DRUG POLICY

STATE OF THE EVIDENCE

Initial Report as required by Laws of Minnesota 2023, Chapter 52, Article 2, Sec. 3, Subd. 8(v)

Report on Approaches to Illicit Drug Use in Minnesota

February 2024

Ari Edelman McHenry, MPH
and Anne Siegler, DrPH

The authors gratefully acknowledge financial support from Minnesota taxpayers and the leadership and vision of Representative Dave Pinto and Senator Clare Oumou Verbeten. This report is dedicated to the people on the ground and behind the scenes who fight tirelessly for the rights and wellbeing of people who use drugs, and in memory of the hundreds of thousands of people lost to the War on Drugs. In July 2024, this report was recognized with a "Notable Document Award" in the Public Health category from the National Conference of State Legislatures and the Legislative Research Librarians Staff Association.

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COMMONLY USED ACRONYMS

ACRONYM	MEANING
ADHD	Attention-deficit/hyperactivity disorder
AIDS	Acquired immunodeficiency syndrome
AMA	American Medical Association
APHA	American Public Health Association
ASAM	American Society of Addiction Medicine
BIPOC	Black, Indigenous, and other People of Color
CAHOOTS	Crisis Assistance Helping Out On The Streets
CDC	Centers for Disease Control and Prevention
DEA	Drug Enforcement Administration
DIH	Drug-induced homicide
DOJ	Department of Justice
ECHO	Extension for Community Healthcare Outcomes
ED	Emergency department
EMS	Emergency medical services
FDA	Food and Drug Administration
FTS	fentanyl test strips
HCV	Hepatitis C virus
HHS/DHHS	Health and Human Services/ Department of Health and Human Services
HIV	Human immunodeficiency virus

LEAD	Law Enforcement Assisted Diversion
MOUD	Medications for opioid use disorder
OEND	Overdose education and naloxone distribution
ONDCP	Office of National Drug Control Policy
OPC	Overdose prevention center
OUD	Opioid use disorder
PDMP	Prescription drug monitoring program
PWUD	Person/people who use drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SIM	Sequential intercept model
SMI	Serious Mental Illness
SNAP	Supplemental Nutrition Assistance Program
SSP	Syringe services program
SUD	Substance use disorder
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
UN	United Nations
WHO	World Health Organization

EXECUTIVE SUMMARY

For roughly 50 years, the federal government and the states have implemented drug policies rooted in prohibition, with the goal of banning the use, sale, possession, production, and cultivation of designated controlled substances in hopes of reducing or eliminating the supply and the demand for drugs.[1]

Yet year over year, deaths attributed to drug use continue to increase, killing more than 1,000 people in Minnesota annually–more than the number killed by firearms or COVID-19.[2] Racially disproportionate sentencing, law enforcement overreach, HIV and HCV epidemics, and collateral consequences that follow people for years and sometimes decades cascade down from these policies.

Recognizing a gap in successful policy, this report was ambitiously commissioned by Minnesota's state government, to advance us toward a comprehensive, evidence-based approach to drug policy that aligns public safety goals with health and socioeconomic goals. For while Minnesota has made important strides in health- and socioeconomic-related drug policies, what we refer to as "drug policing" in this report continues to operate at odds with the evidence.

The research team undertook a rigorous review of the scientific and gray literature to surface successful drug policies. Expanding upon the traditional indicators of drug policy associated with supply and demand reduction, we expanded the definition of success to include health and other socioeconomic impacts as well as public safety. This helps us to evaluate drug policies fully.

This report, the first of two, reviews the scientific evidence across four domains of drug policy: health care, harm reduction, social determinants of health, and drug policing. The report also features the experiences of four jurisdictions that have innovated on drug policy to elucidate what policy looks like when operationalized: Oregon, San Francisco, Rhode Island, and Portugal.

We concluded that the following key policies and interventions **meet the criteria for successful drug policy**:

<u>Health Care</u>

- Medications for opioid use disorder, and telehealth flexibilities that increase their accessibility
- Substance use disorder treatment that is voluntary, available on demand, culturally appropriate, and geographically accessible
- Medicaid coverage for treatment for SUD
- Peer support/recovery coaching
- Across provider types, increased competency working with people who use drugs, including harm reduction techniques and expanding training and education curricula

Harm Reduction

- Safer drug using supplies
- Access to naloxone, including distribution directly to people who use drugs.
- Overdose prevention centers
- Fentanyl test strips

Social Determinants of Health

- Housing First and other programs that ease access to housing for people who use drugs
- Criminal record expungement
- Supporting families to remain together in cases of caretaker drug misuse
- Ensuring access to employment opportunities, public benefits, higher education for people with criminal histories

Drug Policing

- Decriminalization with targeted diversion to health/social services
- Defelonization
- Diversion to drug treatment for people who need it and that is tailored to the individual
- Sentence commutations

Evidence is mixed or limited for the following bulleted policies and interventions: Prescription drug monitoring programs; 911 Good Samaritan laws; depenalization; *de facto* and *de jure* police diversion; decriminalization with civil or administrative penalties; decriminalization with no sanctions attached; and regulation.

We concluded that the following prevalent **health care and harm reduction** policies and interventions **do not meet the criteria for successful drug policies**: compulsory treatment; involuntary civil commitment; policies requiring prior authorization, abstinence, drug screening, and/or counseling before initiating HIV, HCV or SUD treatment; prescription drug take-back programs, and residential rehabilitation houses.

The following prevalent **social determinants** policies and interventions **do not meet the criteria for successful drug policies:** restricting access to housing based on criminal history; removing children to the foster care system for parental drug misuse; policy barriers to employment, education, and public benefits based on criminal history or drug use; laws that prohibit public behaviors associated with houselessness, like sleeping or camping in public, begging, and loitering; and fines, fees, and debt associated with criminal-legal system involvement.

Last, the following prevalent **drug policing** policies and interventions **do not meet the criteria for successful drug policies**: arresting people for drug use and criminal repercussion for simple possession; imprisoning people for drug use; drug paraphernalia laws; drug-induced homicide laws; and opioid-related drug seizures.

The report also reviews the needs of special populations in drug policy, including racial and ethnic minorities; people in detention settings; people experiencing houselessness; people with severe mental

health disorders; women, pregnant, and parenting persons, people who engage in sex work, and youth. The final section closes with recommendations regarding data collection and evaluation.

The failure of contemporary drug policy represents a complex systems problem. Responses to substance use made by one arm of government undermine the responses made by other arms of government. Consider one example of Minnesota taxpayers paying twice for oppositional interventions: until August 2023, the effective date of drug paraphernalia legalization, an individual at an encampment of people experiencing houselessness in Minneapolis could receive evidence-based harm reduction supplies, paid for in part by taxpayer dollars, while law enforcement, also funded by taxpayer dollars, shut down the encampment and confiscate the same supplies.

Solving this problem requires not only excising a prohibition-based law enforcement response but replacing it with a new approach. Such a complex systems problem requires a cooperative, cohesive, "whole of government" solution – one that eliminates situations in which agency policies undermine each other and instead work together to make better use of scarce resources and maximize the health and safety of all Minnesotans.

SCOPE OF THE PROBLEM

Minnesota faces an unprecedented overdose epidemic, with the most recent data showing levels of drug-related morbidity and mortality higher than ever reported. Over 1,000 Minnesotans died of opioid-related overdose in 2022, nearly three times as many as in 2018.[3] This number represents only the tip of the iceberg: in 2021, there were over 4,000 nonfatal opioid-involved overdoses that resulted in emergency room visits and over 11,000 admissions to treatment for opioid use disorder.[4] Strikingly, over two-thirds of patients who entered treatment for opioid use disorder left without completing treatment. This too represents only the tip of the iceberg: nationally, it is estimated that only 15% of people with a substance use disorder even receive treatment.[5]

These population-level reports mask important racial disparities. While Minnesota as a whole reports substance use indicators that are roughly parallel to those of the US (see Table 1), Minnesota has some of the nation's most severe disparities by race/ethnicity in the country. Native Americans in Minnesota have a drug overdose mortality rate that is ten times higher than that of white people (192 per 100,000 residents compared to 19 per 100,000 residents), and African Americans have a rate that is more than three times as high (67 per 100,000 residents).[4]

Rates of drug overdose death vary substantially by county, with some of the counties with the highest proportion of Native American residents having the highest rates. (See Figure 1.)

Accurate reporting of drug use prevalence is notoriously difficult and can hide some of the important ways in which communities are disproportionately impacted by the

Figure 1. Map of Minnesota drug overdose deaths by county per 100,000 population, 2019-2022

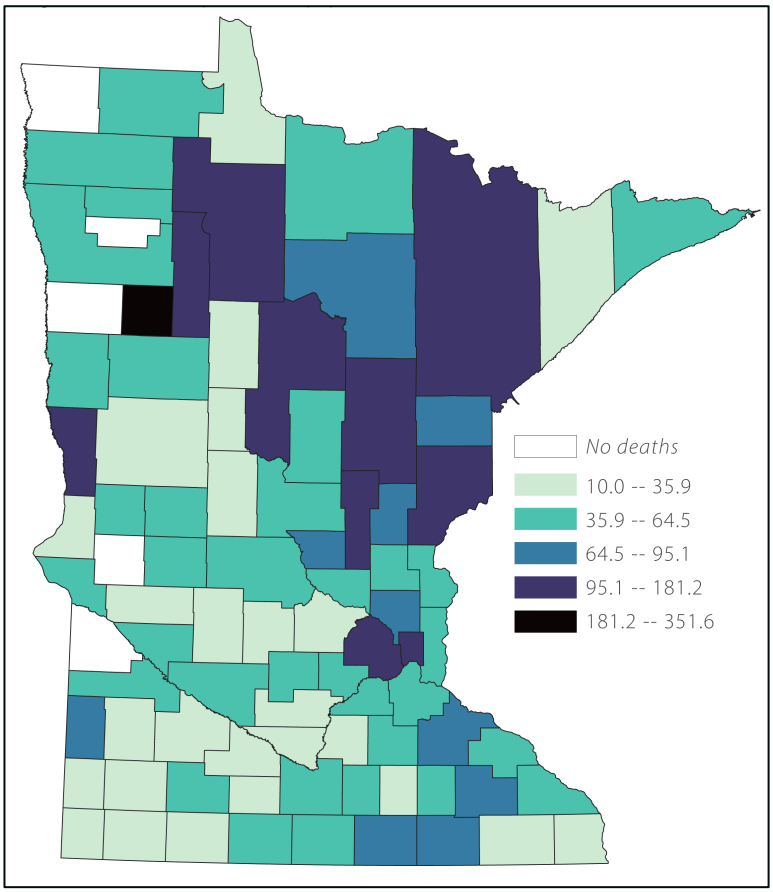


Image Source: Ingraham, C. "The Topline: New data on overdose crisis" (2023). *Minnesota Reformer*. Available at https://minnesotareformer.com/2023/10/16/the-topline-new-data-on-the-overdose-crisis/

morbidities and mortality associated with drug use. About 2.3% of Minnesotans report any illicit drug use other than marijuana in the past month, a number lower than the national average. Opioids make up the most frequently used class of drug, which includes heroin and prescription painkillers. For more detailed information on estimated drug use prevalence, see Table 1.

Table 1. Selected drug use among people aged 12 or older by age group for total US and Minnesota (2021)

	12-17 yrs. Estimate	18-25 yrs. Estimate	26+ yrs Estimate
Illicit Drug Use in the Past Month			
Total US	7.09%	25.32%	13.47%
Minnesota	7.96%	28.35%	12.58%
Illicit Drug Use Other Than Marijuana in the Past Month			
Total US	1.83%	4.07%	3.26%
Minnesota	2.19%	4.00%	2.27%
Cocaine Use in the Past Year			
Total US	0.15%	3.51%	1.61%
Minnesota	0.07%	4.00%	1.98%
Heroin Use in the Past Year			
Total US	–	0.20%	0.47%
Minnesota	–	0.18%	0.45%
Methamphetamine Use in the Past Year			
Total US	0.14%	0.50%	1.06%
Minnesota	0.30%	0.67%	0.83%
Prescription Pain Reliever Misuse in the Past Year			
Total US	1.91%	3.04%	3.27%
Minnesota	1.89%	2.66%	2.97%
Opioid Misuse in the Past Year			
Total US	1.91%	3.09%	3.50%
Minnesota	1.90%	3.21%	2.87%

Another way to understand patterns in drug use is by looking at the ways in which drug crimes show up in the criminal-legal system. Based on data from Minnesota's Uniform Crime Report, 2022 saw a total of 14,933 drug-related arrests, the vast majority of which were for possessing/concealing drugs.[6] By drug type, marijuana was responsible for the greatest number of arrests, with amphetamines/methamphetamines second.

People convicted of drug offenses represented 16% of Minnesota's state prison population in 2023.[7] While Minnesota has one of the lowest incarceration rates in the country, the criminal-legal system also has some of the most severe racial and ethnic disparities. This has been confirmed by bodies like the Minnesota Department of Human Rights, the Minnesota Sentencing Guidelines Commission, and the federal Department of Justice, which found that the Minneapolis Police Department and the City of Minneapolis have violated federal law by unlawfully discriminating against Black people and Native American people.

