Transcript:

Overdose Disparities Series: Community-informed Strategies for Addressing Non-Fatal and Fatal Overdose within Black/African American Populations

Presenter: Kathie Kane-Willis & Kareem Butler
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PRESENTER: Good morning. Thank you for joining us today. Our webinar today is the overdose disparities series-- community-informed strategies for addressing non-fatal and fatal overdose within Black/African American populations part 4. Our presenters for today are Kathie Kane-Willis, the director of research and policy for the Research and Policy Center at the Chicago Urban League, and Kareem Butler, the director of learning and evaluation for the Research and Policy Center at the Chicago Urban League.

Today's webinar is brought to you by the Great Lakes PTTC and SAMHSA, the Great Lakes ATTC, MHTTC and PTTC are funded by the following cooperative agreements. The opinions expressed in today's webinar those are the speakers and do not necessarily reflect the official position of SAMHSA or DHHS.

The Great Lakes PTTC supports the use of affirming language that inspires hope because words have power. Once again, thank you for joining us. If anyone's having any technical issues, please individually message myself, Kristina Spannbauer or Stephanie Behlman using the chat and we'll be happy to help you. Also, please put any questions that you have for the speakers in the Q&A section, which will be located at the bottom of your screen. And we'll also be using automated transcripts for today's webinar.

At the end of today's presentation you'll be redirected to a very short survey. And we would really appreciate it if you could complete that survey. It takes just about two to three minutes. And the responses that you provide are part of how we remain accountable to SAMHSA. We are recording the session and it will also be available with the PowerPoint slides on the Great Lakes page PTTC website, the products and resources page in about two weeks. And everyone that attends the full session today will also receive certificates of attendance via email. And that will take about two weeks for you to receive, as well. You want to find out more about what you're doing, please follow us on social media. And I will turn it over to Kathy and Kareem.

KATHIE KANE-WILLIS: Hi, my name is Kathie Kane-Willis and this is my partner in crime. I'm pointing-- I don't know if I'm pointing in the right direction-- Kareem Butler. And we're going to go through a PowerPoint slide, some

research findings. And then we're going to talk about policy recommendations and things that folks can do. And we're hoping to have time to have a robust question and answer session. And we look forward to sharing this information with you.

I hope that I can get this screen sharing to work easily and effortlessly. And I hope that we have no technical problems today. And I hope everyone who's on this webinar is enjoying their morning and had a relaxing weekend and a wonderful Mother's Day for those who celebrate and for those who are mothers or mothers of anything-- pets, people, plants, to all.

And I'm going to kick it off to Kareem. Oh, I'll just say a couple of things. I co-founded the Illinois consortium on drug policy in 2005, which is a public policy research center focused on drugs and health to see drug policy under a health lens. And then I joined the Chicago Urban League about five years ago to work on this particular issue-- so at the intersection of African-Americans Black folks and the opioid crisis.

KAREEM BUTLER: Hi, everyone. So thank you, Kathie for giving a little bit of background as far as what we're going to be talking about today, and also just welcoming everyone. My name is Kareem Butler. I work for the Chicago Urban League in the Research and Policy Center with my colleague, Kathie here, of course.

And in that role, I'm the director of learning and evaluation. I do come to this work with a background in public health. A lot of my work up until now has involved really work focused on health equity and racial equity, of course. In my work at the league, a lot of it definitely is geared towards supporting our programs, teams, and making sure that our services are responsive and really authentically targeting the most exigent needs of our community.

I also play a role in supporting a lot of the work that goes on with the research policy and advocacy work that my colleagues like Kathie are involved in. So, I'm happy to be here and looking forward to the presentation.

KATHIE KANE-WILLIS: And with that, I'm going to try to start to screen share. Screen share, I think this will work. I think this will work. I think it should be easy. My apologies, and I can't share. OK, from beginning. Oh, hold on.

KRISTINA SPANNBAUER: Just try resharing it really quick. That happens when you pop into presenter's mode sometimes.

KATHIE KANE-WILLIS: Oh, it does. OK, so screen share. Is it working? It's not working. OK, here we go. So this is, we wrote a paper in 2017. And I think that became some of the basis of the SAMHSA paper that was sent to you. But this is an update. So this is an update with updated data. And in 2017 when we released this paper, it got a lot of attention. The situation is a lot worse. And it's not good.

So research notes Black race refers to individuals who are identified in publicly available data sets as Black or African-American. Black or African-American people can also be Latinx, Hispanic. So we're not looking at ethnicity in this. So we're looking at blacks and whites only. The majority of the overdose deaths occur between these two groups. But there's a lot of regional variation.

