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ISSUE BRIEF

Whitewashed:

The African American Opioid Epidemic

This is the inaugural issue brief in a series written by the Research and Policy Center (RPC) at the Chicago Urban League. The RPC will produce timely briefs in response to important issues that impact the African American community in Chicago.

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EXECUTIVE SUMMARY

The opioid epidemic has largely been portrayed as a problem affecting young whites in suburban and rural areas. In Illinois, the Midwest, and indeed much of the United States, this is a wholly inaccurate depiction. The prevailing narrative neglects how people of color have been profoundly impacted:

- African Americans are dying from opioid overdose at a rate higher than the general population in several states, including Illinois, Wisconsin, Missouri, Minnesota, and West Virginia, and in Washington, D.C.;
- In Wisconsin and West Virginia, the African American fatal overdose rate was nearly double that of whites.

Illinois provides a clear example of how hard African Americans have been hit by the opioid epidemic.

- Data from the Illinois Department of Public Health show that all opioid deaths (heroin and pain pills) in Illinois more than doubled among African Americans (132% increase) from 2013 to 2016, rising faster than for any other racial group during that period;
- Among African Americans, deaths from pain pills increased nearly nine-fold while white fatalities tripled.
- African Americans account for nearly *one quarter* of opioid overdose deaths despite making up about 15 percent of Illinois's population;

While much attention has been paid to suburban areas as the focus of the opioid crisis, the city of Chicago is a case study for multiple reasons: 1) the increase in opioid overdose deaths, 2) the rise of fentanyl, and 3) the impact on African Americans.

- Chicago has experienced an extreme increase in fatal opioid overdoses in just one year– an increase of nearly 75%.
- Black people make up approximately 32% of the population in Chicago but account for nearly half (48.4%) of all opioid deaths.
- In 2016, the African American death rate from opioids in Chicago was 56% higher than the white death rate in Chicago (39.3 vs 25.1).
- Compared to U.S. data from 2015, which is the most currently available data from the CDC, in Chicago the African American death rate in 2016 was nearly four times higher than the national average in 2015 (39.3 vs 10.4).
- The neighborhoods with the highest overdose death rate from fentanyl include East and West Garfield Park, North Lawndale, Austin, Humboldt Park, Fuller Park and Englewood – all racially concentrated areas of poverty.

It is good news that attention has now turned to taking a public health approach to addressing the opioid crisis. However, if a public health approach is to work, it is essential to ensure that treatment capacity meets treatment need. Unfortunately, this is not the case in Chicago or Illinois.

- Chicago has the lowest treatment capacity for medication-assisted treatment (buprenorphine) in the Midwest and is third lowest among large cities nationally;
- Low treatment capacity can have a disparate impact on African American communities, especially among those living in poverty, who often face multiple barriers to receiving treatment, including transportation and childcare.

Based on these data, African American people, families and communities should not be excluded from narratives told about the opioid epidemic. African Americans must be included in the development and implementation of national and local public health initiatives, as well as in treatment response plans.

BACKGROUND

Much local and national attention has been paid to the opioid crisis, the ever-increasing use of prescription pain pills, heroin and the synthetic drug fentanyl[1]. The President of the United States recently declared the epidemic a public health emergency and the President's Commission on Combating Drug Addiction and the Opioid Crisis, convened in March 2017, released its final report in November 2017. The crisis has been escalating for years—opioid-related deaths doubled from 2000 to 2015, and in the past few years, the situation has only worsened.[i] The most recent Centers for Disease Control and Prevention data demonstrate a 21% rise in overdose deaths in 2016, largely fueled by an increase in fentanyl-related deaths. Fentanyl, a powerful synthetic opioid, often enters the country in the form of adulterated heroin, which increases potency and reduces costs for distributors, but also increases a user's risk of overdose.[ii] Throughout 2016, a number of jurisdictions saw overdose fatalities increase significantly higher than in the U.S. as a whole, including Illinois (33%)..[iii]

The epidemic has largely been portrayed as a problem affecting young whites in suburban and rural areas. The Commission's report reserved only a few sentences in a nearly 150-page document for discussion of the epidemic's impact on our country's communities of color.[iv] In Illinois, and indeed much of the United States, this is a wholly inaccurate depiction.

