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Opioid Use Disorder: Challenges and Opportunities in Rural Communities

Thoughtful strategies can improve access to high-quality care

Overview

The increasing number of drug overdose deaths in the United States has hit rural areas particularly hard. Between 1999 and 2015, overdose deaths increased 325 percent in rural counties.¹ In 2015, they surpassed the death rate in urban areas.² Additionally, nonfatal prescription opioid overdoses are concentrated in states with large rural populations.³ Helping to drive this trend in rural areas are high opioid prescription rates and challenges accessing medication-assisted treatment (MAT), the gold standard for treating opioid use disorder.⁴

This fact sheet describes some of the challenges rural communities face in providing access to evidence-based treatment and strategies used by federal and state agencies to enhance treatment capacity, including how one rural community responded to the opioid epidemic by addressing the specific needs of its residents. The policies and programs described are not an exhaustive list but are intended to be illustrative.

Medication-assisted treatment (MAT) combines behavioral therapy with one of three Food and Drug Administration (FDA)-approved medications—buprenorphine, methadone, or naltrexone— for the treatment of opioid use disorder (OUD).⁵

These medications minimize or block the euphoric effects of opioids, curtail cravings, and significantly increase a patient’s adherence to treatment.⁶

Rural treatment capacity

Compared with their urban counterparts, rural communities face significant barriers to treatment, such as fewer facilities, which may also offer more limited services, and greater distances to care.⁷

Opioid treatment programs (OTPs), which dispense methadone and may also offer buprenorphine and naltrexone, are a key component of most current opioid use disorder (OUD) treatment systems. Although a shortage of these programs exists nationally, the gap is widest in rural areas, where 88.6 percent of large rural counties lack a sufficient number of OTPs.⁸

An opioid treatment program (OTP) is a facility where patients go, usually daily, to take medications to treat their OUD under the supervision of staff and to receive counseling and other care services.

These programs are regulated and certified by the federal Substance Abuse and Mental Health Services Administration and operate in a number of care settings, including intensive outpatient, residential, and hospital locations.⁹

Another key component of an OUD treatment system is office-based opioid treatment (OBOT), which integrates opioid agonist treatment (i.e., drugs that minimize the effects of opioids) into a patient’s general medical and psychiatric regimen by allowing primary care physicians to provide MAT in their own clinical settings.¹⁰ However, OBOT is particularly limited in rural communities: 29.8 percent of rural Americans live in a county without a buprenorphine provider, compared with only 2.2 percent of urban Americans.¹¹

The shortage of treatment options in rural areas places barriers on patients who must travel farther to access MAT and, in some cases, have to rely on friends or family for transportation.¹² Numerous studies have found that those who live closer to a health care facility have better health outcomes and can more easily access care.¹³ Transportation challenges may be particularly acute for patients with OUD; a small survey of OTP patients in Vermont found that 23 percent missed at least one visit due to lack of transportation, 17 percent due to weather, and 8 percent due to costs.¹⁴ The rural treatment shortage also places burdens on payers that offer patients transportation services.¹⁵ For example, Washington state’s Medicaid program reported in 2011 that it spends \$3 million a year to transport rural enrollees of the program to urban OTPs.¹⁶

Treatment centers in rural areas are less likely than their urban counterparts to provide buprenorphine and to offer additional services, such as case management, that are shown to improve outcomes.¹⁷ Rural facilities also rely more on public funds to care for patients and support innovative programs that may improve treatment quality.¹⁸ Such limitations can contribute to decreased availability of evidence-based care, with fewer tailored treatment options and specialized providers to address complex patients.

Closing the treatment gap by expanding the provider workforce

In 2016, Congress passed legislation temporarily allowing nurse practitioners (NPs) and physician assistants (PAs) to prescribe buprenorphine after completing specified training.¹⁹ Additional legislation passed in 2018 made this allowance permanent and temporarily authorized other providers, such as clinical nurse specialists, to obtain a waiver to become buprenorphine prescribers.²⁰ This expanded prescribing authority is relevant for rural areas; in 2017, 13.8 percent of rural counties had a waived NP and 4.6 percent had a waived PA.²¹ As a result of this workforce expansion—and a 10.7 percent rise in the number of physicians with a waiver to prescribe buprenorphine—from 2012 to 2017, the number of all waived providers (e.g., physicians, NPs, and PAs) per 100,000 residents doubled in rural counties.

