Dismantling War on Drugs Policies in COVID-19's Aftermath

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See also Pro et al., p. S66.

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Each day of the COVID-19 pandemic's transformative months has taught us anew that viruses exploit the weaknesses of their host populations. COVID-19 arrived on our shores to find a nation made fragile by centuries of White supremacy, and the virus surfed our exhalations and inhalations toward Black people, Indigenous people, and other people of color (BIPOC) and Latinae communities. The pandemic collided with the US racialized war on drugs policies—such as police drug crackdowns targeting predominately BIPOC and Latinae neighborhoods—and exacerbated their harms. For generations, these policies have channeled HIV and the hepatitis C virus (HCV) into the networks of BIPOC and Latinae people who use drugs (PWUD); the pandemic is projected to amplify racial/ethnic inequities in these harms and has already escalated inequities in overdoses.[1–3] Likewise, war on drugs policies disproportionately incarcerate BIPOC and Latinae PWUD, and the COVID-19 mortality rate in prisons has been triple the national rate.

This collision has also transformed select war on drugs policies and illuminated possible pathways toward more just, compassionate, and effective approaches to drug use. These transformations are, however, currently time-limited emergency responses to the COVID-19 pandemic. We consider some of these transformations, mining the national investigation by Pro et al. (in this issue of *AJPH*; p. S66) of multilevel correlates of substance use disorder treatment success overall and for particular racial/ethnic groups. Substance use disorder treatment systems are vital to creating populations that are relatively unaffected by a host of drug-related harms, viral and otherwise. We focus in particular on the finding of Pro et al. that Black PWUD (but not other PWUD) have higher rates of substance use disorder treatment success in states with greater access to buprenorphine, a medication to treat opioid use disorder. We argue that COVID-19–era temporary reversals of policies that restrict medication to treat opioid use disorder access, and of policies that surveil, arrest, and incarcerate PWUD, should be made permanent to help eradicate inequities in HIV, HCV, and overdoses.

In the decades before COVID-19 struck, the US opioid use disorder treatment system had created an ongoing crisis of access to buprenorphine and methadone, particularly for BIPOC and Latinae PWUD. Methadone, a schedule 2 controlled drug, was approved in 1970 at the dawn of the war on drugs, when opioid use disorder was largely perceived as a criminal–legal issue, rather than a medical illness, that primarily afflicted urban, impoverished BIPOC and Latinae communities.[4] As a result of this perspective, methadone is highly regulated at both the federal level by the Substance Abuse and Mental Health Services Administration and the state level. Methadone cannot be prescribed for opioid use disorder treatment but must be dispensed in certified opioid treatment programs. Patients are required to attend opioid treatment programs daily for the first 90 days of treatment—including weekends—for observed dosing. Not only is daily dosing burdensome for patients, but travel distances can be exceptionally long: opioid treatment programs are not widespread, creating treatment deserts, in large part because of onerous federal and state regulations.

Regulations governing buprenorphine, however, are far less restrictive. Buprenorphine is a schedule 3 controlled medication that was approved in 2002 for the treatment of opioid use disorder, when opioid use disorder was increasingly viewed as afflicting middle-class suburban and rural White people.[4] During congressional testimony about buprenorphine (congressional record vol. 145, no. 16; January 28, 1999), federal leaders described the methadone model of observed daily

dosing as likely ineffective for "suburban" areas experiencing increasing rates of heroin use. Stigma associated with attending opioid treatment programs and suburban zoning restrictions—themselves often effective strategies to racialize space—was explicitly cited as a barrier to expanding the methadone model beyond urban areas and as a justification for establishing a separate suburban system (Box 1). Per the resulting legislation, buprenorphine may be prescribed in an office-based setting by a variety of health care providers (e.g., primary care physicians), provided they have registered with the Drug Enforcement Agency. Patients then fill buprenorphine prescriptions at pharmacies without any supervised dosing requirement. Buprenorphine marketing aligned with federal testimony, targeting White people and their health care providers.[4] Because of these regulatory and commercial systems, before the pandemic struck BIPOC and Latinae PWUD were far less likely to take buprenorphine than were their White counterparts and far more likely to enroll in heavily regulated opioid treatment programs.[4]

In the pandemic's early months, the Substance Abuse and Mental Health Services Administration and the Drug Enforcement Agency lifted several major regulatory barriers that may have increased BIPOC's and Latinae PWUD's access to these lifesaving medications. The Drug Enforcement Agency increased buprenorphine access via telehealth by waiving the requirement of in-person initial evaluations and by authorizing telephone consultation for initiation (rather than requiring two-way audiovisual contact).[5,6] Although helpful for all PWUD, these changes may have been especially vital for Black PWUD: Black PWUD have exceptionally poor access to the traditional buprenorphine providers,[7] and the research of Pro et al. suggests that increased access to buprenorphine increases opioid use disorder treatment success among Black PWUD. In another vital advance for BIPOC and Latinae PWUD, the Substance Abuse and Mental Health Services Administration revised regulations to allow state regulatory authorities to request blanket exemptions for more lenient take-home methadone policies, although implementation has not been uniform across states.

Unfortunately, most pandemic era expansions to medication to treat opioid use disorder will expire at the end of the COVID-19 emergency. However, crises of HIV, HCV, and overdoses—particularly among BIPOC and Latinae PWUD—are escalating rather than ending. In the midst of these drug-related crises, these policy expirations will herald a regression to war on drugs era policies that restrict the access of BIPOC and Latinae PWUD to medication to treat opioid use disorder. Instead of ending these pandemic era medication to treat opioid use disorder policy advances, the Substance Abuse and Mental Health Services Administration and the Drug Enforcement Agency should recognize the ongoing (and indeed escalating) nature of these drug-related crises among PWUD, particularly BIPOC and Latinae PWUD, and make these regulatory changes permanent.