These racial disparities in the criminal-legal system extend to drug crimes:

- Despite drug use rates that are similar across races, Black and Native American Minnesotans are more likely to be arrested, denied bail, incarcerated, and have their probation revoked compared to white Minnesotans.[8]
- In 2019, Hispanic Minnesotans were 1.2 times as likely, Black Minnesotans 3.1 times as likely, and Native American Minnesotans 9.0 times as likely as white Minnesotans to be arrested for drug possession or cannabis sales.[9, a]
- In 2023, 100% of Minnesotans incarcerated for a drug offense involving crack and 86% of those incarcerated for a drug offense involving cocaine identified as Black, Native American, and/or Hispanic.[7]

Policy responses to date

There is an emerging recognition in state legislatures, including Minnesota's, that an evidence-based response to drug use means approaching it with a public health lens. We see evidence of this in policies like "Good Samaritan Laws" that provide some legal protections for people who call 911 following an overdose, and in policies expanding access to medications for opioid use disorder.

In Minnesota, significant evidence-based changes passed by the Minnesota legislature during the last couple years include:[b]

- Extending medical assistance's coverage of telehealth services, which will support more people's ability to access medications for opioid use disorder in street outreach settings (§ 62A.673);
- Establishing the Task Force on Pregnancy Health and Substance Use Disorders (2023 Laws, Chapter 70 – S.F. No 2995, Sec. 110);

[a] All reported risk-ratios for Minnesotans are population-adjusted by race, using the racial distribution of the adult Minnesota population reported by the Minnesota Sentencing Guidelines Commission.[430]

[b] Evidence supporting these policy interventions is described in the following pages.

- Leveraging a Medicaid 1115 waiver demonstration to integrate the American Society for Addiction Medicine levels of care into statutes governing treatment for substance use disorder (§ 256B.0759);
- Creating funding dedicated to culturally specific recovery communities (2023 Laws, Chapter 61 – S.F. No. 2934, Sec. 21);
- Funding "safe recovery sites" (§ 254B.18);
- Creating protections and boosting funding for syringe services programs;
- Removing barriers to public assistance for people who commit drug offenses (§256J. 26, Subd. 1 and 3).
- Creating the Psychedelic Medicine Task Force (2023 Laws, Chapter 70 - S.F. No. 2995, Sec. 99); and
- Restricting instances when revocation is used for parole and probation violations (§ 609.14).

At the same time as state lawmakers in Minnesota are legislating policy best practices to address the harms of drug use in the arenas of health care, harm reduction, and social determinants of health, the question of how to legislate on what we call here "drug policing" remains more contested. Minnesota and most states continue to address personal drug use and possession as crimes, in conflict with the evidence that drug use is best addressed using a public health lens.[10]

Alternatives to the criminalization approach have been tested in several jurisdictions, including in Oregon (which decriminalized the possession of small amounts of drugs for personal use), Vermont (which decriminalized the possession of non-prescribed buprenorphine), and Denver (which decriminalized psilocybin). Twenty-four states, including Minnesota, and the District of Columbia have legalized the personal use of cannabis. Minnesota's Legislature also legalized drug paraphernalia and established a Task Force to consider the legalization of psychedelic medicines during the 2023 session.

The Minnesota Legislature in 2023 voted to commission a research report to help further inform illicit drug policy in Minnesota. Three main goals of the one-time appropriation are to:

1. Review current policies, practices, and funding;
2. Describe alternative approaches utilized effectively in other jurisdictions; and
3. Make policy and funding recommendations toward a drug policy that reduces and, where possible, prevents harm and expands individual and community health, safety, and autonomy.

This initial report, which comes at the midpoint of the contract period, aims to address Goals 1 and 2. A final report that addresses Goal 3 will be released in 2025.

What's in this report?

This report will present evidence associated with different approaches to drug policy. Evidence will be divided into six sub-sections: Health Care, Harm Reduction, Social Determinants of Health, Drug Policing, Special Populations, and Data Collection and Evaluation. The first four section titles are adapted from the white paper series, "A Transformative Whole of Government Model to Reduce Opioid Use Harms and Death," which groups policy recommendations into those four domains.[10] We add two additional domains: Special Populations, to discuss populations that deserve special attention in each of the four previous domains, and Data Collection and Oversight, to discuss evaluation needs specific to drug policy.

In addition to reviewing the evidence in each of these domains, this report features four case studies highlighting the way drug policy can be operationalized on the ground. These include two US states (Oregon and Rhode Island), one US city (San Francisco), and one country (Portugal).

Public policy plays a vital role in shaping health outcomes. This is true not just for public policies that have an obvious link to health, like health insurance or tobacco control, but also for policy subjects where the connection to public health might be less clear.[11] For example, zoning regulations can have the unintended consequence of placing factories that emit pollution near communities of color, increasing the prevalence of asthma in those communities.

The World Health Organization defines the social determinants of health as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life."[12] This framework illustrates how upstream policy, governance, and socioeconomic factors cascade downstream to influence people's health (See Figure 2, next page).

Thus, aside from understanding the public safety outcomes associated with a criminal-legal system approach to the crisis of overdose, this report will review the health and social outcomes associated with different drug policy schemes. Whereas only analyzing public safety outcomes would not provide a complete look at the costs or benefits, this report will provide a comprehensive view of the effects of these policies on society.

This report is not an exhaustive review of all drug policies; it prioritizes those that have the most evidence base and those with documented outcomes in the areas of health, safety, and socioeconomic factors. It does not evaluate cost effectiveness, which is a key consideration and important body of literature, but beyond the scope of this report. Last, this report does not systematically connect the available scientific evidence to the current policy context in Minnesota: that will be more thoroughly explicated in the final report in 2025.

Figure 2. Conceptual framework of the social determinants of health

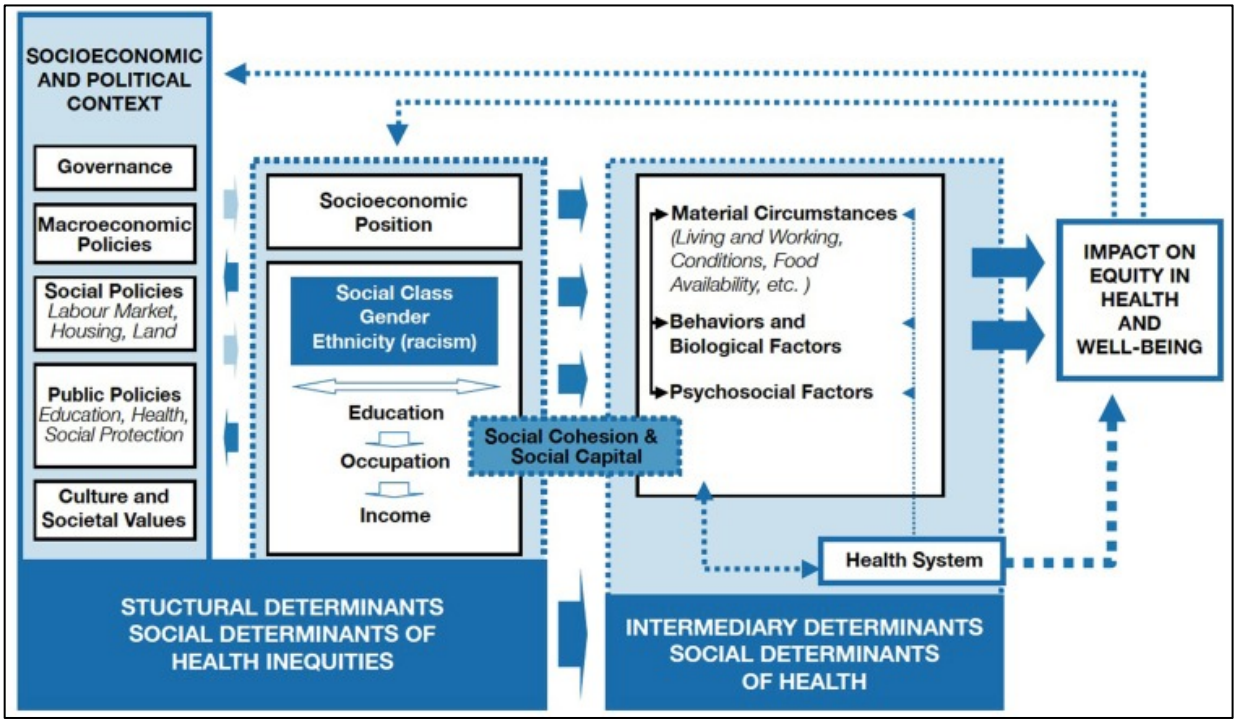


Image Source: Solar, O., and A. Irwin. 2010. *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization. Available at: https://iris.who.int/bitstream/handle/10665/375732/9789240088320-eng.pdf?sequence=1

In this report, we have used language that is non-stigmatizing, neutral, and non-judgmental. We are guided by the National Movement to End Addiction Stigma, and uphold the belief that language has the power to shape opinion. For example, we use terms such as "person with a substance use disorder," if clinically accurate, or "person who uses drugs," rather than abuser, addict, or user. Likewise, we use "person arrested for a drug violation" or "person with criminal legal involvement" rather than drug offender. In some places, however, we have included terminology that may perpetuate stigma to ensure fidelity to cited literature. For more information on non-stigmatizing language and word choice employed in this report, see Shatterproof's Addiction Language Guide.

The report proceeds as follows. After discussing our methodological approach, we review the state of the evidence in drug policy as it relates to the four domains in a Whole-of-Government approach to drug policy: (1) Health Care, (2) Harm Reduction, (3) Social Determinants of Health, and (4) Drug Policing.[10] We then address the specific needs of several subpopulations as they relate to drug policy and end with a discussion of data collection and evaluation needs.

METHODOLOGY

Search strategy and selection criteria

We performed a review of peer-reviewed scientific evidence as well as government reports and other grey literature on drug use, drug policy, and the treatment and care of people with substance use disorders. We searched databases including PubMed and Google Scholar, and hand-searched reference lists of published reviews and meta-analyses. We did not use a firm date range, as data on some types of drug policies and interventions are available in more recent literature than others, but prioritized wherever possible the most recent literature available.

All study designs were included in the review, including observational studies. Only English-language materials were included, except for two studies in Portuguese which were translated using Google Translate.

All types of illicit drugs, modes of consumption, drug policy, and drug treatment were included in the review. Policies regarding cannabis use and treatment were excluded because cannabis is no longer an illicit drug in Minnesota, where this study has been commissioned. Policies regarding the regulation of cannabis were included, when relevant, as much of the available evidence about alternative legal frameworks to criminalizing drug use and possession comes from cannabis models.

The same methods, including key search terms, inclusion, and exclusion criteria, were applied to both the reviews of the scientific literature and the grey literature.

Data analysis

All article titles and abstracts were reviewed for relevance, and irrelevant articles were excluded. Full copy texts were obtained for the remaining articles. One author (AEM) conducted the primary review of the grey literature, while the other author (AS) conducted the primary review of the scientific literature. To ensure consistency in data extraction, the authors developed a standardized tool for data extraction, which drew on the theoretical framework in Terry et al.'s legal analysis, dividing drug policies and implementation models into four pillars: Health Care, Harm Reduction, Social Determinants of Health, and Drug Policing.[13] Priority was placed on papers with strong quality evidence and rigorous methodology.

We came to a consensus to define elements of successful drug policy *a priori*. These elements are:

- Improved health outcomes, as evidenced by measures of morbidity and mortality at the individual level and the population level, as well as improved access to health care and treatment.
- Improved safety outcomes, which we define as decreased violent crime and decreased drug-related harms.[14]
- Improved socioeconomic outcomes, such as employment, education, poverty, housing, and houselessness.

For each element, attention was paid to measures at both the individual and community levels with particular focus on reducing racial and ethnic inequity. Such an expansive definition of successful drug policy is a diversion from traditional metrics of drug policy success: the price of illicit drugs, the perceived availability of illicit drugs, the number and volume of illicit drug seizures, the number of drug-related arrests and incarceration, and the prevalence of drug use in the general population.[15] But those measures do not adequately capture the impact of drug policy on communities and individuals. Including broader health, safety, and socioeconomic outcomes allow us to view the full picture.

This review of the evidence is of course only as good as the state of the evidence, and there are significant challenges to rigorous evaluation of drug policy. Two key challenges, common across ecological studies where broad policy change is attempting to be evaluated, are (1) disentangling effects from changes in other policies and population trends in the same place, across the same period of time; and (2) heterogeneity in policies and interventions implemented in different places, limiting the ability to aggregate and summarize effects.

