COVID-19 and the extraordinary normality of the War on Drugs

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By

As if it were not challenging enough during the “normal emergencies” [1] of the United States-led War on Drugs, research and advocacy for sane drug policies becomes even more complicated during a global pandemic.

COVID-19 has exposed the deep and enduring health and social inequities that mark our biopolitical moment, and the punitive ways that we govern people who use drugs serve as one stark example of how some lives are prioritized over others. Given that drug use often intersects with other vulnerabilities, including mental health concerns, housing and food insecurity, incarceration, and lack of access to competent healthcare, people who use drugs are disproportionately vulnerable to COVID-19 and merit attention in our public health response. But in addition to the immediate threats to individual health, the broader context of our responses to drug use tell us something important about the precarity of this moment: not only does the pandemic amplify the injustices of our drug policies, it offers a critical point of departure in which we can refuse to return to a system designed to oppress. This commentary reflects on drug policies in a time of crisis, including my own observations as an anthropologist working in a region where the pandemic has at once destabilized and intensified our local efforts to develop research and programming to reduce the harms associated with drug use.

Peeling back the layers of drug policy must start at the top: early in the pandemic, the President coopted a White House coronavirus task force press briefing to declare a new phase in the War on the Drugs focusing on “enhanced counter-narcotics operations in the Western Hemisphere to protect the American people from the deadly scourge of illegal narcotics.” The supposed urgency was to “not let the drug cartels exploit the pandemic to threaten American lives” [2]. However, border closures and ongoing travel disruptions have likely already altered some drug supply chains and rendered crossing borders more difficult [3]. Even as cartels figure out how to adapt, uncertainties in U.S. supplies will put current drug users at risk. When drug supplies are unstable, overdose rates can increase as drug potency becomes variable and more difficult to dose. People may change their routines and substitute with other substances, which creates additional uncertainly in dosing. Supplies are most likely to

be disrupted first in rural areas that already lack access to adequate healthcare resources, further compounding morbidity and mortality. Some places are already beginning to detect increases in overdose, and experts predict a new deadly wave of the opioid crisis is yet to come [4]. Thus, it is our own officials who are exploiting the pandemic, as a continued focus on interdiction and law enforcement diverts attention and resources away from the growing numbers of people who will need treatment and support for safer drugs use.

Fortunately, innovations like telehealth are changing traditional care delivery models to meet drug treatment needs. Many providers are offering virtual counseling sessions, but inequitable access to technology among rural, unstably housed, and otherwise disadvantaged communities excludes the most vulnerable. Emergency federal guidelines have expanded support for telemedicine to facilitate medication-assisted opioid treatment, or pharmacological approaches intended to minimize painful withdrawal symptoms, reduce overdose, and stabilize patients on non-intoxicative doses. These new guidelines allow providers to induct certain patients virtually and increase the allowable number of take-home doses of medication for some patients to reduce in-person clinic visits [5]. However, these recommendations are non-binding, differentially rolled out across states, and rely on organizations and providers' willingness and ability to adopt the practices. These long-overdue reforms streamline care for some but deepen inequalities in access to care for others.

Furthermore, new guidelines on telehealth raise old questions about the disciplinary biopower of medication-assisted treatment within a racialized drug war. The two major medications used in opioid treatment are methadone and buprenorphine, which as Julie Netherland and Helena Hansen (2017) argue, have developed into a two-tiered racialized system of treatment. Methadone is tightly controlled and dispensed in clinics that require daily office visits, directly observed dosing, and urine toxicology screening, which has become symbolically associated with black and Latinx populations criminalized for their drug use. In contrast, marketing and lobbying campaigns have highlighted buprenorphine as a less-abusable formulation that could be prescribed by private physicians who obtain waivers, essentially encoding this treatment in a privileged whiteness wherein drug use is considered a medical condition rather than crime [6]. Indeed, national data show that buprenorphine treatment is primarily concentrated among white populations with private insurance or the ability to self-pay [7]. Upholding this racialized regime, the new telemedicine guidelines on induction do not apply to methadone, thus requiring new patients to present in person at clinics, some of which have also not expanded take-home dosing for existing clients. Daily trips to clinics heighten the risk of exposure to the virus among primarily minoritized populations who are already disproportionately affected by

COVID-19 [8]. The pandemic represents a critical moment to reconsider punitive approaches to treatment in a highly racialized and classed system of care [9, 10].

