

Contributions from the Civil Society Forum on Drugs to the EU-USA bilateral dialogue on drugs

September 2019

This paper by the Civil Society Forum on Drugs (CSFD) aims to contribute to the bilateral dialogue between the EU and the USA planned for 11th September 2019, highlighting key issues of concern which we hope the EU will be able to raise during the discussion. This document updates and complements our contribution published ahead of the first EU/USA dialogue in October 2018.¹

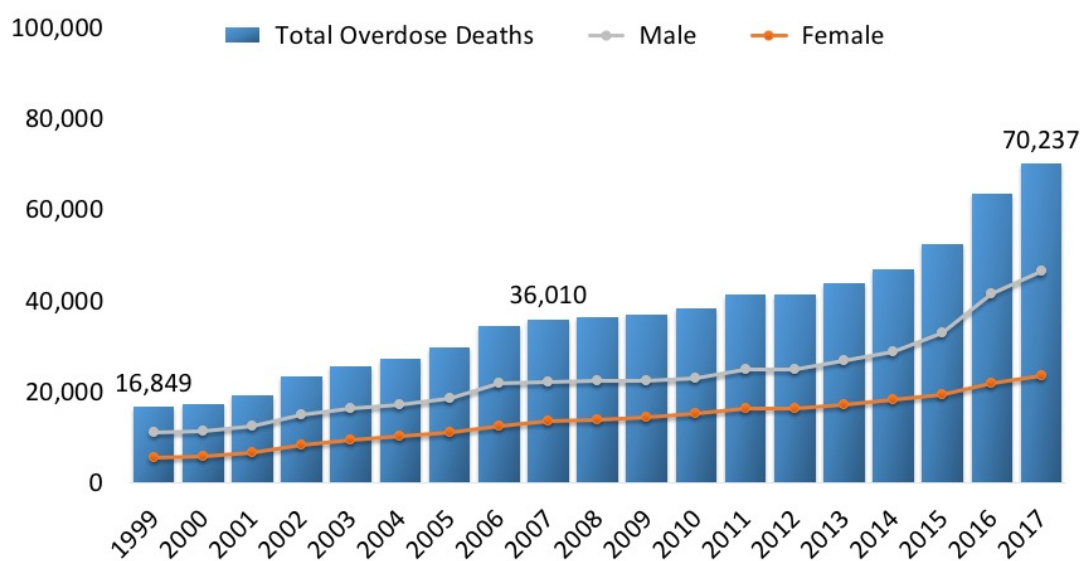
1) Responding to the opioid overdose crisis

Relevant paragraph in the UNGASS Outcome Document: Paragraph 1.m.

Relevant action in the EU Action Plan on Drugs 2017-2020: Action 8.a, 8.b.

The rates of drug overdose deaths in the USA are alarmingly high. In 2017 alone, the total number of overdose deaths reached 70,237.² Of these, 68% involved opioids – including prescription opioids which represented 24% of overdose deaths, synthetic opioids and heroin.³

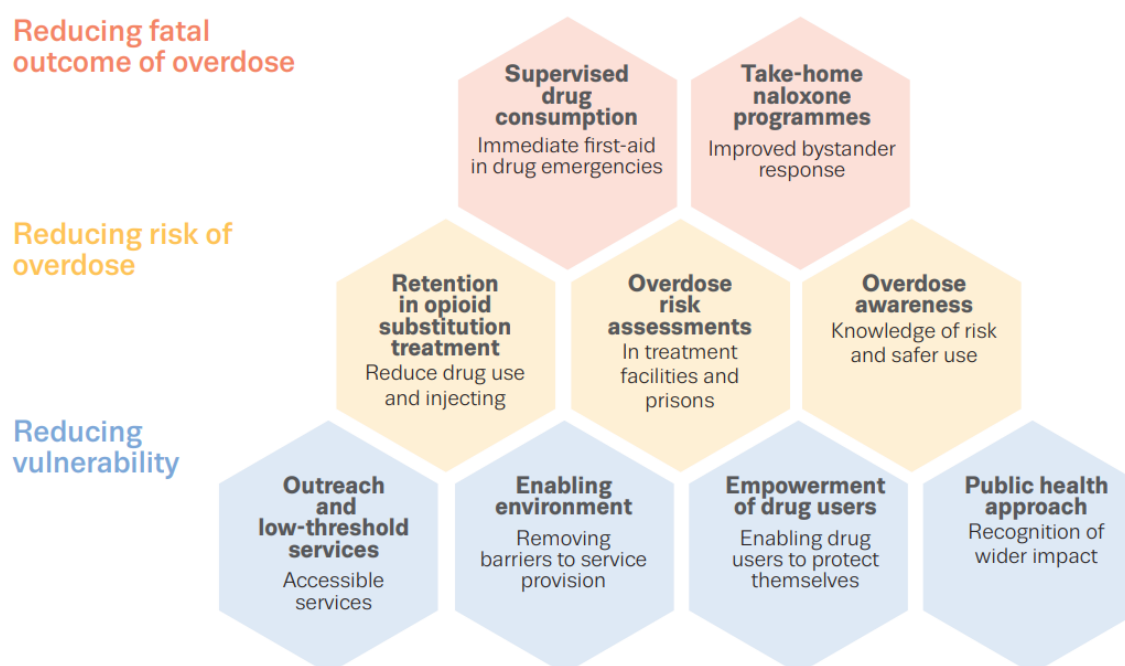
Figure 1. National drug overdose deaths: Number among all ages, by gender, 1999-2017⁴



Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

Worryingly, the USA has responded to this public health crisis mainly with a law enforcement-oriented approach, with limited investment in health programmes such as drug dependence treatment or overdose prevention interventions such as naloxone distribution. This is despite the fact that the US National Drug Control Strategy, released in January 2019, promotes three pillars: ‘prevention’, ‘treatment and rehabilitation’, and ‘reducing the availability of illicit drugs’.⁵ It is concerning, however, that ‘risk and harm reduction’ is not mentioned as another key pillar in the strategy, despite being endorsed by the Centers for Disease Control and Prevention⁶ and the Surgeon General.⁷ And while naloxone distribution is promoted, no other critical harm reduction intervention is mentioned – for example safe injection facilities which are promoted as an effective response by the EMCDDA (see Figure 2),⁸ and which does not feature in the US strategy.

Figure 2. EMCDDA recommended interventions for preventing opioid-related deaths⁹



As a result, in 2017, 43 US states (out of 50) had a standing order to authorise non-medical personnel to issue naloxone, but only 34 states had laws to protect naloxone prescribers from civil and criminal liability, while only 10 states had Good Samaritan Laws in place to prevent a person calling 911 from arrest and prosecution for drug possession, drug paraphernalia possession, and probation/parole violation.¹⁰ Additionally, 25 US states retain drug induced homicide laws,¹¹ further deterring people witnessing an overdose from calling emergency health professionals.¹² It is also estimated that only 8% of US counties are implementing overdose education and naloxone distribution programmes.¹³ Meanwhile, there are still no state-sanctioned safe injection facilities in the country.

We call on the EU to strongly promote a public health and social inclusion approach to the opioid overdose crisis in the USA, including the interventions promoted as best practice by the EMCDDA (see Figure 2).

2) Ensuring improved access to drug dependence treatment

Relevant paragraphs in the UNGASS Outcome Document: Paragraphs 1.i, 1.j, 1.k, 4.c and 4.m.

Relevant action in the EU Action Plan on Drugs 2017-2020: Action 6, 8.a, 8.d and 10.d.

A significant proportion of Americans struggle with drug dependence, and quality treatment and disease management services are essential – as is recognised in the US National Drug Control Strategy.¹⁴ Currently, however, only a small percentage of people meeting diagnostic criteria for drug dependence receive treatment, and most of those who do receive treatment either do not benefit from evidence-based care, nor do they receive it in sufficient intensity and duration to promote long-term positive outcomes. This is due to several critical impediments.

Firstly, under the Mental Health Parity and Addiction Equity Act of 2008,¹⁵ most private and public insurers are required to cover drug dependence treatment in the same way they cover treatment for any other disease. Although the Act was adopted more than a decade ago, it has not yet been fully implemented or enforced. As a result, individuals and families face many barriers to navigating their insurance system and accessing drug dependence treatment. Some plans deny coverage for treatment altogether, while others approve limited treatment services that are not necessarily aligned with the levels of care recommended by health

professionals. As a result, the majority of those seeking drug dependence treatment are unable to obtain the care they need, contributing to nearly 200 lives lost each day due to an overdose.¹⁶

Secondly, the treatment criteria developed by the American Society of Addiction Medicine are yet to be formally accepted and recognised as a national standard for the treatment of drug dependence. Currently, these criteria are only required in about 30 US states. The use of nationally-recognised guidelines for the treatment of drug dependence would help ensure the full implementation and enforcement of the Mental Health Parity and Addiction Equity Act by reinforcing that dependence requires care and treatment similar to other chronic conditions; providing a standardised nomenclature for prescribing a continuum of treatment services; emphasising the importance of person-centred care; and helping to ensure that individualised treatment and care plans developed by health professionals are covered by public and private insurers.¹⁷

Thirdly, access to medication-assisted treatment (MAT) remains limited in the USA.¹⁸ Between 2006 and 2016, opioid substitution therapy was only available in 8.5% of all facilities, both public and private, that can provide this medication in the country. In 2015, it was estimated that 2.1 million people used medically prescribed or illicit opioids, but only 411,300 accessed MAT. And although access broadened in 2016 when nurses and physician assistants were granted permission to prescribe buprenorphine, in 28 US states nurses must still work with a doctor who has a federal licence in order to prescribe it, and half of those do not have a single physician with such a licence.¹⁹

Access to drug dependence treatment in the criminal justice system is even more limited. This is all the more problematic that over the past four decades, the incarceration rate in the USA has more than quadrupled,²⁰ and hold more individuals suffering from mental illnesses or drug use disorders than any other public institutions in the country.²¹

We call on the EU to promote expanded access to a range of evidence-based drug dependence treatment services in the USA, including in prison settings, in line with the UNGASS Outcome Document and the EU Action Plan for 2017-2020.