A few challenges are specific to evaluating drug policy. First, much of the available research has focused on specific instances of reform, such as Portugal's move to decriminalize the use and possession of all illicit drugs or the decriminalization of cannabis use and possession in US states. While this body of research examines outcomes of the policy changes, it does not analyze how specific aspects of the policy change contributed (or did not) to the key outcomes.[14]

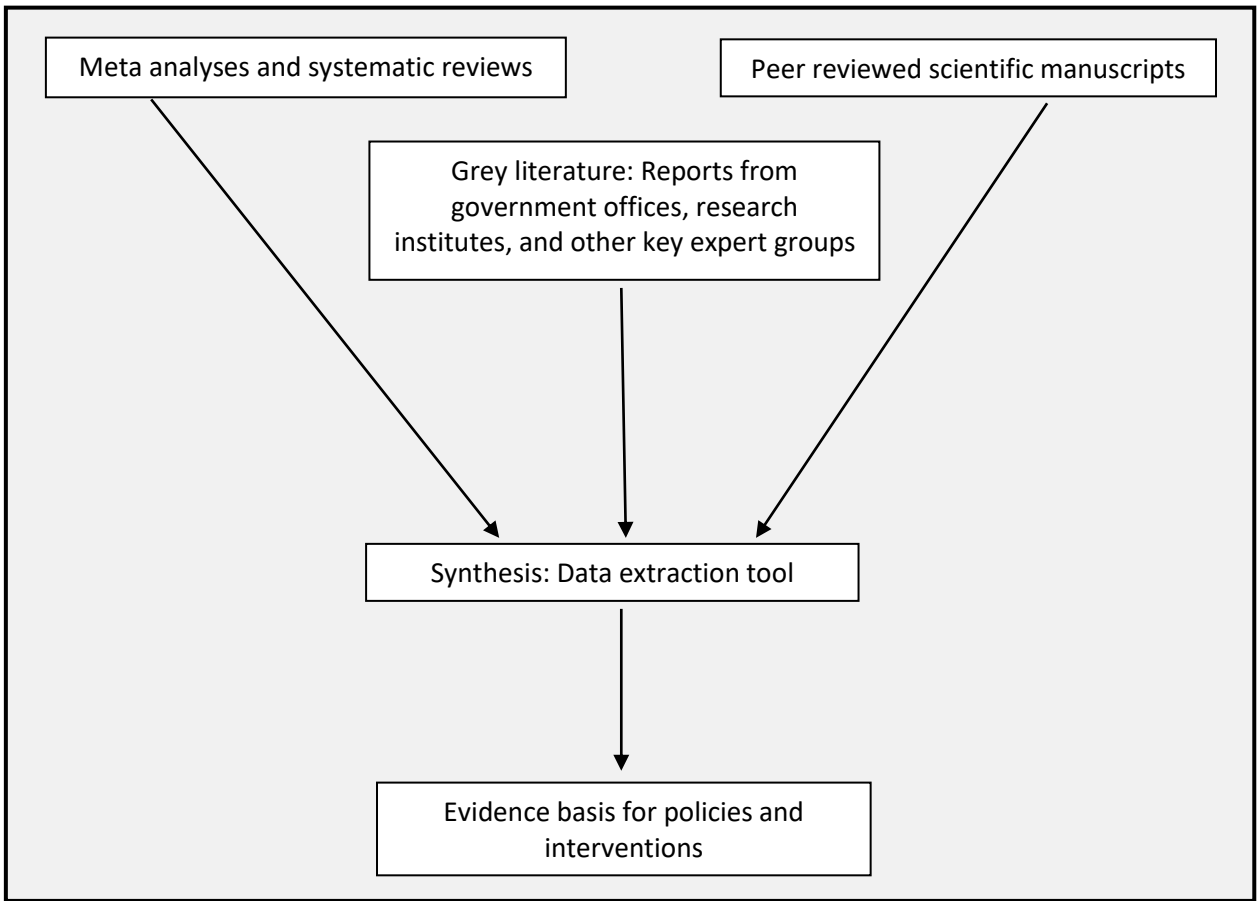
Second, research into alternatives to criminalization rarely delves into the political or cultural context of the policy changes.[14]

Third, research that examines the outcomes of alternatives to criminalization tends to focus on the prevalence of drug use, comparing jurisdictions that have or have not decriminalized drugs.[14,16] While these studies conclude that decriminalizing drug use is not associated with large increases in drug use, this outcome is not tightly responsive to drug policy. These evaluations have less focus on other health outcomes or the ways in which specific aspects of the policy and local context work to produce either positive or negative results.[14,16]

Finally, much of the available research about drug decriminalization and legal regulation is concentrated in the US and on cannabis.[16] Most have been published since 2014, driven by the evaluation of cannabis legalization programs in many US states. The evidence base is therefore likely

to grow as more jurisdictions implement and evaluate alternatives to criminalization. For an excellent synopsis of the methodological challenges to measuring drug policy impacts, see Methodological challenges and proposed solutions for evaluating opioid policy effectiveness.[17]

Figure 3. Flow diagram of materials reviewed



HEALTH CARE

Substance use disorder is widely recognized as a chronic disease, and while the disease model is sometimes contested, many of the responses to substance use disorder with the strongest evidence base are in the domain of health care. This section addresses those responses. It is divided into subsections on **Interventions**, **Policies**, and the **Health Care Workforce**. And while we've divided this section into these three subsections for organizational reasons, we recognize that a conducive policy context is necessary but not sufficient to implementing interventions and establishing a robust workforce.

Interventions

Medications for Opioid Use Disorder (MOUD)

Over five decades of research has shown that medications are an effective treatment for opioid use disorder (OUD). There are three main types of medications to treat OUD that have been approved by the FDA: methadone, buprenorphine or Suboxone, and naltrexone. Methadone and buprenorphine in particular have copious amounts of evidence supporting their success in suppressing the use of illicit opioids, retaining patients in treatment, protecting against opioid overdose, and minimizing risk of infectious disease transmission.[18–21]

A multitude of government and non-governmental expert bodies endorse MOUD as the gold standard evidence-based practice for the treatment of OUD, including the Office of National Drug Control Policy (ONDCP), the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services (SAMHSA), the American Medical Association (AMA), American Society of Addiction Medicine (ASAM), the American Public Health Association (APHA), the Global Commission on Drug Policy, and locally, the Minnesota Medical Association.

Access to MOUD for people with opioid dependence is uneven and presents specific issues of equity and inclusion. A large national study found that only about one quarter of people needing OUD treatment received MOUD in the past year.[22] Methadone, the oldest and most studied medication, is only available for OUD through specialized, federally regulated opioid treatment programs, which are divorced from the mainstream health care system. Opioid treatment programs often put into place enormous hurdles to access, such as daily attendance for dosing under direct observation, required participation in counseling, and regular urine drug screening. (The federal government provided flexibility around the rules for take-home dosing for methadone treatment during the COVID-19 pandemic, providing a natural experiment. Extended take-home schedules of up to 28 days were not associated with worse retention or adverse events, suggesting that daily dosing or short-term take-home allowances may not be necessary.[23] In January 2024, SAMHSA made these flexibilities permanent, though many states still enforce stricter regulations.)

Buprenorphine, until recently, could only be prescribed by practitioners who had applied to the DEA for a special "X waiver" and had completed special training. Waivered providers were subject to caps on the maximum number of patients to whom they could prescribe. Buprenorphine treatment, which can be prescribed outside opioid treatment programs, has more opportunities for take-home dosing and autonomy from the clinic setting.

Access to MOUD is stratified by race, with rates of buprenorphine treatment higher in areas with the highest incomes and lowest percentages of Black and Hispanic people. In a study from New York City, rates of methadone treatment were highest in areas with the highest percentage of low income and Hispanic people.[24] Another study found that buprenorphine treatment expanded nationally from 2007 to 2017, but growth was highest in areas with higher percentages of white people.[25]

There are a few key vulnerable populations for whom MOUD is especially important, and for whom treatment has been documented to be even less accessible than the general population. First, people in detention settings have a higher prevalence of substance use disorder, and when re-entering the community after periods of incarceration, they are at heightened risk of overdose fatality. Among individuals leaving jail and prison, overdose is the leading cause of death.[26,27] A groundbreaking study out of Washington found that during the first two weeks after release from prison, relative risk of death from drug overdose was 129 times that of the general population.[28] Yet very few correctional settings offer MOUD, and referrals to treatment at release are highly variable.[29–31] Key to decreasing overall opioid fatality rates will be connecting people exiting detention settings to MOUD at this highly vulnerable time.[32]

Second, people who are pregnant with OUD are at increased risk of a variety of complications affecting both the parent and the infant. For the parent, potential complications include infectious disease, bacterial endocarditis, septicemia, and cellulitis. For the infant, complications may include fetal growth restriction, placental abruption, preterm labor, and even fetal death.[33] Both methadone and buprenorphine are effective treatments for perinatal people and are the standard of care, recommended by the American College of Obstetricians and Gynecologists. Yet access remains a challenge.[34,35] Data is minimal, but one study found that only one third of pregnant people with OUD received any type of MOUD, despite it being the standard of care.[36] Black and Hispanic women are less likely to be treated with MOUD during pregnancy.[37,38] Additionally, prenatal child abuse laws present in many states, including Minnesota, are significantly associated with lower rates of accessing MOUD.[39]

Non-medication/psychosocial treatment

Non-medication treatment is an extremely heterogenous category of treatment and includes all behavioral and psychosocial interventions, such as cognitive behavioral therapy, peer-led self-help groups, and residential rehabilitation treatment. While the phrase "Treatment works" is quoted often

among the addiction community, in fact, there is little or weak evidence for many types of non-medication treatment.[40] Residential rehabilitation houses, for example, have little evidence supporting their use, despite their prevalence.[41] Peer-led self-help organizations, such as Narcotics Anonymous, are perhaps the most common type of intervention and certainly the most accessible to PWUD. Evidence is mostly favorable for opioid users but limited for people who use stimulants and alcohol.[42,43]

Two specific types of non-medication treatment have robust evidence supporting their effectiveness.

Contingency management, the practice of giving patients vouchers or other positive reinforcements, usually monetary, for drug- free urine screens, has been tested in randomized controlled trials and found to decrease opioid use and improve treatment retention.[44,45] A systematic review of 29 studies found that contingency management was the only effective intervention for treating stimulant use disorder. There was insufficient evidence about psychostimulants, n-acetylcysteine, opioid agonist therapy, disulfiram and antidepressant pharmacological interventions for the treatment of stimulant use disorder.[46]

Brief interventions are structured, time-limited interventions often conducted in primary care, emergency medicine, and other general medical and ancillary service settings.[47] They often focus on a single behavioral change associated with reducing one's risk from the use of substances and are usually theoretically based in the Stages of Change model. Brief interventions have been found to increase help-seeking behavior and decrease risky drug use.[40,47]

Voluntary access to treatment on demand that is culturally appropriate.

Not all people who use substances want treatment, and in fact, not all need it; research shows that a portion will recover from substance use disorders without accessing any treatment.[48] What we know about the remaining portion of the population with SUDs that require treatment to recover is that treatment is more effective when it meets several criteria. One study showed that, among unhoused individuals, *how* substance use treatment is delivered is even more important than the types of services provided.[49]

Substance use disorder treatment has been shown to be more effective when it is based in evidence, and when:[50]

- It is voluntary, not mandated or coerced;[51,52]
- It is available on demand, and patients do not have to wait on waitlists, go through time-consuming bureaucratic processes, be abstinent, lack co-occurring disorders, or lack the ability to pay;[50]
- It is culturally appropriate, particularly for BIPOC communities, for whom structural racism and stigma compound to impact access to treatment;[53] and
- It is geographically accessible.[54–56]

In December 2023, SAMHSA released an important advisory calling for an increase in low barrier care as a means to increase access to and engagement in treatment for SUD (see below). Defined as a model that "seeks to minimize the demands placed on clients and makes services readily available and easily accessible,... it also promotes a non-judgmental, welcoming, and accepting environment."[57] Evidence shows that low barrier care can improve treatment engagement and outcomes, reduce risky drug use, and lower rates of emergency department visits and hospitalizations.[58,59]

COMPONENTS OF LOW BARRIER MODELS OF CARE

- ⇒ **Available and accessible.** Treatment for substance use is incorporated into elements across the health care system, particularly outside of specialty SUD settings. Treatment can be delivered via telehealth, in person, and on mobile medical units.
- ⇒ **Flexible.** Treatment programs are able to adapt to individual needs, and do away with rigid requirements, conditions, and preconditions. Medication can be offered on the first visit, and can be initiated at home, rather than in clinic. Dosages and duration of medication therapies are individualized.
- ⇒ **Responsive.** Treatment requirements, such as visit frequency, is determined based on the needs of the individual client, rather than clinic-wide policy. Clients cannot receive punitive measures, such as discontinuation of treatment or reduction in dosage, based on ongoing substance use or receipt of other services.
- ⇒ **Collaborative.** Care involves the partnership of other health and supportive service providers, such as housing, mental health, and peer support.
- ⇒ **Engaged in learning and quality improvement.** Providers and staff must be trained in low barrier principles and evidence-based practices.

