

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

May 2020

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 27 May 2020, 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 third EU/USA dialogue in September 2019 and October 2018.¹

1) The COVID-19 pandemic and people who use drugs in the United States

Relevant paragraph in the UNGASS Outcome Document: Paragraphs 1.j, 1.l., 1.m, 1.p, 2.e, 4.a, 4.b, 4.j, 4.l, Relevant action in the EU Action Plan on Drugs 2017-2020: 6, 8.a, 8.b, 9, 29.a, 41

People who use drugs are particularly vulnerable to the COVID-19 pandemic due to stigma, discrimination, criminalisation, underlying health issues, social marginalisation, and economic and social vulnerabilities.² In order to ensure that their health, safety and human rights are upheld during the response to the pandemic, we urge you to raise the following issues with the US authorities.

Ensuring access to life-saving harm reduction and drug treatment interventions.

In the wake of the COVID-19 pandemic, civil society across the world³ raised the alarm that the pandemic could greatly reduce access to crucial life-saving interventions, from harm reduction to drug treatment, as lockdown movement restrictions, lack of protective equipment for staff, and disruptions in supply chains could result in the closure of a number of services and centres. In that regard, the UN Special Rapporteur on the Right to Health has highlighted that these services are essential for the protection of the life of people who use drugs, and that states must make sure that they remain available, accessible, of adequate quality and free from discrimination.⁴

Early research in the US and Europe shows that these fears were founded. An April 2020 survey found that the availability of syringes in Needle and Syringe Programmes (NSPs) in the US has dropped by over 40% in surveyed programmes.⁵ Recent research by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) shows a similar trend, with a sharp decline in the availability and demand of both harm reduction and drug treatment services in Europe.⁶ It has also been reported that some police departments in the US are no longer using Naloxone to reverse opioid overdoses during the pandemic out of fear of contagion.⁷ The overarching concern is that, in situations of heightened stress and isolation, and without adequate access to treatment and harm reduction services, dangerous substance use and overdose deaths will increase.⁸

In response to this, in a recent briefing⁹ the EMCDDA described a series of good practices that have been adopted in Europe to increase accessibility to drug treatment and harm reduction services in times of COVID-19. These include:

- A relaxation of the regulations on take-home opioid substitution therapy (OST), (i.e. methadone or buprenorphine programmes) for OST clients. While US authorities have increased the size of take-home doses for stable OST patients,¹⁰ methadone is still only dispensed in federally-approved Opioid-Treatment Programmes, which may result in increased difficulties and danger for patients amidst the pandemic. The US medical community has urged US authorities to allow for methadone to be distributed in pharmacies as an emergency relief measure.¹¹

- Using online tools/telemedicine, remote services and/or adapting their services to reduce the need for physical contact for providing drug treatment and harm reduction services.
- Establishing proactive measures to reach out to the most vulnerable clients, such as street-based people, through mobile OST programmes.
- Some European NSPs have encouraged users to take away larger quantities of injecting and harm reduction material.
- Shelter rules have been adapted to facilitate access for a variety of people, and to reduce restriction on drug and alcohol use, including increased alcohol harm reduction measures. Temporary shelters have been successfully established by requisitioning hotels, or adapting residential treatment.

We call on the EU to urge US authorities to ensure that people who use drugs have access to life-saving harm reduction and drug treatment interventions, including through relaxing regulations on OST prescriptions and take-home doses, and through the innovations highlighted as best practice by the EMCDDA in its briefing on the impact of COVID-19 on drug services in Europe.¹²

Spread of the pandemic amongst populations incarcerated for drug offences.

Since the outbreak of the virus, at least 398 people incarcerated in the US have died of COVID-19¹³, including several people convicted for drug offences, including the mere possession of drugs for personal use¹⁴. As the EMCDDA has highlighted, prisons are closed environments in which over-crowding, poor infrastructure, and delayed diagnosis make controlling COVID-19 particularly challenging; with negative repercussions on prisoners, prison staff, and communities¹⁵. Cramped conditions mean that it is hardly possible to maintain physical distancing, hygiene and sanitation standards.

In response to this, the US authorities should be urged to take all necessary measures to guarantee the health and safety of prisoners, prison staff, and communities at large, by preventing the spread of the virus in prisons and other detention centres, including:

- As urged by US civil society organisations¹⁶ and UN agencies such as the UNODC, UNAIDS, WHO and the OHCHR,¹⁷ take immediate measures to reduce prison populations through recourse to alternatives to incarceration, pardons, and early releases, ensuring that people who use drugs and/or are detained for drug offences are not excluded from such measures. While many detention facilities are managed at a state level, the Federal government can establish general recommendations and lead by example in federal prisons. EU officials can point to successful examples in California¹⁸ and Texas,¹⁹ as well as across the world.²⁰
- Adopting measures analogous to those envisaged in the WHO/Europe Office guidance on preventing a COVID-19 outbreak in prisons,²¹ which include recommendations on personal protection measures, use of masks, or environmental prevention, among others.
- Adopting measures analogous to the Council of Europe principles on ensuring that the human rights of persons deprived of liberty are fulfilled during the pandemic, including recommendations on maintaining contact with the outside world, daily access to open air, and psychological support.²²

We call on the EU to urge US authorities to ensure the health and safety of prisoners and other persons deprived of liberty, including people detained for drug offences, during the COVID-19 pandemic, especially by adopting/implementing the prison overcrowding alleviation measures urged by UN agencies.

