

Exploring the impact of the opioid epidemic in Black and Hispanic communities in the United States

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Abstract

Context: In recent years, due to an alarming increase in the number of opioid-related overdose fatalities for White, Non-Hispanics in rural and suburban communities across the United States, they have been considered as the face of this epidemic. However, there has also been a staggering rise in the number of opioid overdoses in urban, minority communities, which have not been thoroughly addressed by the literature.

Methods: We reviewed deaths where opioid-related substances were reported as the leading cause of death to the Centers of Disease Control Multiple Cause of Death database from 1999 to 2017. Deaths were analyzed by year, State, drug type, and race and ethnicity.

Results: There were 399,230 total opioid-related deaths from 1999 to 2017 amongst all ethnic groups in the U.S. During this timeframe, approximately 323,939 total deaths were attributed to White, Non-Hispanics, while 75,291 were attributed to all other ethnicities. Examination of opioid-related overdose death data by ethnicity reveals that while White, Non-Hispanics have experienced the largest numbers of opioid-related overdose deaths in the U.S with up to 37,113 deaths occurring during 2017, there has also been a sharp rise in the number of opioid-related overdose deaths for minorities. Opioid-related overdose deaths for Black, Non-Hispanics climbed from 1130 deaths in 1999 to 5513 deaths in 2017, while opioid-related overdose deaths for Hispanics climbed from 1058 in 1999 to 3932 in 2017. According to the Centers for Disease Control and Prevention, over the past 19 years, age-adjusted opioid-related deaths for Hispanics have climbed from 3.5 overdoses per 100,000 in 1999 to 6.8 overdoses per 100,000 in 2017. However, greater increases have been reported for Blacks during the same 19-year timeframe with age-adjusted rates of 3.5 overdoses per population of 100,000 in 1999 to 12.9 overdoses per population of 100,000 in 2017.

Conclusion: While Opioid-related overdoses have overwhelmingly plagued rural and suburban White, Non-Hispanic communities, there has been a surge in the number of deaths in Black and Hispanic Minority communities in recent years. Although there have been significant increases in the number of opioid-related overdose deaths in Black and Hispanic communities, the media narrative for this epidemic is often portrayed as a White, Non-Hispanic rural and suburban crisis. As a result, intervention strategies and policies have failed, both, to assess the severity of the problem in minority communities and to offer culturally sensitive preventative and treatment solutions. In this paper, the impact of the opioid epidemic on Black and Hispanic minority communities will be presented. Racial disparities in the U.S. Government's current approach to an epidemic, which plagues rural and suburban White America, will be compared to its past criminal justice response to drug pandemics in urban minority communities. Culturally sensitive policy considerations and recommendations that can be used to, both, mitigate and offer treatment options for the opioid epidemic in these minority communities will also be addressed.

Keywords

ethnicity, opioid-related overdose deaths, policy recommendations, race, racial disparities, urban communities

Introduction

In recent years, the Opioid Epidemic has been depicted as a National public health crisis that is spreading across rural and suburban communities in the United States at an alarming rate (Trump formally declares US opioid crisis a “public health emergency”, 2017).

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Traditionally, the term “opioid” has been used to describe a wide variety of addictive narcotic substances, such as opium, morphine, heroin, oxycodone, hydrocodone, and codeine, which have been traditionally used as pain relievers. Although many of these drugs have acceptable medical uses, due to their high potential for abuse and risk of dependency, they are all scheduled according to the Controlled Substances Act, and the number of overdose deaths involving this class of drugs has climbed in recent years (CFR – Code of Federal Regulations Title 21, 2019). The current face of the opioid epidemic in America has been one considered to primarily plague rural and suburban communities with White, Non-Hispanics overwhelmingly suffering its devastating effects. However, in recent years, there has been a historic surge in the number of opioid overdose deaths (OODs) sweeping across urban, minority communities in the United States, but their stories are often not addressed in the narrative for addressing this alarming epidemic (Drake and Bourgeois, 2019; Samuel, 2019).

The U.S. Government’s response to this current drug epidemic, which has focused more on preventative and rehabilitative measures rather than punitive measures, has been criticized as one distinct example of the many racial disparities in the criminal justice system. Despite the U.S. media’s portrayal of the opioid epidemic as an unprecedented phenomenon of addiction plagued with devastating residual effects to public health and safety in mainstream society, critics argue that the drug and addiction problem in this country is not a novel one (James and Jordan, 2018). The overwhelming physiological and psychological effects along with the high likelihood of dependency for the opioids are not a new phenomenon and have been thoroughly documented in the literature (Morgan and Christie, 2011). Akin to the heroin and Crack epidemics, which led to epic surges of addiction in urban and minority communities in the decades spanning from the 1970s to the 1990s and also created devastating effects to public health and safety, the opioid epidemic has been now touted as a National public health crisis. While the opioid crisis in rural and suburban White communities has been addressed with appeals from Government stakeholders for the implementation of new policies, creation of preventative measures and an increase in the number and types of rehabilitative treatment options available to assist addicted users, many argue that the U.S. Government’s past response was significantly more punitive and depicted as a “War on Drugs” with less compassion and treatment options for addicted users in urban communities (Om, 2018).

