Letters

In Reply We thank Harris for her interest in our research letter1 describing increases in drug overdose mortality in the US by race and ethnicity before and during the COVID-19 pandemic. We wholeheartedly agree that sex- and age-specific analyses of overdose deaths by race and ethnicity would be highly useful for understanding the evolution of the overdose crisis.

The COVID-19 pandemic has highlighted the need to improve the speed and granularity of mortality reporting, especially for rapidly changing causes of death, such as overdose. We were initially concerned when provisional records were made available showing large-magnitude increases in overdose deaths during the pandemic that did not include information by race or ethnicity.2 This disparity mirrored many other instances where race- and ethnicity-specific data were lacking during the pandemic, even as reporting times were shortened for many forms of information. To resolve this gap, we initially searched for proxy measures, including emergency medical services–observed overdose deaths, that could be used to assess increases in overdose deaths during the pandemic in a more timely fashion.3 Those efforts yielded concerning findings suggesting rising racial and ethnic inequities in overdose.4

When the first national data released by the US Centers for Disease Control and Prevention (CDC) became available providing drug overdose death data by race and ethnicity for the 2020 period, we opted to quickly analyze it for publication in our research letter.1 Unfortunately, those data did not allow for simultaneous assessment by sex, age, or other dimensions.

However, in the proceeding months, the CDC took the laudable step of making provisional death data available, including records describing overdose mortality, in a provisional version of its Wide-ranging Online Data for Epidemiologic Research (WONDER) platform.5 This allows for timely assessment of the latest data by race and ethnicity, alongside numerous other dimensions such as sex, age, geography, and drug involved in each death. We hope this development will usher in paradigm shift wherein intersectional inequalities in overdose and other socially influenced causes of death are tracked and responded to in a rapid fashion.

Harris correctly noted that increases in overdose have been larger among men compared with women in the past decade. We would further add that distinct age patterns in overdose by race, ethnicity, and sex must be considered. For instance, the national spread of illicit fentanyl through the drug supply resulted in the highest overdose rates in 2019 being observed among Black men aged 50 to 64 years.6 Among women, the highest overdose death rates in 2019 were observed among American Indian or Alaska Native women, especially those aged 25 to 49 years.6 A careful assessment of how these inequities have shifted during the COVID-19 pandemic by race, ethnicity, sex, age, and state of residence remains an important area for further study. As the overdose crisis exhibits worsening racial and ethnic inequities, we appreciate and echo the prompt from Harris to consider these inequities in an intersectional fashion for surveillance, prevention, treatment, harm reduction, and access to resources.

Joseph Friedman, PhD, MPH
Helena Hansen, MD, PhD

Author Affiliations: Medical Scientist Training Program, University of California, Los Angeles (Friedman); Center for Social Medicine and Humanities, University of California, Los Angeles (Friedman, Hansen).

Conflict of Interest Disclosures: None reported.