Source: Substance Abuse and Mental Health Services Administration (2023). SAMHSA Advisory: Low barrier models of care for substance use disorders. Available at: https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf

Policies

A number of problems associated with substance use disorders and their treatments can be addressed by interventions aimed at individuals, but through changes to health care policies and law.[60]

Medicaid and other insurance

While funding for substance use services broadly has increased in recent years, funding for treatment for SUD is still not on par with that of other chronic illnesses. Payment reform can help increase access to treatment by increasing insurance coverage, increasing provider reimbursement rates, and removing outdated reimbursement regulations that require activities that are not evidence-based. States with Medicaid expansion have demonstrated lower overdose rates than states without Medicaid expansion.[61] The Office of National Drug Control Policy asserts that in order to successfully reach groups most at risk, reform is needed so that providers can make a business case for treating more patients and for accepting insurance.[32]

Requirements for prior authorization for SUD services and medications, common in private health insurance plans, can pose significant barriers to treatment. Removing requirements for prior authorization would allow patients to be initiated into treatment the same day they see their physician, rather than having to wait up to several days for an insurance provider to approve the physician's order.[62]

Federal law requires that insurance plans provide coverage for behavioral health services, including substance use services, in ways that are comparable to physical health services, though not all health plans are in compliance.[32]

Laws regulating access to prescription opioids

As a response to a dramatic increase in high-risk use of prescription opioids and prescription opioid-related fatalities, the last decade has seen several laws and policies enacted to regulate access. Mandatory limits imposed on providers reduce the amount and duration of prescription opioids that can be prescribed or dispensed at a time. While evidence is still minimal because most of these laws have been enacted since 2017, evidence suggests they are not associated with any changes in the prescribing or dispensing of prescription opioids.[30,63]

Specific laws have been enacted to target pain management clinics, often termed "pill mills." These laws increased requirements for inspections, restricted cash payments, and imposed other operational and personnel-related requirements. Evidence is mixed with respect to these laws' impact on prescription opioid prescribing.[29] While some studies have found a decline in prescribing in states that have instituted these laws, others found no effect.[64,65] Furthermore, in places that experienced decreases in opioid prescribing, some research suggests that these policies had the downstream effect of increasing demand for heroin and other illicit opioids (which are inherently riskier).[29]

Prescription drug monitoring programs (PDMPs) are databases implemented at the state level that collect prescribing, and sometimes dispensing, information on controlled substances. PDMP policies and practices vary state by state, and evidence is mixed.[66–69]

Relatedly, while not legally binding, many medical bodies strengthened their recommendations for providers around prescribing opioids, particularly for chronic, noncancer pain. Notably, the Centers for Disease Control and Prevention released guidance in 2016 that addressed when the benefits of prescribing opioids outweigh the risks and when they do not, how to prescribe the lowest effective dose, and dangerous drug-drug interactions.[70] We do not yet know if guidelines like these have had an impact on prescription opioid use or overdose.[66,69]

Right to medical treatment

In addition to the policies described above, there are some policies that pose additional barriers for PWUD seeking to access health care. Despite studies showing that people who actively use drugs can successfully complete complex treatment regiments, and that treatment for diseases such as HCV and HIV are just as effective in this population, some states impose abstinence restrictions, and others require drug screening and counseling, before initiating treatment. Frequently states will require a prior authorization for HCV medications, regardless of insurance status, often delaying treatment initiation, and many providers and practices are still reticent to treat PWUD, even in states where policy restrictions are not in place.[71] The Department of Justice has clarified that people with substance use disorders are a protected class under the Americans with Disabilities Act and that doctor's offices and medical facilities may not refuse to admit a patient who is taking medications for opioid use disorder. The guidance does not extend to people who continue to use illegal drugs.[72]

Workforce

A critical component of ensuring individuals who use drugs have access to quality treatment is establishing and maintaining a competent workforce.

Substance use treatment and harm reduction

Estimates predict that there will continue to be a nationwide shortage of behavioral health workers, including for SUD treatment.[32] A new workforce will need to be cultivated and trained. SAMHSA, in its newly released harm reduction framework, has several recommendations to support this goal, broadly applicable to the addiction treatment field:

- Offering training and technical assistance for community-based providers;
- Offering living wages and essential benefits for workers;
- Offering wellness services and support for staff and volunteers; and
- Supporting organizational leadership from people with lived and living experience.[73]

Important disparities exist in the racial and ethnic make-up of addiction treatment providers, which may explain some of the racial and ethnic disparities in health care utilization. A particular emphasis must be put on training and hiring diverse providers who mirror the communities they serve.[32]

Key values agreed upon by the field and supported by evidence can be effectuated through accreditation and licensing of the treatment offered in addiction treatment facilities. These could include evidence-based, patient-centered care, and care that acknowledges and addresses the broader social determinants of addiction.[53] Shatterproof's "Principles of Care" offer one standard against which treatment facilities could be assessed.[74]

Additionally, specific training for providers is needed on harm reduction and medications for opioid use disorder. This training is needed both to address the gaps in the harm reduction workforce and also to address gaps in training among the broader substance use disorder treatment field. The ONDCP's National Drug Control strategy adds:

> *"All sectors of the SUD field would benefit from updated evidence-based knowledge regarding how and why harm reduction programs are reducing overdoses, addressing stigma, improving the health and safety of PWUD, and providing valuable new entry points to treatment."*[32]

Skepticism of harm reduction within the SUD field can be addressed through training, "dialogue, site visits, and other appropriate mechanisms" that normalize harm reduction.[32]

Key gains were made during the COVID-19 pandemic to extend the capabilities of telemedicine in the treatment of substance use disorders. Some of these addressed the ability of providers to serve patients across state lines, while others addressed the ability of providers to facilitate induction onto buprenorphine remotely. SAMHSA made these rules permanent in January 2024, and they will remain an important pathway to maximizing patients' access to care, particularly in rural areas and addiction treatment deserts.[32,75]

Peer support

In the past decade, peer support in substance use disorder treatment has experienced a surge in attention. Peer support is rooted in the framework that people with similar experiences or conditions can uniquely offer "help, empathy, validation, information, and hope."[76] And while peer support has been widely accepted historically in other areas of chronic care, including cancer and diabetes, among behavioral health conditions, it was not accepted until more recently.

A growing literature now supports peer support, also known as recovery coaching, as an integral part of SUD care. While findings across outcomes are mixed due to the wide variety of ways in which peers are employed and in a diverse array of clinical and non-clinical settings, evidence points to an association of peer-delivered services with reduced substance use and reduced incidence of return to use, increased engagement and retention in care, improved relationships between providers and

patients, and greater treatment satisfaction.[77-80] In order to expand the peer workforce, there is a need for adequate compensation and greater professionalization.

General health care

Zooming out from substance use disorder treatment specifically, healthcare providers of all kinds encounter people who use drugs, and all providers could benefit from increased competency in working with this population. Research shows that discrimination and stigma in medicine prevent many PWUD from accessing care; including general education about the health care needs of PWUD in medical school could help to address these issues.[81]

Legal and disciplinary action against medical professionals

As a response to the overdose epidemic, there have been an increasing number of lawsuits and disciplinary actions filed against medical professionals in recent years. Some address medical malpractice by individual providers while others address the operations of larger offices and clinics, or "pill mills." Some of these cases have used state medical licensing boards to investigate and/or discipline providers.

There is not enough research to know if these actions have had an impact on population-level opioid-related outcomes such as prescribing and overdose fatalities.[63]

General practitioners, psychologists, nurses, pharmacists, and social workers all engage with PWUD regularly.[32,82] General training and education of these professions specifically should be improved, including adding more addiction curricula to their education and training programs.

In areas with few MOUD providers, general practitioners can be trained and coached to prescribe buprenorphine, capitalizing on recent federal policy changes making this medication easier to prescribe and dispense to those at risk. Buprenorphine, for example, has been successfully initiated by emergency medical services, and in some states can be dispensed at pharmacies. The Extension for Community Healthcare Outcomes (ECHO) model supports providers across geographical distances in specific aspects of care for PWUD, such as buprenorphine prescribing. ONDCP has also suggested the ECHO model could be used to provide training for providers and first responders who encounter people using psychostimulants (like methamphetamine).[83]

Interventions lacking evidence

There are a few notable health care policies and interventions that research has found are *not* associated with improved outcomes, and yet are still commonplace.

Compulsory treatment, or the "mandatory enrollment of individuals, who are often but not necessarily drug-dependent, in a drug treatment program," can include a variety of treatment modalities such as drug detention facilities, short- and long-term inpatient, and community-based treatment.[84] Compulsory

treatment is not associated with improved outcomes, and in some studies, is actually associated with negative impacts, suggesting potential harm.[52]

Relatedly, **involuntary civil commitment statues**, or statutes that force patients into treatment, have been shown to cause harm, and yet are increasing in use, with 25 jurisdictions either expanding existing laws or promulgating new laws that allow for civil commitment of individuals with SUD between 2015 and 2018.[30] A Massachusetts study found that individuals re-entering the community from a period of forced civil commitment experienced fatal drug overdose at more than twice the rate of those entering the community who voluntarily chose to enter treatment.[85]

Prescription drug take-back programs were developed in response to the growing supply of un-used opioid prescriptions in people's homes. These programs serve to provide a safe and convenient method to dispose of extra pills. The DEA organizes two National Take Back Days a year, and in addition, many local pharmacies and police departments provide their own drop boxes. Evaluations of these programs have found that while they do succeed at collecting prescription opioids, the amount collected is only a small portion of the supply of unused medication in the community, suggesting that they are unlikely to reduce the misuse of prescription opioids.[63]

HARM REDUCTION

Harm reduction is a philosophy—a broad public health approach designed to support the health, wellbeing and autonomy of people who use drugs—as well as a set of strategies and concrete interventions. Based on several decades of evidence, harm reduction is a federal drug policy priority of the Biden-Harris Administration, and supported by SAMHSA, ONDCP, and the UN's World Health Organization. Common harm reduction interventions include overdose prevention and naloxone administration and syringe exchange.

Harm reduction as an approach

Harm reduction is both a policy approach and set of strategies.

A few studies have assessed the effectiveness of harm reduction *as a policy approach* by comparing regions or countries where such policies are in place with those where they are not. In a comparison between Australia and the United States, researchers found that the introduction of Australia's harm reduction policies could explain a reduction in HIV rates, compared to the increase in the United States absent harm reduction policies.[86] A similar study found that the United Kingdom's harm reduction response potentially prevented an HIV epidemic.[87]

In addition to a broad policy approach, harm reduction can be thought of as *a set of strategies* that aim to reduce the harm that drugs cause. There is evidence supporting harm reduction for drug users as an approach and set of strategies more generally.[88]

For an example, educating people who use drugs around specific strategies to reduce risk, such as strategies that minimize the chance of HIV and HCV infection while ingesting drugs, is highly effective.[19] Counseling can prevent people who are already using drugs from progressing to riskier forms of drug use, such as injecting.[89] Outreach, a strategy to engage hard to reach populations and bring them into treatment and care is also associated with improved health outcomes.[90]

Harm reduction strategies

Syringe service programs (SSPs)

By far the most studied harm reduction interventions are syringe service programs (SSPs). SSPs reduce the incidence of infectious diseases caused by injection drug use. (According to the CDC, in 2017, people who inject drugs accounted for nearly 1 in 10 new HIV diagnoses across the US, and in 2018, injection drug use was the key risk factor in 72% of newly diagnosed HCV cases.)[91,92] A systematic review and meta-analysis found that SSPs are associated with an approximately 50% reduction in HIV

and HCV incidence across all studies.[93] Most studies on SSPs in large urban cities were conducted in the late 1990s and early 2000s because by 2010, SSPs were well established into public health systems and were no longer studied for effectiveness. With the onset of the current overdose epidemic, there has been a scale up of services in rural and suburban areas.

A large body of evidence demonstrates that SSPs provide linkage to substance use treatment and other health care services. Several studies cited in a review of studies from the last 30 years show people who inject drugs and who regularly use an SSP are five times more likely to enter treatment for a substance use disorder than those who have never used an SSP.[94] Studies show that SSPs are an effective contact point to provide low barrier access to evidence-based overdose prevention tools, like naloxone and fentanyl test strips.[95,96] Two studies from Baltimore separately found that the use of SSPs was associated with an increased use of drug treatment and increased access to drug detoxification services.[97,98]

Positive outcomes associated with syringe service programs (SSPs)

- ⇒ In Scott County, Indiana, the introduction of an SSP was associated with a 16% reduction in sharing syringes to inject drugs, a 23% reduction in sharing syringes to divide drugs, and a 19% point reduction in sharing other injection equipment over 10 weeks.[99]
- ⇒ In 2018, Kanawha County, West Virginia SSPs were shuttered. In the two years following, HIV cases in the county more than doubled.[100]
- ⇒ In Seattle, individuals who are regularly connected with a local SSP are nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP.

While critics have raised concerns about the potential negative impact of SSPs on the broader community, there is now a plethora of evidence showing that SSPs do not harm the communities in which they are located. A 2011 study compared the top-quartile of drug-affected neighborhoods in San Francisco (with an SSP) and Miami (without an SSP). Miami had eight times the amount of syringe litter, with people who inject drugs being 34 times more likely to dispose of syringes publicly in Miami compared to San Francisco.[101] Baltimore communities that implemented an SSP did not see an increase in economically motivated crimes or individuals resisting arrests, while communities that did not implement an SSP saw rises in the rate of these crimes. Further, communities that implemented a SSP reported a reduction in assaults, while arrests in communities without SSPs increased. (Both types of communities saw increases in drug possession crimes.)[102] A survey of Harlem residents demonstrated no association between proximity to an SSP and robberies, witnessing a fight, having experienced violence, or being robbed by a drug user.[103]

Barriers to syringe services in Minnesota

Minnesota has allowed for the legal distribution of syringes for over a decade, and currently has 13 active syringe service programs providing services at 18 sites around the state. Despite an amenable legal and political climate, SSPs in Minnesota still face substantial barriers to providing harm reduction services. Funding for SSPs is limited, unstable, and can be inflexible in what is allowed to be purchased. The federal ban on syringes and other types of funding restrictions results in a limited amount of supplies that SSPs can dispense to their participants. The harm reduction workforce is consistently underpaid, exposed to trauma and other difficult working conditions, and subject to frequent staff turnover, creating a staff capacity issue. Other SSP barriers have to do with the shortage of safety net services more generally available for their participants, including affordable housing and transportation. And lastly, negative law enforcement interactions and frequent displacement of houseless individuals presented additional barriers to outreach and continuity of care, and sometimes the confiscation of the supplies dispensed by SSPs.[104]

Pharmacy access to syringes

A second method of increasing access to sterile syringes for the purpose of reducing the risk of infectious disease transmission is through pharmacy sales. Evidence shows that in states that allow for the nonprescription sale of syringes at pharmacies, there is high utilization, increased access, decreased HIV risk behaviors, and no change in area drug-related crime.[105-107] One review found that there was no significant difference in impact between different methods of syringe dispensation.[108]

Safer use practices for non-injecting drugs

Research in harm reduction has historically centered people who inject drugs, though there is growing attention to the risks associated with other forms of drug use, including smoking and snorting drugs. A recent review that included 32 studies on the use of safer smoking practices found that when people who smoke drugs were provided with safer smoking materials, they engaged in less risky behaviors, such as injecting or sharing pipes, resulting in improved health outcomes.[109]

There is broad support for an increase in access to harm reduction interventions aimed at people who use drugs other than injectors. Calls have been made by Substance Abuse and Mental Health Services Administration (SAMHSA), Drug Policy Alliance, the Global Commission on Drug Policy, and locally, the Minnesota Medical Association.[50,110-112]

Overdose prevention and response interventions

Overdose fatalities have reached unprecedented highs, with over 106,000 people dying of drug-involved overdose in 2021 in the United States.[113] In response, a large amount of research has been devoted to preventing drug overdose and reducing overdose mortality. This section will review the evidence around three types of overdose prevention interventions: naloxone, overdose prevention sites, and 911 Good Samaritan laws.