3) Ensuring adequate access to controlled medicines

Relevant paragraphs in the UNGASS Outcome Document: Chapter 2.

The fears associated with the surge in opioid overdose deaths in the USA has impacted upon the rights of patients to receive opioid medicines for pain relief and palliative care. These fears, however, are unfounded. It has been suggested that 21-29% of patients receiving opioids abuse them, but this also includes non-compliance, such as not taking medication regularly as instructed – seen in about 25% of all prescribed medication. Furthermore, only a small proportion of all people treated with opioids for pain management develop dependency (estimated at between 0.01 and 4%).²² A 2019 study concluded that the risk of opioid use and dependence may be higher among adolescents and young adults after exposure to prescription opioids.²³ Pregnant women, people in the criminal justice system and people who inject drugs may suffer higher levels of harms associated with the use and misuse of prescription opioid medicines.²⁴

Nonetheless, the many problems associated with opioid overdose deaths and other associated harms should not hamper legitimate access to opioid medication for palliative care and the relief of pain and suffering for the 50-100 million US people who need it. A national pain strategy, which includes assessment, prevention and treatment can ensure that the quality of pain care is improved, and opioid medicines are used both effectively and appropriately.²⁵

We call on the EU to stress the importance of ensuring adequate access to controlled substances, including opioids, for palliative care and pain relief.

The Civil Society Forum on Drugs (CSFD) is an [expert group of the European Commission](#) that was created in 2007 on the basis of the [Commission Green Paper](#) on the role of civil society in drugs policy in the EU. Its purpose is to provide a broad platform for a structured dialogue between the Commission and European civil society which supports drug policy formulation and implementation through practical advice. The CSFD is consistent with the [EU Strategy on Drugs 2013-2020](#) and the new [Action Plan on Drugs 2017-2020](#) both of which require the active and meaningful participation and involvement of civil society in the development and implementation of drug policies at national, EU and international level. Its membership comprises 45 CSOs from across Europe and representing a variety of fields of drug policy, and a variety of stances within those fields. Below is the list of CSFD members for the period 2018-2020:

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| 1. ABD - Associació Benestar i Desenvolupament | 23. Forum Droghe |
| 2. AFEW International | 24. FUNDACIÓN ATENEA |
| 3. AIDES | 25. GAT - Grupo de Ativistas em Tratamentos |
| 4. Ana Liffey Drug Project | 26. HRI - Harm Reduction International |
| 5. APDES - Agência Piaget para o Desenvolvimento | 27. IDPC - International Drug Policy Consortium |
| 6. APH - Association Proyecto Hombre | 28. INPUD - International Network of People who use Drugs |
| 7. ARAS - Romanian Association Against AIDS | 29. IREFREA - Instituto Europeo de Estudios en Prevención |
| 8. Citywide Drugs Crisis Campaign | 30. MAT - Magyar Addiktológiai Társaság |
| 9. De Regenboog Groep | 31. Médicos del Mundo España |
| 10. Dianova International | 32. PARSEC Consortium |
| 11. Diogenis Drug Policy Dialogue | 33. Polish Drug Policy Network |
| 12. EAPC - European Association for Palliative Care | 34. Prekursor Foundation for Social Policy |
| 13. EATG - European AIDS Treatment Group | 35. Proslavi Oporavak |
| 14. ECAD - European Cities Network for Drug Free Societies | 36. Romanian Harm Reduction Network |
| 15. EFSU - European Forum for Urban Security | 37. Rights Reporter Foundation |
| 16. ENLACE | 38. San Patrignano |
| 17. EURAD | 39. SANANIM |
| 18. EuroTC - European Treatment Centres for Drug Addiction | 40. SDF - Scottish Drugs Forum |
| 19. EUSPR - European Society for Prevention Research | 41. UNAD |
| 20. FAD - Fundación de Ayuda contra la Drogadicción | 42. UTRIP |
| 21. Federation Addiction | 43. WFAD - World Federation Against Drugs |
| 22. FEDITO BXL | 44. WOCAD |
| | 45. YODA - Youth Organisations for Drug Action |

Endnotes

¹ See: Civil Society Forum on Drugs in the EU (October 2018), *Contributions from the Civil Society Forum on Drugs to the EU-USA bilateral dialogue on drugs*, <https://drive.google.com/file/d/1zwwVWBOpwnvxfFfpMukkVv674Xe8s5Jq/view>

² National Institute on Drug Abuse (January 2019), *Overdose death rates, Revised January 2019*, <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

³ Ibid.