However, as of 2017, 28 states prohibited NPs from prescribing buprenorphine unless they are working in collaboration with a doctor who also has a federal waiver to prescribe.²² To further increase access to MAT, states may need to change laws and regulations that restrict NPs from prescribing buprenorphine.

Using technology to address physician barriers

For rural physicians, barriers to prescribing buprenorphine include time constraints and a lack of mental health or psychosocial support services for patients, specialty backup for complex problems, and confidence in their ability to manage OUD.²³ Treatment models that use technology to address these barriers have been shown to increase access in rural populations.

For example, Project ECHO (Extension for Community Healthcare Outcomes), which was launched in New Mexico, contributed to a nearly tenfold increase in buprenorphine-waivered physicians over a 10-year period.²⁴ In this model, prescribers are recruited to obtain a waiver and are provided regular opportunities for mentoring and education, thereby increasing treatment capacity in rural areas.

West Virginia's Comprehensive Opioid Addiction Treatment program is a telemedicine model that uses videoconferencing to prescribe buprenorphine and for medication management.²⁵ Patients residing hundreds of miles from the treatment center participate in virtual group-based medication management followed by in-person group therapy. Retrospective analysis of this program found that rates of treatment retention and abstinence from drug use were comparable to the rates observed when MAT is provided in person.

Developing innovative, local responses to the opioid epidemic

Strategies to address the opioid epidemic must address community needs to effectively reach and treat patients with OUD. For example, Indiana's Scott County Partnership Inc. responded to an HIV outbreak that was linked to the misuse of prescription opioids and sharing of syringes by developing a "one-stop shop" model to provide buprenorphine, mental health counseling, HIV and hepatitis C treatment, primary care, and syringe exchange in an existing mental health clinic.²⁶ Prior to this model, this rural county had no OUD or HIV treatment services.²⁷

Scott County responded to this local public health crisis by comprehensively addressing the barriers to care faced by people with OUD and HIV. In addition to health care services, patients receive clothes and meals if needed, obtain help finding a job, and have care coordinators to help them enroll in health insurance.²⁸ The partnership also transports patients to appointments and conducts outreach and education to increase the number of physicians who can prescribe buprenorphine.²⁹ Evaluations of the one-stop shop model have not been published, although Scott County's experience provides an example of a targeted response that takes specific community needs into account.

Closing the rural treatment gap

Policymakers and leaders within health care systems can ensure that effective OUD therapy is available in rural communities by implementing emerging and evidence-based practices and studying the effectiveness of these models within their states. These efforts can help close the treatment gap in rural America and save lives.