Naloxone is an opioid antagonist, a medication that reverses the effects of opioids, and can reverse opioid overdose. It is dispensed by harm reduction providers and more recently has become available over-the-counter in pharmacies. Multiple studies have demonstrated that naloxone access saves lives.[114,115] In Massachusetts, for example, overdose education and naloxone distribution (OEND) implementation in 19 communities between 2002 and 2009 led to a nearly 50% reduction in the rate of overdose deaths in communities that were high OEND-implementers, compared to a 25% reduction in the rate of overdose deaths in the communities that were low OEND-implementers.[116] The most effective method of distributing naloxone is to give it directly to people who use drugs, who are the most likely to witness an overdose.[116,117] Innovative naloxone distribution strategies in the United States include publicly accessible "Naloxboxes,"[c] vending machines, through the mail,[d] and through leave-behind EMS programs.[118,119]

While some studies suggest that naloxone effectiveness may vary depending on the types of opioids consumed, others have demonstrated that the same amount of naloxone works to reverse an overdose regardless of opioid type used, including fentanyl.[120–122]

Concerns that naloxone distribution may exacerbate substance use have been invalidated. Patients that receive naloxone from a medical provider do not increase their drug use compared to those who use drugs and do not.[123] People who use drugs and access naloxone through a harm reduction network do not increase their drug use compared to those who use drugs and do not.[124] Patients that received naloxone through a Boston emergency department were just as likely as those who did not to continue using drugs but were twice as likely to call 911 when present for a future overdose event.[125] In Howard County, Maryland, patients who received a naloxone leave-behind kit from EMS were 2.5 times more likely to connect with follow-up services compared to those who did not receive a kit; patients were over five times as likely to be connected with follow up services if the kit was left with a family member.[119]

Overdose prevention centers (OPCs) are safe, staffed centers where people can bring their own drugs and ingest them under supervision. While new to the US, internationally, evidence has been strong for OPCs. A systematic review found that of eight studies, six found protective effects related to overdose outcomes.[126] A Vancouver study, for example, found their OPC associated with a 35%

[c] See NaloxBox, available at https://naloxbox.org/.
[d] See NEXT Distro, available at https://nextdistro.org/naloxone.

reduction in overdose fatalities in the immediate vicinity of the center, compared to a 9% reduction in the rest of the city.[127] Another summary of the evidence concluded that OPCs are positively associated with lowered overdose mortality, fewer calls to EMS, and decreased HIV transmission.[128]

The US currently has one city-sanctioned OPC operating two sites in New York City. In the first two months of its operation, over 125 overdose deaths were averted. In addition, the center provided support services and other harm reduction services to more than half of the individuals who visited, including naloxone, counseling, hepatitis C testing, and medical care.[129] The first state-sanctioned site is meant to open in Rhode Island in 2024. This site, made legal under legislation passed in 2021 that allows for a harm reduction center pilot program, will be inspected and licensed by the Rhode Island Department of Health. It will primarily be funded through opioid settlement funds.

In 2022, the Minnesota Medical Association released a statement in support of the development and implementation of OPCs in order to reduce the harms and health care costs related to drug use.[111] In 2023, the American Medical Association did the same.[130]

911 "Good Samaritan" laws are local or state laws that aim to reduce barriers to help-seeking behaviors in the case of an overdose by providing overdose victims and bystanders limited immunity to drug-related charges. They vary widely in who they protect and in what criminal and other judicial consequences they cover. While federal government agencies, including the CDC and ONDCP, have come out in support of these laws, and some studies have found associated decreases in fatal overdoses, others have found no effect.[66,67,69,131] Evidence around the effectiveness of 911 Good Samaritan laws are hampered by the heterogeneity in how the laws are structured and implemented, and by low levels of awareness that these laws exist among the people who could benefit from them.[132,133]

Safe supply: Fentanyl test strips and other drug checking

Unlike alcohol and pharmaceuticals, the contents of illicit drugs are usually unknown by the consumer, increasing the risk for overdose and other serious morbidities. With the proliferation of fentanyl, xylazine, and other contaminants, practices to ensure a safer drug supply are emerging, and there is a call for increased access to drug checking technologies. A recent study of providers and harm reduction employees in North America (United States and Canada) reported that the current drug supply is unpredictable and dangerous with the increase in fentanyl analogues and other contaminants like xylazine.[134]

Drug checking provides PWUD with an opportunity to understand the substances they are using and adjust their behavior to reduce risk. A systematic review of 90 studies found that drug checking services influence the behaviors of people who use drugs.[135] Fentanyl test strips (FTS) are the most commonly used drug checking technology and have been studied more than other interventions. Surveyed people who inject drugs in Greensboro, North Carolina were five times more likely to change their drug use behavior when their drugs tested positive for fentanyl.[96] In a 2021, over 70% of

people who use drugs surveyed in a study in Baltimore and Delaware reported using fentanyl test strips. Following utilization of FTS, about 25% of participants in Baltimore and 70% in Delaware reported adopting risk reduction behaviors.[136] In 2021, CDC and SAMHSA loosened restrictions allowing for the use of federal funds to purchase fentanyl test strips.

SOCIAL DETERMINANTS OF HEALTH

Punitive responses to drug use and possession are not limited to the criminal-legal system. Instead, the repercussions follow people into every sector of society, including housing, employment, public benefits, consumer finance, education, family life, and immigration.

These areas are referred to in the public health literature as "social determinants of health"—upstream environmental factors that shape personal choices and influence health outcomes. Drug offenses can both lead to a lack of access to social determinants of health like housing and employment; and lack of housing and employment can increase the risk that someone will commit a drug offense. This graphic illustrates the way that social determinants of health (as well as physical and mental health) both impact, and are impacted by, the criminal-legal system.[137]

Figure 4. Criminal justice and public health framework

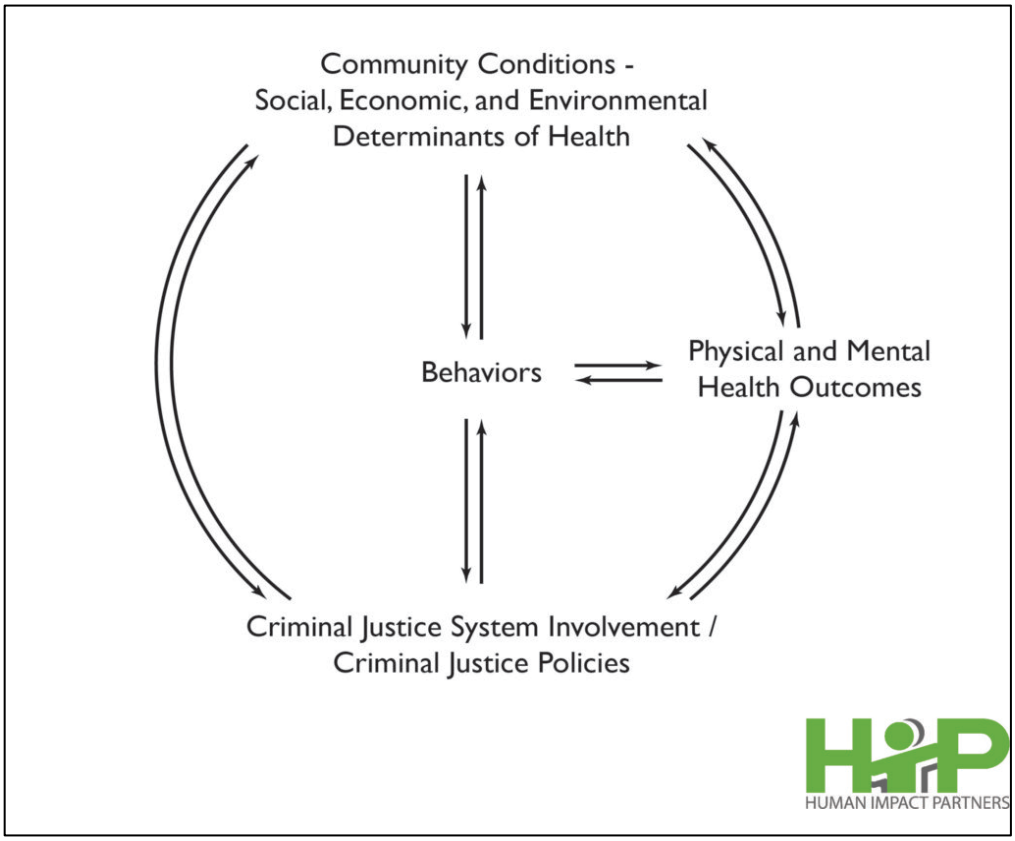


Image Source: Human Impact Partners (2016). Available at https://humanimpact.org/a-framework-connecting-criminal-justice-and-public-health/

Collateral consequences are restrictions on the rights and privileges to participate in society and on certain benefits for people with criminal convictions, many of them with links to the social determinants of health. They prolong punishment after the criminal conviction and sentence imposed by the court and while people on parole or probation in the community complete their criminal sentences. Common collateral consequences to drug offenses include restrictions on housing, employment, access to public benefits, and education.

Housing

People with criminal convictions face barriers to accessing both public and private housing. Federal and state laws bar people with certain criminal convictions from living in public or subsidized housing, including for "drug-related activity."[138] Private housing providers may establish policies that prohibit people with arrests or criminal convictions, ostensibly out of concern for public safety.[139] In fact, research has established that a criminal history is not predictive of unsuccessful tenancy.[140,141]

In addition, local laws that prohibit certain public behaviors like sleeping or camping in public, begging, loitering, and sleeping in vehicles criminalize survival for people without housing.[142,143] Some government officials and law enforcement have justified these laws as necessary to protect public safety, maintain sanitation in public spaces, and reduce the visibility of houselessness.[144] But research has found that these laws increase people's risk of returning to prison, which starts the whole cycle over.[138,143]

Tenuous access to housing for people with criminal records puts them at high risk of housing insecurity and houselessness, which in turn leads to increased risk of recidivism.[143,145,146] Rather than restricting access to housing, housing has been determined to be protective of harms associated with drug use.

Housing First is an assistance approach for people experiencing houselessness that does not, as many programs do, require them to first address substance use issues before they are eligible to access housing. An extensive systematic review found that Housing First programs decrease houselessness, increase housing stability, and improve quality of life for unhoused people.[147] An independent panel of the CDC recommended a Housing First approach, underlining the economic benefits: every dollar invested in the programs result in $1.44 in savings.[148] Recent studies have found that participants in Housing First programs are more likely to report using less alcohol, opioids, and stimulants than participants in high-barrier housing programs.[149,150]

Access to housing as a remedy for the harms associated with drug use is recommended by the Office of National Drug Control Policy, the American Society for Addiction Medicine, SAMHSA, a DOJ Civil Rights Commission on Collateral Consequences Human Rights Watch, the International Guidelines on Human Rights and Drug Policy, the United Nations, the Global Commission on Drug Policy, and more.[32,110,112,139,151–154]

Case Study: Oregon

In 2020, 58% of Oregon voters approved a ballot initiative known as Measure 110, or the Drug Addiction Treatment and Recovery Act. The measure has two primary pieces, the first associated with changes to possession of controlled substances, and the second with expanding health services.

The passage of Measure 110 made Oregon the first state in the country to remove criminal penalties (i.e., decriminalize) personal possession of small amounts of all drugs, using thresholds established in 2017 in a "defelonization" bill. Before Measure 110, Oregonians in possession of small amounts of drugs were charged with a misdemeanor criminal offense. After the Measure's passage, possession of small amounts of drugs resulted in a citation and fine of up to $100 that could be waived if the person submitted verification of undergoing a health needs screening to a court.[155] Failure to pay the fine would not lead to additional penalties or to incarceration, a common practice in other US jurisdictions.[156]

In tandem, the state allocated hundreds of millions of dollars annually to a broad range of services for people with substance use disorders, including low barrier treatment for substance use disorders, housing, peer support, recovery, and harm reduction services. The primary funding source was state tax revenues from cannabis sales. The legislature allocated $350 million for Measure 110 services during the 2021-2023 biennium, with an additional $11 million going to tribal organizations. Services were provided at no cost and were "evidence-informed, trauma-informed, culturally specific, person-centered, and non-judgmental."

