Hidden Faces of the Opioid Epidemic

By Swathi Srinivasan | February 25, 2019

As of January 16, 2019, Edwin Chindongo is three years sober. If asked a few years earlier whether he would be able to follow a path to recovery, Chindongo might have said no. “I thought if I die, I die,” Chindongo told the HPR. That was before Chindongo met Dr. Avik Chatterjee, a physician at Boston Health Care...
for the Homeless, a shelter-based program at the heart of Boston’s opioid epidemic. Chatterjee helped Chindongo recover from the opioid substance use disorder he had developed following his use of prescription Percocet. Chindongo now finds himself working in the very same shelter where he once lived, helping those who see themselves as incapable or undeserving of receiving help.

Chindongo’s story does not fit squarely into the public narrative of the modern opioid crisis. He is not a member of the white, rural working class which has become the face of the crisis, nor are his parents survivors of the 1960s and 1970s heroin epidemic that plagued non-whites in inner cities. Although Chindongo’s story seems atypical, it is representative of many that remain hidden from the public eye, reflecting the media’s failure to cover the diverse experiences of opioid use in America. Yet an effective response to the opioid crisis must address all people affected. This requires focusing on systemic causes of substance use disorders and prescription practices as well as reducing the negative consequences of drug use through ground-level harm reduction.

Understanding America’s Opioid Crisis

The modern opioid epidemic is unlike any other this country has previously seen by sheer virtue of the vast number of people it affects. In 2015, more than 33,000 Americans died as a result of an opioid overdose, including overdoses on prescription opioids, heroin, and illicitly manufactured fentanyl. That same year, an estimated 2 million people suffered from
substance use disorders related to prescription opioids and more than half a million people suffered from a heroin use disorder in the United States.

Although heroin use was declining among Americans until the late 1990s, the first prescriptions of Oxycontin in 1996 would reverse this trend. With them came the beginning of overprescription and the prescription opioid abuse that would ultimately produce a generation of white working-class drug users. They would later switch to heroin due to the unavailability and expense of pills. Now, with the recent influx of fentanyl, a drug responsible for more deaths than both heroin and prescription opioids, opioid overdoses are soaring.

Yet the white working class is not the only demographic affected by heroin and fentanyl. Nearly three decades before this generation began using prescription opioids, there was a higher mortality rate among non-white heroin users than white users. Mostly black and Latinx individuals now in their 40s and 50s, these people managed to survive the AIDS epidemic, which killed tens of thousands of people who inject drugs. Now, however, these same survivors are “dying [at] a much higher rate because we’ve never had such a dangerous heroin supply,” Dr. Andrew Kolodny, co-director of opioid policy research at the Heller School for Social Policy and Management at Brandeis University, told the HPR. This supply, laced with fentanyl, has led to a sharp rise in overdose deaths, mostly among older black men and Latinos in inner-city Washington,
D.C., Philadelphia, South Bronx, and Baltimore.

Ignorance of the varied experiences of the opioid crisis has reinforced popular misconceptions and exacerbated the lack of discussion about the impact of the opioid crisis on communities of color. Some states, like California, have not seen an increase in opioid-related death rates, while others, such as Oklahoma, have actually seen a decrease in prescription opioid deaths. Likewise, state-based data also reveals racial disparities, such as in Wisconsin and West Virginia, where the fatal overdose rate among black individuals was nearly double that of white individuals.

Responding to the Popular Narrative

Compared to the white working class, this older, non-white generation of heroin users receives little media coverage. Beyond a few recent articles, coverage of the opioid epidemic has largely excluded the plights of non-white individuals. Leonard Bernstein, health and medicine reporter at The Washington Post, attributes this disparate coverage to greater public interest in the “white pill epidemic.” Bernstein said in an interview with the HPR that the media is “always looking for the newest thing that people haven't heard about before, though sadly the heroin epidemic has been with us for decades and largely in the inner cities.”

Coverage of the modern opioid crisis's impact on communities of color and the responses it has invoked differ from the coverage and responses seen during the 1970s and 1980s
crack cocaine epidemic, largely due to the modern epidemic's impact on white people. Presenting highly negative media coverage of substance users of color, the earlier crack cocaine epidemic contributed to the mass incarceration of low-income black and Latinx drug users. Today's response to the modern opioid epidemic, however, has not merely been to "arrest our way out of it," as Kolodny put it. Rather, it has been more accommodating in terms of congressional and judicial leniency and public compassion toward opioid users.

While the impact of the modern opioid epidemic on white communities has inspired new calls to improve the U.S. health system to better address opioid use disorder, many worry that improving the health care system would result in traditionally underserved groups, such as low-income whites and people of color, receiving benefits last. This would perpetuate current inequalities between white and non-white patients. Dr. Mathew Kiang, a postdoctoral research fellow at Stanford University, concluded, however, that this would not necessarily be the case. In an interview with the HPR, Kiang explained how improving health care overall can benefit the entire U.S. population while alleviating inequalities. Accomplishing both goals simultaneously may be difficult, according to Kiang, but it is not impossible.

Chatterjee agreed that this increased public recognition of the opioid epidemic can also benefit the non-white users excluded from the epidemic's public narrative: "It means more money, more innovation and more treatment
models that can serve all patient populations.” Even if that requires accepting “a bit of hypocrisy,” said Chatterjee, the results may be worth it. In clinical practice, “opioid use disorder is opioid use disorder ... the things you see and the things that benefit people are universal.” Having more accessible treatments and resources, such as the life-saving drug Narcan, can help reduce all opioid overdose deaths.