And so if we're looking at Native Americans, we did try to look at Native Americans by state. That was very difficult because there's not enough number to generate statewide data, you know what I mean. In terms of there's just not enough population in the state to get reliable rates.

So it's not that we don't care about Asians and we only care about whites and blacks or comparison between the two, but it's more about the statistical power that you have when you're looking at different groups, especially within a state or even smaller than that, a locality. Latinx does generally occur at lower rates than whites and blacks. And rates are not age adjusted. We're just doing pure crude rates.

Because people sometimes get confused about rates. Just remember like the murder rate. What it is, is it is making it so that we can compare small areas to large areas. Because we're adjusting for the population. And so that's what it is. It's like the rate per 100,000. And so those are the research notes.

Oh, a couple of things. The data is mostly taken from Studio C Wonder. There's some medical examiner data and then there's the treatment episode data set. OK, so if you can see, this is the opiate overdose deaths. These are fatalities. I'm not dealing really with non-fatal deaths here.

But you can see that in 2019 was the first year of that-- well, 2018 it was crossing that whites and blacks were at the same rate. But then in 2019 you see in the United States the rate of Black deaths was higher than the rate of white deaths. And so when we're talking about this crisis that most people view as a white problem, actually Black people are dying at a higher rate than whites are across the country, when you look at all the way across the country.

So these are synthetic deaths, overdose deaths. So we don't know always what's in the synthetic. But it means non-methadone synthetic drugs. And it's usually a proxy for fentanyl. It doesn't mean that it's a fentanyl or fentanyl analog but most likely it is. And because we don't have the detail on that-- like when you look at Wonder it's going to categorize things in a bigger category. Because just like I said with the smaller racial groups, the smaller numbers, you just don't have as much oomph, you don't have as many numbers. So you get like lots of little things.

But this shows-- and you can see it's pretty dramatic. If you look at 2016, this is the year that blacks started dying in more significant numbers and the rates started to change. So these are synthetic opioid overdose deaths. And you can see, this is fentanyl again, or proxy for fentanyl. And you can see that this is even more dramatic than the death rate for Black folks in this. The blue line is Black folks and the red line is white.

And it will stay that way throughout the presentation. But you can see that it's much more dramatic, several points higher among blacks than among whites. And if we had a full year of 2020 data, this would be much, I think, higher in 2020. So that's my guess on that.

So I just pulled some data from Cook County, which is Chicago. Chicago is in Cook County. It's not that Chicago's only Cook County, or Cook County is only Chicago, rather. There are suburbs included in here. So the data for the city of Chicago is even more stark and extreme. But you can see that this is an analysis of the medical examiner data in Chicago. And this is a partial year. I think it actually went up to 84% of deaths were included fentanyl or fentanyl analog.

So over time just from 2015, you can see 85% of decedents did not have fentanyl. And this is not a testing error. This is actually when we had good data. And now it's less than 19% because it really went up to 80% are fentanyl. So when we're thinking about this, we really have to understand that fentanyl is a main driver of these deaths, which I'm sure that you already know.

Here's another thing that's changed and changed in a pretty significant way. You can see that in 2009, there's always been a bit of a difference. Blacks are more likely to die from stimulant deaths than are whites by the rates. But in 2015, it was pretty close. And now it's gotten more of a gap.

And when we talk about stimulants, we're talking about cocaine, methamphetamine. And I actually looked at some of the data from the treatment episode data set to look at because a lot of the deaths are mostly all polysubstance use. So whether that means alcohol and heroin, or heroin and cocaine, or heroin and methamphetamine and alcohol, or heroin and benzodiazepines. Or so I looked at all of the drugs that people use as their second drug.

So there's a first, the first drug that they use, their primary drug. And then there's a secondary drug. And I looked at that by race. And so it's interesting-- and this is probably not surprising. And I'm not done totally with this analysis. But blacks and whites use stimulants and they report the same percentage of stimulant use as their second substance after heroin, among heroin users. But whites are more likely to use methamphetamine and blacks are more likely to use cocaine. Now, I do think that there's a regional variation in this. That in areas where, obviously, there's less cocaine and there's more

methamphetamine that there's going to be the regional variation of like, I think this is true in Missouri, for example. We do not see cocaine deaths but we see methamphetamine deaths.

And so I think that in particular areas-- and this is true of everything. Even the kind of heroin you get is going to be determined by what part of the country you're in and even what neighborhood you're in. And the adulteration of the substances is probably related to the proximity of the drug market those kinds of things.

