DRUG POLICY ALLIANCE.

THE IMPACT OF THE OVERDOSE CRISIS ON BLACK COMMUNITIES IN THE UNITED STATES

JULY 2024

To date, the United States has lost over one million lives to drug overdose during this crisis. Drug overdoses have affected all communities in all regions across the United States. Yet there are notable racial and ethnic disparities that have emerged over the past 25 years, even though people of all races and ethnicities use drugs at similar rates. At different points in the overdose crisis, certain groups experienced more loss than others.

Recognizing racial disparities in overdose deaths can help develop effective policy solutions. This fact sheet describes overdose death trends among the Black community. It also provides policy recommendations and strategies for how we can save lives.

THE FOUR WAVES OF THE OVERDOSE CRISIS

First Wave- Early 2000s. Prescription Opioids. When the crisis began in the early 2000s, Native American and white people had the highest rates of overdoses compared to other groups. Initially, these deaths were driven by prescription opioids, and it marked the "first wave" of the overdose crisis.[1]

"Second Wave" - 2010- 2014. Opioid prescribing reduced; people turn to heroin. As opioid prescribing and dispensing was reduced, many people transitioned to buying street heroin. The "second wave" of the crisis began in 2010 when heroin overdose deaths increased among all groups.

Third Wave- Started in 2014. Fentanyl is introduced to east coast drug supply. Fentanyl, a highly potent opioid, entered the east coast drug supplies after 2014 in response to heroin supply disruptions. Underground drug suppliers saw it was cheaper and easier to produce fentanyl and bring it into the country than heroin. However, people who use drugs were unprepared for the highly potent drug and people began to die of overdose at higher rates. This began the "third wave" of the overdose crisis and overdose deaths rose and all racial and ethnic groups.[2]

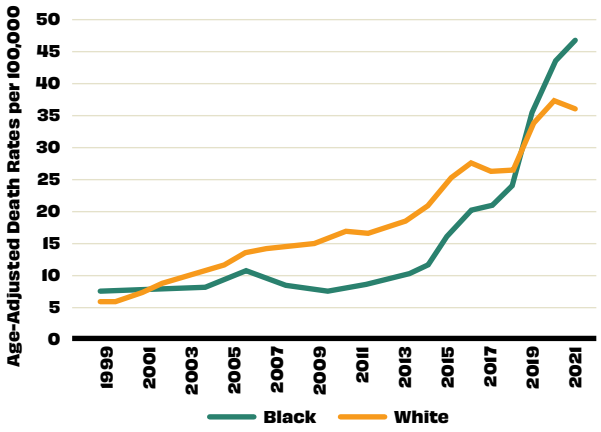
Fourth Wave- 2017 to present. Polysubstance overdose deaths from stimulant drugs, often in combination with fentanyl, increase. Overdose deaths involving stimulant drugs such as cocaine and methamphetamine started to increase nationally in 2017. Cocaine-involved overdoses increased on the east coast, while methamphetamine-involved overdoses increased on the west coast. Many of these deaths involve both stimulants and fentanyl.[3] Mixing drugs or using multiple drugs together can increase overdose risk because it places more stress on the body. A small portion of deaths involve stimulants with no opioids.

We are currently still in the "fourth wave" of the crisis.

BETWEEN 1999 AND 2022, THE BLACK OVERDOSE DEATH RATE INCREASED MORE THAN SIX-FOLD, DRIVEN LARGELY BY FENTANYL.

According to data from the Centers for Disease Control, the Black overdose death rate was 7.5 per 100,000 in 1999 but increased to 47.5 per 100,000 by 2022.[4] This increase happened gradually over time. Black overdose deaths were stable during the first two waves of the crisis, and rates stayed below the national average. But Black overdose death rates increased after fentanyl entered the drug supply during the third wave of the crisis. Black overdose death rates increased even more during the fourth wave of the crisis and since the COVID-19 pandemic in 2020 due to polysubstance use.

