



BETWEEN THE LINES:

Understanding Our Country's Racialized
Response to the Opioid Overdose Epidemic

CLASP

Policy solutions that work for low-income people



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EXECUTIVE SUMMARY

The increase in opioid use and overdose is a hot topic of conversation, playing out in different ways — often with the top-line narrative that policymakers aren't doing enough. CLASP recognizes that responses are more public health-focused when white populations are reported to be using drugs, and more punitive when substance users are reported to be people of color.

The opioid overdose and general substance use responses are not reaching communities of color. Now that the current opioid overdose epidemic is impacting mostly white, rural populations, policymakers are feeling significant political and social pressure to do something about it.

The Center for Law and Social Policy's (CLASP's) mental health work focuses on the design of systems and policies in the health system and the affect of race and ethnicity on how a person interacts with the health system and receives services. Over the following pages, we provide an overview of how history and the response to the opioid overdose epidemic play a part in widening health inequities, and what we need to do about it.

Unless we figure out how to make significant upstream economic and policy changes, we will continue to see inequities in prevention, screening, and treatment, resulting in greater racial disparities in opioid overdose and substance use disorders (SUD) overall.

The report is divided into six sections:

- 1. Defining the Context:** How implicit bias impacts who receives opioid prescriptions and why drug overdose deaths for communities of color in poverty are increasing.
- 2. How the Racial Wealth Gap and Poverty Contribute to the Epidemic:** Racist policies, economic disparity, and the flooding of drugs to communities of color living in poverty are all connected.
- 3. Historical Racial Bias Impacts on Drug Enforcement:** Since the 1800s, laws have existed criminalizing communities of color due to the narrative associating Black people with drugs, when both white and Black communities were using drugs. Communities of color continue to feel the effects of the War on Drugs and related punitive laws to this day.
- 4. Differences in Response, Access to Treatment:** Treatment is often based on insurance, proximity to services, whether someone is incarcerated or not, the availability of culturally responsive providers, and one's willingness to seek care. Effective treatment provision depends on the provider, and if substance use is criminalized in a jurisdiction or not.
- 5. The Federal Response:** Policymakers increased funding to address opioid overdoses affecting white and rural communities, giving priority to areas where federal datasets show high rates of overdose, but may not capture overdoses in Black and Brown communities. Resource-poor communities, often including communities of color, have a much harder time getting funding and resources.
- 6. Recommendations, Strategies:** Truly addressing the opioid overdose epidemic for communities of color involves major policy and system changes, reversing damaging effects of past policies and narratives.

OVERVIEW

The opioid overdose epidemic exposes lines drawn around perceived racial identities and across socioeconomic status.

Because of opioid overdose rates in white people, policymakers have responded to the resounding and repeated narrative that the epidemic primarily affects white people. They have focused funding efforts in white communities, while neglecting and further criminalizing communities of color for general substance use.

This report provides a different perspective to the predominant discussion by outlining how harmful policies weakened infrastructures, using race as a tool. This weakening has caused opioid overdoses to increase. Without critically examining the response of policy makers, inequities between rich and poor, people of color and white, will continue to increase. To think about the large-scale solutions necessary to help communities receive the supports they need to thrive, we must look beyond opioids to substance use more broadly.

Historical racism, implicit racial bias, and discrimination have shaped the response mechanisms of the past, and unfortunately are a part of the responses we see

today. Rather than providing communities of color with treatment/resources, policies criminalize these communities, resulting in disproportionate suffering from drug epidemics. The effects of criminalization are lasting—affecting individuals' ability to get employment, education, housing, or even vote. These detrimental policies erode the foundation of entire neighborhoods, destabilizing economic stability, mobility, and complete infrastructures.

Without major systemic and policy changes that address the root causes preventing all communities, particularly in communities of color, from reaching true economic justice, there cannot be health equity. In developing strategies to curb the opioid epidemic, policymakers and advocates must consider the complexities of behavioral health issues that communities of color experience and combat historical racial bias within the health and criminal justice sectors.



DEFINING THE CONTEXT

In the opioid overdose epidemic, death rates have risen for all populations, including African-American, Latino, Native, and Asian-American and Pacific Islander populations. Although the highest overdose death rates are in White people in the United States, death rates for particular communities of color are on the rise.