So despite the stimulant use being pretty much the same, there's a big gap that's happening right here. You can see it increasing. So these are the top 15 states with the biggest disparity in deaths between Blacks and whites. So this is not the states with the highest rates. It's the highest disparities. You can see in West Virginia, for example, here, this disparity is-- whoopsies. Oh no, shoot. How do I go back-- escape.

Sorry about that, I was trying to point that out. OK, here we go. So if you look at the sample-- and I will not click on it-- West Virginia, 60.4. That's extremely high rate. Now, if you were to look at the certain parts of Chicago, it would be this high. We're talking very high numbers. But because there's so few African-Americans in West Virginia, we wanted to look at the difference between.

West Virginia has very high rates for both. So what's the disparity. So this is the disparity index between. And if you notice in this chart, like Missouri, Illinois Wisconsin, Michigan Iowa, Minnesota, Ohio, Pennsylvania-- well Pennsylvania is not the Midwest but it's in between. More than half of these states are in the midwest. More than half of the states where the disparity is significantly high are in the Midwest. And I want people to understand that and to think about why that's happening. We need to do better in the Midwest. We're not doing a very good job.

So I wanted to talk about the ways in which people actually administered, the route that they use their drugs. So there's a number of different ways of using drugs. You could swallow it. You could smoke it. You could snort it. Or you can inject it. Or you could use it in some other way, like boofing I suppose you could do. So this is for the whole United States. And I want you to see the main difference.

What is the main difference in this slide is that Black people actually don't inject very much. 2/3 of Black people snort their drugs. Whereas 3/4 of whites inject their drugs. The Midwest, this difference is even more significant in the Midwest. If you're in the Midwest, Black people are much more likely to snort their drugs than white people. And white people are much more likely to inject their drugs.

Now remember, regional variation is the theme of this webinar, brought to you by regional variation. So I'm going to show you another slide. So here's Illinois. And look at how high this is, and these numbers. So then we're going to look at Minnesota.

So Minnesota you see a difference. There's less snorting and more injecting in this population. And look what pops up here that you don't see in Illinois-- smoking. And why would that be. What's the difference. Why are these patterns different. Well, it has to do with the kind of heroin.

OK, so I'm going to go back. And actually let me previous, let me go back here. OK, so we're talking about heroin, there's very big differences East of the Mississippi and West of the Mississippi. And it's not so clearly defined as that because there's a lot of regional variation. But West of the Mississippi, more commonly is solid form heroin tar heroin, which is like hash. It's a solid. You can smoke it.

And that's what these numbers are indicative of. Also, when you have tar heroin, because it's a solid and not a powder, it's a lot harder to snort it. Like you have to liquefy it and then get it up your nose. You have to make it into some-- Because you know, you can't snort a rock. I mean, you could try. But it would be pretty hard. It probably wouldn't give you the effect that you were looking for. It would just stick in your nose. So you have to liquefy into it. And so these are some of the differences that you see. Ohio also has very high injecting rates. I mean, in any state you look at though, I will tell you this. It doesn't matter the state, Black people will have lower injecting rates than will white. It doesn't matter the state. Even though I'm talking about regional variation, there's no state where Black people inject more than white people. And now we're going to get to why that's important. The majority of naloxone is provided through syringe service programs, which may better serve the needs of injectors rather than snorters or smokers. But it's important to be giving out safer snorting kits and safer smoking kits and really reaching out to this population.

Harm reduction services are mostly or exclusively provided through SSPs. And Black people are more likely to have stigma related to needle usage. And this might be due to the HIV/AIDS epidemic. They're strong attitudes. Many SSPs do not have staffs or leadership of color. I know I've been working in this area for a very long time. I'm also a former heroin user.

And I use syringe service-- then it was syringe exchange, for real-- before it was legal in San Francisco. And the people who ran the syringe exchanges just in general were white folks. And harm reduction came from a lot of gay folks who are working on HIV prevention. And so, you know, it wasn't necessarily by Black people and for Black people. And a lot of syringe service providers in a lot of states are giving out IM naloxone, intramuscular naloxone, which is a big needle. And it's a big kit compared to a nasal kit, which is very tiny.

I know the IM naloxone is so much cheaper. But if you're giving IM naloxone to people who do not use needles and who have significant stigma about needles and who are going to face high rates of arrest, and to use an emergency situation, perhaps this is not the best tool. Perhaps we might want to use nasal Narcan.