Beyond treatment, whether people want to confront it or not, drug use – as it has throughout human history – is going to continue during a pandemic. We should be sensitive to the wide range of reasons that people may not be willing or able to stop using drugs right now, that many more will not have access to help even if they want it, and more yet may relapse back into drug use due to the emotional strain of social isolation and ongoing conditions of uncertainty. Given the increased risk for overdose in uncertain markets, especially among those who reinitiate drug use, and the limitations in treatment described above, the pandemic also forces us to rethink access to potentially life-saving harm reduction services.

Harm reduction is a social justice movement and a practical set of strategies that reduce the negative health and social consequences related to drugs use. Under this umbrella, syringe services programs (SSPs) provide sterile injection equipment to prevent infectious disease transmission including HIV and hepatitis C, and naloxone, a medication to reverse opioid overdoses, among other health services and referrals. Across the United States, SSPs are both state and locally regulated, which means that local political actors and law enforcement can effectively restrict programming even if state-level policy is supportive. My colleague Robin Pollini and I have argued that uneven access to harm reduction programming is produced through “landscapes of antagonism” in which contentious, ideologically-driven interactions among multiple actors at federal, state, and local levels means that where one lives, rather than public health evidence, dictates one’s access to life saving resources [11].

In California, we continue to have strong support for harm reduction at the state level during the pandemic. However, as usual, local enactment is geographically uneven and in some places, like where I live, the burden of outreach and service provision falls entirely to volunteers. Across the state, supportive harm reduction responses have been overwhelming in the way of new opportunities for funding and resource sharing, including some organizations quickly adapting to “taco truck” style mobile service delivery to keep workers and participants safe.

In my own jurisdiction, where we do not yet have an authorized (i.e. legally recognized) SSP, our all-volunteer harm reduction organization has been officially limited to an overdose education and naloxone distribution program. Our collective community-based efforts toward education and coalition-building to become authorized was gaining momentum when the pandemic hit and state-wide shelter in place guidelines took hold. Now local health department employees have been reassigned to the

COVID-19 response and their recent grant-funded efforts to address opioid overdose have been temporarily suspended. This created uncertainty in our ability to apply for authorization and funding to support services in the context of unfinished local buy-in and community support. In similarly socially conservative parts of our state, new SSPs are winning state approval, but in another such jurisdiction local citizens and business owners found time amidst the pandemic to sue a newly-authorized SSP using an environmental law to claim syringe litter as an endangerment to the community (despite the contrary that SSPs help reduce syringe litter) [12]. Antagonism toward harm reduction continues even as the pandemic threatens to exacerbate inequities in places where we were already struggling.

What is an appropriate anthropological response to pandemic drug policy? Personally, my anthropology has veered into outright advocacy. To be neutral is to accept a biopolitical status quo that devalues the lives of people who use drugs even as their risk for COVID-19 is intensified. As with federal drug priorities and systems of drug treatment, the pandemic offers an opportunity to rethink how we do harm reduction, including questioning why we let a robust science documenting its public health effectiveness [13, 14] succumb to a politics of life in times of crisis.

Outbreaks are typically conceived of as extraordinary events requiring short-term, emergency solutions to guide us “back to normal.” However, as Thurka Sangoramorthy points out, we need to recognize how the deepening disparities generated in the context of COVID-19 “are not an anomaly, but rather are systemic, productive, generative, and valuable to the operation of governing bodies and the management of populations” [15]. Likewise, the pandemic reminds us that the “normality” of our punitive, racialized, and abstinence-based War on Drugs is intentionally designed as a system of oppression. The pandemic clarifies and potentially deepens the fissures, but we do not have to accept this as normal.

Our local organization views this as a moment of transformation. Amidst the pandemic, we submitted our application to become an authorized SSP and are actively applying for funding for a collaborative, peer-led model of services that amplifies the long-neglected voices of people who use drugs. The recent uprisings around antiblack police violence and calls for inclusive visions of social justice has only heightened our urgency to move forward with a harm reduction approach that rejects violent, racist regimes of punishment for drug use even in the context of “treatment.” The fissures exposed by crisis can move us to operate in new ways; as anthropologists, this means not just what we write, but what we do, and how we enliven theory into action in our own communities.

Now more than ever, we need to build an allied anthropology to unmask the enduring injustices of the drug war and support those who are on the frontlines of service provision. We need to consider the innovations generated by the pandemic, like easing drug treatment access and "taco truck" style mobile harm reduction, not as extraordinary and temporary responses in the midst of crisis, but rather as an opportunity to shift from carceral to compassionate drug policy approaches. Going back to the normal emergencies of the drug war in which 750,000 individuals (and counting) have died from a drug overdose since the new millennium is not good enough [16]. Anthropologists are well suited to advocate for new approaches forward not only through critique but a committed politics of engagement for social justice.

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