From 2016 to 2017, the most recent data available, the opioid overdose death rate increased the highest for Black people at 25.2 percent, followed by American Indian/Alaska Native (AI/AN) people¹ at an increase of 12.9 percent. The highest death rate increases from synthetic opioids over the same timeframe were for Black people at 60.7 percent and for AI/AN people at 58.5 percent.²

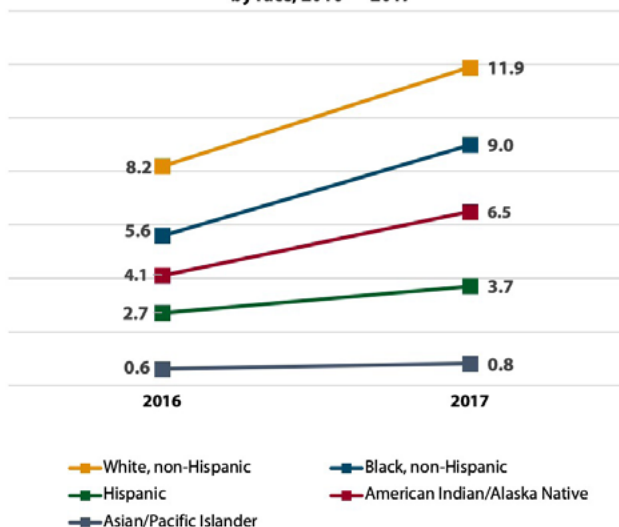
Opioid deaths are rising annually due to an increase in the availability of prescription opioids, heroin, and synthetic fentanyl.^{3,4} In 2011, the Centers for Disease Control and Prevention (CDC) found that prescription opioid addiction reached epidemic heights. The lack of belief that substance use was linked to health issues, limited access to opioid treatment programs, limited rehab facilities, a sense of hopelessness, trauma, and

lack of education on the dangers of opioids are likely contributing factors to the opioid death toll.

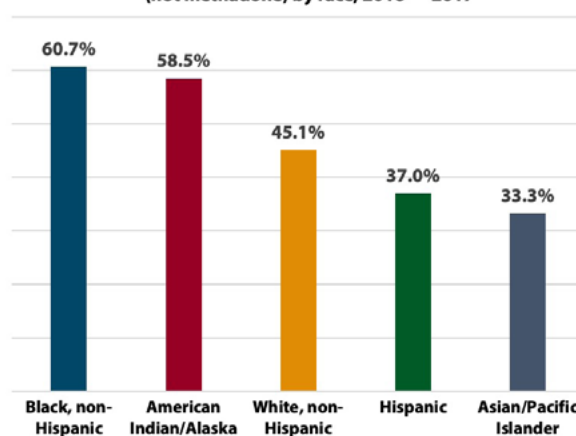
States with higher poverty levels had disproportionately worse rates of overdose deaths from prescribed opioid drugs. CDC data from 2002 to 2013 shows that heroin use increased nearly 77 percent in households with an average income of \$20,000-49,000 and 62 percent in households with an average income of under \$20,000. Less than 5 percent of those individuals had Medicaid coverage, and around 5 percent had no insurance coverage.⁵

The opioid epidemic harms many communities living in concentrated levels of poverty, often in communities of color. This makes those who already experience trauma and toxic stress vulnerable.⁶ Deep

Rate of overdose deaths due to synthetic opioid use (not methadone) by race, 2016 — 2017*



Percent change in overdose deaths due to synthetic opioid use (not methadone) by race, 2016 — 2017



Source: Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths—United States, 2013-2017. Centers for Disease Control and Prevention, Morbidity and Mortality Report. 4 January 2019. 67(51&52): 1419-1427.

*Rates are calculated per 100,000.

concentrations of poverty are often caused by racist and discriminatory policies in housing, immigration, barriers to public benefits, as well as limited access to jobs, food, and other opportunities to help communities thrive. Threats and instability also define the impact on communities because of policies like the “War on Drugs,” placing many young men of color in prison for minor substance infractions, including possession. These factors contribute to the isolation and negative conditions that open the door for substance overuse. Harmful policies lead to broken neighborhood infrastructures, which prevent communities from receiving adequate and effective treatment, causing long-term economic and health concerns for communities living in poverty.