I know that it's just from my personal experience. I was an injection drug user. I don't think it's so easy to get the naloxone out of those little teeny vials in an emergency with a big needle. I do not. That's just me. Everybody's different. But you know, emergencies make people's hand shake and it's very stressful. So I wonder if that might be something to do with this.

Increasing fentanyl adulteration in heroin, cocaine, and other drugs, including pills-- which might be tied to proximity to the drug market or social networks. And so, I know there's probably been talk about cocaine adulteration for some time and methamphetamines adulteration for some time. I want to tell you that in Chicago we have seen this on and off. It is not always in the stimulants, but it is occasionally.

And here's the thing, some of these people might not-- in the decedents-- they might not have wanted to use opioids, but they got opioids and it killed them. And so we have to think about making sure that we are giving naloxone to people who use stimulants. Less access to harm reduction services. Because most of all are conducted through SSPs, and the higher stigma-- I mentioned this-- in the much lower rates of injection.

And then the IM naloxone might not work, I guess. I was ahead of myself with this. But the fear of police is real. And there's a journal article about the qualitative experiences of why people are not carrying naloxone. Because actually most people are not carrying naloxone.

This was in New York and I'm still not done doing the communication, but very few people did carry it because of the stigma, of the largeness, of the fear of police, not sure if they were going to ruin someone's high-- which translates into money, too. Because somebody spent the money to get the drugs. And if put them into withdrawal, like what is that ramification going to look like. So I mean those are real possible potential barriers. But we don't really know. Because there has been very little research done on this.

So basically we're just kind of doing stuff and not understanding how people use, how people procure, what their concerns and barriers are. That's pretty small. Kareem, did you want to say something? Go ahead.

KAREEM BUTLER: No I mean, I think all of this is just-- I think this leads nicely into the next slide really because I think—

KATHIE KANE-WILLIS: Oh, I'm sorry. I didn't—

KAREEM BUTLER: No, no, no, no, go ahead. No, please. I'm not asking you to change slides yet. I was just saying that I think ultimately what this is doing is really, I think a lot of the data that has been described I think really well by Kathie so far is trying to tell a story. Ultimately we're trying to build a narrative that really explains why rates or disparities in overdose between blacks and whites have become so prominent.

And in doing that, I think the data, as we're explaining it we need to keep in mind what sort of social situations Black people and white people are coming up in the world, how they're navigating the world based on race. And that's just the point I wanted to throw out there in leading into the next slide just to get people thinking about some of those social determinants of health that I'm going to be mentioning shortly.

KATHIE KANE-WILLIS: Absolutely. And I do think that people think that you have to really look at the whole picture. And I'm going to advance the slide so you can talk now.

KAREEM BUTLER: Yeah, thank you. Exactly. I think you have to look at the whole picture. And just in continuing on that point, the first bullet right here speaks about untreated pain among Black people and increased rates of disability as an additional driver of increased overdose deaths among blacks. And when you're talking about untreated pain, in the medical community there are a lot of misconceptions about how Black people respond to pain.

Research has shown that there are medical students, people who we would consider extraordinarily intelligent and capable, who believe and cling to a lot of really wild misconceptions about Black pain tolerance and just the various ways that Black bodies respond to pain. And you have to really consider that when you're talking about something like overdose deaths, when you're talking about something like opioids.

Because one thing that gets commonly overlooked is, when you're talking about untreated pain, Black people are also less likely to be prescribed opioids by a medical practitioner. And it also forces, therefore, Black people to then go look for those sorts of options and opportunities for treatment elsewhere and they end up going to the street to find those things in a lot of cases. Which puts them in more contact with things like fentanyl and other synthetic opioids that are driving up the rate of overdose among Black populations.

And so here's where I think we need to talk more about the social determinants of health and health disparities. There are a lot of things that also drive overdose deaths among blacks that don't really get attention very often. Some of those things do include pollution, of course, and then access to medical care as I did allude to.

That can take the form of access to medical care can be hampered by a lack of trust that certain communities may have in doctors and nurses and in clinicians in general. But also physically there is a big lack of access to pharmacies and communities of color. There's a lot of evidence out there that really specifically, research done within Chicago, that just paints a really vivid picture for how within communities like Englewood, communities like Austin, North Lawndale, pharmacy deserts are just commonplace. You can drive around and really be hard pressed to find access to just even a CVS or Walgreens where there's staff available to really provide people with the needed resources and medication that they need in order to treat their various chronic conditions.

KATHIE KANE-WILLIS: Can I jump in on this, Kareem? All the CVSes on the West side are closed. So we can get naloxone via the pharmacist. But if there is no pharmacy, how are you going to get that. I mean, you can't get buprenorphine filled if there's no pharmacy. Like all of these things.