Academic peer-reviewed journals have begun producing preliminary findings. First, Measure 110 has led to significant reductions in arrests for possession of controlled substances, even accounting for a decrease in arrests during the first year of the pandemic.[155,157] Arrest is the entry point to the criminal legal system. Even if people do not proceed any further through the legal system, arrest is still associated with negative health and social consequences.[158] In addition, fewer arrests necessarily mean fewer people proceeding to prosecution and incarceration, community supervision, and criminal records for possession of controlled substance. Arrest rates for Black people in Oregon declined by a greater amount than those for white people (77% and 67% respectively) after Measure 110 went into effect. Nevertheless, Native American and Black Oregonians continued to be arrested for possession at disproportionate rates compared to white Oregonians.[157]

Two longitudinal studies found that after a year of implementation, Measure 110 had not resulted in significant changes to drug overdose rates, in either a positive or negative direction.[159,160] The authors posited a few reasons for this finding–most significantly, that the observation period of one year was relatively short. They also pointed to the delayed rollout of funding to expand services, which if implemented on time had the potential to reduce risky drug use patterns and support pathways to recovery, which can reduce overdose. Finally, few calls to the statewide treatment hotline may be due to variability in law enforcement practices issuing citations and the associated referrals.[159]

The increasing prevalence of fentanyl in the drug supply, which is driven by factors upstream from Measure 110, is an important driver of increased overdose mortality in Oregon and across the West coast.[161] Synthetic opioids, including fentanyl, are much more potent than heroin, thereby increasing the risk of fatal overdose. Whereas fentanyl was limited to the drug supplies of Midwestern and Northeastern states from 2014 to 2017, it began to spread to the Western US around 2019.

Case Study: Oregon

From 2017 to 2019, the share of synthetic opioid overdose deaths (a category that includes fentanyl) in seven western jurisdictions more than tripled.[162-165] Fentanyl became prevalent in Oregon in 2019, and fentanyl seizures increased from 690 dosage units in 2018 to more than 2 million in 2022.[166]

The transition in Oregon's drug supply from black tar heroin to powder fentanyl induced a switch from injecting to smoking, an evidence-based harm reduction strategy.[161] Similar behaviors were found among people who use drugs in San Francisco.[167]

No studies have linked Measure 110 to increases in crime.[155] In fact, research found that the number of 911 calls in Portland did not change significantly after Measure 110 took effect compared to the prior two years and mimicked the comparison cities of Seattle, Sacramento, and Boise that did not decriminalize possession.[168]

There is also no evidence linking Measure 110 to increases in the number of unhoused people.[155] The significant uptick in houselessness, including unsheltered houselessness, in Multnomah County (the county that houses Portland) from 2019 to 2022 was attributed to the COVID-19 pandemic. Other contributing factors include rising rents, inadequate incomes, racial injustice, and lack of access to physical and behavioral health services.[169] Preliminary findings show that 400 more people entered shelter between 2022 and 2023.[170]

While the decriminalization components of the law took effect in February 2021, bureaucratic delays associated with COVID-19 in implementing the housing, health, and social services components of Measure 110 limit the ability to evaluate those measures.

Behavioral Health Resource Networks (BHRN) in each county meant to be established by January 2022 were not established until August 2022. Distribution of the associated funds began in September 2022, but 87% of implementation dollars had not been approved or released within the measure's first year.[155] Exacerbating the bureaucratic delays, a workforce shortage, ongoing nationally, meant that as recently as December 2023, providers who were awarded funds were having trouble spending them.[171] These delays slowed the ability of service providers to reach their intended capacity, and it is still too early to determine the overall effectiveness of this aspect of the Measure.

Still, during the first full year of funding, from July 2022 through June 2023, BHRN partners reported a 298% increase in client screening, 296% increase in people seeking housing services, a 148% increase in people seeking harm reduction services, and a 143% increase in people seeking substance use treatment services.[172]

Oregon's decriminalization of personal possession is only one policy change in the vast landscape of interconnected structural forces that impact drug market forces. It did not address the severe housing shortage, nor did it impact the quality or safety of the drug supply. In January 2024, Oregon's state legislature released announced a bill that would recriminalize the possession of small amounts of drugs as a low-level misdemeanor [173]. Unfortunately, this decision does not address what evidence shows are the root causes of houselessness and overdose. Instead, it returns to an approach that evidence shows has failed to reduce drug supply and demand for fifty years.

Employment

Barriers to employment are one of the most pervasive collateral consequences for people with criminal convictions and even arrests without conviction.[138]

Of the more than 44,000 state and federal collateral consequences, roughly 70% are associated with employment. Thousands of additional ordinances limit access to employment for people with criminal convictions at the local level.[174] Finally, private and public employers can place limits that block the hire of people with criminal convictions.[175] Mechanisms vary and can include restrictions in statute, occupational licensing laws,[e] and the policies and practices of individual employers that favor people without criminal records.[175]

Rather than restricting access to employment for people with drug convictions, policymakers should try to improve employment rates. Unemployment is a major driver of recidivism, and when people who are formerly incarcerated obtain jobs that pay a living wage, the risk of reoffending decreases.[176–178] Removing barriers to employment for people with criminal records also generates economic benefits like increased earnings, higher taxpayer revenues from employment, and avoiding costs associated with recidivism.[179]

Policies like "banning the box" on job applications and "fair chance" hiring practices have led to increased hires among people with criminal records.[180]

Consumer Finance

People involved with the criminal-legal system face multiple financial challenges at every stage of the system. At the pre-trial stage, people in detention settings and their families are pressured to accept commercial bond agreements from private companies, regardless of the terms or overall costs. In addition, courts and private bond agents often charge substantial fees for electronic monitoring equipment, drug testing, and to participate in diversion programs. During incarceration, the challenges of managing one's personal finances may result in increased debt, credit delinquency, and lower credit scores.[181]

These challenges exacerbate access to other social determinants of health like housing and employment at the time of reentry. For example, negative credit scores can limit housing options and access to financial options like small business loans. If people are unable to pay the fines imposed by criminal-legal system actors, the penalties may include incarceration, driver's license suspension (though many states, including Minnesota, have removed this penalty), and exorbitant interest rates

[e] As in Minnesota, where statues governing licensing for workers in DHS-licensed facilities disqualify candidates who were not convicted of any crime if there was a "preponderance of the evidence" that a crime was committed.[429]

that contribute to the churn of the system.[181,182] Debt can have a negative effect on financial well-being, reentry, family structure, and mental health.[183]

Researchers have called for significant reform in this area, including reducing or eliminating fines and fees associated with the criminal-legal system, debt collection practice reforms, bolstering access to legal services for people with debt, financial guidance for people entering and leaving incarceration, and broad anti-poverty measures like public health care and access to jobs with living wages and decent benefits.[183]

The Consumer Financial Protection Bureau has begun to address this issue by taking action against prison financial services groups that exploit people in the corrections system and publishing a financial empowerment guide for providers supporting people reentering the community from detention settings, and states also have pursued reforms.[181,183]

Access to Public Benefits

People re-entering the community after periods of incarceration, with the barriers to housing and employment described above, often need temporary public assistance to pay for rent, food, clothing, and other basic needs. However, some states impose bans on federal benefits like TANF and SNAP for people with felony drug convictions. (Minnesota reformed the laws governing medical assistance and state public benefits to remove bans for people with felony drug convictions during the 2023 session.) These bans stem from the idea that people with felony drug convictions are not worthy of public assistance.[184]

An issue brief from the federal Department of Health and Human Services found that drug testing people seeking welfare and social assistance benefits was likely to add program costs without having any clear effect on child well-being or the employability of recipients. The brief also found that the presence of drug testing is likely to discourage participation in the program and increase food insecurity.[185]

Rather than restricting access to public benefits, policymakers can implement pre-release procedures to connect people leaving detention settings with federal benefits like Social Security and Medicaid that lapse during the period of incarceration. Based on the strength of evidence supporting this approach, the federal government has encouraged states to apply for funding that aims to connect people exiting incarceration to Medicaid and health services, including medications for opioid use disorder, in their communities.[186]

Education

For decades, people convicted of drug offenses could lose access to federal grants, loans, or work assistance for higher education. This policy was recently revised, and drug convictions no longer affect federal student aid eligibility.[187]

But barriers to access remain within the college admission process if organizations ask about a student's criminal history. These questions inequitably impact students of color, who are more likely to be arrested, convicted, and imprisoned than white students. Students of color are also more likely than white students to need financial aid to attend college.[188] The downstream impacts on barriers to higher education are clear: evidence shows that post-secondary education is critical to finding work that offers a sustainable wage. People with college degrees are more likely to find employment, earn higher incomes, and are less likely to rely on public assistance programs.[189,190]

The federal government has recommended that colleges and universities remove criminal history questions from their application materials, and several states have passed policies that ban them in public college admissions processes, including Minnesota.[191,192]

Children and families

Another critical area where punitive drug laws have caused unintended consequences is the child welfare system, where drug use among parents has been a primary driver of family separation. As the US incarcerated more people for drug use in the 1980s and 1990s, it also brought more families under foster system supervision.[193–195] Like in the criminal-legal system, the majority of people caught up in the foster system are low-income and disproportionately Black, Native American, and Hispanic—though they use drugs at rates similar to white people.[196] The harms of drug use on children and families are real – a substantial proportion of out-of-home placements are due to caretaker drug misuse—but policymakers' choice to focus their response on separation is not rooted in evidence of successful outcomes for either caretaker or child.[f]

Research has not found a causal link between drug use and child maltreatment, largely because of the many confounding factors that can accompany drug use, like poverty, poor nutrition, or living in highly policed environments.[197] Indeed, research has found that environmental factors like socioeconomic insecurity, lack of access to health care, and lack of housing likely account for much of observed child maltreatment.[198–201]

[f] In Minnesota, the number of children in out-of-home placements for caretaker drug misuse has steadily decreased from 2017 to 2022. The number of out-of-home placements that ended in reunification with their caretakers who were misusing drugs has also been decreasing, and less than half of these children were reunited with their caretakers in 2022.[3]

Instead, many studies have documented the harms of foster care on children's health, including studies that compare outcomes between maltreated children in the foster system and comparably maltreated children who are left in their own homes.[202] Separating children from their parents causes short- and long-term negative health outcomes that range from behavioral problems like ADHD to physical chronic health conditions like hypertension, diabetes, and asthma.[203–206] For mothers who use drugs, child removal is associated with increased odds of unintentional, non-fatal overdose. This effect is particularly pronounced among Native American women.[207]

Acknowledging this research, states and jurisdictions across the country are attempting to roll back policies that aim to separate children from parents who use drugs. One initiative gaining ground requires medical providers to obtain informed consent before drug testing pregnant people.[g] (Accusations of child maltreatment are often based on a drug test alone rather than on demonstrated harm to the child.)[197] Other initiatives aim to focus funding on keeping families together, rather than placing children in foster care.

The International Guidelines for Human Rights in Drug Policy state that children's best interests are the primary consideration in cases where the parents are using drugs. In addition, parents' drug use or dependency should never be the sole justification for removing children from parental care or for preventing reunification. Governments should direct support to keeping children in the care of their parents or returning children to them.[153]

Immigration

Punitive law enforcement responses to drug crimes have become a primary method of removing immigrants from the US. Drug offense felonies can cause serious immigration consequences, like making someone deportable, inadmissible to the US, ineligible for citizenship, and ineligible for forms of relief like asylum. These repercussions can affect immigrants of any status, from people who are undocumented to lawful permanent residents. Criminal repercussions, including immigration, are not an evidenced-based method of responding to simple possession.

Because immigration policy is made at the federal level, states have limited tools to address the impacts on immigration. Governors may issue pardons for people facing deportation.[208] State and local governments may also provide funding for legal representation in immigration hearings: immigrants do not have the right to an attorney under immigration law. Research shows that immigrants with level representation fare better at every stage of the court process than those who do not.[209] States can also choose to employ some of the other evidence-based tactics described in the Drug Policing section rather than imposing criminal consequences.

[g] Minnesota made this change in statute during the 2023 legislative session.

Retroactive expungement

One way to address the impact drug use and its sequelae can have on social determinants of health is through retroactive expungement. Research has established that having a criminal record is a social and economic burden because of the collateral consequences a record generates.[210] Conversely, research has found that expunging records improves employment and social outcomes and is likely to reduce recidivism.[211–213] Recognizing this, states have established expungement policies for people convicted of cannabis offenses after its decriminalization. These laws have taken different forms, including record sealing and record destruction, petitions by individuals or automated systems, and pardons.

Now, expungement is being recommended for offenses associated with all illicit drugs, not just cannabis. For example, the American Society for Addiction Medicine (ASAM) recommends that policymakers consider expungement in order to alleviate the disparate harms of criminalization for personal drug use faced by people of color.[53] The US Civil Rights Commission also recommends that states clarify and expand opportunities to expunge or seal criminal records in a comprehensive report about collateral consequences.[139] The American Public Health Association and the Minnesota Medical Association support the same.[111,214]

DRUG POLICING

Drug use is inextricably bound up with what we are calling here Drug Policing, an umbrella term capturing the ways that drug use and drug sales in the US have been addressed for the last fifty years using a punitive, enforcement-based approach to achieve drug prohibition– to ban the use, sale, possession, production, and cultivation of designated controlled substances in hopes of reducing or eliminating the supply and demand for drugs.[1]

The federal government focuses its effort on supply reduction techniques like interdictions at the borders, countering criminal networks, disrupting illicit finance efforts, targeting drug transportation routes, and other modes of "aggressively reduc[ing] the trafficking of illicit drugs." The federal government also works with drug producing and transit countries to prevent illicit drugs from entering the country.[32]

This section **focuses on state and local law enforcement efforts to address simple possession and drug sales,** particularly in those places where drugs are sold and consumed. In the US, law enforcement is the primary response to reducing both drug supply and demand.[10] Street-level enforcement of drug laws aims to achieve a few goals that follow from prohibition: disrupting established markets, thereby reducing public disorder; and disrupting supply and driving up retail prices.[215–219] Enforcement activities also try to reduce the personal use of drugs by inducing fear of criminal-legal system outcomes.[220,221]

In the Methodology section, we described a few of the challenges associated with evaluating drug policy generally. These included the difficulty of disentangling the effects of a single policy from other policies and trends happening in the same place and at the same time, and heterogeneity in policies and interventions implemented in different places, which limits the ability to aggregate or summarize effects. There are additional challenges to measuring the effectiveness of drug policing specifically.