Endnotes

- 1 Karin A. Mack, Christopher M. Jones, and Michael F. Ballesteros, "Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas—United States," *Morbidity and Mortality Weekly Report* 66, no. 19 (2017): 1-12, https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s_cid=ss6619a1_w. The 325 percent increase in overdose deaths is an age-adjusted calculation, meaning it allows for the comparison of communities with different age structures.
- 2 Ibid.
- 3 Katherine M. Keyes et al., "Understanding the Rural-Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States," *American Journal of Public Health* 104, no. 2 (2014): e52-59, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935688>.
- 4 Ibid.; Roger Rosenblatt et al., "Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder," *Annals of Family Medicine* 13, no. 1 (2015): 23-6, <https://dx.doi.org/10.1370%2Fafm.1735>; Substance Abuse and Mental Health Services Administration, "Addressing Substance Use and the Opioid Epidemic in Integrated Care Settings" (PowerPoint, Primary and Behavioral Health Care Integration Central Regional Meeting, Denver, March 8-9, 2018), https://integration.samhsa.gov/pbhci-learning-community/regional_clusters/Hamblin.Disselkoe.Mountain_Plains.ATTC_PBHCI_SUD_Presentation.pdf.
- 5 American Society of Addiction Medicine, "The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use" (2015), <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>; U.S. Department of Health and Human Services, "Addressing Prescription Drug Abuse in the United States: Current Activities and Future Opportunities" (2013), https://www.cdc.gov/drugoverdose/pdf/hhs_prescription_drug_abuse_report_09.2013.pdf.
- 6 Richard P. Mattick et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," *Cochrane Database of Systematic Reviews* no. 3 (2009), <https://doi.org/10.1002/14651858.CD002209.pub2>.
- 7 Ellen Pullen and Carrie Oser, "Barriers to Substance Abuse Treatment in Rural and Urban Communities: A Counselor Perspective," *Substance Use & Misuse* 49, no. 7 (2014): 891-901, <http://dx.doi.org/10.3109/10826084.2014.891615>; Quentin Johnson, Brian Mund, and Paul J. Joudrey, "Improving Rural Access to Opioid Treatment Programs," *Journal of Law, Medicine & Ethics* 46, no. 2 (2018): 437-39, <https://doi.org/10.1177/1073110518782951>.
- 8 Andrew W. Dick et al., "Growth in Buprenorphine Waivers for Physicians Increased Potential Access to Opioid Agonist Treatment, 2002-11," *Health Affairs* 34, no. 6 (2015): 1028-34, <https://dx.doi.org/10.1377%2Fhlthaff.2014.1205>.
- 9 U.S. Department of Health and Human Services, "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: Inservice Training" (2008, reprinted 2009), <http://www.woema.org/pdf/WHOHC2013PDF/SAMHSA-Med-Assist%20tx%20for%20opioid%20addiction.pdf>.
- 10 American Society of Addiction Medicine, "Public Policy Statement on Office-Based Opioid Agonist Treatment (OBOT)," (2010), <https://www.asam.org/docs/default-source/public-policy-statements/1obot-treatment-7-04.pdf?sfvrsn=0>.
- 11 C. Holly A. Andrilla et al., "Geographic Distribution of Providers With a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update," *The Journal of Rural Health* 35, no. 1 (2018): 108-12, <https://doi.org/10.1111/jrh.12307>.
- 12 Andrew Rosenblum et al., "Distance Traveled and Cross-State Commuting to Opioid Treatment Programs in the United States," *Journal of Environmental and Public Health* (2011): 1-10, <http://dx.doi.org/10.1155/2011/948789>; Stacey C. Sigmon, "Access to Treatment for Opioid Dependence in Rural America: Challenges and Future Directions," *JAMA Psychiatry* 71, no. 4 (2014): 359-60, <http://dx.doi.org/10.1001/jamapsychiatry.2013.4450>; Pullen and Oser, "Barriers to Substance Abuse Treatment."
- 13 Charlotte Kelly et al., "Are Differences in Travel Time or Distance to Healthcare for Adults in Global North Countries Associated With an Impact on Health Outcomes? A Systematic Review," *BMJ Open* 6, no. 11 (2016): 1-9, <http://dx.doi.org/10.1136/bmjopen-2016-013059>.
- 14 Sigmon, "Access to Treatment."
- 15 Erik Kvamme et al., "Who Prescribes Buprenorphine for Rural Patients? The Impact of Specialty, Location and Practice Type in Washington State," *Journal of Substance Abuse Treatment* 44, no. 3 (2013): 355-60, <https://dx.doi.org/10.1016%2Fj.jsat.2012.07.006>.
- 16 Ibid.