Researchers link implicit racial bias, disparate access to health insurance, and variable access to treatment centers as contributing factors to the over-prescription of opioids in white communities compared to communities of color.⁷ However, national datasets may not be capturing the entire picture of substance use and overdose among people of color, leading to misleading narratives. Use of non-prescription opioids versus

those provided through a prescription in communities of color may be underreported through existing data collection mechanisms and processes. The ways in which questions are asked, if at all, and locations where people are interviewed may create additional barriers from understanding true rates in overuse.

The discrimination and stigma around people of color led and continues to lead, as recently as a 2016 survey of providers, to the misperception that Black people have a higher pain tolerance than white counterparts.⁸ Misconceptions about how thick Black people’s skin was compared to white people’s skin date centuries back in America’s history. Some providers do not prescribe opioids to people of color and ultimately leave them on their own to seek pain relief without any treatments to combat the severe effects of opioids. Additionally, physicians taught and practicing through a traditional American medical lens may screen for pain using a numeric scale, although some ethnicities (e.g., Native populations) may not be able to translate their level of pain on such a scale. This may prevent providers from giving prescriptions for pain medications when they might otherwise do so.⁹



HOW THE RACIAL WEALTH GAP AND POVERTY CONTRIBUTE TO THE EPIDEMIC

Racism and systemic oppression are key contributors to economic and health inequities along racial and ethnic lines, particularly through laws that limit resources and opportunities to Black and Brown communities.

Racism and systemic oppression, often leading to interactions with the justice system, also constrains access to social and economic drivers like jobs, mortgages, and affordable housing, forcing people to live in neighborhoods with higher rates of community violence, less safety overall, environmental toxicity, and inadequate access to appropriate health care facilities.

All these factors, plus the lack of generational transfer of wealth and the high demand of heroin from suburban white people, made neighborhoods in communities of color easy targets for the proliferation of drugs like heroin in sale and use.¹⁰

To understand the current response to the opioid epidemic, we must first take a closer look at how economic inequities lead to the barriers communities of color face. Our health care and broader social services systems contribute to these barriers. Beginning in the 1800s, our nation implemented segregation and exclusionary policies against all communities of color.¹¹ Such harmful policies extended to the 20th century.

Under President Nixon and President Reagan, two waves of the so-called “War on Drugs” worsened stereotypes surrounding communities of color and further emphasized the unequal use of enforcement and punitive measures.

Such harmful public policy extended to efforts in the 1980s to decimate the social safety net by cutting programs like Medicaid, hollowing out housing and lending policies, failing to enforce equal employment opportunities, making cuts to what is now known as the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) and Temporary Assistance for Needy Families (TANF), and launching Reagan’s War on Drugs. All of this widened the gaps in education, employment, and quality of life between white and Black populations, resulting in white households having an average household income of three times that of African Americans.^{12, 13}

These economic inequities produce health inequities. Immigration and discrimination-related policy restrictions contribute to the disparity in wealth in African-American populations and other communities of color. Because of this disparity, these communities have less ability to access health care and difficulties with how they approach the medical system in the first place. This, coupled with implicit bias against communities of color within the health care system, complicates a comprehensive racially and culturally sensitive response.

As the racial and income gap widens, we will see more populations and their families and communities harmed by addiction and its sequelae, including HIV, hepatitis B, and C infection, and overdose.



HISTORICAL RACIAL BIAS EFFECTS ON DRUG POLICY

While the shift in public perception and policy responses to addiction and overdose as something that can be addressed through prevention and treatment moves in the right direction to serve white communities today, drug policies and responses continue to use a punitive frame for people of color.

This punitive frame began through an 1875 ordinance in San Francisco, prohibiting psychoactive substance use. The ordinance criminalized the “smoking of opium in smoking-houses or dens” mainly owned by Chinese immigrants. Although the ordinance used race-neutral language, the ordinance’s intent focused on preserving “white morals” after white individuals began using opioids at Chinese-owned smoking houses. This municipal law set a precedent of criminalizing the use of substances instead of focusing on treatment and prevention for people with substance use disorders.