The federal government's response to the opioid epidemic has lacked much, if any, focus on how African Americans are impacted. The final report of the President's Commission noted that the majority of black Americans with opioid use disorders (OUDs) fall in the lowest income bracket, rarely receive treatment, utilize public insurance programs like Medicare and Medicaid, and primarily live in metropolitan areas.[v] However, the majority of whites with OUDs share many of these same characteristics, the exception being a greater likelihood of being enrolled in private insurance.[vi]

Despite the fact that many who need and seek opioid treatment rely on public insurance, the current administration has backed federal legislation that cut or restricted these essential health benefits and federally-backed health centers during the spring and summer of 2017. While none of these pieces of legislation came to fruition, there is no doubt that cuts to Medicaid and to subsidies under the Affordable Care Act (ACA) will have dire consequences for the opioid epidemic. Without insurance and health centers, people lack access to even basic health services, let alone access to medication- assisted treatment (MAT), the most effective treatment approach to reducing dependence on opioids and reducing overdose risk. Without access to evidence-based treatment, more people will die, even if the opioid epidemic were to plateau today. Unfortunately, the opioid overdose epidemic shows no signs of ebbing; rather, the evidence points to a fast and sharp increase in the number of deaths due to opioid overdose.

[1] Fentanyl is a synthetic opioid that is 40 to 100 times stronger than heroin. While it is used as a prescription in hospitals and in very critical pain situations, the fentanyl crisis in the US is one of illicit fentanyl that is often mixed into heroin prior to it entering the US by drug trafficking organizations.

CONFLICTING APPROACHES: PUBLIC HEALTH CRISIS VS THE WAR ON DRUGS

Since the 1980s, the policies and practices promoted under the banner of the War on Drugs – which relies heavily on policing, arrests and mass incarceration – have been applied disproportionately to African American communities. This stands in stark contrast to the current compassionate response in the form of public health and treatment approaches to the "white" opioid epidemic. African Americans made up just 13% of the U.S. population in 2016, but comprised 27% of all arrests for drug crimes. [vii] In contrast, non-Hispanic whites made up about 61% of the population and ~55% of drug arrests.[viii] While the total number of whites arrested on drug crimes was higher, a closer interpretation shows that African Americans' share of drug arrests was more than *twice* their share of the population. This is the type of disparity often found in the criminal justice system, particularly as it pertains to drug crimes.

This is not a new phenomenon—black Americans have been arrested for drug crimes at wildly disparate rates for decades under the War on Drugs. As crack cocaine devastated black communities in cities around the country during the 1980s, punishment was the only solution; countless families and communities were torn apart by the criminal justice system. Policies like mandatory minimum sentences and "stop and frisk" policing practices made black communities into sites of intense control and surveillance. And they remain so to this day.

An analysis conducted by Chicago Million Dollar Blocks, shows the neighborhoods that have been disproportionately been impacted by drug arrests and incarceration. For example, during the period from 2005-09, in Austin nearly $300M was spent on incarcerating individuals for drug crimes, and nearly 200M was spent in East and West Garfield Park[ix] to *total than half a billion dollars* in those three community areas.

The War on Drugs is alive and well in Chicago. From 2012 to 2016, the Chicago community areas with the highest rates of felony drug arrests were overwhelmingly the city's racially concentrated areas of poverty; the neighborhoods with the lowest rates were primarily white and wealthy. Setting aside arrests, black Chicagoans experience verbal and physical abuse at the hands of police on a regular basis. As evidenced in the Department of Justice's report last year, CPD officers call the black people they serve "savages," "animals," and "pieces of sh*t. " CPD received 354 complaints for officers' use of the word "n****r" from 2011 to 2016[x]. The same report showed that police used excessive force against black Chicagoans *10 times* more often than against whites, and when black people reported these abuses, their allegations were three times less likely to be upheld. It is no wonder that one young black Chicagoan described their neighborhood as, "an open air prison."[xi]