Preventing Increased Incidence

Although the opioid crisis has manifested in different ways among different populations, fentanyl remains a primary killer among all people who use heroin. But addressing fentanyl use goes beyond U.S. hospital systems and pharmaceutical companies, extending to U.S.-China relations. “We have to figure out ways to get this fentanyl out of the illicit drug system,” explained Bernstein. While critics argue that alternate sources would arise for fentanyl production if Chinese distribution to the United States ended, Bernstein maintained that “we have to deal with it in the streets here and we have to deal with it government to government.”

In addition to reducing the accessibility of drugs, minimizing opioid incidence requires stopping individuals from trying heroin or fentanyl in the first place. Inspired by his own experience with opioid abuse, Chindongo approaches prevention using education. He recommended educating youth to be aware of what their peers are offering them and educating patients to be aware of what doctors are prescribing them: “I’m pretty sure that if
you tell someone, ‘here's some pills — they're going to help with the pain but in a year from now you'll be broke, you're going to be homeless, and you're not going to have anything,’ I'm pretty sure they'll say, 'don't give me that.’”

As seen in Chindongo's case, preventing increased rates of opioid substance use disorder also requires doctors to exercise caution when prescribing various drugs. Part of the reason today’s epidemic is framed as a white issue is that data seems to show fewer African-Americans becoming opioid-dependent in the past few years. Studies show doctors have been prescribing less frequently to non-whites, which may have a “protective effect” on non-white people. While this perspective risks minimizing the burden non-white opioid users face, this prescribing behavior does give a clear message, according to Kolodny, that “doctors need to be cautious in prescribing to all people.”

Doctors are not the only ones who must focus on prescription opioid accessibility; the federal government must also be stricter with pharmaceutical companies. In covering the cases of pharmaceutical distributor McKesson and pharmaceutical manufacturer Mallinckrodt, Bernstein described the federal government's unwillingness to cooperate with media, which has subsequently elicited public skepticism about the cases’ handling. For example, while Mckesson was fined $150 million, the general feeling among field agents on the case was that there was sufficient evidence to justify fining Mckesson out of
existence. The government had the potential to impact the overall opioid crisis, but litigation, bureaucracy, and competing interests prevented it from acting.

One promising channel for government intervention is addressing the socio-economic distress that often burdens health care access. Since Medicaid programming has been pivotal in providing many low-income individuals with care and treatment, its expansion allows frontline treatment to be made accessible and affordable to many non-white and low-income white communities. For instance, Kolodny described how buprenorphine, an opioid substitution therapy, is often offered by private doctors who do not take commercial insurance, let alone Medicaid. This treatment limitation only exacerbates long-standing class-based divides in health care access.

Enabling Recovery in Communities

Addressing opioid use disorder is largely about meeting people where they are — not only in the recovery process, but also in their ability to understand the health system and in their geographic location. Understanding a patient’s individual journey with substance use disorder is essential for providing proper treatment. Some have lived with heroin and other illicit substances around them for decades or have been unable to seek treatment due to a lack of proximity to health clinics. Others have turned to opioids to replace another substance.

Expanding access to health care is crucial, but the identities of health professionals can also
impact those seeking treatment. Around the country, a lack of diversity in medical staff can prevent communication with patients, creating a high barrier to entry for those receiving important care. At BHCHP, Chatterjee has had Latino patients report experiencing fear and anxiety about social isolation as well as discriminatory treatment by both staff and guests due to their ethnic backgrounds; in other residential treatment programs, this made them resistant to new treatment. To avoid alienating patients of diverse backgrounds, BHCHP has hired a chief diversity officer who works to maintain a diverse staff and ensure that BHCHP’s programs are socially inclusive.

It is also important to recognize that not all people who need care know exactly when and where to seek it, according to Chatterjee. State-level data can be helpful here: Boston-specific data is utilized by the CareZONE van, for example, in order to provide mobile preventive caretakers, substance use disorder services, and methods to mitigate the harms of drug use to people in different parts of the city — not just in the vicinity of the clinic. The van’s inclusive approach, according to Chatterjee, engenders trust from people of all communities.

Building trust with patients is especially important given the poor historical treatment of minorities with regards to medical and scientific experimentation in the United States, ranging from the Tuskegee experiments of the 1930s to the 1970s to the forced sterilization of Native American, Latinx, and black women that lasted through the 1960s. Some people
who use opioids have seen their history of substance use disorder invoked as an excuse to not provide them with treatment and to dehumanize them. “If [patients] come into a clinic space and it reminds them of past [negative] experiences, you’re going to turn them off. This makes it all the more important the way staff is able to engage with people on the front lines,” Chatterjee noted. Individualizing experiences with health professionals can help account for this issue which, in turn, requires having diverse staff and people on the front lines who are willing to listen to what people who use opioids need.

Seeing faces at the shelter from day to day, Chindongo said that the one thing he knows is that “addiction does not discriminate.” He advised, “if you’re going to be helping people ... don’t look down on them.” Helping support people through recovery also means recognizing that they may have different motivations — for Chindongo, it was his son — and that the recovery process can be a long one. “You just have to take it a day at a time,” Chindongo said. “One day at a time.”

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