By the start of the 20th century President Woodrow Wilson would enact the Harrison Narcotics Act, the first congressional action dedicated to countering the internal United States drug trade, limiting the production, sale, and distribution of opiates, even by physicians, imposing taxes and the police as enforcement mechanisms. The federal government lauded and promoted punitive measures for drug sales and use. The presence of law enforcement increased in African-American communities, creating and exacerbating trauma, under the guise of the “War on Drugs.”¹⁴ In 1971, President Nixon declared drugs as “public enemy number one”¹⁵ and would establish the Drug Enforcement Agency as the lead agency responsible for drug enforcement in the U.S. John Ehrlichman, Nixon’s then domestic policy chief, infamously said in a 1994 interview with journalist Dan Baum:

“We knew we couldn’t make it illegal to be either against the war or black [people], but by getting the

public to associate the hippies with marijuana and black [people] with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did.”¹⁶

During his presidency, President Reagan would bolster the work from his “War on Drugs” predecessor which led to increased rates of incarceration for nonviolent drug crimes. The “War on Drugs,” continues to this day and unequivocally continues to disproportionately impact communities of color.

Communities living in poverty in the 1980s and 1990s, particularly African Americans, were impacted by policies that exacerbated housing and economic injustices defined decades before. In response to the economic trench they faced, African Americans and some Latino communities in urban areas increased their use and sale of drugs for economic reasons, and were disparately penalized. In 2016¹⁷, 80 percent of simple drug offenders were Latino and another 7.1 percent were Black. The culture of white supremacy, when combined with the authoritative mandate of law enforcement to penalize communities of color, led police and the justice system to use drug laws as tools to disproportionately criminalize communities of color.

The country’s narrative fueled anti-Blackness and an aversion against populations of color including immigrants, influencing those who came into power and made policy decisions. Racist characterizations

of communities of color, in particular Black communities, as “immoral, subhuman, and dangerous” have saturated media messages and shaped attitudes toward these populations since before the first African slaves were kidnapped from the African continent. This racism pervades our country’s history, reaching another peak when communities of color were plagued and criminalized by responses to the crack cocaine epidemic.¹⁸ The dichotomy between the response to crack cocaine and powder cocaine possession and use, defined by who was perceived to be using the drugs, is very similar to what we see today. Although basically the same substance, the sentencing disparity for crack cocaine versus powder cocaine possession was 100 to 1 until 2010. Laws have changed to reduce the inequity, but disparities remain, disproportionately impacting Black people and communities of color at large.^{19, 20}

These same communities experienced an increase in heroin and other opioid use after the war in Vietnam. These drugs came into inner-city neighborhoods including people living in poverty in the U.S., facilitated by the military administering heroin and other opioids during soldiers’ service to reduce stress and pain from combat.^{21, 22} Today, some policymakers are once again applauding law enforcement tactics, with the Trump Administration rolling out a three-fold plan on opioids, including implementation of the death penalty for those selling opioids. History and data suggest that harsh criminal justice policies disproportionately harm communities of color, and are ineffective. Moreover, CLASP’s analysis of young people from small and hard-to-reach populations living in poverty notes that many look to substance use as a coping strategy; a way to self-medicate to alleviate the impact of community trauma and lived experiences.²³

TIMELINE:

Racial Bias Effects on Drug Policy

1875

The first legislative action prohibiting psychoactive substance use through an ordinance in San Francisco criminalizing the “smoking of opium in smoking-houses or dens” mainly owned by Chinese immigrants.

1914

President Woodrow Wilson enacted the Harrison Narcotics Act, the first congressional action dedicated to countering the internal United States drug trade.

1971

President Nixon declared drugs as “public enemy number one” and established the Drug Enforcement Agency as the lead agency responsible for drug enforcement in the U.S.

1982

Reagan announced the second War on Drugs, vilifying Black and Brown communities and legislating punitive actions, including harsher sentences for crack.

1980s - 90s

Communities living in poverty, particularly African Americans, were impacted by policies that exacerbated housing and economic injustices defined decades before.

DIFFERENCES IN RESPONSE: ACCESS TO TREATMENT

The increased preference for criminality over substance use prevention, harm reduction, treatment, and recovery among impacted communities is due to negative narratives misrepresenting Black and Brown people as immoral.

Entire neighborhoods are left unsupported due to federal and state solutions favoring communities that can show “greater impact.” Funds tend to be allocated to white communities, rather than helping communities of color build neighborhood responses with providers, treatment facilities, community centers, community health centers, etc. to help communities in need.