And I mean we were shocked, we were going through-- I think it was you and me-- that we're looking at like where you can get. And the fact that the CVS is closed, you can see it on a map of where naloxone can be gotten. It's just not as much.

KAREEM BUTLER: It's just not available in the same way that it is in predominantly white communities where there's better access to care, there's better access to pharmaceuticals. And that's just worth really paying attention to when we're trying to figure out how to resolve this problem, how to address it through policy, through legislation, and things like that, as well.

And in speaking a little bit more about the social determinants of health, I think people sort of forget what exactly that means. Generally speaking, again, coming from a public health background, I like to talk about this. Because there are a lot of things that will influence an individual's health outcomes. And few of them have to do with that individual's health behaviors, very few of them. I mean, of course those things do play an important role, whether or not you're physically active. The types of food that you're eating of course, matters.

But larger than that, your environment plays a massive role. Your household influences, your economic status, whether or not you are Black, whether or not you are white, these things also matter, as we just mentioned. So they're important to keep in mind. Because when we're talking about health and why overdose deaths and overdose in general is more significant among Black populations right now when it comes to opioids, health in general is more vulnerable within Black communities. The health and wellness of Black people is just more in jeopardy at a constant in our society.

And so when you're considering that people who are much more vulnerable and have more existing health complications, more chronic conditions, are

more likely to experience adverse reactions to various adulterated drugs that they might be consuming, especially if they have high concentrations of fentanyl and things like that. And on top of that, if they can't access adequate medical care, if they can't access naloxone that they need in a way that's accessible to them, based on the route of administration that you just mentioned also, Kathie.

KATHIE KANE-WILLIS: Yeah, can I just jump in on this food desert, because it's a weird thing that I found in the literature. I don't know if people know about the mind gut connection and the gut microbiome, that it's a bidirectional relationship.

And so they found that lack of diversification in microbiome effects anxiety and depression and substance use disorder. So if you take an opioid addicted rat and take a fecal transplant and put it into an opioid naive rat, guess what. It's addicted and it goes through withdrawal. So when we're thinking about these things as being sort of moral characteristics or dealing with the stigma related to making poor choices, I just really want to emphasize that the research is starting to show that this is much more physiological than it is psychological. And that the physiology affects the mind.

And so, having less access to good quality foods is going to disrupt your gut microbiome and can cause more anxiety, depression, and substance use disorders among people with this kind of low diversification of their microbiome. So I just thought that was fascinating and I wanted to throw that in there.

KAREEM BUTLER: I think that's good. If we could just move to the next slide, actually. I think this also leads into something else I just wanted to build on. Again, just to kind of build on what we previously had talked about, specifically about there being a lack of medical care and medical treatment facilities in pharmacies within Black communities, especially in other communities of color. You know again, this comes back to there being a lack of medication assisted treatment available in Black communities.

And when we're talking about, again, how we can really avoid dealing with so many mounting overdose deaths within these communities, MAT is a big way to prevent those things. Naloxone is a big way to prevent those things. And if we have pharmacy deserts, if we have a lack of providers who are available to prescribe MAT, that's a huge problem.

Moving on from there, speaking again about some of the social determinants of health that we were talking about earlier, mass incarceration is something that puts Black people in particular at way higher risk of experiencing fatal overdoses after release. One thing that people don't recognize is that recently released individuals that are returning to the community are at way higher risk of experiencing a fatal overdose than those in the general population, including those who are using substances in the general population.

And the reason for this is, a lot of folks they go in. They go to a prison setting, they go into a jail setting. And especially if they're using opioids or things that they require MAT for, MAT is rarely, if ever, offered in a prison setting. Because of that, people are going to—

KATHIE KANE-WILLIS: Rhode Island. Rhode Island does a good job. It's like the size of-- you know.

KAREEM BUTLER: Very few select examples, Rhode Island being one of them. And outside of that, it's extremely uncommon. People come out. Their tolerance is extremely low. And over the course of their stint within a correctional setting, that makes them more vulnerable to overdoses when they come out and now they're dying at way higher rates than people in general population because of the fact that when they were in prison and they should have had an opportunity to receive MAT they didn't.

And because Black people are more likely to be incarcerated, this of course then just compounds the rates that we're seeing that are increasing between blacks and whites, that disparity that we're seeing increased between blacks and whites in overdose. So again, I think that's just something important to keep in mind. There are a lot of different factors that I think influence overdose between blacks and whites that often get overlooked, some of them including some of the preexisting conditions that people have, like I mentioned before. The health that you have as an individual prior to-- whether it's part of using substances, prior to consuming anything that you're putting in your body. Your pre-existing medical conditions, your pre-existing health prior to that is going to have an effect on how you react to that.