For 40 years, governments and other policymaking bodies have focused on a narrow set of indicators to evaluate drug policy success.[222] These include the price of illicit drugs, the perceived availability of illicit drugs, the number and volume of illicit drug seizures, the number of drug-related arrests and incarceration, and the prevalence of drug use in the general population—with no distinction between problem and non-problematic forms of use.[15] These indicators do not capture many outcomes associated with drug policing, like impacts on health and criminal-legal system involvement that are faced by both individuals and communities.

Critical discourse theory questions the notion that the role of police is to enforce the laws. Rather than an institution or an organization, critical discourse understands policing to be a process of maintaining social and capitalist order. Scholars use this definition to explain why governments spend more time pursuing crimes committed by working class people than by wealthy people (for example, focusing on public benefits fraud rather than tax evasion) and why working class people are over-represented in jails and prisons.[223] Other scholars have written about the ways police maintain racial order by disparately enforcing drug laws and quality of life laws, which are racially neutral, exposing bias in police discretion that leads to an overrepresentation of people of color in the criminal-legal system.[224–226]

In order to meaningfully evaluate drug policing, a new set of indicators is needed.[222,227] And indeed, advocates, academics, and experts working at the global level have established a new set of indicators, many of which have a law enforcement component, that rank jurisdictions on measures grouped into five areas, four of which are relevant to the US context:

- The **presence or absence of extreme sentencing and responses**, including imposing the death penalty for drug offenses, militarized drug law enforcement, life sentences for drug offenses, and involuntary confinement as "treatment;"
- **Proportionality of the criminal-legal response** in the name of drug control, including police violence, mandatory minimum penalties for drug offenses, fair trial rights, decriminalization and other alternatives to arrest, the extent of imprisonment for non-violent drug offenses, and the differentiated impact of policies on women, ethnic groups, and people living in poverty;
- **Health and harm reduction**, including availability and adequate funding for syringe services programs, medications for opioid use disorder, peer distribution of naloxone, and drug checking;
- **Access to controlled medicines** for the relief of pain.[228]

Unfortunately, this robust set of indicators is not in place in the US or in Minnesota. In this section, we will attempt to describe and evaluate the evidence associated with the current prohibition-based approach to possession and sales in the US, using law enforcement as our primary lens. We will then describe and examine the evidence supporting legal framework alternatives to enforcement and criminalization. Finally, this section concludes with a review of various "off-ramps" from the criminal-legal system.

Public safety impacts

Keeping in mind the inadequacy of common drug policing indicators, a systematic review of street-level drug law enforcement interventions looked at "drug crime" outcomes including: Selling, buying,

manufacturing, or possessing drugs or paraphernalia; Public nuisance due to illicit drugs; Drug-related arrests; Drug-related fines; Drug-related calls for service; and Drug-related convictions.

Of eighteen studies in a systematic review that looked at the impact of street-level drug law enforcement on drug crime, only four showed statistically significant impacts on drug crime. On the whole, the overall synthesized effect of the eighteen studies found that place-level policing interventions significantly reduced drug crimes in the area exposed to the intervention compared to the control. The systematic review found that proactive "problem oriented" and community-wide interventions, where police collaborate with partnering agencies, are more effective in reducing drug crime and calls for service than reactive "hot spot" interventions.[229]

Other evidence indicates that drug law enforcement has failed to achieve its stated aims of reducing the supply and use of illicit drugs.[230]

Enforcing prohibition does not reduce or eliminate the market for drugs, but rather pushes markets underground.[231] There is robust evidence that drug markets are incredibly resilient in response to enforcement: open markets become closed markets, making enforcement more challenging as people resume their use in more clandestine locations.[232–235]

Drug-induced homicide laws

Drug-induced homicide (DIH) laws criminalize the delivery of drugs that contribute to overdose death. Roughly half of US states, including Minnesota, have dedicated laws for this purpose, and in others prosecutors deploy existing murder or manslaughter charges in pursuit of the same outcome.[30] The exact number of DIH prosecutions is unknown but appears to be increasing based on counts of news articles.[236]

Employed to deter illicit drug activity, research consistently has shown that neither increased arrests nor increased severity in punishment for drug law violations result in lower levels of drug sales or drug use.[237] Instead, these laws deter people who are present at an overdose from seeking medical care.[238] Often, the person charged under DIH laws is a friend, acquaintance, or low-level seller trying to support their own drug dependence.[239] DIH laws also exacerbate racial disparities: evidence indicates that the median sentence for DIH charges for people of color is roughly twice that of white people.[240]

The federal government's National Drug Control Strategy recommends that "laws designed to punish drug traffickers harshly are not inadvertently applied to those with [substance use disorders] who are not significant drug traffickers, but essentially are purchasing drugs with another user."[32]

Street-level enforcement seldom leads to the arrest of high-level drug sellers and more typically involves the arrest of low-level sellers and drug users.[241] It also leads people who sell drugs to sell more potent drugs with higher value, in order to counter the costs of prohibition (prison time, evading police, etc.). More potent drugs are also easier to transport, and violence results from a system in which players do

not have legal methods of recourse to resolve disputes.[231] Still, a few studies identified in a systematic review found that street-level enforcement is more effective at suppressing "flagrant" use of drugs than reducing drug use broadly.[40]

Drug law enforcement is unlikely to reduce drug-related violence, and evidence suggests that instead drug prohibition enforcement likely contributes to drug violence and increased homicide rates.[230] A massive illicit market produces more drugs every year.[242] These profits fuel violence, crime, and corruption across the world and have destabilized entire countries, including Colombia, Mexico, and Afghanistan. Prohibition enforcement policies also have resulted in the "cartelization" of drug suppliers, as only those groups most willing to endure and employ violence remain.[231]

Arresting people for drug use does not deter future use, crime recidivism, arrest, or incarceration.[237,243–245]

While the primary intent of imprisoning people is deterrence, there is no evidence that it is effective. Studies show that imprisonment does not impact rates of drug use or arrest.[246] Critically, however, release from prison is positively associated with heightened overdose risk.[247,248]

Research has also found that opioid-related drug seizures by police are associated with increased drug overdose clusters in the same geographic areas, compared to periods without drug seizures. This is likely due to people seeking new drug suppliers and unfamiliar product following the arrest of their known supplier.[249]

Public health and social impacts

Downstream from criminal-legal system involvement and imprisonment are collateral consequences that make it difficult for people to re-enter society successfully. Every year, 50,000 – 60,000 students are denied financial aid because of past drug convictions.[250] Employers are less likely to hire people with histories of drug offenses.[231] These outcomes, discussed in detail in the section Social Determinants of Health, are not included in government indicators that evaluate drug policing practices.

Evidence also has shown that enforcing prohibition via policing and imprisonment can have wide-ranging adverse public health impacts. All of these adverse consequences are most severe for communities of color, who bear the brunt of disparate policing. A large body of evidence published in journals including the Lancet, New England Journal of Medicine, and the Journal of the American Medical Association has established that police violence, mass incarceration, and the criminal-legal system constitute forms of structural racism.[226,251,252] Structural racism is racism that is reproduced by laws, rules, and practices sanctioned and implemented by different levels of government. Like redlining and racial segregation, police violence and mass incarceration—much of it launched at the outset of the War on Drugs—have led to population-level health harms for Black people, Native American people, and other people of color that were discussed in this paper's Scope.[251]

Here are several of the many ways that drug policing impacts health:

- **Increased risk of use in secluded areas:** street-level enforcement causes people who use drugs who are unhoused to seek increased privacy in areas like alleys and doorways. This can increase overdose risk, as people are out of sight of bystanders who could assist or call for help.[253–255]
- **Creates higher risk behavior and forces isolation:** People who are subject to enforcement practices exhibit riskier drug use behaviors. For example, people seeking to avoid police surveillance may rush during injections.[256–259] This leads people to use less clean injection sites, risking abscesses and bacterial infections.[253,260] When avoiding police, they are also more likely to share injection equipment or accidentally mix up injecting equipment, which can increase the risk of infectious disease transmission.[257,259] An influential systematic review of the available evidence in the *Lancet HIV* determined conclusively that the criminalization of drug use—examining modalities like street-level policing, incarceration, and drug paraphernalia laws—has a negative effect on HIV prevention and treatment at the individual, programmatic, and population levels.[261] Enforcement also causes health harms by physically displacing people who use drugs into remote locations.[262] The classic example is "shooting galleries," where people who use drugs congregate out of fear of arrest.[263–265] Sterile drug use equipment is often unavailable in these spaces, and spaces where people use drugs together without access to sterile equipment have subsequently been associated with HIV infections.[266–269]
- **Undermines HIV prevention work:** Enforcement efforts also disconnect people who use drugs from outreach workers who connect them with health and social supports.[256,259,270–274] People who use drugs may also be reticent to carry sterile syringes, which prevent the transmission of infectious disease, for fear of arrest related to drug paraphernalia laws.[270,272,275–277] This can also lead to improper disposal of syringes if people drop their equipment to avoid being stopped by police.[256,258,259]
- **Escalates risk of violent confrontations:** Physical confrontations between law enforcement and people who inject drugs can lead to adverse health outcomes. Enforcement often involves "hands on" policing like physical searches, physical restraints, and stun guns or pepper spray, which can increase the likelihood of harm for both law enforcement officers and people who use drugs.[278,279] Prohibition enforcement has also been associated with increased volatility or violence, particularly when drug sellers are arrested or otherwise displaced and established relationships are disrupted.[235,259,280,281]
- **Accelerates introduction of synthetics and contaminants:** Fentanyl and other synthetic opioids in the drug supply have contributed to drug overdose rates in the US that continue to climb[282,283] Because of its potency, a small amount of fentanyl or another synthetic opioid can greatly increase the risk of overdose.[283,284] Research indicates that supply side enforcement tactics like poppy eradication and heroin seizures led to heroin shortages in parts of the US and Europe during the years 2009 - 2013, which in turn encouraged drug suppliers to innovate.[285] Fentanyl is a synthetic opioid that is cheaper to produce than heroin and is 30 to 40 times more potent, and it penetrated the market in heroin's vacuum starting around

2013.[162,286,287] Fentanyl's potency makes it easier to smuggle, another benefit to drug suppliers.[286] This progression, of increased enforcement leading to riskier formulations of illegal drugs, can be seen in the transition from the off-label use of prescription opioids, to heroin, and then to fentanyl; the transition from regulated beer and wine to moonshine during Prohibition, and from coca leaf to powder cocaine to crack cocaine are also textbook cases of the effect.[288]

- **Hurts community health:** Police enforcement can also impact the health of members of the community who do not have direct contact with law enforcement. Residents of neighborhoods that bear high levels of police surveillance experience elevated levels of psychological distress and worse chronic health outcomes.[289,290]
- **Leads to imprisonment, which is associated with myriad poor health outcomes:** When compared to the general population, people with histories of incarceration are in worse mental and physical health. They are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases like tuberculosis, hepatitis C, and HIV. The health harms of prison then trickle down to families: children of parents who are imprisoned are more likely to live in poverty and be houseless. They often have higher rates of learning disabilities, developmental delays, speech and language problems, and attention disorders. They are also five times more likely to enter the criminal-legal system than children of parents who are not imprisoned.[291]

In sum, policing with the goal of reducing or ending drug supply or demand has not met the stated aims. Not only is an enforcement approach to drug use ineffective, it has also caused serious negative repercussions, particularly in communities of color that are subject to disproportionate levels of policing.

- More than 60% of people involved in the criminal-legal system are racial or ethnic minorities, though they make up just 30% of the US population.[292,293]
- Police interactions with racial and ethnic minorities are more likely to end in arrest than interactions with white people.[294]
- Black people are much more likely to be arrested for drug crimes than white people, even though they use and sell drugs at roughly the same rates.[295]
- Black people make up 12% of the US population but comprise 30% of people arrested for drug law violations and nearly 40% of people incarcerated in state or federal prison for drug violations.[296]
- Hispanic people make up 17% of the US population but 20% of the people in state prison for drug offenses and 37% of people in federal prison for drug offenses.[296]

Multiple groups have called for a reduction in the violence and racial and ethnic (and other forms of) discrimination associated with drug policing, including the Office of National Drug Control Policy, the American Society for Addiction Medicine, Human Rights Watch, the Johns Hopkins-Lancet Commission on Public Health and International Drug Policy, and the United Nations.[1,53,83,152,297]

Case study: San Francisco

The city of San Francisco has a long history of taking a health-based approach to drug use due to a mix of factors, including its history as a center of the counterculture movement in the 1960s, the profound impact of the HIV and AIDS epidemic on communities of gay men and people who inject drugs, and a large politically progressive populace.[298] The legalization of cannabis started in San Francisco in the early 1990s because of the drug's efficacy treating pain associated with AIDS: the San Francisco Board of Supervisors was the first city government to officially recognize that cannabis had medicinal uses.[299] Activism around access to treatment for HIV/AIDS by the group ACT UP meant that San Francisco was one of the first cities in the US to authorize syringe services programs, in 1993. Harm reduction organizations there were also some of the first to distribute the opioid overdose antidote naloxone to people who use drugs.[300]

Like Portland, Oregon, San Francisco has come to represent in the media what some say are the inevitable outcomes of a health-based approach to drug use: public drug use, concentrated areas of visible houselessness, and increased rates of overdose mortality. But in reality, the city has not made many significant drug policy changes; certainly nothing like Oregon's Measure 110, which decriminalized the personal use and possession of small amounts of illicit drugs. From January to December 2022, the City of San Francisco authorized a pilot overdose prevention center (OPS) located in the Tenderloin neighborhood.[301] Former District Attorney Chesa Boudin, who ran as a reformer, sought to tackle mass incarceration and police misconduct but was recalled in the middle of his first term on the basis of an opposition campaign that blamed his policies, without evidence, for the city's longstanding, complicated problems (Levin 2022).