In this paper, the mortality rates for opioid overdose deaths in Black and Hispanic communities will be presented and compared to the U.S. National average and

those reported for White, Non-Hispanics. OODs will be examined by year, race, ethnicity, State, and drug-type. Racial disparities in the U.S. Government’s current approach to an epidemic, which plagues rural and suburban White America, will be compared to its past criminal justice response to drug pandemics in urban minority communities. Culturally sensitive policy considerations and recommendations that can be used to, both, mitigate and offer treatment options for the opioid epidemic in these minority communities will also be addressed.

In the United States, there are a number of definitions for opioid-related overdoses according to the International Classification of Diseases (ICD) codes, which have been used in this study to estimate the number of opioid-related fatalities. The Centers for Disease Control and Prevention (CDC) multiple cause-of-death mortality files were used to identify drug overdose deaths (CDC Wonder, 2019). Drug overdose deaths were classified using the International Classification of Disease, Tenth Revision (ICD-10), based on the ICD-10 underlying cause-of-death codes X40-44 (unintentional), X60-64 (suicide), X85 (homicide), or Y10-Y14 (undetermined intent). Among the deaths with drug overdose as the underlying cause, the type of opioid involved is indicated by the following ICD-10 multiple cause-of-death codes: opioids (T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6); opium (T40.0); heroin (T40.1); natural and semisynthetic opioids (T40.2); methadone (T40.3); other synthetic opioids (T40.4), and other unspecified narcotics (T40.6). Additionally, as a point of reference, differentiated overdose death data related to the use of illicit or manufactured fentanyl as opposed to legitimate pharmaceutical preparations was not available, so all overdose data for fentanyl is pooled within.

Methods

Secondary data were retrieved from the CDC Wonder Online Multiple Cause of Death database (CDC Wonder, 2019). Deaths where opioid-related substances were reported as the leading cause of death to the Centers of Disease Control database from 1999 to 2017 were obtained for analysis. Deaths were also analyzed by year, State, race, and ethnicity. Data were analyzed by the following races/ethnicities: White, Non-Hispanic; Black, Non-Hispanic; and Hispanic. All Hispanic origins were pooled and categorized as Hispanic. Secondary data for comparison to cocaine overdose deaths in minority communities were also obtained and analyzed using the CDC Wonder Online database.

Opioid drug overdose deaths were classified using the ICD-10, based on the ICD-10 underlying cause-of-death codes X40-44 (unintentional), X60-64

(suicide), X85 (homicide), or Y10-Y14 (undetermined intent). Among the deaths with drug overdose as the underlying cause, opioids are indicated by a ICD-10 multiple cause-of-death code of T40.0-T40.4 and T40.6. Among the deaths with drug overdose as the underlying cause, heroin is indicated by a ICD-10 multiple cause-of-death code of T40.1. Among the deaths with drug overdose as the underlying cause, synthetic opioids are indicated by a ICD-10 multiple cause-of-death code of T40.4. Among the deaths with drug overdose as the underlying cause, prescription (Rx) opioids are indicated by a ICD-10 multiple cause-of-death codes of T40.2 and T40.3.

Cocaine drug overdose deaths were classified using the ICD-10, based on the ICD-10 underlying cause-of-death codes X40-44 (unintentional), X60-64 (suicide), X85 (homicide), or Y10-Y14 (undetermined intent). Among the deaths with drug overdose as the underlying cause, cocaine is indicated by a ICD-10 multiple cause-of-death code of T40.5. The overdose deaths involving Rx opioids identified using an underlying cause of X40-X44, X60-X64, X85, or Y10-Y14.

In this paper, age-adjusted rates (AARs) will be used to make fairer comparisons between the death rates of groups with different age distributions.

Results

Opioid overdose deaths long-term overview

There were 399,230 total opioid-related deaths from 1999 to 2017 for all ethnic groups in the U.S. During

this timeframe, an overwhelming majority of 323,929 deaths were attributed to White, Non-Hispanics, while 75,291 deaths were attributed to all other ethnic groups combined. The leading opioids reported in OODs were Rx and synthetic opioids.

Trends by race and ethnicity (1999–2017)

According to CDC data, from 1999 to 2017 in the United States, White, Non-Hispanics experienced the highest rates of opioid overdose deaths amongst any ethnic group, as shown in Figure 1. The AAR of overdoses increased by over six-fold for White, Non-Hispanics during this timeframe. During this same period, AARs opioid overdose deaths (OODs) for Hispanics climbed from 3.5 overdoses per 100,000 in 1999 to 6.8 overdoses per 100,000 in 2017. However, greater increases have been reported for Blacks during the same 19-year timeframe with AARs of 3.5 overdoses per population of 100,000 in 1999 to 12.9 overdoses per population of 100,000 in 2017.