KATHIE KANE-WILLIS: Absolutely. And just to tie back to the pollution thing, which we discovered during the COVID paper, is that environmental racism and increased pollution put people who live in these areas-- and these are majority Black and brown people-- at higher risk for cardiovascular disease and endocrine disorders because of the pollution. So the pre-existing medical conditions are also due to the environment that folks are born into. And the zip code that you're born into determines your life expectancy.

KAREEM BUTLER: Right, right, very much so. I mean, within Chicago if you were to look at life expectancy across zip codes that are no more than five miles apart, the life expectancy can differ by over 10 years. [INAUDIBLE] North Lawndale, the life expectancy might be 66, 67, around there, based on the most recent data. And you look at a community like Lincoln Park, Lakeview, and the life expectancy it could be as high as 81. And these communities are separated by at most seven miles, maybe eight, at most. But in the same city.

KATHIE KANE-WILLIS: And the difference is, they're majority Black communities, majority white communities. And I think that this is part of the

thing that we're seeing in the Midwest, is the Midwest has high levels of segregation and this could be part of the reason why we're seeing these disparities most in the Midwest, the highest level of disparities.

I really do think that segregation-- I mean, because all of these drivers, a lot of them are about segregation, too. Racism and segregation.

KAREEM BUTLER: Exactly. And so I think that was just something that was important to really highlight. The how again, when we're talking about zip codes, when we're talking about where you are, your environment, and how that really plays a role in your health outcomes, overdose is not-- The opioid epidemic, the overdose crisis that we're in isn't isolated from all of these other issues that we're constantly battling and dealing with, including systemic racism.

KATHIE KANE-WILLIS: And COVID, now.

KAREEM BUTLER: Yeah, and COVID. And all of these things are playing compounding roles. They're just important to consider. So, I think if you could move onto the next slide.

So, there are a couple of principles that I think we could really rely on and try to adhere to do a better job of preventing a lot of these deaths and really working to restore the health that these communities deserve to be able to experience equitably in our society. So, Black people, African-American people, families, and communities can't be excluded from narratives that are told about the opioid epidemic, opiate overdose deaths, or the needs of impacted individuals, families, and communities.

As far as the opioid epidemic is concerned, obviously one of the reasons why the report that kept that we've been talking about is referred to as whitewashed is because, historically, the opioid epidemic is painted as a white problem that primarily impacts white individuals. And the way that we have responded to the opioid epidemic through criminal justice measures, the way that we have responded to people suffering from opioid use disorders, generally there are significant differences from how people were treated during the crack epidemic of the 80s.

And why is that? Well, we know for sure, we know that Black people were definitely the target of a lot of the different policies that came out, the tough on crime policies that came out throughout the 80s and 90s that were tougher on crime that were geared towards addressing the crack epidemic in particular and that really did a number on the wealth and the stability of Black communities at that time.

KATHIE KANE-WILLIS: Despite the fact that white people were more the users of crack cocaine than Black people. I mean, in totality, right. So it was perceived to be-- and I think this is the thing that you're getting at. The

perception of this drug is used by this population, and this drug is used by this population. The difference in the policy response, I have to say that when we first started to bring attention to this, I worried about the policy response being like the crack epidemic or the crack issue.

And that the kinder, gentler drug war would turn into—

KAREEM BUTLER: Something more sinister and—

KATHIE KANE-WILLIS: Even more sinister.

KAREEM BUTLER: Right. And that's a very legitimate concern. I think in telling the stories that we're trying to tell, the goal is to take the very well-placed sympathies and concerns that should exist for people who are living with substance use disorders and at risk of dying from an overdose who are at risk of increased harm as a result of this epidemic that we're experiencing right now, I think that the goal is to provide and extend those same sympathies, that same attention, that same care and concern for Black communities.

When we're telling these stories, a lot of times Black communities and families and people just get left out of the conversation. And for those reasons, we see a lack of harm reduction services. We see a lack of SSPs. We see a lack of medical providers who are available to prescribe the types of MAT that's needed to prevent the deaths that we're talking about here.
And that's what we're trying to really correct going forward. So as far as other principals are concerned,

KATHIE KANE-WILLIS: Let me move back, sorry.

KAREEM BUTLER: No worries.