Cities have often responded to the heroin epidemic by using methadone, which has been highly regulated.²⁴ Methadone use is highly stigmatized, and is associated with both Black and Latino communities and the “inner city.”²⁵ The negative associations of methadone often prevent people from disclosing methadone use, impacting their health treatment effectiveness for other conditions.²⁶

In contrast, white populations are **35 times** more likely to visit the doctor for buprenorphine treatment than African Americans. This is partly due to the high costs of treatment, limited facilities providing buprenorphine in primarily African American and Latino neighborhoods, and likely also because many providers turn away patients with public insurance—preferring out-of-pocket payments and private insurance.²⁷

Methadone and buprenorphine need to be given on a daily basis to be effective and to prevent relapse, but regulations on methadone require individuals to receive treatment in person, in facilities with strong Drug Enforcement Association (DEA) oversight and

multiple urine screens.²⁸ In seeking buprenorphine treatment, although all state Medicaid plans cover it, barriers exist with Medicaid reimbursement for multiple visits, transportation/general adherence, clinic accessibility in the communities where people of color live, and stigma, all of which make it difficult to assure adequate treatment.^{29, 30} Increasing work requirements tied to state Medicaid plans make adherence to daily treatment even harder to achieve. In 10 states, Medicaid does not cover methadone; 15 out of the remaining states create limitations on the provision of methadone, and 8 states require a copayment.³¹ Additional reasons why people are not getting treatment include lacking insurance and/or having limited financial resources for treatment. Few providers exist who specialize in SUD treatment generally, and who are culturally and linguistically responsive.^{32, 33}

Policymakers must work to ensure that public insurance payments for treatment meet the needs of communities and determine how access to treatment can be more equitable.³⁴ Furthermore, they must make stronger efforts to ensure all types of first-responders and front-line staff have access to the current opioid overdose antidote, naloxone, ensure that the physical health care system is more welcoming and coordinated for those who use substances, and work towards solutions to make syringe exchange readily accessible to reduce the spread of hepatitis B, C, and HIV. Finally, they need to reduce punitive associations with substance use, in order to rebuild communities and build more comprehensive supports.

THE FEDERAL RESPONSE

“If Black lives mattered, our government would not have tolerated a decades-long defeat in the war against drugs...If Black lives mattered, today’s overdose crisis would be ameliorated by decades of public health policies focused on reducing stigma and promoting treatment over punishment.”

—Kassandra Frederique, New York State Director for the Drug Policy Alliance³⁵

Policymakers have prioritized funding for white communities where opioid overdose rates are high but have generally glossed over communities of color where the highest increases in rates are occurring. Today, the opioid epidemic continues to draw a number of responses mainly spearheaded by state legislatures and followed by actions from Congress. From 1999 to 2018, Congress enacted 30 bills related to opioids.

Although the opioid epidemic has spurred a sizable increase in public health funding, policymakers have left large gaps between where they are prioritizing the response and where funds are most needed. When

defining solutions, policymakers need to keep in mind substance use generally.

States depend on federal funding to increase treatment, reduce harm, and help with policy implementation, but we are concerned that the ever-changing plan at the federal level is neither sustainable, strategic, nor encompassing of the trauma-informed services that many communities need. Furthermore, funding mechanisms, while broad in scope, do not recognize or prioritize the response in communities of color. In its final report published in late 2017, the President’s Commission on Combating Drug Addiction and the Opioid Crisis recommended block granting opioid and substance use disorder (SUD) opportunities to reduce the “administrative burden” placed on state agencies, focusing on evidence-based practices. Unfortunately, the resources federal policymakers are allocating to opioid-related therapies are not required to focus on culturally and linguistically appropriate mental health services for communities of color.

Moreover, the report recommended increasing funding to the Department of Justice for law enforcement and implementing Drug Courts in every state.³⁶ Increased federal attention on punitive measures will disproportionately impact communities of color through discriminatory enforcement in communities where toxic stress from prior “Wars on Drugs” have occurred; continuing the cycle of trauma, substance use, arrest, and incarceration, increasing mental health disparities.³⁷

Despite some increased federal funding to combat the opioid epidemic, current funding levels do not reach

Both the Trump Administration and Congress declared the opioid crisis a public health emergency in 2017.