In recent years, as white Americans have increasingly felt the impact of the opioid epidemic, responses have softened, and white lawmakers and citizens now call for a "gentler War on Drugs."[xii] This sort of rhetoric is bittersweet. The War on Drugs *was* an abject failure, yet that failure is only recognized when white people suffer. We do not need a return to punitive policies or an increase in white drug arrests to balance this inequity. Rather, we need to acknowledge the systemic racism built into the War on Drugs

and move toward a public health approach to opioid use that accounts for how all Americans, including African Americans, are impacted by the current crisis.

APPLYING A PUBLIC HEALTH MODEL TO THE OPIOID CRISIS

Although the President called the opioid crisis a "public health" emergency, there may be misconceptions about what this approach looks like. The first essential component of a public health model is that any intervention is evidence-based. This means that any intervention uses methods that have been tested empirically by scientists and researchers and is proven to work. In terms of opioid use, there are three types of interventions that can be applied:

1. **Primary Prevention.** These prevention programs target drug use before it begins. Although the President recommended the use of advertising for primary prevention, these tactics have not been demonstrated to work, and may have unintended consequences that actually increase use.[xiii] However, there are many primary prevention programs that are evidence-based and do reduce drug use and other behaviors that may cause harm to an individual, the family, and society. These may be implemented in a variety of settings, with individuals, in schools or in the community.

2. **Secondary Prevention.** This is what most Americans think of when they think about opioid use disorders – it is treatment for a substance use disorder (SUD). The evidence shows that opioid agonist[2] medications, like the buprenorphine and methadone used in MAT programs, are the most effective methods of reducing injury and death in people with opioid use disorders. Medication-assisted therapy also reduces criminal justice involvement and health costs and is extremely cost effective, returning $12 for each dollar invested.[xiv]

3. **Tertiary Prevention**. Tertiary prevention refers to additional strategies and programs to help reduce morbidity and mortality among people who use drugs. The main focus of these programs is to reduce the harm associated with drug use, which is why they are often referred to collectively as "harm reduction" methods. Examples of tertiary prevention include syringe exchange; distribution of naloxone (the opioid overdose antidote) to people who use drugs and to first responders; drug checking kits to detect adulterants; and safe consumption facilities. All of these interventions are evidence-based, reduce illness and death, and are extremely cost effective.

[2] Agonist treatments include methadone and partial agonists include buprenorphine. These drugs fill the opioid receptors to prevent withdrawal and block other opioids from attaching to the opioid receptors at adequate medication levels.

TREATMENT NECESSITY AND CAPACITY TO TREAT IN URBAN AREAS

If a public health approach to the opioid crisis is to work, it is essential to ensure that treatment capacity meets treatment need. Although heavily populated central cities may have more treatment resources, they also have more people, which can put a strain on treatment capacity. A recent analysis featured in the Huffington Post examined the availability of buprenorphine providers (doctors who actively prescribe and treat individuals with buprenorphine) showed a significant gap between need and capacity to provide this lifesaving and cost-saving treatment[xv].

It is not possible to calculate the treatment gap by city or county, but we are able to infer it based on gaps in state treatment provider data. For example, New York State has a very low treatment gap – for every 100,000 people, just 20 who need opioid use disorder treatment will not receive buprenorphine treatment based on the state's ability to provide it. On the other hand, Illinois has a gap that is much higher– 380 people who need treatment per 100,000 will not receive these essential services due to a lack of providers[xvi].