- 17 Mary Bond Edmond, Lydia Aletraris, and Paul M. Roman, "Rural Substance Use Treatment Centers in the United States: An Assessment of Treatment Quality by Location," *American Journal of Drug and Alcohol Abuse* 41, no. 5 (2015): 449-57, <https://dx.doi.org/10.3109%2F00952990.2015.1059842>.
- 18 Ibid.
- 19 Comprehensive Addiction and Recovery Act, sec. 303: Medication-Assisted Treatment for Recovery From Addiction (2016), <https://www.congress.gov/bill/114th-congress/senate-bill/524/text>.
- 20 Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, sec. 3201: Allowing for More Flexibility With Respect to Medication-Assisted Treatment for Opioid Use Disorders (2018), <https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf>.
- 21 Andrilla et al., "Geographic Distribution of Providers."
- 22 Christine Vestal, "Nurse Licensing Laws Block Treatment for Opioid Addiction," Stateline (April 21, 2017), accessed Aug. 28, 2018, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/04/21/nurse-licensing-laws-block-treatment-for-opioid-addiction>.
- 23 C. Holly A. Andrilla, Cynthia Coulthard, and Eric H. Larson, "Barriers Rural Physicians Face Prescribing Buprenorphine for Opioid Use Disorder," *Annals of Family Medicine* 15, no. 4 (2017): 359-62, <http://dx.doi.org/10.1370/afm.2099>.
- 24 Miriam Komaromy et al., "Project ECHO (Extension for Community Healthcare Outcomes): A New Model for Educating Primary Care Providers About Treatment of Substance Use Disorders," *Substance Abuse* 37, no. 1 (2016): 20-4, <http://dx.doi.org/10.1080/08897077.2015.1129388>.
- 25 Wanhong Zheng et al., "Treatment Outcome Comparison Between Telepsychiatry and Face-to-Face Buprenorphine Medication-Assisted Treatment for Opioid Use Disorder: A 2-Year Retrospective Data Analysis," *Journal of Addiction Medicine* 11, no. 2 (2017): 138-44, <http://dx.doi.org/10.1097/ADM.0000000000000287>.
- 26 Ibid.; P. Todd Korthuis et al., "Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review," *Annals of Internal Medicine* 166, no. 4 (2017): 268-78, <https://dx.doi.org/10.7326%2FM16-2149>.
- 27 Ibid.
- 28 Michelle Goodin, Scott County Health Department, pers. comm. to The Pew Charitable Trusts, Nov. 20, 2018.
- 29 Elizabeth Beilman, "State-Ordered 'One-Stop Shop' for HIV Outbreak Open in Scott County," *News and Tribune*, April 1, 2015, https://www.newsandtribune.com/news/state-ordered-one-stop-shop-for-hiv-outbreak-open-in/article_31572476-d8d7-11e4-9aad-33610ed3dbd0.html; Korthuis et al., "Primary Care-Based Models"; Goodin, pers. comm.

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Letters

RESEARCH LETTER

Buprenorphine Treatment Divide by Race/Ethnicity and Payment

Opioid mortality rates continue to increase throughout the United States¹; however, growth in buprenorphine hydrochloride treatment for opioid use disorder (OUD) might be limited to communities with higher income and low percentages of racial/ethnic minorities.² Buprenorphine, a partial opioid agonist, is 1 of 3 evidence-based medications for treating OUD and can legally be prescribed in office-based settings.

To our knowledge, no national studies have examined the differences in the receipt of buprenorphine prescription by race/ethnicity and payment in office-based settings, in which most patients with buprenorphine prescription receive care.³ In this article, we present changes in buprenorphine treatment at office-based visits in the United States since 2004 as well as the race/ethnicity and payment characteristics currently associated with its receipt.

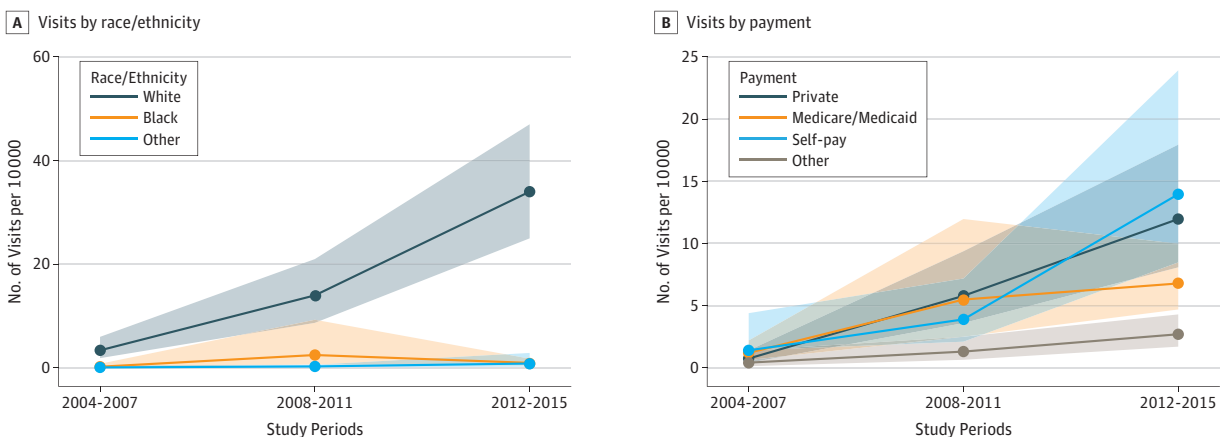
Methods | We combined data from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey outpatient department component from 2004 to 2015. The surveys, which provide nationally representative estimates of ambulatory care provided in the United States by non-federally employed physicians, capture physician-reported medications prescribed during each office visit as well as demographic characteristics and expected source of payment. The University of Michigan Institutional Review Board did not require approval for this study, given that sec-