Trends in opioid overdose related deaths by state, race and ethnicity

This growing trend is demonstrated in Figure 2 below, which provides 2017 data for States where the AARs of OODs for minority groups were higher than the National U.S. average AAR of 14.9. In comparison to the U.S. national average AAR of 14.9 opioid-related deaths per population of 100,000 in 2017, the opioid epidemic was found to disproportionately

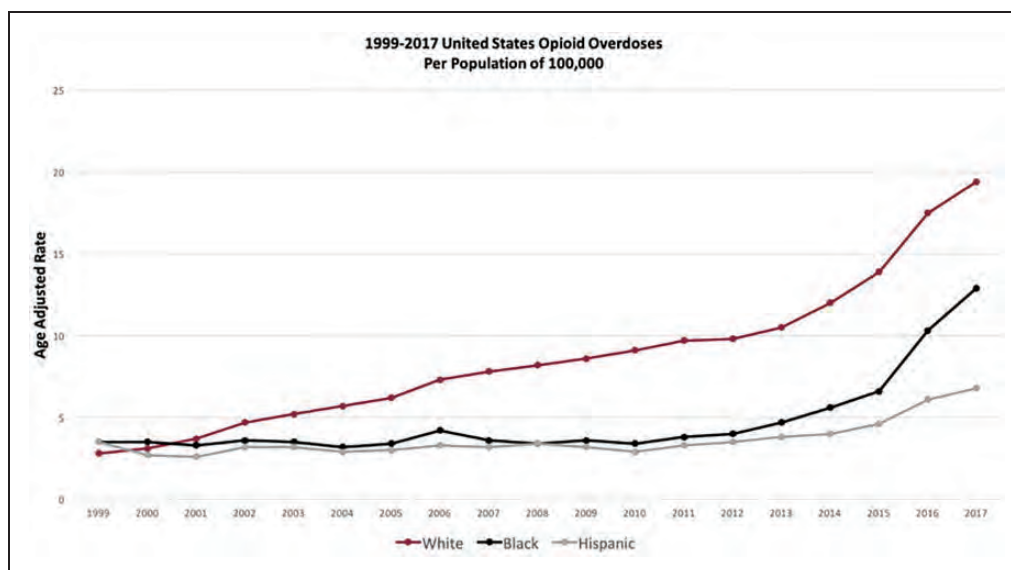


Figure 1. United States opioid overdose deaths by race and ethnicity 1999–2017.

Source: reproduced with permission from Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Available at: <http://wonder.cdc.gov/mcd-icd10.html> (accessed 2 July 2020).

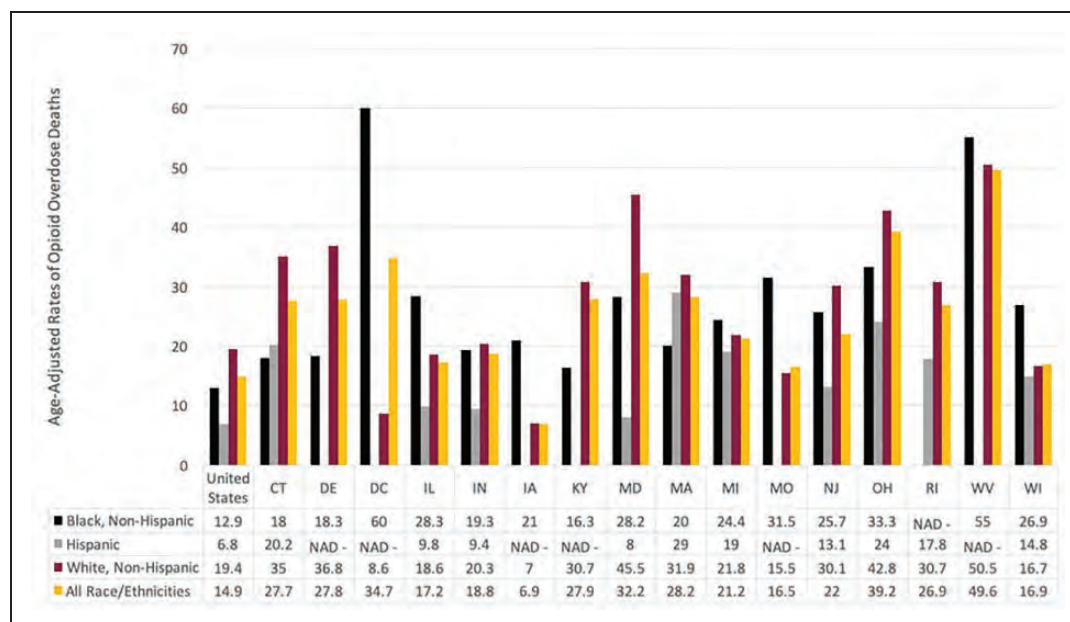


Figure 2. States with minority opioid overdose death age-adjusted rates higher than the U.S. national average in 2017.