NATIONAL DRUG OVERDOSE DEATH RATES, BY RACE

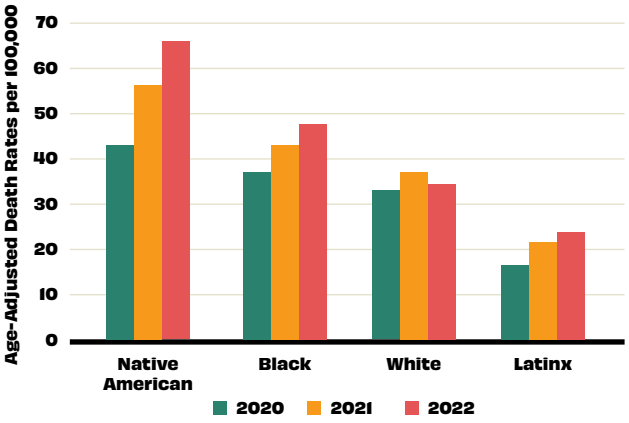


Source: CDC WONDER, 2024

BLACK PEOPLE HAVE DIED OF DRUG OVERDOSES AT A HIGHER RATE THAN WHITE PEOPLE SINCE THE COVID-19 PANDEMIC IN 2020.[5]

Overdose death rates among Black people have continued to increase. Between 2021 and 2022, the Black overdose death rate increased by 7% as white rates went down.[6] Since 2020, Black communities have had the second highest overdose death rate after Native Americans nationally.

NATIONAL DRUG OVERDOSE DEATH RATES SINCE 2020, BY RACE



Source: CDC WONDER, 2024

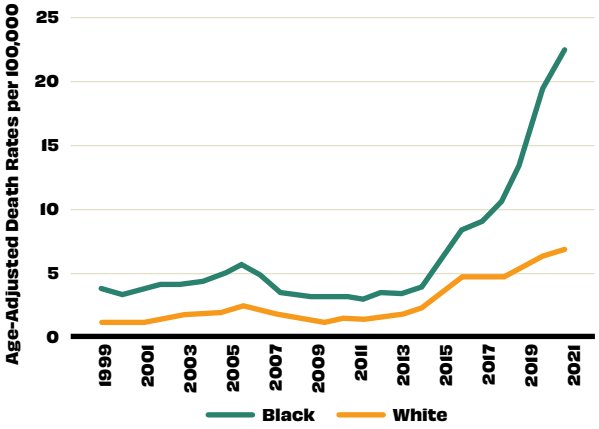
Black people have had a higher rate of drug overdose deaths in urban counties than in rural counties in recent years.[7]

Although Black women have lower overdose death rates than some other groups, overdose is the fourth leading cause of death after cancer, heart disease, and COVID-19.[8]

In 2022 in many major cities across the nation, Black middle-aged and older men had the highest rates of overdose across all demographic categories. This includes cities like Washington DC, New York City, St. Louis, Chicago, Philadelphia, and others.[9, 10, 11, 12, 13]

While the majority of overdose deaths among the Black community involve fentanyl, many of these overdose deaths also involve cocaine.

COCAINE-INVOLVED OVERDOSE DEATH RATES, BY RACE



Source: CDC WONDER, 2024

Black people have the highest rates of cocaine-involved overdose death rates compared to all other groups. However Black people do not use cocaine at higher rates than other groups.[14] It is possible Black people are more vulnerable to cocaine overdose due to underlying risk factors, including high rates of untreated heart disease, blood pressure, diabetes, and disparities in structural and social determinants of health.[15]

Overdose deaths involving both opioids and cocaine increased by 575% among Black people between 2007 and 2019[16]

WHY OVERDOSE DEATHS ARE SO HIGH IN THE BLACK COMMUNITY

DIFFICULTY ACCESSING MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

There are two lifesaving MOUD: methadone and buprenorphine. Research shows that they can cut the risk of overdose in half for people with opioid use disorder (OUD).[17] However, both medications are very difficult to access. Patients can only get methadone at an Opioid Treatment Program (OTP). OTPs often require daily or near-daily pick-ups and observed dosing of medication. Strict attendance requirements, random drug testing, and other restrictive policies discourage or make it very difficult for patients to enroll or stay enrolled in OTPs.