KATHIE KANE-WILLIS: OK, wait, wait, wait, hold on. I'm sorry. It's good that I was running the PowerPoint considering I'm so good at it. OK, so we've talked about this. We're on principles, right.

KAREEM BUTLER: Yeah, I think we're on like slide 18.

KATHIE KANE-WILLIS: OK, should I go back to 18. OK, I'm so sorry.

KAREEM BUTLER: No worries, no worries. This happens in the Zoom group.

KATHIE KANE-WILLIS: Do you want to go to the next slide.

KAREEM BUTLER: This is fine right now, actually. If you could just leave it here. So again, speaking about some of the other principles that are just contained in this slide and things that we should try to adhere to prevent some of the deaths that we're seeing. A lot of the deaths that we're seeing occur

throughout this opioid crisis and the overdose epidemic. The development and implementation of national and local public health policy and plans need to include the participation of Black individuals, families, leaders, and organizations through all phases of the planning process.

And to just build on that, public health and treatment interventions must be tailored to address the experiences and needs of the African-American community. So those two points again, they really are part and parcel, related to each other. We need to have Black communities and families and leaders at the table when we're deciding on things that are going to have a direct impact on them.

So when we're deciding on what types of harm reduction services we're going to provide or what types of naloxone is going to be made available for people across the state or across the region, we need to be able to have Black communities and individuals at the table. Because as we just talked about, there have been policies created to really try to combat the opioid epidemic that are, of course, important and helpful to a lot of to a lot of people. But they also leave folks out. Because they're not always considering the different routes of administration that certain communities might try to administer heroin or other substances when they're creating these policies.

And again, that's exactly why when we're talking about how we need to create treatments and interventions that are tailored to the experiences of the African-American community, by having these organizations and other folks of color at the table, we can create those sorts of policies that are reflective and responsive to the different needs and experiences that these communities go through.

So, there are a couple of legal and implementation implications that I'd just like to mention and highlight. So despite having strong overdose prevention laws, naloxone isn't being distributed in African-American communities. While Medicaid covers MAT and naloxone, there may be gaps in knowledge about these medications used to treat opioid use disorder.

And buprenorphine capacity is very low for a variety of reasons, including the underfunding or the support of treatment generally during the grants process. And in Chicago, cities like Chicago and many other places, heroin arrests are concentrated in the same place where the highest rates of death are occurring. So these are-- I'm sorry, Kathie, did you want to just quickly jump in or say something.

KATHIE KANE-WILLIS: I just want to say, it goes down to like, you could look at D.C., the ward level. There's one ward in St. Louis. There's one area, it's always the poorest, most fragile most vulnerable place where both the arrests and the deaths are happening. And so this does suggest I mean there is possibly a relationship between-- well, there is a relationship between the

arrests and the deaths. Because we know that arresting loses tolerance, those kinds of things.

I just found it interesting like how concentrated it is, that we're talking about even lower than a zip code, a community area, award. You know what I mean, and I'm sure in every state and every area there is going to be a couple of zip codes that just are the bell ringers. And I would say that five years ago, this was not the case in Illinois. In 2015, the majority of deaths were occurring in the rural parts of the state.

And so this is the difference we're seeing. I don't know if everybody's seeing that kind of difference. But I think they are. And so, I just want to say to the existing infrastructure, when you add a population who is majority white dying, and then now it's flipped to a completely different population, that requires organizations that are delivering services to the people most at risk to change completely everything that they're doing to make sure that they're reaching these people. When they were trying to reach those people in a completely different part of the state. And that is a huge pivot that I think that most-- I mean, because things don't usually happen like that.

And so this is why I think it's so disturbing and frustrating, not just because of the inequity, but how you pivot to address it requires-- and it's happening so fast and so dramatically that how do you get ahead of this.

KAREEM BUTLER: Right. And one thing I'd also add, I don't want to necessarily build out a really detailed example for each of these different legal and implementation implications just for the sake of time. And I also think some of these things in here we've already spoken about in some way or alluded to throughout the presentation so far.

But regarding the first bullet point, I think one thing that, Kathie, you mentioned and that we can just speak to a little more right now is stigma and how that also has a relationship to and how that also affects the availability of different services of naloxone, of different life saving drugs and treatment within these communities. I think it's often overlooked how, as a community, we as Black people have had our consciousness shaped by the different policies and the different criminal justice practices that have targeted Black communities largely. And then have largely centered on Black people and their behavior as the menace to society in these instances.

And so, it can be difficult in a lot of communities of color, especially Black communities, to really encourage naloxone distribution. And to really find points of access where there are organizations and people willing to work with you to make these drugs and this treatment available. And a lot of that can come down to stigma and how that is something that's really difficult to uproot based on a lot of different forms of trauma that have been done to our communities for years.