Source: reproduced with permission from Kaiser Family Foundation's State Health Facts, Centers for Disease Control and Prevention (CDC), and National Center for Health Statistics.

NAD: no available data (either reported as NSD: not sufficient data. Data suppressed to ensure confidentiality or NR: data not reported. Data unreliable.).

Note: Specific ethnicity-based data were not available or reported for all states.

impact Blacks with them leading the AAR of opioid overdoses in the District of Columbia, Illinois, Iowa, Michigan, Missouri, West Virginia, and Wisconsin. In 2017, the AAR of OODs were found to disproportionately impact either Blacks with them leading the AAR of OODs in the District of Columbia, Illinois, Iowa, Michigan, Missouri, West Virginia, and Wisconsin. Interestingly, in 2017, West Virginia led the nation in opioid overdoses with AARs of 50.5 deaths per 100,000 for White, Non-Hispanics with Black, Non-Hispanics experiencing more opioid overdoses (55 deaths per 100,000) than for any other ethnic group. In addition, Hispanics experienced AARs of OODs well above the U.S. national average of 14.9 in the states of Connecticut, Massachusetts, Michigan, Ohio, and Rhode Island.

Opioid overdose death trends by race, ethnicity, and drug type

According to the Centers for Disease Control (CDC), there has been a rapid growth in opioid deaths in the U.S. from 8050 total deaths occurring in 1999 to 47,600 total deaths in 2017. Examination of opioid-related overdose death (OOD) data by ethnicity reveals that while White, Non-Hispanics have experienced the largest numbers of OODs in the U.S with an AAR of 19.4 per 100,000 occurring during 2017, there has also been

a sharp rise in the number of opioid-related overdose death (OODs) for minorities, as shown in Figure 3. As a point of comparison, in 2017, more Black, Non-Hispanics died from opioids (AAR of 12.9 per population of 100,000) than from cocaine (AAR of 8.3 per population of 100,000). In 2017, in a similar trend, Hispanics experienced AAR of 6.8 OODs per population of 100,000 versus AAR of 2.5 per population 100,000 for cocaine-related overdoses. Additionally, in the U.S. in 2017, there was an AAR of 4.3 per 100,000 reported for cocaine-related overdoses amongst all ethnic groups. According to CDC data, the reported number of cocaine overdoses for Blacks doubled from 3.7 per population of 100,000 in 1999 to 8.3 per population of 100,000 in 2017. This increase may largely be due to the presence of fentanyl or other synthetic opioids in the manufacture of other illicit drugs, which has led to fentanyl epidemics in several jurisdictions across the U.S.

Synthetic opioid overdose death trends

In 2017, the leading opioids reported in opioid-related overdose deaths were for Rx and synthetic opioids (excluding methadone). Throughout, any use of the term synthetic opioids will refer to all other synthetic opioid substances, excluding methadone. According to CDC data, there has been a surge in the number of

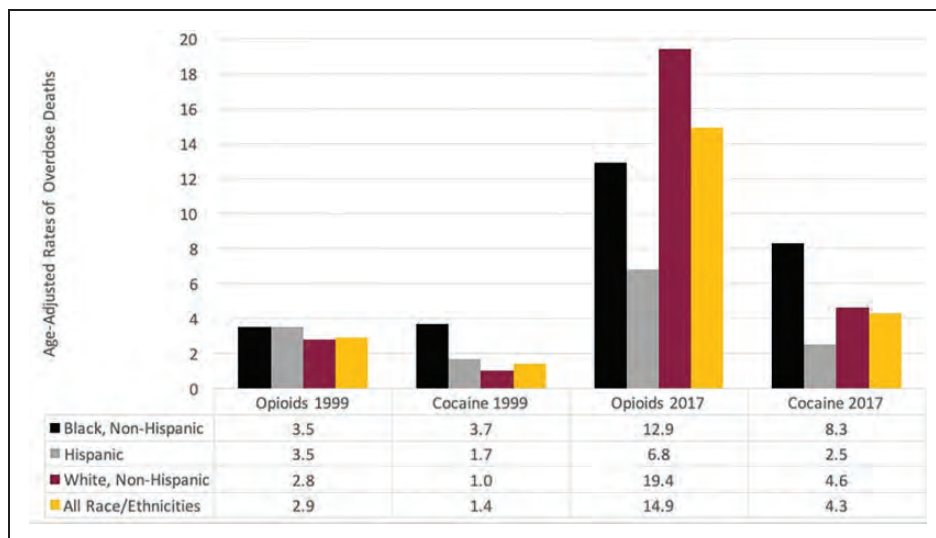


Figure 3. U.S. comparison of opioid and cocaine age-adjusted overdose deaths by race, ethnicity and year (1999 and 2017). Source: reproduced with permission from Centers for Disease Control (CDC) Wonder. Available at: <http://wonder.cdc.gov/mcd-icd10.html> (accessed 7 July 2020).