Due to recent policy changes, buprenorphine can be prescribed by many healthcare providers. However, research shows that Black patients with OUD are less likely to receive a prescription than white patients.[18] Research suggest that, while patient preferences may play a role, it is possible that prescriber biases could contribute to disparities.[19] Insurance issues, out of pocket costs, and difficulty at pharmacies also make it difficult to get buprenorphine.

LIMITED ACCESS TO OVERDOSE PREVENTION AND HARM REDUCTION EDUCATION, TOOLS, AND SUPPLIES.

Many harm reduction programs target people who inject drugs and use opioids. This may mean that Black people who smoke or snort cocaine may not seek services at traditional syringe service programs. In many states, it is not legal for harm reduction programs to distribute smoking equipment or fentanyl test strips. Without access to overdose prevention or harm reduction programs, Black people who use stimulants may not get free naloxone, supplies, and harm reduction education to stay safer.

RACIST DRUG LAW ENFORCEMENT TARGETING BLACK PEOPLE

Black people are disproportionately targeted and criminalized for drug possession, even though they do not use drugs at higher rates than other groups.[20] Alcohol and drug overdose deaths are high in jails and prisons because treatment is often unavailable. It is estimated that MOUD is unavailable in over half of all jails and in 90% of state prisons.[21] Overdose risk is also highest in the first two weeks of release from incarceration.[22] This is because drug tolerance goes down after abstinence or without treatment. It is also challenging to find treatment after release, especially for those without insurance. For those on probation, parole, and in drug courts, access to MOUD can be limited. In addition, having a criminal record can create barriers and obstacles in people's lives. It can affect one's health by limiting job options, housing options, and other social determinants of health.

Social determinants of health refer to the non-medical factors that impact health outcomes (i.e. job opportunities, immigration status, housing, food security etc.)

MISTREATMENT AND STIGMA IN HEALTHCARE SETTINGS DUE TO RACISM AND NEGATIVE ATTITUDES AGAINST PEOPLE WHO USE DRUGS

Many Black people face discrimination in medical settings, especially Black people who use drugs. They are less likely to have high-coverage health insurance and less access to quality services from providers and local healthcare facilities.[23] As a result, many do not seek or finish treatment for mental health, addiction, or other medical issues. When people have untreated medical needs, they are more vulnerable to experiencing drug harms.

It is also important to note that medical discrimination explains why Black patients have been historically undertreated for pain due to racial bias in pain assessment, treatment, and healthcare provider false beliefs about Black pain.[24] Opioid prescribing has always been low among Black patients, which explains lower rates of prescription opioid-involved overdose deaths during the first wave.

WHAT WE NEED TO DO TO SAVE LIVES

Decriminalize drug possession and harm reduction tools. Drug use is a health issue and should not be treated as a criminal issue. If drugs were no longer criminalized, people who use drugs would not face arrest and incarceration for personal possession. People who use drugs would not get a criminal record that would create future obstacles in life. It is important to decriminalize syringes, smoking equipment, and drug checking tools in all states. When supplies are decriminalized, harm reduction programs can distribute them in the community.

Improve access to MOUD. In other countries, people can access methadone in pharmacies. We must explore options beyond the OTP model to make methadone easier to access for people with OUD. We must provide access to methadone and buprenorphine in jails and prisons. We must also make it easier to start patients on MOUD while in the emergency room and in other medical settings. Treatment should be available with few requirements and restrictions.

Expand and fund more overdose prevention and harm reduction services. Harm reduction services must be available in all communities. This can include brick and mortar programs, but also mail-order and mobile outreach programs. Drug checking, including fentanyl test strips and more advanced methods, are an important tool to save lives. Overdose prevention centers are needed in communities across the nation. They provide life-saving services and help connect people to other services too.

Increase culturally sensitive services. Black people who use drugs need services that are culturally sensitive to their needs and acknowledge their histories of mistreatment. We also need more Black harm reduction, treatment, and medical providers in communities.

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