Increases in Disparities in US Drug Overdose Deaths by Race and Ethnicity
Opportunities for Clinicians and Health Systems

For more than a decade, drug overdose deaths have been the leading cause of injury death in the US. During the COVID-19 pandemic and its related stressors and disruptions in access to care, the number of overdose deaths increased substantially and are predicted to account for more than 107 000 deaths in the US in 2021. The unprecedented increase in overdose deaths has been fueled by the continued proliferation of highly lethal synthetic opioids, such as illicitly manufactured fentanyl and fentanyl analogues, and a resurgence of stimulants, particularly methamphetamine, into the illicit drug supply. Importantly, as overdose deaths have increased, the demographic profile of those dying has shifted and disproportionately affects certain racial and ethnic minority populations. A multisectoral approach that includes structural and policy-level changes and clinician- and health-system–based approaches, with an intentional focus on racial and ethnic disparities and the long-standing inequities that contribute to increased risk for overdose, is essential to respond to this urgent public health crisis.

A recent report by the Centers for Disease Control and Prevention (CDC), using data from the State Unintentional Drug Overdose Reporting System (SUDORS), found that in 25 states and the District of Columbia, non-Hispanic White, Hispanic, American Indian/Alaska Native (American Indian/Alaska Native) and non-Hispanic Black (Black) persons experienced the highest increases in drug overdose death rates during 2019-2020: 39% (26.2 to 36.4 per 100 000 persons) and 44% (27.0 to 38.9 per 100 000 persons), respectively. Further, during the first year of the COVID-19 pandemic, overdose disparities widened between Black persons and non-Hispanic White (White) persons. For example, in 2020, overdose rates among Black men 65 years or older (52.6 per 100 000) were nearly 7 times those of White men of the same age (7.7 per 100 000). Significant disparities were also found when sex, age, and racial and ethnic subgroups were examined. Among women, during 2019-2020, the largest relative rate increase (88%) occurred among American Indian/Alaska Native women aged 25-44 years (33.6 to 63.1 per 100 000). Among men, the largest relative rate increase (92%) occurred among young Black men aged 15-24 years (10.7 to 20.5 per 100 000). Furthermore, evidence of prior treatment for substance use disorders among persons dying of an overdose was low across most racial and ethnic groups, particularly among Black persons, with approximately 8.3% having evidence of prior treatment.

The CDC report also identified inequities across several social determinants of health that appear to further exacerbate overdose-related health disparities among certain racial and ethnic minority populations. For example, overdose death rates increased across most racial and ethnic groups as county-level income inequality (defined as the ratio of household income at the 80th percentile to income at the 20th percentile) increased. However, this disparity was most pronounced among Black persons and Hispanic persons. In 2020, among Black persons, overdose rates were more than 2 times as high in counties with greater income inequality compared with counties with lower income inequality (46.5 vs 19.3 per 100 000). Also, opioid-involved overdose rates in 2020 were higher in counties with at least 1 opioid treatment program compared with those with no opioid treatment programs, especially among American Indian/Alaska Native (33.4 per 100 000 persons in high-availability counties vs 16.2 per 100 000 in low-availability counties) and Black (34.3 vs 16.6 per 100 000) persons. Further, increases in overdose death rates from 2019-2020 were more pronounced among American Indian/Alaska Native (20.7 vs 32.1 per 100 000) and Black (23.7 to 35.4 per 100 000) persons compared with White (24.0 vs 28.6 per 100 000) persons in counties with higher potential buprenorphine capacity from Drug Addiction Treatment Act–waived clinicians (ie, qualified practitioners granted waivers to prescribe buprenorphine for opioid use disorder treatment in office-based settings), highlighting long-standing inequities in access to care, which may be due to systemic barriers, stigma, and mistrust in the health care system.

Raising awareness about worsening disparities in overdose deaths among racial and ethnic minority populations and inequities (eg, economic disadvantage) contributing to these disparities is critical to informing an equity-driven response to the overdose crisis. Along with raising awareness, actions to remedy the long-standing disparities in access to medications for opioid use disorder (MOUD), harm reduction services, and other overdose prevention strategies among racial and ethnic minority persons are urgently needed. Clinicians and health care systems can serve as key touch points for treatment and prevention strategies. They can play an
essential role in responding to the escalating crisis by addressing clinician and systems-level barriers to initiating or linking to MOUD, facilitating continuity of care for co-occurring physical and behavioral health conditions, making culturally competent care universal across clinical settings, and building connections with public health, public safety, and community-based organizations.

Given the substantial protective effects of MOUD on opioid-related morbidity and mortality, improving access to treatment is paramount. However, prior research demonstrates that many racial and ethnic minority populations cannot access MOUD in hospital or community settings at rates comparable to those for White populations. In addition, these populations have experienced stigma by health care practitioners related to drug use and hold misperceptions around MOUD, sometimes viewing this approach as “replacing one drug with another” instead of treatment. Culturally competent care, awareness of biases, and nonjudgmental communication can help address treatment access barriers, such as stigma and mistrust in health care systems. Systems-level interventions that can improve culturally competent care include hiring diverse staff that reflect the community they serve and universal clinician training and education to recognize and address biases.

Integrating substance use disorder and harm reduction services into routine clinical care is an important approach to countering rising overdose deaths. Emergency department encounters may be the only interface some patients have with the health system and could serve as an opportunity to provide harm reduction resources, such as naloxone for overdose reversal, fentanyl test strips, and linkage to community harm reduction programs as well as substance use disorder and mental health care services. Studies have shown that hospital-based harm reduction interventions can reduce stigma, engage populations who are underserved and harder to reach, and strengthen patient-clinician relationships. Additionally, comprehensive, multisectoral health system approaches, such as the model from Massachusetts General Hospital, have shown positive benefits in MOUD initiation and retention and in reaching populations who are underserved and disproportionately affected. This approach included establishing an inpatient addiction consult team, a low-threshold bridge clinic (ie, transitional outpatient clinic for patients leaving the emergency department who are not yet connected to care), and integrating treatment within primary care using recovery coaches and office-based addiction treatment nurses.

Other actions clinicians and health-systems can implement include using innovative service delivery models, such as telehealth and remote initiation of MOUD, co-locating health and harm reduction services, and linking and retaining persons with opioid and other substance use disorders to care. Remote health care delivery, such as through telehealth, also has the potential to reach populations who are underserved and experience barriers to accessing treatment (eg, transportation, childcare, lack of access to addiction medicine specialists).

Opportunities also exist to strengthen collaboration between health care systems, public safety, and public health to implement a holistic community response to overdose prevention. For instance, policy makers can work to remove coverage and reimbursement barriers for prescribing MOUD; build linkages between criminal justice and health systems to support reentry and access to care; expand comprehensive syringe service programs; and expand provision of naloxone and fentanyl test strips in communities disproportionately affected by overdose.

Last, it is essential to acknowledge that disparities in overdose deaths are exacerbated by underlying social determinants of health, structural racism, and historical trauma that contribute to increased risk for multiple health-related outcomes, including substance use and overdose, and can serve as substantial barriers to lifesaving care. Progress in current efforts to respond to the overdose crisis will be difficult to fully realize until these deep-rooted systemic challenges and their associated adverse childhood experiences and trauma are addressed. The clinical community is well positioned to be leaders in this effort.

ARTICLE INFORMATION

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REFERENCES