OODs involving synthetic opioids, such as fentanyl and carfentanyl, in the U.S. As shown in Table 1, the largest increase was reported for synthetic OODs from 1999 to 2017. An AAR of 0.3 was reported for synthetic OODs among all ethnic groups, and this number increased by 30-fold in 2017 where there was a reported AAR of 9.0. Large increases were also amongst all ethnic groups during this same timeframe. White, Non-Hispanics experienced staggering increases in the number of synthetic OODs, which rose from a reported AAR of 0.3 in 1999 to an AAR of 11.9 in 2017. This represents an increase of over 39-fold. Large increases in the number of OODs attributed to synthetic opioids were also reported for Hispanics, who experienced a surge from an AAR of 0.1 for OODs in 1999 to an AAR of 3.7 for OODs in 2017. This represents a 37-fold increase in the number of deaths. However, the most alarming increase in the number of synthetic opioid related deaths have been reported for Black, Non-Hispanics, who have experienced unprecedented increases from a reported AAR of 0.1 in 1999 to an AAR of 9.0 in 2017. During this timeframe, the 90-fold increase in the AARs of synthetic OODs reported for Black, Non-Hispanics is striking when compared to that of White Non-Hispanics and Hispanics, who also experienced alarming increases of 39-fold and 37-fold, respectively, during this same time period.

Trends in heroin-related overdose deaths

As it relates to heroin-related OODs, there was a large overall increase reported amongst all races and ethnicities from an AAR of 0.7 in 1999 to an AAR of 4.9,

Table 1. U.S. opioid overdose deaths by drug-type (synthetic opioids, heroin and prescription (Rx) opioids), year (1999 and 2017) and race and ethnicity.

	1999		2017	
	N	AAR	N	AAR
All races/ethnicities				
All opioids	8050	2.9	47,600	14.9
Synthetic Opioids	730	0.3	28,466	9.0
Heroin	1960	0.7	15,482	4.9
Prescription (Rx)	3442	1.2	17,029	5.2
Black, Non-Hispanic OODs				
Synthetic opioids	37	0.1	3832	9.0
Heroin	266	0.8	2140	4.9
Prescription (Rx)	262	0.8	1508	3.5
White, Non-Hispanic OODs				
Synthetic opioids	628	0.3	21,956	11.9
Heroin	1301	0.7	11,293	6.1
Prescription (Rx)	2625	1.3	13,900	6.9
Hispanic OODs				
Synthetic opioids ^a	45	0.1	2152	3.7
Heroin	346	1.1	1669	2.9
Prescription (Rx)	472	1.6	1211	2.2

N: number of overdose deaths; AAR: age-adjusted rate per population of 100,000; OODs: opioid overdose deaths.

^aSynthetic opioids refer to substances excluding methadone.

which was reported in 2017. The largest increase from 1999 to 2017 was reported for White, Non-Hispanics who experienced an 8.7-fold increase during this time frame. Black, Non-Hispanics experienced heroin OODs from an AAR of 0.8 in 1999 to an AAR of 4.9 in 2017, which represents over a six-fold increase.

Hispanic ethnicities experienced heroin OODs from an AAR of 1.1 in 1999 to an AAR of 2.9 in 2017, which represents over a two-fold increase.

Trends in Rx opioid-related overdose deaths

There has been a sharp increase in Rx OODs amongst all ethnicities, which rose from an AAR of 1.2 in 1999 to an AAR of 5.2, which was reported in 2017. The lowest increase in Rx OODs was reported for Hispanics, which showed an increase of AAR of 1.6 in 1999 to 2.2 in 2017, which represents a 1.4-fold increase. However, there has been a larger increase in the number of Rx OODs reported for Black, Non-Hispanics, who experienced an AAR of 0.8 in 1999 to an AAR of 3.5 in 2017, which represents a 4.4-fold increase. This is slightly lower than the over 5.3-fold increase reported for White, Non-Hispanics, who experienced an increase in their AAR of 1.3 (1999) to an AAR of 6.9 (2017), during this same time frame.

Discussion and recommendations

Racial disparities in opioid Rx prescribing

Rx opioids, such as morphine, oxycodone, hydrocodone, or codeine, have contributed to the large number of OODs in, both, the urban and rural communities (Paulozzi and Xi, 2008). Although Rx opioids were initially marketed to physicians as safe, and non-habit forming options by large pharmaceutical companies, the devastating effects of these drugs in recent years have led to hundreds of lawsuits against these companies for understating the dangerous addictive properties of these drugs (Lyon, 2017). This led Purdue Pharma to reformulate its signature drug, OxyContin, as an abuse-deterrent by making it harder to crush and to snort pills, which led to an immediate short-term period of decline in overdoses attributed to this drug (Facher, 2019). However, this limited decline in the number of OxyContin Rx abuse overdoses was countered with a surge in the number of heroin overdoses and the transmission of infectious diseases, such as Hepatitis C, which is fueled by the use of contaminated needles by users during intravenous drug use (Cicero and Ellis, 2015).

