access for specifically low-income individuals, especially after the COVID-19 pandemic. It is clear even when marginalized groups want to improve their health and living conditions there are still barriers preventing them, and generations, from doing so. The solution is to make health, recovery, and education easier to access. Small, attainable programs similar to the anti-stigma training can have a vast impact; mental barriers stemming from fear and dread can be prevented and overcome from small efforts. Proactive measures, such as quality education early, is another solution to curb the problem before it occurs. Structural violence leads to worse quality education as well as a common practice of students dropping out prematurely. Before young children are trapped by systematic injustice we should provide them with engaging resources and opportunities to learn. As the CHOICE experiment proved, something as simple as an after-school program prevented many students from a dark future that was predetermined for them by society’s dreadful history.

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