⁴ Ibid.

⁵ Office of National Drug Control Policy (January 2019), *National drug control strategy*, <https://www.whitehouse.gov/wp-content/uploads/2019/01/NDCS-Final.pdf>

⁶ Centers for Disease Control and Prevention, *Syringe Services Programs*, <https://www.cdc.gov/ssp/index.html>

⁷ Joseph, A. (September 2018), 'Expanding addiction treatment, embracing the bully pulpit: Jerome Adams on his first year as surgeon general', *StatNews*, <https://www.statnews.com/2018/09/20/surgeon-general-jerome-adams-year-one/>

⁸ European Monitoring Centre on Drugs and Drug Addiction (September 2018), *Preventing overdose deaths in Europe*, Perspectives on drugs, http://www.emcdda.europa.eu/system/files/publications/2748/POD_Preventing%20overdose%20deaths.pdf

⁹ Ibid.

¹⁰ National Institute on Drug Abuse, *Is naloxone accessible?*, <https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/naloxone-accessible> (accessed August 2019)

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- ¹¹ Health in Justice Action Lab and Legal Science, *Drug induced homicide laws, updated through: January 1, 2019*, <http://pdaps.org/datasets/drug-induced-homicide-1529945480-1549313265-1559075032> (accessed: August 2019)
- ¹² Drug Policy Alliance (November 2017), *An overdose death is not murder: Why drug-induced homicide laws are counterproductive and inhumane*, <http://www.drugpolicy.org/resource/DIH>; Friend, E. (July 2019), 'Drug dealers could face murder charges under 'death by distribution' law', *North Carolina Public Radio*, <https://www.wunc.org/post/drug-dealers-could-face-murder-charges-under-death-distribution-law>
- ¹³ Lambdin, B.H., Zibbell, J., Wheeler, E. & Kral, A.H. (2018), 'Identifying gaps in the implementation of naloxone programs for laypersons in the United States', *International Journal of Drug Policy*, **52**: 52-55
- ¹⁴ Office of National Drug Control Policy (January 2019), *National drug control strategy*, <https://www.whitehouse.gov/wp-content/uploads/2019/01/NDCS-Final.pdf>
- ¹⁵ Available here: https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html
- ¹⁶ Center on Addiction (March 2019), *Uncovering coverage gaps II: A review and comparison of addiction benefits in ACA plans*, <https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-ii-review-and-comparison-addiction-benefits-aca>
- ¹⁷ Reported by Westcare Foundation, Inc, August 2019
- ¹⁸ See, for instance: Weber, E., Gupta, A. (July 2019), *State Medicaid programs should follow the "Medicare Model": Remove prior authorization requirements for buprenorphine and other medications to treat opioid use disorders*, <https://lac.org/wp-content/uploads/2019/07/access-to-meds-in-medicaid-eweber-FINAL-070919.pdf>
- ¹⁹ Harm Reduction International (2018), *The Global State of Harm Reduction*, pp. 114-6, <https://www.hri.global/global-state-harm-reduction-2018>
- ²⁰ Southern Poverty Law Center, *Criminal justice reform*, <https://www.splcenter.org/issues/mass-incarceration> (accessed August 2019)
- ²¹ Reported by Westcare Foundation, Inc, August 2019
- ²² Von Gunten, C.F. (2016), 'The pendulum swings for opioid prescribing', *Journal of Palliative Medicine*, **19**: 1
- ²³ In adolescents, the rate is estimated at 6.8% in: Schroeder, A.R., Dehghan, M., Newman, T.B., Bentley, J.P. & Park, K.T. (February 2019), 'Association of opioid prescriptions from dental clinicians for US adolescents and young adults with subsequent opioid use and abuse', *JAMA Intern Med.*, **179**(2): 145-152, <https://www.ncbi.nlm.nih.gov/pubmed/30508022>
- ²⁴ Bonnie, R.J., Ford, M.A., Phillips, J.K. (2017), *Pain management and the opioid epidemic: Balancing societal and individual benefits and risks of prescription opioid use, A consensus study report of the National Academies of Sciences, Engineering, Medicine* (Washington D.C.: The National Academies Press), https://www.ncbi.nlm.nih.gov/books/NBK458660/pdf/Bookshelf_NBK458660.pdf
- ²⁵ Mackey, S. (2019), 'Twin crises in pain and prescription opioids', *Br Med J*, **364**: 432, https://www.bmj.com/bmj/section-pdf/993475?path=/bmj/364/8191/This_Week.full.pdf