An inference can therefore be made regarding treatment capacity in large cities using New York State and New York City as a yardstick. The assumption we made based on treatment need and capacity is that a large city would need ~700 treatment slots per 100,000 individuals to be effective. Most large cities do not have the capacity to treat all of those who need treatment – especially as the crisis escalates. (Table 1)

Data shows that Chicago has the lowest treatment capacity for buprenorphine treatment in the Midwest and is third lowest among cities nationally. In Illinois, the majority of African Americans live in Chicago. A low treatment capacity rate in urban cities like Chicago, makes these services less available to African Americans who need OUD treatment.[xvii] (Tables 1-2)

Table 1: Major United States Cities and Corresponding Counties by Buprenorphine Treatment Capacity, 2015[xviii]

Rank	City	County	County Population	Treatment Capacity (n)	Treatment Capacity (Rate/100,000)
1	Philadelphia, PA	Philadelphia	1,526,006	12,570	824
2	New York, NY	Multiple	8,175,133	63,840	781
3	San Diego, CA	San Diego	3,095,313	15,970	516
4	Phoenix, AZ	Maricopa	3,817,117	15,040	394
5	San Jose, CA	Santa Clara	1,781,642	6,630	372
6	Los Angeles, CA	Los Angeles	9,818,605	33,510	341
7	Houston, TX	Harris	4,092,459	12,780	312
8	Chicago, IL	Cook	5,194,675	15,360	296
9	Dallas, TX	Dallas	2,368,139	6,820	288
10	San Antonio, TX	Bexar	1,714,773	4,810	281

Table 2: Major Midwestern Great Lakes Cities and Corresponding Counties by Buprenorphine Treatment Capacity, 2015[xix]

Rank	City	County	County Population	Treatment Capacity (n)	Treatment Capacity (Rate/100,000)
1	Columbus, OH	Franklin	1,163,414	12,460	1,071
2	Indianapolis, IN	Marion	903,393	5,930	656
3	Milwaukee, WI	Milwaukee	947,735	6,220	656
4	Cleveland, OH	Cuyahoga	1,280,122	8,130	635
5	Detroit, MI	Wayne	1,820,584	10,940	601
6	Minneapolis, MN	Hennepin	1,152,425	5,540	481
7	Chicago, IL	Cook	5,194,675	15,360	296

RACE IN THE NATIONAL PERSPECTIVE

While the narrative around the opioid epidemic has been a story of white youth living outside central cities, this narrative neglects how people of color have been profoundly impacted by the epidemic. For example, there are a number of states where African Americans are dying from opioid overdose at a rate higher than the general population.[3] Four of the top 10 states are located in the Midwest, including Wisconsin, Missouri, Illinois and Minnesota (Table 3). In Illinois the opioid overdose death rate for African Americans in 2015 was 11.6 per 100,000, compared to 10.4 for the general population. In some states, the African American opioid overdose death rate exceeds all other races, like in Missouri (14.8 per 100,000) and Wisconsin (21.9 per 100,000). Beyond the Midwest, in West Virginia the African American overdose rate was double that of whites, despite media coverage suggesting otherwise.

According to survey data[xx], OUDs occur less frequently among African Americans. Yet survey data of this nature may have limitations, especially people of color living in poverty and for stigmatized self-reported behaviors. But if we assume that the African American opioid use rate is lower than the rate among whites, then there is something else at play that is causing African Americans to experience such high death rates. One hypothesis is that many large cities do not have good treatment systems, or do not have treatment systems that can handle the capacity of need among potential patients. Treatment is a key component in preventing further injury and death. As African Americans with OUDs are likely to be in the lowest income group with less access to medical care overall, let alone addiction treatment services, it stands to reason that this lack of access could be a significant factor in the observed death rates for this group.

African Americans who live in poverty may face multiple barriers to accessing care – lack of insurance, transportation issues, childcare, among myriad other issues facing those living in racially concentrated areas of poverty often found in major metropolitan areas. These issues are not confined to African Americans living in poverty – these same barriers to treatment can be issues for whites who live in poverty either in urban, suburban or rural areas. However, health disparities among African Americans are well documented and are a known contributor to lower life expectancies. Based on these issues and the escalating rise in overdoses in specific states, the Chicago Urban League's Research and Policy Center expects the number of African Americans dying from opioid overdoses to again rise once national data are updated for 2016.

[3] Many of these states have experienced significant rises in overdose deaths in 2016, but these data are not yet available for all states, nor are they available by race and ethnicity.