The White House budget, and House and Senate appropriations have included billions in the fiscal year 2020 budget to combat opioids through several departments. They include the National Institutes of Health within Department of Health and Human Services for prevention, data collection, and comprehensive behavioral health care, as well as for grants to the Department of Justice because of the Comprehensive Addiction and Recovery Act (CARA), passed in 2016. Both of these appropriations priorities hold promise to reform and redirect efforts to focus on prevention and treatment alternatives (e.g. to incarceration), but implementation efforts have been rocky.

far enough to undo the long history of not making serious investments in prevention and treatment in communities of color.³⁸ The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act), passed in 2018, as well as the Comprehensive Addiction and Recovery Act (CARA), passed in 2016, have provided money towards key programs (see box on page 9). Both appropriations and legislation provide a starting point, but a targeted implementation plan is needed to truly address health inequities in communities with low incomes affected by the opioid overdose epidemic, and previous epidemics (e.g. crack cocaine).

We will continue to see racial inequities in opioid use and overdoses, as well as in treatment, as long as policymakers continue to respond differently in drug policy and treatment based on race.^{39, 40, 41} Our country started down this path by creating public policy that discriminates against and criminalizes communities of color instead of focusing on getting people into treatment. We have continued that today by responding with treatment policy that mostly uses asset-based framing to meet (mostly white) communities “where they are,” while ignoring the severe impacts caused by the harmful epidemics and policies of the past.

The differential response is slated to continue with these types of messages from the Trump Administration:

My administration is also confronting things called “sanctuary cities” that shield dangerous criminals. And every day, sanctuary cities release illegal immigrants and drug dealers, traffickers, and gang members back into our communities. They’re protected by these cities. And you say, “What are they doing?” They’re safe havens for just some terrible people. Some terrible people. And they’re making it very dangerous for our law enforcement officers. You see it all the time.

—Donald Trump, White House speech, March 19, 2018 in New Hampshire⁴²

Instead of focusing on how policies and the economic downturn lead to drug sales in urban areas, the Trump Administration has vilified communities of color, based on racist ideologies. As a result, the public and political discourse has turned to discussions and actions to increase criminalization for drug possession, feeding into the negative framing around immigrants. This, in turn, is leading to punitive immigration and criminalization policies disproportionately affecting young people from immigrant backgrounds, instead of positive policy approaches in public health and human services.



RECOMMENDATIONS AND STRATEGIES

Expand the reach of opioid funding to address behavioral health challenges

CLASP's analysis of the opioid strategy focuses on how the response can best serve communities of color. First, we believe that strategies to curb the opioid epidemic must consider and address the complexities of behavioral health issues in communities of color, which include the breadth of mental health services and supports currently available to them, and how they can be expanded to be culturally responsive. Policymakers must adequately fund effective services so that everybody negatively affected by opioids and other drugs, and at risk of overusing opioids, can get the services they need.

The populations at risk may experience a multitude of stressors from work, family, environment, and interactions with one's community.⁴³ However, opioid funding cannot address the range of mental health challenges experienced by Americans, including 19% of all adults, 37% of lesbian, gay, and bisexual adults, 37% of people incarcerated in state and federal prison, and 70% of youth in the juvenile justice system. Mental health conditions can lead to cardiovascular diseases, substance use disorders, and lasting impacts on one's family and community.⁴⁴ Funding to respond to the opioid overdose crisis must complement the current and future infrastructure of integrated mental and behavioral health service provision.

Secondly, since the current opioid epidemic has higher rates in white communities, the dominant narrative and subsequent policy developments and investments around opioid usage is one of compassion. However, communities of color that were historically impacted by the heroin and crack cocaine epidemics faced greater law enforcement, displacing and destroying communities. This continues to happen today and must be rectified to reduce opioid misuse and overdose and to improve overall health and wellbeing.

Policymakers must address diverse populations with system and policy strategies that do not focus solely on those currently affected by opioid overdose, but in substance overuse overall. In crafting strategies, policymakers need to include people with lived experience to help construct what an effective response would look like, including a diverse workforce not only of race and ethnicity, but also of those who have used substances who can meet individuals who need help where they are, with empathy.