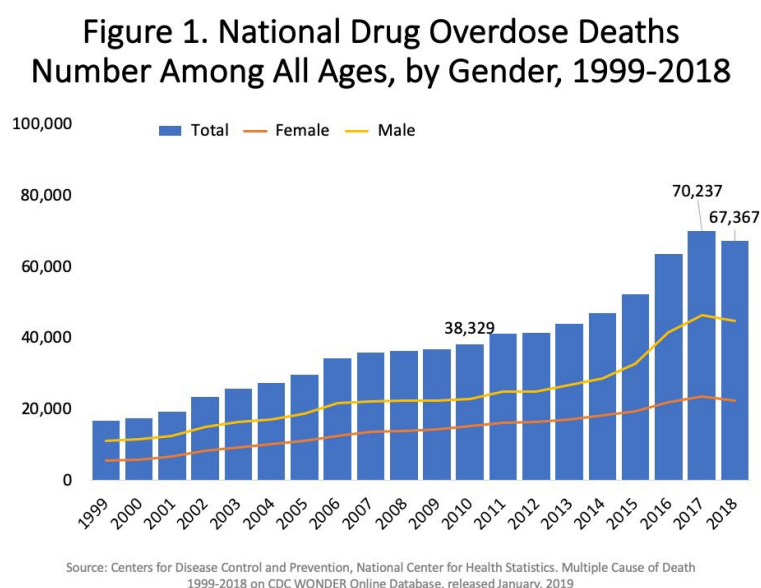
2) Responding to the opioid overdose crisis

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.

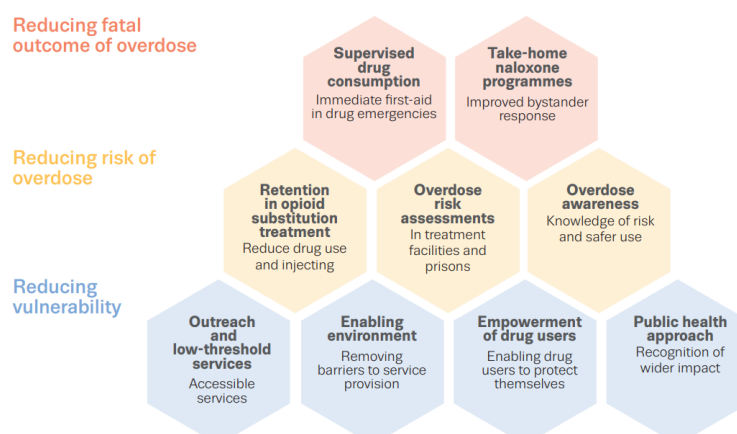
The rates of drug overdose deaths in the USA are alarmingly high. In 2018, the total number of overdose deaths reached 67,367²³, which represents a 4.1% drop from 70,237 deaths in 2017.²⁴ Of these, 69% involved opioids – including prescription opioids which represented 22% of overdose deaths (down from 24%), synthetic opioids and heroin.²⁵

Figure 1. National drug overdose deaths: Number among all ages, by gender, 1999-2018²⁶



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 harm reduction, 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’.²⁷ 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 Prevention²⁸ and the Surgeon General.²⁹ 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).³⁰

Figure 2. EMCDDA recommended interventions for preventing opioid-related deaths³¹



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 being arrested and prosecuted for drug possession, drug paraphernalia possession, and probation/parole violation.³² In a worrying trend, the number of US states that have adopted drug induced homicide laws has risen in 2019 to 26, and the number of charges brought on that basis soared to 717 from 496 in 2018,³³ further deterring people witnessing an overdose from calling emergency health professionals.³⁴

In 2018 it was estimated that only 8% of US counties are implementing overdose education and naloxone distribution programmes.³⁵ Meanwhile, there are still no state-sanctioned safe injection facilities in the country.³⁶

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).

3) 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.

Quality treatment and disease management services for Americans that experience substance use disorders are essential – as is recognised in the US National Drug Control Strategy.³⁷ 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 2008,³⁸ 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.³⁹

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. In 2019, these criteria were 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.⁴⁰

Thirdly, access to medication-assisted treatment (MAT) remains limited in the USA.⁴¹ 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, as of 2018 in 28 US states nurses still had to work with a doctor who had a federal licence in order to prescribe it, and half of those did not have a single physician with such a licence.⁴²

Access to drug treatment and harm reduction services in prisons

Access to drug dependence treatment in the criminal justice system is even more limited. As of 2019, no prisons in the US had a Needle and Syringe Program in place,⁴³ despite these being recognised by UNODC, WHO and UNAID as a key intervention for HIV prevention, treatment and care in closed settings.⁴⁴ As of 2018, OST was only available in a limited number of prisons. And wholly inadequate to respond to the needs of the prison population.⁴⁵ This is all the more problematic that over the past four decades, the incarceration rate in the USA has more than quadrupled,⁴⁶ and prisons hold more individuals suffering from mental illnesses or drug use disorders than any other public institutions in the country.⁴⁷ A punitive-led approach to drug use and drug offences is generally recognised as one of the main drivers of mass incarceration in the US. It is estimated that almost 500,000 people are behind bars for a drug law violation on any given night in the United States - ten times the total in 1980.⁴⁸

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

4) 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 have 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%).⁴⁹ 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.⁵⁰ 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.⁵¹

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.⁵²

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 |

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| 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. Diogenes 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 (September 2019, October 2018), *Contributions from the Civil Society Forum on Drugs to the EU-USA bilateral dialogue on drugs*.

² OHCHR (2020), *Statement by the UN expert on the right to health on the protection of people who use drugs during the COVID-19 pandemic*, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25797&LangID=E>.

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