Table 3: Top 10 States with the Highest Rate of Opioid Overdose Deaths among Whites, African Americans and the General Population - 2015[xxi]

State	White	African American	General Population
West Virginia[4]	36.2	55.5	36.0
District of Columbia	NR	22.8	14.5
Wisconsin	11.3	21.9	11.2
Ohio	27.7	15.2	24.7
Maryland	25.0	14.8	17.7
Missouri	11.9	14.8	11.7
Massachusetts	27.1	13.2	23.3
Michigan	14.7	12.4	13.6
Illinois	13.1	11.6	10.7
Minnesota	6.0	10.0	6.2
United States	***13.9***	***6.6***	***10.4***

[4] Text in red indicates a higher death rate among African Americans than among the general population in that state.

RACE AND THE ILLINOIS EPIDEMIC

The opioid overdose crisis in Illinois shows few signs of abating. In just three years, overdoses related to opioids increased by 82%. Illinois provides a clear example of just how hard African Americans have been hit by the opioid epidemic. Recent data from the Illinois Department of Public Health show that all opioid deaths (heroin and pain pills) in Illinois rose faster among African Americans than any other racial group from 2013 to 2016, more than doubling in just three years with a 132% increase (Table 4). Over the same time period, African American deaths from pain pills increased dramatically, by *nearly nine-fold*, compared to a three-fold increase in white fatalities (Table 5).

As of 2016, African Americans make up about 15% of Illinois's population, but account for nearly 1 out of 4 opioid overdose deaths in the state (Table 6). This disparity is missing from the current opioid narrative as discussion of African Americans who have died from overdose is significantly lacking. Various media outlets have reported on the "largely white opioid epidemic," or sought to answer, "why so many white American men are dying."[xxii]

The issue here is not that white people aren't dying - they are and in record numbers, leaving families throughout the country devastated. The issue is that African Americans, who in some places are dying at rates *exceeding any other racial group*, are excluded from the conversation. The "white" opioid epidemic is in truth no such thing. Black people around the country have been hit hard by this epidemic and will continue to suffer unless we recognize the full scope of the problem and advocate for evidence-based, public-health-focused solutions inclusive of all impacted people and communities.

Table 4: Illinois Fatal Overdoses from Any Opioid 2013-2016[xxiii]

Racial Group	2013	2014	2015	2016	% Change
White	758	876	1029	1230	62%
African American	198	229	235	459	132%
Other	12	7	8	24	100%
Latino	104	91	110	204	96%
Total	1,072	1,203	1,382	1,946	82%

Table 5: Illinois Fatal Overdoses from Opioid Analgesics (Pills)[xxiv]

Racial Group	2013	2014	2015	2016	% Change
White	286	374	491	804	181%
African American	33	42	68	308	833%
Other	4	5	3	19	375%
Latino	21	20	27	135	543%
Total	344	441	589	1,266	268%

Table 6: African American Fatal Overdoses in Illinois as a % of All Overdoses 2013-2016[xxv]

2013	2014	2015	2016
18.5%	19.0%	17.0%	23.6%

CHICAGO AS A CASE STUDY

Chicago has experienced an increase in fatal opioid overdoses in a relatively small period of time – an increase of nearly 75% from 2015 to 2016 (Table 7). However, the opioid crisis in Chicago is truly an African American opioid crisis. In 2016, the African American death rate from opioids in Chicago was 56% higher than the white death rate (39.3% vs 25.1%). Compared to U.S. data from 2015, which is the most currently available data from the CDC, the African American death rate in Chicago in 2016 was nearly four times higher than the national average in 2015 (Table 8)[xxvi].

Overdose death rates in Chicago involving heroin, fentanyl, and other opioids are highest in Black communities on the South and West sides, with Austin suffering the highest death rate of all community areas. Black people make up approximately 32% of the population in Chicago but account for nearly half (48.4%) of all opioid deaths (Table 9).