Although the prevalence and availability of Rx opioids have created increases in OODs in the U.S. across all races and ethnicities, as shown in Table 1, previous research has suggested that the increasing threat of the opioid epidemic is worst in black and urban, minority communities, such as in Chicago (Knopf, 2016), and may be attributed to several factors, such as the under-prescribing of Rx opioids to minorities, the availability of potent new non-

methadone synthetic opioids, and the lack of evidence-based treatment solutions (James and Jordan, 2018). Under-prescribing in minority communities can be the result of several factors, which include but are not limited to the lack of accessibility to health insurance and/or cognitive biases of healthcare professionals that minorities have higher pain tolerances than Whites. As a result, healthcare professionals may limit pain management Rx for minorities. Other more general contributing factors to the opioid epidemic may include an increase in the number of pain clinics opened in urban areas, misconceptions that Rx medications are safe and non-habit forming and patients who “doctor” shop, which results in the possibility of multiple prescribers for various pain medications for an individual patient.

Disparities in the under-prescribing of Rx opioids in minority communities were once thought to shield these communities from the devastating effects of the opioid epidemic (Buchmueller and Carey, 2018; Hansen and Netherland, 2016). However, several studies have suggested that this racial disparity in the under-prescribing of Rx opioid medications in urban communities may cause minorities to access illicit preparations of these drugs, which are often laced with potent synthetic opioids, such as fentanyl. In recent years, many urban communities have experienced a significant spike in the number of opioid overdoses, which may be linked to the availability of synthetic opioids, such as fentanyl or carfentanyl. These potent synthetic opioids, which are roughly over 100 times more potent than morphine, are lethal at very low levels and are often used as cutting agents in illicit drugs, such as heroin and cocaine. It has also been suggested that the addition of these potent synthetic opioids to street drugs and counterfeit pill preparations that are available on the black market may also be linked to the increased rates of overdoses over recent years in minority communities. In 2019, a research study found that the prevalence of Rx opioid use amongst Blacks to be comparable in, both, rural and urban communities (Rigg and Nicholson, 2019). It has also been suggested that the lack of legal pain management options, due to the under-prescribing of Rx opioids for Hispanics and Blacks, may be linked to increased abuse of illicit pharmaceuticals and other drugs, such as cocaine and heroin (Hansen and Netherland, 2016; James and Jordan, 2018; Netherland and Hansen, 2017). This is further evidenced in places with large minority populations, such as in Cook County, Illinois, where there was a historic surge of 342 fentanyl-related opioid deaths, which was reported by the Cook County Medical Examiner’s Office between April 2005 and December 2006 (Schumann et al., 2008). Moreover, with limitations in healthcare affordability in minority

communities, pain management options such as detoxification, rehabilitation, or counseling services may not be attainable.

Racial disparities in the criminal justice response

According to the previous research, there is also a lack of evidence-based solutions and policies for addressing the opioid abuse problem in urban, minority communities. Although the opioid epidemic has been declared a new emerging threat, it has striking resemblances to the heroin and crack cocaine epidemics, which plagued urban, minority communities in the 1970s and 1980s. Akin to the opioid epidemic that has greatly impacted middle-class White, Non-Hispanics in rural and suburban communities in recent years, these epidemics had lasting and devastating effects in urban, minority communities. The U.S. Government's "War on Drugs" and criminalization of drug offenses during these eras led to the mass incarceration of Blacks (Alexander, 2010). However, the War on Drugs did little to reduce street-level drug activity and instead introduced increased police militarization and brutality in these communities (Cooper, 2015). According to the Bureau of Statistics, in 2016, though Blacks made up only 12% of the U.S. population, they comprised over 33% of those incarcerated in the criminal justice system.

There have been similar devastating effects in the Hispanic communities. According to the 2019 Annual Drug Policy Alliance Report, although Hispanics make up approximately 17% of the U.S. population, they make up 50% of all Federal Drug cases (Drug Policy Alliance 2019). According to Michelle Alexander, who authored *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (2010), "nothing has contributed more to the systematic mass incarceration of people of color in the United States than the War on Drugs". Racial disparities in the criminal justice response and re-entry policies and programs have also created racial inequalities in the War on Drugs (Rosenberg et al., 2016). For example, in a 2018 research study of drug-arrests in 78 neighborhoods in St. Louis, racial profiling and racially discriminatory policing practices were discovered (Gaston, 2018). Due to the traditional criminal justice response to substance abuse in urban communities, minorities may also be less likely to seek rehabilitative treatments out of their fear of incarceration (Alexander, 2010).

As a result, the complexities of the urban community's strained relationship with the criminal justice system has to be considered when creating culturally sensitive solutions for addressing the opioid problem in these communities (James and Jordan, 2018). Socioeconomic factors, such as disparities in access to

affordable healthcare, that may also create barriers for minorities seeking help from rehabilitative treatment facilities must also be considered (Lagisetty et al., 2019). In order to effectively assess and mitigate the devastating effects of the opioid epidemic in minority communities, there is a need to create evidence-based policies which take into account the unique cultural experiences of these populations. These policies should focus on key issues and culturally sensitive solutions to coping with this epidemic, such as exploring minority relations with the criminal justice system, increasing the availability of faith-based rehabilitative treatment alternatives, and the availability of low-cost rehabilitative treatment facilities.