ondary analysis of publicly available, nonidentifiable data set is not regulated. Informed consent was not applicable for this type of study.

We limited our sample to visits in which buprenorphine was prescribed, and we aggregated the sample into 4-year periods. We estimated buprenorphine prescription rates by race/ethnicity and payment. We chose the most recent period (2012-2015) to test the association of race/ethnicity with receipt of buprenorphine prescription using logistic regression adjusted for age, sex, and payment method. Analyses were completed in Stata, version 15.1 (StataCorp LLC), and accounted for complex survey design elements to generate nationally representative estimates.

Results | From 2004 to 2015, the number of buprenorphine visits rose from 0.04% to 0.36% of all ambulatory visits, representing 13.4 million visits between 2012 and 2015. From 2012 to 2015, buprenorphine prescription was received at considerably more visits by white patients than patients of other races/ethnicities (12.7 million [95% CI, 8.6 million-16.8 million] vs 363 000 [95% CI, 134 000-594 000]) (Figure). Self-pay and private insurance were the most common payment methods across all years (Table). The number of buprenorphine visits by self-pay patients dramatically increased from 585 568 (95% CI, 0-1.3 million) visits in 2004 to 2007 to 5.3 million (95% CI, 2.5 million-8.5 million) visits in 2012 to 2015, accounting for 39.6% of the visits. After accounting for payment method, sex, and age, we found that black patients had statistically significantly lower odds of receiving buprenorphine prescription at their visits (adjusted odds ratio, 0.23; 95% CI, 0.13-0.44).

Figure. Buprenorphine Visits by Race/Ethnicity and Payment Type, 2004-2015



Buprenorphine visits ($n = 1369$) and 95% CIs per 10 000 visits (shaded areas), grouped by year and stratified by race/ethnicity and payment type. Estimates account for complex survey design elements and are nationally representative.

Table. Demographic Characteristics Associated With Buprenorphine Prescribing in Outpatient Care in the United States in 2004-2007 and 2012-2015

Variable	2004-2007		2012-2015		Adjusted OR (95% CI) ^b
	Visits Without Buprenorphine (n = 244 274), % ^a	Visits With Buprenorphine (n = 183), % ^a	Visits Without Buprenorphine (n = 204 527), % ^a	Visits With Buprenorphine (n = 718), % ^a	
Race/ethnicity ^c					
White	83.5	90.5	83.1	94.9	1.00
Black	11.5	6.5	10.6	2.7	0.23 (0.13-0.44)
Other	5.0	3.0	6.3	2.4	0.27 (0.08-0.90)
Payment method					
Private insurance	52.0	19.8	49.2	33.9	1.00
Medicare/Medicaid	35.1	31.5	38.1	18.9	1.16 (0.74-1.82)
Self-pay	4.5	37.8	4.5	39.6	12.27 (6.86-21.91)
Other or unknown	8.5	11.0	8.2	7.5	1.35 (0.78-2.35)
Sex					
Female	58.8	47.5	58.3	39.7	1.00
Male	41.2	52.5	41.7	60.3	2.22 (1.82-2.70)
Age, y					
<30	29.9	40.0	25.4	30.3	1.00
30-50	23.8	47.5	21.4	47.2	1.68 (1.33-2.12)
>50	46.3	12.5	53.2	22.4	0.38 (0.27-0.52)

Abbreviation: OR, odds ratio.

^a Analyses were completed using survey design elements accounting for visit weight, clustering, and stratification to generate nationally representative estimates.