The rise of fentanyl-adulterated heroin plays a large role in Chicago's evolving crisis, much as it does in the rest of the United States. Fentanyl-related deaths represented nearly 58% of opioid deaths in 2016, more than three times fentanyl's share of deaths in 2015.[xxvii] The neighborhoods with the highest overdose death rate from fentanyl include East and West Garfield Park and North Lawndale, with Austin, Humboldt Park, Fuller Park and Englewood following just behind. All of these neighborhoods are racially concentrated areas of poverty on the South and West sides of Chicago.

Table 7: Chicago Fatal Opioid Overdoses by Number, Rate per 100,000 and % Change 2015-2016[xxviii]

2015		2016		%Change 2015-16
#	R	#	Rate	
426	15.5	741	26.7	73.9%

Table 8: Chicago Opioid Death Rate by Race and US Total 2016

Group	2016 Rate
African Americans	39.3
Whites	25.1
Latinos	16.5
US Rate 2015	10.4

Table 9: Chicago Fatal Opioid Overdoses by Race 2015-2016[xxix]

Racial/Ethnic Group	2016	
	#	%
African American	357	48.4%
White	251	34.1%
Latino	123	16.7%

CONCLUSION: WHERE DO WE GO FROM HERE?

A criminal justice system response to substance use has been the mainstay of drug policy and policing practices since the War on Drugs first came into being in the 1970s and was only heightened during increased enforcement efforts undertaken in the 1980s. Any effort to introduce a "kinder, gentler War on Drugs" is a preliminarily welcome start, but not all people and communities benefit from this change equally or equitably. Much of the movement toward embracing less punitive treatment and public health approaches to address substance abuse was born from the narrative surrounding the face of the new heroin user – one that is often young, white and suburban. These people and communities are absolutely being impacted in this epidemic, and should be recognized. But we must also be diligent in our efforts to recognize all people and communities impacted, particularly the Black people and communities that have not only borne the brunt of this epidemic for years, but have done so with relative silence from media and policymakers.

To ensure that we are equitably leveraging new treatment and public health resources across all populations and geographies in need of these services, the following guiding principles should be adopted when proposing and implementing policies and practices to address the opioid epidemic:

1. **Principle 1 – African American people, families and communities cannot be excluded from narratives told about the opioid epidemic, opioid overdose deaths or the needs of impacted individuals, families and communities**. There must be a deliberate and intentional effort to include these stories and experiences, highlighting not just commonalities with other groups, but also the set of characteristics or issues that make the opioid epidemic different for African American communities. It is through accurate depictions of a problem that policymakers will have the information they need to advance effective policy solutions.

2. **Principle 2 – The development and implementation of national and local public health policy and plans must include the participation of African American families, leaders and/or organizations through all phases of the planning process**. There must be a deliberate and intentional effort to include African American community members, community leaders and community organizations in the planning of national/local governmental and policy responses to the opioid epidemic. Experiences and issues unique to African American families and communities must be accounted for in the development of any programs, policies or initiatives designed to reduce opioid use, dependency and overdose. This will require grassroots efforts to identify and meaningfully connect with community members to engage in participatory research and decision-making processes. Governmental and policy planning often takes a top-down approach, but the lived experiences and preferences of impacted persons are crucial elements of creating sound, sustainable policy.

3. **Principle 3 – Public health and treatment interventions must be tailored to address the experiences and needs of the African American community.** Experiences and issues unique to African American families and communities must be accounted for in the development of any programs, interventions or initiatives designed to reduce opioid use, dependency and overdose.

Known social determinants of health, such as poverty, racism and discrimination, as well as environmental and community conditions, such as transportation and resource barriers, reduce service access and availability and discourage people from seeking help. Culturally, economically and geographically-tailored interventions ensure that educational materials, service locations and service models are developed in such a way to recognize the barriers, fears, needs and preferences of the community. Access to critical health and public health resources underpins much of the advocacy and planning efforts for people living in under-resourced neighborhoods. But there is also much work to be done to ensure that the resources and services delivered are reflective of, and responsive to, the people being served.

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