As policymakers, advocates, and other opinion leaders continue conversations on federal measures to help those affected by opioids, we feel the time is ripe for action. We provide the following recommendations for federal action, categorized by level of response:

Economic Justice Policy Recommendations:

We will not achieve a sustainable, equitable, and effective solution to the opioid overdose crisis unless we work toward economic justice, leading to health equity. To that end, we offer these essential recommendations, which are not a comprehensive list:

- **Provide reparations** to African Americans and Native communities. This could manifest in a number of different ways, but conversations need to change not only the differential opioid response, but also make substantial changes to rectify the damage done over decades to communities of color. In parallel, in order to truly affect the impact of crises like the opioid overdose epidemic, policymakers need to make changes that decrease criminalization for communities of color, address the negative and debilitating consequences of the formally incarcerated by changing education and employment admission processes, increase wages, enforce equal employment opportunities, provide equal education opportunities, work toward debt-free college and student loan forgiveness, and eliminate Medicaid work requirements.

- **Increase the minimum wage** to support communities, and **bolster access** to federal programs like SNAP, Medicaid, and child care assistance that support basic needs at a minimum.⁴⁵
- **Invest in quality postsecondary and workforce training** opportunities, prioritizing the federally defined career pathway model, and removing barriers for those who were formally incarcerated.
- **Identify effective reimbursement strategies, reduce reimbursement obstacles, and support advocates and policymakers to understand and take full advantage of existing reimbursement opportunities and levers** that make prevention, screening, treatment, and harm reduction affordable and accessible.
- **Ensure prevention and treatment strategies are evidence informed**, including periodic assessments to understand what works for each community and individual.
- **Ensure funding mechanisms include supports for individuals living with low-incomes for programs such as transportation benefits and other supportive services** (e.g. language accessibility, health education, case management) for people who need treatment. While current funding responses for treatment are important, they are not comprehensive.
- **Increase funding to help community-based organizations respond to the opioid crisis happening in their neighborhoods**—whether these organizations have an opioid focus or not—by making the federal application process easier and increasing outreach to make sure communities know about the services available.

Health Equity Recommendations:

- **Prioritize Medicaid expansion and reject changes to Medicaid programs** that create additional barriers to care.
- **Commit to full implementation and enforcement of the mental health parity and prevention**

provisions of the Affordable Care Act, the Mental Health and Substance Use Disorder Parity Action Plan, and the Mental Health Parity and Addiction Equity Act. Further commit to ensuring that mental and behavioral health are not siloed and are funded accordingly.

- **Provide adequate paid family and medical leave** for all Americans.
- **Diversify the behavioral health workforce by working towards debt-free college and strengthening and expanding loan repayment strategies** for individuals from communities and neighborhoods impacted by any of the SUD epidemics.
- **Ensure a diverse workforce by integrating providers** credentialed at multiple levels in mental and behavioral health systems, from multiple backgrounds/identities, while ensuring that there is adequate racial and ethnic representation at the medical professional level.
- **Increase the number of culturally responsive and linguistically concordant practices** accepted and provided so communities of color feel comfortable entering the health system and continuing to receive treatment.
- **Focus on promising and evidence informed practices** alongside evidence-based practices to find effective and reliable community solutions from community members.
- **Take advantage of lesser-known provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act** to address mental health needs and community trauma more broadly, i.e., move beyond buprenorphine and methadone clinics to peer support and prevention resources.

- **Modify existing regulations** to ensure methadone and other treatment centers can be co-located where people already seek care, rather than in a separate location.

ENDNOTES

- 1 The authors use the same terms for racial and ethnic groups as they were used in original sources; racial and ethnic groups may not be defined as such by the Center for Law and Social Policy (CLASP).
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CLASP publications on mental and behavioral health, including strategies on how to address challenges through policy:

Looking at Life Different: Equitable Mental Health Support for Young Adult Parents, Nia West-Bey, 2019

Behind the Asterisk: Perspectives on Young Adult Mental Health from “Small and Hard-to-Reach” Communities*, Nia West-Bey and Marlén Mendoza, 2019

Policy for Transformed Lives, Nia West-Bey, Shiva Sethi, and Paige Shortsleeves, 2018

Unjustice: Overcoming Trump’s Rollbacks on Youth Justice, Kisha Bird and Duy Pham, 2018

Maternal Depression and Young Adult Mental Health, Nia West-Bey, Ruth Cosse, and Stephanie Schmit, 2018

Everybody Got Their Go-Throughs: Young Adults on the Frontlines of Mental Health, Nia West-Bey and Stephanie Flores, 2017

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