^b Adjusted odds ratios (AOR) were generated using logistic regression (1 = buprenorphine prescribed; 0 = no buprenorphine), including the variables reported in the Table. The AOR reflects the OR for buprenorphine treatment

for a given visit characteristic during 2012 to 2015. The 2004 to 2007 visit characteristics are provided for comparison; they are not included in the logistic regression.

^c White (Hispanic and non-Hispanic), black (Hispanic and non-Hispanic), and other (Asian, native Hawaiian/Pacific Islander, American Indian/Alaskan native, and multiple race, both Hispanic and non-Hispanic).

Discussion | This study demonstrates that buprenorphine treatment is concentrated among white persons and those with private insurance or use self-pay. This finding in nationally representative data builds on a previous study that reported buprenorphine treatment disparities on the basis of race/ethnicity and income in New York City.² It is unclear whether the appearance of a treatment disparity may reflect different prevalence in OUD by race/ethnicity. We did not restrict the analysis to individuals with OUD because the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey are unlikely to accurately capture OUD prevalence, but a recent analysis of the National Survey on Drug Use and Health suggests that the prevalence of opioid misuse is similar for black (3.5%) and white (4.7%) adults.⁴

Despite the enactment of both mental health parity legislation and Medicaid expansion, the proportion of self-pay buprenorphine visits remained relatively steady across the study period.⁵ A recent study demonstrated that half of the physicians prescribing buprenorphine in Ohio accepted cash alone,⁶ and our findings suggest that this practice may be widespread and may be associated with additional financial barriers for low-income populations.

This study provides a snapshot of the national differences in buprenorphine treatment for OUD. With rising rates of opioid overdoses, it is imperative that policy and research efforts specifically address racial/ethnic and economic differences in treatment access and engagement.

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Accepted for Publication: March 12, 2019.

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Published Online: May 8, 2019. doi:10.1001/jamapsychiatry.2019.0876

Author Contributions: Dr Lagisetty and Mr Ross had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

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Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Lagisetty, Ross, Maust.

Critical revision of the manuscript for important intellectual content:

All authors.

Statistical analysis: Ross.

Administrative, technical, or material support: Lagisetty, Clay.

Supervision: Lagisetty, Maust.

Other - mentoring: Bohnert.

Conflict of Interest Disclosures: None reported.

1. Alexander MJ, Kiang MV, Barbieri M. Trends in black and white opioid mortality in the United States, 1979-2015. *Epidemiology*. 2018;29(5):707-715. doi:10.1097/EDE.0000000000000858
2. Hansen H, Siegel C, Wanderling J, DiRocco D. Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City. *Drug Alcohol Depend*. 2016;164:14-21. doi:10.1016/j.drugalcdep.2016.03.028
3. Breen CT, Fiellin DA. Buprenorphine supply, access, and quality: where we have come and the path forward. *J Law Med Ethics*. 2018;46(2):272-278. doi:10.1177/1073110518782934
4. Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. Results from the 2017 National Survey on Drug Use and Health: Detailed Tables. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf>. Published September 7, 2018. Accessed April 2, 2019.
5. Andrews CM, Grogan CM, Smith BT, et al. Medicaid benefits for addiction treatment expanded after implementation of the Affordable Care Act. *Health Aff (Millwood)*. 2018;37(8):1216-1222. doi:10.1377/hlthaff.2018.0272
6. Parran TV, Muller JZ, Chernyak E, et al. Access to and payment for office-based buprenorphine treatment in Ohio. *Subst Abuse*. 2017;11:1178221817699247.

The Opioid Crisis Isn't White

Contrary to media portrayals, overdose deaths are ravaging communities of color.

By Abdullah Shihpar

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Feb. 26, 2019

Last April, The Baltimore Sun ran [an op-ed essay](#) by a woman in mourning. Her sister, a “middle-class suburban mom,” had become addicted to alcohol and opioids and died. Two years earlier, The Wall Street Journal [published](#) the names and photographs of some of the 300,000 Americans who had died of opioid overdoses since the 1990s. Smiling faces stared back at the reader with eyes full of promise. The families of the dead described how their once-vibrant loved ones had fallen into opioid use, how an injury or divorce led to medication, which then spiraled into addiction. In 2016, the NPR podcast “Embedded” told [the heartbreaking story](#) of a nurse with three children who hurt her back at work and was soon hooked on opioids.