Although beyond the scope of the study of Pro et al., we turn next to war on drugs era criminal–legal policies. For decades, racialized inequalities have pervaded the criminal–legal continuum: compared with their White counterparts, BIPOC and Latinae PWUD are more likely to be stopped, searched, and killed by police; detained, prosecuted, and imprisoned by courts; and reincarcerated by parole and probation officers. Among the multitudes of harms these inequalities have generated are reduced reach and effectiveness of harm reduction programs (including substance use disorder treatment), elevated HIV, HCV, and overdose incidence, and accelerated HIV and HCV progression for BIPOC and Latinae PWUD. As with medication to treat opioid use disorder, pandemic era emergency powers authorized vital revisions to these policies. For example, some jurisdictions enacted moratoria on arrests for nonviolent offenses, and governors and courts issued executive and judicial orders that accelerated early release from jails and prisons.[8] Unfortunately, these changes have been fleeting, and arrest and incarceration rates are

BOX 1— Department of Health and Human Services Testimony about "Amending the Drug Addiction Treatment Act of 1999" to accommodate buprenorphine (Congressional Record Vol. 145, No. 16; January 28, 1999, p. S1092)

"The issue then becomes why should buprenorphine products be delivered differently from . . . methadone . . . there are many narcotic addicts [*sic*] who refuse treatment under the current system. In a recent NIDA funded study (NIDA/VA #1008), approximately 50% of the subjects had never been in treatment before. Of that group, fully half maintained that they did not want treatment in the current [OTP-based] narcotic treatment program system. . . . Fear of stigmatization is a very real factor holding back narcotic dependent individuals from entering treatment. . . . Narcotic addiction is spreading from urban to suburban areas. The current system, which tends to be concentrated in urban areas, is a poor fit for the suburban spread of narcotic addiction. There are many communities whose zoning will not permit the establishment of narcotic treatment facilities, which has in part been responsible for the treatment gap described above." Alan Leshner, National Institute on Drug Abuse director, October 5, 1998

already regressing to prepandemic levels.

Pandemic era emergency criminal–legal policies, however, reveal an untapped potential to mobilize existing legal mechanisms and discretionary powers to accelerate progress toward decriminalization, decarceration, and abolition. Police chiefs and prosecutors could indefinitely extend pandemic era moratoria on drug-related arrests and prosecutions for PWUD; and governors, courts, and jailers could use constitutional and statutorily granted emergency authority to accelerate the large-scale release of people sentenced under draconian drug laws. The pandemic also witnessed shifting public support for decriminalization; for example, the majority of Oregonians voted for a 2020 ballot measure that decriminalized low-level drug possession and expanded resources for substance use disorder treatment across the state.

Together, such legal reforms are vital to addressing inequitable access to medication to treat opioid use disorder and other harm reduction services in communities disparately harmed by decades of war on drugs policies. Closely monitoring the implementation of these initiatives is critical to ensuring that revenue and resources are distributed to entities committed to dismantling racialized inequities in access to substance use disorder treatment and to holding law enforcement accountable to adopting decriminalization in good faith. Such actions, combined with impact evaluations, could build broad momentum for legislative reforms to remove criminal penalties for drug possession and thus could enhance substance use disorder treatment success and bolster resilience to HIV, HCV, overdoses, and COVID-19 among BIPOC and Latinae PWUD.

Regressing to past criminal–legal approaches, by contrast, threatens to further erode this resilience.

Racialized social systems undermine the welfare of the US body politic as a whole, and the war on drugs has also collided with COVID-19 to further jeopardize the health of non-Hispanic White PWUD in rural areas, some of which (e.g., rural Appalachia) are epicenters of drug-related epidemics. Prepandemic war on drugs policies curtailing access to medication to treat opioid use disorder were also detrimental to accessing medication to treat opioid use disorder in rural areas, where transportation access can be poor and distances to opioid treatment programs exceptionally long.[9] Likewise, war on drugs criminal–legal approaches to drug use followed the opioid epidemic into rural areas: by the early 2010s, jail-based incarceration rates in rural counties nationally were more than 30% higher than in suburban or urban metros[10]; incarceration rates in rural Appalachian counties are especially high.[11] The projected benefits of reversing war on drugs era restrictions on medication to treat opioid use disorder access and punitive policies in rural areas may be substantial: in rural Kentucky, for example, decriminalization accompanied by diversion from jail or prison to medication to treat opioid use disorder and scale-up of harm reduction could prevent an estimated 57% of new HCV infections over 10 years.[12]

Pandemics can catalyze major social and political transformations, and the COVID-19 pandemic has generated significant evolutions in US war on drugs policies. Regressing to prepandemic policies because COVID-19 infections may be waning ignores escalating crises of HIV, HCV, and overdoses among BIPOC, Latinae, and rural PWUD. The research of Pro et al. suggests that expanding pandemic era advances in medication to treat opioid use disorder policy reforms—and, we would add, criminal–legal reforms—may strengthen resilience to HIV, HCV, and overdoses among BIPOC, Latinae, and rural PWUD in part by enhancing substance use disorder treatment effectiveness. AJPH

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CONFLICTS OF INTEREST

M. Lofwall has been a scientific consultant for Titan Pharmaceuticals.

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