And so I just wanted to mention that because yes it does have to do with the lack of access to physical medical treatment, a lack of access to pharmacies and things like that as well, and just bad policy making at times. But it also does come down to the toll that problematic policies have had on communities of color and how that shaped our consciousness today in whether or not we're going out and trying to make sure that we have access to these lifesaving drugs and treatments.

KATHIE KANE-WILLIS: Yeah, it's been my experience-- I know we're running short on time-- that there's more just more stigma in the Black community. We work for a Black organization. And it's just there's more, the politics of respectability, because Black people are, like you said, the menace. And like trying to change that narrative means it's difficult to—

KAREEM BUTLER: It's difficult. It can feel intractable at times. And as a Black person like I understand why that exists. I mean ultimately, it's like you're trying to both provide. You're trying to both create a better future for Black people. But you're also trying to deal with reality as it is as a Black person. And the reality is, you will be treated differently because of your race than a white person if you're using drugs. Whatever it is you do, you will be treated differently because of who you are and because of the way you look and appear to others.

And so it can be difficult to navigate these worlds. And again, that's why we need Black leaders. We need Black organizations and community members at the table when we're talking about how to create solutions to these problems.

And finally, just to provide some of the policy recommendations that have come out of this report, that have come out of some of the research that has been presented to you so far, you know number one, we need to ensure access to nasal naloxone by people who don't inject drugs. As we've shown, the routes of administration definitely differ by race as far as heroin and opioids are concerned.

Going further, we have to decriminalize simple drug possession. We have to stop the targeting of Black people by the police. We also have to work on creating funding streams for Black led harm reduction initiatives. And we also have to have more providers that are from the communities that were actually trying to serve and to build better trust with.

So more Black doctors, more Black treatment providers. There's definitely an absence of that within communities of color already. And that would do a lot to restore the trust that is very much needed between the community and the medical community as well. And then finally, we also have to provide more research on racial differences and harm reduction access, use patterns and purchasing patterns, and we have to consider the safety of the supply.

All of this should inform, I think, how harmful the war on drugs has really been, where it's taken us to. And I think it should really give us some sort of insight into what could be done to provide for a better safe and more regulated experience for the communities that we're talking about in this presentation, as well.

KATHIE KANE-WILLIS: Yeah, and I forgot to leave off overdose prevention sites that allow for smoking and snorting. And that overdose prevention sites, if they're only dealing with injection use, is not going to touch this population. And I know we're running, we're like 1 minute to 11. So I know there's questions in the chat box. And maybe we can see.

PRESENTER: We have some really great questions. Maybe we can get that first one done. But then would you be willing to possibly answer the rest. Like email, and we can post them with the slides.

KATHIE KANE-WILLIS: I'm sorry, could you repeat it. I was reading the question.

PRESENTER: Well, we're actually at time right now. Would you both be open to sending the questions and you could respond via email? And then we can include the answers with the slides on the website.

KAREEM BUTLER: Sure, sure. Yeah.

PRESENTER: OK, great.

KAREEM BUTLER: Right, yeah I think there's no problem for the sake of time.

KATHIE KANE-WILLIS: And then stimulant overdose is really important. I think stimulant overdose is complicated by stimulants. And like that there is fentanyl sometimes in the stimulants. But it's also stimulants, the contingency management for stimulants.

I know that we're at time. So I was just going to say contingency management is the thing that you can do with stimulants. And harm reduction is harm reduction. People think harm reduction with stimulants is some other different kind of harm reduction. It's really not. It's the same kind of thing of making sure you take care of yourself, go slow, go slow. Use with somebody. Carry naloxone.

And encouraging people to use less. Using less ways that would the lower the risk. And mainly not using alone. And I think that's really important.

PRESENTER: Thank you both so much. This has been fantastic information. Everyone in the chat is thanking you as well. We appreciate everyone who

joined us today. Kathie and Kareem, we really appreciate it. And we'll get back to everybody with answers to all the fantastic questions.

KATHIE KANE-WILLIS: They are great questions. Thank you for asking them. And I look forward to corresponding with the people who ask the questions. Because they have some interesting—

KAREEM BUTLER: Interesting questions in there. Look forward to getting back to those. Thank you everyone for your time. And thank you for hosting us, as well.

PRESENTER: Absolutely. Well you have a great rest of your day, everyone.

KAREEM BUTLER: All right, take care.

PRESENTER: Bye.