It's notable how this kind of coverage emphasizes the humanity of opioid users. Phrases like “introduced to,” “caused by” and “fell into” are increasingly used to describe pathways to addiction, and we often hear the perspectives of loved ones who vouch for the lives of victims were before they became addicted. Something else stands out, too: It seems the majority of the victims whose stories have been told in recent years are white. This has led to journalists and others [pointing out the stark contrast](#) between the kind of compassionate treatment opioid users receive now and the contempt that dominated reports about the largely black victims of the crack epidemic of the 1980s and 1990s.

[“The Gentrification of Addiction”](#) read one headline in The Philadelphia Inquirer, [“Why Is the Opioid Epidemic Overwhelmingly White?”](#) asked NPR. Teen Vogue pointed out that [“The Opioid Crisis Only Became a Crisis When It Affected White People.”](#)

But the opioid epidemic is not entirely white — and it's a mistake to characterize it that way, given how opioids are harming nonwhite communities.

According to [statistics](#) collected by the Kaiser Family Foundation, black people made up 12 percent of all opioid-related fatal overdose victims in 2017, with 5,513 deaths, more than double the number in 2015. (Non-Hispanic whites accounted for 78 percent of all victims — 37,113 deaths in total, a 37 percent increase from 2015 — and Hispanics 8 percent.)

Twelve percent may not seem like a lot, but it is roughly proportional to the number of African-Americans in the United States population as a whole. In some areas, most victims of fatal overdoses are black, as in the District of Columbia, where black people make up [more than 80](#) percent of opioid-related deaths. In Massachusetts, meanwhile, opioid death [rates are going down](#) for all other groups, but continue to rise for black people.

Dr. Tom Gilson, a medical examiner in Cuyahoga County, Ohio, told the Boston NPR affiliate [WBUR](#) that there was a “Fourteen-fold increase in fentanyl deaths among African-Americans” in three years; most of those deaths involved fentanyl mixed with cocaine. [A recent study](#) found that between 2012 and 2015, black men died from cocaine overdose at rates as high as white men who died from opioids during that period. If fentanyl-laced cocaine becomes more common, overdoses among black Americans could get much worse.

Native Americans have also been hit hard by the opioid crisis. According to the Centers for Disease Control and Prevention, between 1999 and 2015 Native Americans had the [largest increase](#) in overdose deaths compared to other groups. The C.D.C. also reported that in 2016, rates of prescription-opioid-related overdose [were higher](#) among both non-Hispanic whites and Native Americans than other groups. In response to this, several Native American tribes have [filed lawsuits](#) against the manufacturers and distributors of prescription opioids.

Where the opioid crisis has affected nonwhite communities, the response has often been slow and inadequate. In Puerto Rico, before Hurricane Maria, there were 600 fentanyl-related overdoses and 60 deaths [in 2017](#). There are no official statistics for the time after that, but those who work with drug users say they have [seen an increase in overdoses since the hurricane](#). Puerto Rico has not applied for federal funding to tackle the opioid crisis, nor has it passed a law to allow the administration of the lifesaving overdose drug naloxone by nonmedical personnel.

Similarly, the District of Columbia has faced criticism for its [slow response](#) to overdose deaths, distributing naloxone at a lower rate than other cities and failing to establish addiction treatment programs.

In cities like New York, [access to addiction treatment can be segregated by income](#) and race: low-income Latino and black users often have to travel far from home to get methadone from clinics, while more affluent white patients can afford to get prescriptions of newer drugs used to treat addiction, like buprenorphine, from private doctors. A [2016 study](#) found that rates of buprenorphine use increased the most in areas with higher incomes and low percentages of black and Latino people.

Labeling the opioid crisis as “white” risks overlooking the very real damage experienced by black, Latino and Native American communities. This is not a call to ignore the wrongs of the past. We should continue to scrutinize how attitudes toward drug users seem to change depending on the racial identity of the people whose stories the media tells.

But this crisis is a reminder that anyone can become addicted to drugs. Our empathy should not be conditional.

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