Policy recommendations

According to a 2019 CDC report, concerted efforts from Federal, State, and local jurisdictions are needed to offer evidence-based solutions, preventative strategies, and treatment solutions in order to address the opioid epidemic (Scholl, 2020). There is also an urgent need for strong public safety and public health partnerships to address this issue (Scholl, 2020). Although the role of race and ethnicity as it relates to the opioid crisis in minority communities (James and Jordan, 2018), there is a need for more data regarding how this epidemic may uniquely affect these communities in order to provide evidence-based solutions for policy implementation. Previous research has asserted that racially-biased media coverage paints a picture of the opioid epidemic that excludes certain groups of users from receiving the attention they need in order to determine their specific risks and needs for their addictions (Netherland and Hansen, 2016). Researchers have suggested that the opioid epidemic in the United States is being treated as a crisis rather than a war on drug abuse due to it impacting largely the majority race (Dennis, 2017). Although there is a significant amount of discourse regarding treatment solutions for the opioid epidemic, void from the conversation are culturally sensitive options for disadvantaged minority communities. There is also need for more awareness and scholarly research that addresses the racial divide regarding the opioid epidemic.

Recommendation 1: Offer culturally sensitive treatment solutions. As the face of the opioid epidemic has been whitewashed or told through the narratives of Whites, there has been a shift in the public's negative perceptions and attitudes toward the drug abuser themselves (Kane-Willis et al., 2019). A recent public policy poll in 2017 indicated that the public is in support of opioid users receiving treatment, 61% for heroin users and 72% for Rx drug abusers (Commitment To Privacy,

2020). In contrast, the media portrays minorities as addicts instead of as victims in comparison to their White counterparts (Williams, 2019). This phenomenon is evident not only in regards to opioid use but also for abuse of other drugs, such as methamphetamine (Cobbina, 2008). However, amongst the latest conversations regarding the opioid crisis and policy implications for harm reduction, the role of race is missing. Although research indicates that Blacks and Whites use drugs at the same rate, the response to drug offenses amongst the two groups is different (Rosenberg et al., 2016). Due to the public health crisis of opioid addiction impacting Whites at a disproportionate rate, treatment options and solutions are tailored to the majority population (Lagisetty et al., 2019). Some of the treatment options that are being used to address opioid addiction are limited to communities that have access to financial resources and a lower percentage of minorities (Lagisetty et al., 2019). Due to the high numbers of opioid overdoses in middle class White America along with racially-biased media portrayal, the response garnered from the government has been to declare the problem as a public health epidemic in need of emergency intervention (Trump formally declares US opioid crisis a “public health emergency”, 2017). Over the past 10 years, the face of the opioid crisis has been one of White middle class Rx users in contrast to the War on Drug’s minority heroin users. An inaccurate portrayal of opioid use results in different policy approaches. Punitive versus rehabilitative policy approaches can have long lasting negative and devastating effects in disadvantaged communities (James and Jordan, 2018). Research has suggested that faith-based rehabilitative treatments have been more effective for minorities (James and Jordan, 2018). There is also a need for concerted efforts by government and community stakeholders in working with forensic science agencies to gather intelligence of the geographic prevalence of dangerous drug cuts (i.e. fentanyl) and in examining drug treatment court records to target hotspots for drug activity and opioid abuse.

Recommendation 2: Increase affordable treatment solutions.

Previous research has demonstrated the racial and socioeconomic disparities in opioid abuse treatment, where the uninsured minorities and Blacks were found to underutilize opioid treatment options (Krawczyk et al., 2017; Wu et al., 2016). According to a 2019 report by the Chicago Urban League, many of the black Americans who experience opioid abuse disorders are socioeconomically disadvantaged, live in urban cities, and are uninsured or utilize public health-care options, which limit their treatment options (Bechteler and Kane-Willis, 2017). The establishment of a comprehensive Rx monitoring and reporting

program that utilizes arrest records to determine drug hubs may also aid in establishing patterns and trends of opioid abuse in minority communities. Additionally, ensuring the availability of resources for in-patient treatment options that are, both, cost-effective and accessible to minority communities will be essential in moving forward with practical solutions to the opioid epidemic in these areas.

Current drug treatment options for opioid addiction include buprenorphine, methadone, naltrexone, and naloxone. Although each drug is available only by Rx, for the uninsured, costs may be an issue, particularly with buprenorphine, as insurances plans often do not cover this drug for opioid abuse disorder. Of the four available drugs, naloxone has limited access and is routinely only administered for reversal of respiratory depression during opioid overdoses (Toderika and Williams, 2018). According to Drugs.com, the cost for naltrexone oral tablets (50 mg) averages around \$46 for 30 tablets. This price is associated with a discount card for cash paying customers only and is not valid with the use of insurance plans. Although pharmaceutical companies often provide free or discounted medications for low-income patients, currently there are no patient assistance programs for this drug. However, the extended formulation of naltrexone, also known as Vivitrol®, is much more expensive. The average cost for the once a month injection is \$1900, and even with a coupon discount, the average cost is \$1300. Depending on the formulation of methadone, the cost range is \$18.77 for 100 tablets up to \$471.34 for 50 grams of the compounding powder. Similarly, available formulations of buprenorphine costs range from \$66 to \$261.05. Each of the above-mentioned prices are for cash paying customers who use a discount card (Naltrexone Prices, Coupons & Patient Assistance Programs – Drugs.com, 2019).

Recommendation 3: Establish Rx monitoring programs and uniform reporting requirements.

There have also been outcries by community stakeholders for more regulation and the establishment of national and local registries to track access to Rx opioids. There is a need to establish uniform Rx monitoring programs, such as the Statewide Electronic Health Record Integration of Rx Data Program, which has been implemented in West Virginia to address their opioid-induced fatality rate, which is at an all-time high (West Virginia Board of Pharmacy Announces Statewide Electronic Health Record Integration of Prescription Data – Current Topics – WV Board of Pharmacy, 2019). To further combat the number of people who misuse Rx opioids, the CDC also released a set of guidelines for primary care physicians in the prescribing of opioids for long-term chronic pain (Centers for Disease Control and

Prevention, 2016). There is also a need for a more uniform reporting between jurisdictions of specific drugs and ethnicity and race information identified on death certificates in suspected OODs.

Conclusions

Presently, it appears that the opioid epidemic, which is significantly impacting rural and suburban White, Non-Hispanic communities, is being treated as a public health crisis rather than the U.S. government's past "War on Drugs", which initiated swift and harsh penalties for the sell or abuse of controlled substances in urban, minority communities. However, more public media outlets are starting to bring more awareness to the opioid problem in disadvantaged, minority communities (Mauer, 2019). It also appears that more scholarly and peer-reviewed articles are recognizing the opioid epidemic's racial divide (Cicero and Ellis, 2015; Hansen and Netherland, 2016; Netherland and Hansen, 2016, 2017). There are many layers to the opioid problem, but there is a lack of attention to this problem in lower socioeconomic minority communities (Dennis, 2017). In February 2019, the Surgeon General tweeted:

And in 2016, Black and African American youth 12–17 were more likely than whites to have used opioids in the past year. This data shows that we are moving in the wrong direction, and may be a precursor to even more opioid overdose fatalities in the black community in coming years.

This paper contributes to the scholarship in this area by addressing the role that race plays in the opioid epidemic. As urban minority communities are impacted by the opioid epidemic, they should receive the same rehabilitative and non-punitive approaches that are extended to rural and suburban White communities. The response to the opioid epidemic has been divided by race and class and represents a systemic failure to ensure that minorities are a part of the conversation about solutions and future policy implications. The media and the government framed the opioid problem by identifying physicians, drug dealers, and pharmaceutical companies as the main contributors, while failing to recognize race as a contributing factor. The different government responses, media portrayal, and drug prosecutions between the opioid epidemic and the War on Drugs era clearly shows alternative narratives (Cooper, 2015). Current criminal justice policies reinforce preferential treatment toward Whites when a drug problem impacts their community in comparison to minorities, who have been dying from the effects of the heroin and Crack epidemics for decades

(Williams, 2019). Researchers have suggested that by "Whitewashing" this epidemic, devastating increases in the number of deaths in minority communities have been overlooked (Kane-Willis and Bechteler, 2018). Rethinking policy implications requires the U. S. government to change its approach in order to ensure that every one impacted by the opioid epidemic, regardless of their race or ethnicity, is included in the dialogue in addressing this epidemic.

Limitations

The findings in this paper are subject to several jurisdictional and reporting limitations. One limitation to assessing the totality of the opioid epidemic in Black and Hispanic Communities is a lack of specific race or ethnicity-based reporting in some jurisdictions. There may also be inaccuracies in the assignment of race and ethnicity on the death certificate, which is used for reporting. Another key limitation in presenting the numbers/rates for specific drugs is that the specific drugs involved in overdose deaths are not always reported (Scholl et al., 2018). Additionally, many drug overdose deaths may involve multiple drugs. This use of drug combinations may introduce ambiguity in the death certificate and reporting, which may lead to a death being attributed to more than one drug category (Hedegaard et al., 2018). There are also jurisdictional variabilities in the reporting of specific drugs, which affect the quality and completeness or available data for reporting (Hedegaard et al., 2018). The authors also encourage caution when reporting state-level differences in drug-specific OODs based race and ethnicity, due to the variability in the reporting of specific drugs on death certificates, due to jurisdictional requirements and CDC limits on State reporting (Scholl et al., 2018).

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