Research, however, indicates that it was not drug policies driving these outcomes.

First, San Francisco has long dealt with high levels of houselessness. Zoning mandates that restrict building height, skyrocketing housing costs, and geography bound by water have led to a severe housing shortage.[302] The amount of affordable housing in particular does not meet demands, and a lack of systems-level regional coordination has also contributed to increasing levels of houselessness in the Bay Area.[303] One researcher put it succinctly: "Many Californians experience homelessness because they cannot afford housing."[304]

That said, unsheltered houselessness in San Francisco actually decreased by 15% between 2019 and 2022. The number of people staying in shelters increased by 18% over the same period. While the number of houseless people reporting alcohol and drug use increased from 42% to 52%,[305] this aligns with research that found that that drug and alcohol use increased nationally during the COVID-19 pandemic.[306–309]

Other factors contributing to increased overdose rates over the last few years are tied to the pandemic: these include social isolation; people using drugs alone; and decreased access to substance use treatment, harm reduction services, and emergency services.[310]

Legal frameworks for reform

Recognizing that an enforcement approach to drug markets has not reduced supply or demand and has led to unintended negative consequences, policymakers and communities are increasingly employing new models. As discussed in the Methodology section, several limitations make it complicated to say with certainty that any one approach is linked to the strongest outcomes.

A recent paper by Hughes, Stevens, Hulme, and Cassidy (2019) attempts to address gaps in the research by delineating the key elements of alternative ways to respond to simple possession and the evidence associated with them. Because the research was undertaken on behalf of a working group convened by the Irish government tasked with considering alternatives to criminalization for simple possession–that is, a body of legislators–we thought it would be particularly useful to include here. All tables in this section are adapted from the analysis in this paper.

Hughes and colleagues undertook a comprehensive review of the existing literature and selected nine countries with a mix of alternative policy approaches to possession of illicit drugs. The researchers broke the different approaches into five main categories: **Depenalization, police diversion (*de facto*), police diversion (*de jure*), decriminalization with no sanctions, decriminalization with civil or administrative sanctions, and decriminalization with targeted diversion to health or social services**. Some models pursued alternatives to simple possession of all illicit drugs, others only to cannabis.

Depenalization

In the depenalization scheme, police de-emphasize the pursuit of simple possession to focus instead on more serious crime. This scheme includes the initiatives in some US jurisdictions in which law enforcement deprioritizes cannabis or psychedelics possession.

Table 2 outlines advantages and disadvantages of this approach. Reviewing the available research, Hughes and colleagues found that a key advantage of depenalization is that it is easy to implement, requiring no changes to law. There is a minor risk of overwhelming adjacent systems, like treatment. It may also increase voluntary access to treatment and harm reduction services. Disadvantages include the risk of net-widening, the risk of a sense of impunity, the risk of increasing drug use, and the risk of differential application or "justice by geography."[311]

Table 2. Advantages and disadvantages of depenalization

Advantages	Disadvantages
• Simple to achieve and few implementation costs • Reduces convictions of PWUD • Reduces demands on and costs to the CJS (unless net-widening) • May reduce other more serious crimes • Avoids over-burdening other services	• Risk of net-widening • Rise of a sense of impunity • Rise of increasing drug use • Risk of differential application/justice by geography

De facto police diversion

In the *de facto* police diversion scheme, police divert people in possession of illicit drugs to drug treatment programs or to social or health services. This scheme includes the LEAD (Law Enforcement Assisted Division/Let Everyone Advance with Dignity) model, widely implemented in US jurisdictions, including Minneapolis' Lake Street area. The logic of this approach is that drug use is a health or social issue rather than a criminal legal system issue. Because police are often the frontline of contact with people who use drugs, they are well positioned to connect people to services. In the aftermath of George Floyd's murder in 2020, many jurisdictions are innovating around approaches that remove police from responding to behavioral health and mental health issues; this topic is explored in the section Community Responder Models below.

Intended outcomes of police diversion include avoiding collateral consequences associated with convictions, reducing the burdens and costs of the criminal-legal system, and reducing drug-related harms. The literature distinguishes between three types of police-based diversion:[312]

- Pre-arrest, where police advise (or order) the person to participate in treatment or an educational program to avoid arrest;[313]
- Pre-booking, where the police have arrested someone who is in encouraged (or coerced) to participate in treatment or a prevention program to avoid formal charges;[314] and
- Self-referral, where people go to the police station seeking services or treatment.[315]

Advantages and disadvantages of *de facto* police diversion are shown in Table 3. Evidence suggests that there are many advantages to this approach, including connecting people to treatment and other services and reductions in drug-related harms.[311] They have also been found to be effective in preventing criminal offending, improving health, and decreasing the social and health-related costs associated with drug use.[312] Research found no evidence of the effect of police diversion programs on drug consumption, drug accessibility, or on the socioeconomic conditions of participants.[312]

Table 3. Advantages and disadvantages of de facto policy diversion

Advantages	Disadvantages
• Reduces convictions of PWUD • Increases access of PWUD to treatment/mental health/social services • Assessment and early intervention • Addresses PWUD needs, such as access to treatment, employment or legal (dependent on model) • Reduces costs of criminal-legal system • Reduces drug-related harms, such as high frequency use • Reduces recidivism	• May be resource intensive (in short term) for police/justice system • Increases costs for other services • Given this is discretionary, there may be specific groups of PWUD who "miss out," such as people of minority backgrounds • Access may vary by region, such as regional versus metropolitan areas

On the other hand, a key risk of police diversion is inequitable application. Because it is a discretionary model, police diversion can lead to particular groups, including racial and ethnic minorities, being less likely to be diverted.[311] Net-widening is another major risk, especially when it targets people committing low-risk offenses and involves conditions like participating in a program.[312] High start-up costs as the program is established can detract jurisdictions from investing in this tactic.[311]

Importantly, this model also relies on coerced or mandated treatment, which evidence shows is ineffective and may instead be associated with potential harm.[52] This is discussed in more detail above, in the section Voluntary access to treatment.

In addition, studies have found that people who use drugs have negative perspectives about the justice system and police overall, and this can pose a barrier to participation in diversion programs.[316] Communities of color that have been overpoliced and experienced police brutality may also distrust police to link them to services.[317,318]

De jure police diversion

The *de jure* police diversion approach is similar to the *de facto* approach described above, except that in this scheme, police refer all people who might otherwise be arrested for simple possession to services. This seeks to avoid the bias and inconsistent application that can accompany the *de facto* form of the policy. There have only been a few instances of this policy being implemented, making it difficult to evaluate. That said, researchers identified several advantages and disadvantages (shown in Table 4).

Table 4. Advantages and disadvantages of de jure police diversion

Advantages	Disadvantages
• Reduces convictions of PWUD • Removes discretion that may limit access in *de facto* approaches • Increases access of all PWUD to treatment/mental health/social services • Addresses PWUD needs, such as access to treatment • Reduces costs of criminal-legal system • Reduces drug-related harms • Reduces recidivism	• May be resource intensive for police/justice system • Increases costs for treatment services • May lead to individuals entering the program on frequent, repeated occasions

Decriminalization with civil or administrative sanctions

This scheme asserts that while possession of illicit drugs should not be a crime, neither should it be ignored. It is found in a number of jurisdictions, including the Czech Republic (all drugs), Australia (cannabis), Jamaica (cannabis), and many US states (cannabis). Treating possession like a civil or

administrative offense avoids the adverse outcomes associated with a criminal conviction while also allowing the state to sanction the behavior via non-therapeutic means, perhaps with a fine or civil citation. This approach also recognizes that sending someone to treatment is not always the best approach, particularly for low-risk drugs like cannabis.[311]

This approach is associated with both positive and negative outcomes, shown in Table 5. Positive outcomes include a reduced burden on the criminal-legal system, social benefits to people who no longer face the collateral consequences of conviction, and removing the stigma associated with harm reduction and drug treatment services. Negative outcomes include some increases in drug use and drugged driving, as well as significant net-widening in jurisdictions including New York and Chicago. A fine-based system can also disproportionately burden people with the least ability to pay.[311]

Table 5. Advantages and disadvantages of decriminalization with civil/administrative sanctions

Advantages	Disadvantages
• Reduces convictions for PWUD • Faster for police • Very inexpensive to run (particularly with new revenue) • Social benefits for PWUD from reducing conviction, such as increased employment prospects	• Need a civil/administrative system • Need a system for payment • Alternate system may not be fair for all, for example, by advantaging wealthy people • Risk of net-widening as "easy" for police • Risk of increased drug use and driving

Decriminalization with targeted diversion to health/social services

This scheme proposes that drug possession should be dealt with outside the criminal-legal system. It also recognizes that while most people use drugs in non-problematic ways, there should be options for engagement in health and social services for people who need them. It therefore aims to reduce collateral consequences associated with criminal-legal system involvement while also providing social supports to people with high-risk drug use behaviors. This model is most strongly associated with Portugal, where all people found in possession of drugs are referred to "dissuasion committees," and problematic drug users are subsequently referred to drug treatment and other social services.[311]

Advantages and disadvantages are shown in Table 6. Studies have shown that this approach is associated with lower rates of regular and problematic drug use, compared to states implementing civil penalties alone.[319] Portugal's model was associated with reduced illicit use in people with problematic drug use behaviors and adolescents; it was also associated with declines in opioid-related death and infectious diseases.[320] Drug treatment engagement increased by 94% after the reform, and HIV infections decreased from 28.0% to 19.6%.[321] That said, these changes cannot be attributed solely to changes in criminal law, as the Portuguese model included significant investments in health and harm reduction services.[320] This model is also associated with reduced burdens on the criminal-legal system and arrest rates.[319,320]

Table 6. Advantages and disadvantages of decriminalization with diversion to health/social services

Advantages	Disadvantages
• Holistic response system based on need: "low" versus "high" risk • Increases access of PWUD to treatment/mental health/social services • Reduces problematic drug use • Reduces drug-related harms, such as overdose, HIV and hepatitis C • Reduces burden on the criminal-legal system • Reduces costs • Increases social reintegration	• Requires new infrastructure including new administrative legal basis and new referral pathways • Some increased costs for other services (but much lower than models above)

Decriminalization with no sanctions attached

In this model, police cease arresting people for simple possession alone, in recognition that such a response is disproportionate and costly. Envisioned outcomes include eliminating collateral consequences of conviction, reducing burden and cost on the criminal legal system, re-focusing policing on serious crime, reducing stigma against people who use drugs, and increasing voluntary treatment.[311]

There is a limited body of evidence about this approach. What exists is primarily drawn from Germany: in a constitutional court decision in 1994, Germany decriminalized possession of small amounts of drugs for personal use if there was no danger to third parties. The question of what constituted small amounts was left up to the states, which led to large variations in threshold amounts across the countries' 16 states, and also with regard to the types of drugs included (the ruling refers to cannabis, but many states have extended this to all illicit drugs) and the question of repeat offenses.[311]

Table 7. Advantages and disadvantages of decriminalization with no sanctions attached

Advantages	Disadvantages
• Eliminates convictions for possession alone • Reduces stigma of people who use drugs • Reduces costs of criminal-legal system • Reduces barriers to harm reduction and treatment seeking • Reduces drug-related harms, such as high frequency use • Simple to achieve and few set up costs	• Little evidence of effect on prevalence and frequency of drug use • Reduces legal possibility to intervene in problematic drug use

Decriminalization with no sanctions attached, or full decriminalization, is promoted by many health professionals and by organizations of people who use drugs. It removes punitive drug policies, involuntary treatment, and other stigmatizing and onerous sanctions.[16,322] Removing administrative and civil penalties associated with drug use in addition to criminal penalties is supported by the American Society for Addiction Medicine and the American Public Health Association, as well as Health Canada

Expert Task Force on Substance Use, and international bodies (the International Guidelines on Human Rights and Drug Policy, the Global Commission on Drugs).[53,110,153,214,323]

While research has delineated the models above in order to study them, jurisdictions can and do apply multiple models in tandem: to different drugs or to different groups (like people with repeated offenses or youth).[311] For example, the Netherlands has depenalized cannabis and implemented *de facto* police diversion for possession of other illicit drugs. South Australia has decriminalized cannabis with civil penalties while implementing *de jure* police diversion for other illicit drugs.

Hughes and Stevens (2019) summarize the advantages and disadvantages of all models in the table below.

Table 8. Summary of advantages and disadvantages of different models

	Model	Start-up requirements	Prevalence of recent use	Criminal -legal system burden	Treatment/ harm reduction service access	Drug- related health harm	Social reintegration	Net-widening	Differential application
1	Depenalization	Low	No change	↓	↑(v)	No change	No change	High	High
2	Police diversion (de facto)	Moderate	No change	↓↓	↑↑↑↑	↓↓	↑↑	Low	High
3	Police diversion (de jure)	High	No change	↓↓	↑↑↑↑↑	↓↓↓	↑↑	??	Low
4	Decriminalization with civil or administrative sanctions	Moderate	No change	↓↓↓	↑↑(v)	↓	↑↑	High	Moderate
5	Decriminalization with targeted diversion to health/social services	Very high	No change	↓↓↓↓	↑↑↑	↓↓↓	↑↑↑↑	Low	Low
6	Decriminalization with no sanctions attached	Moderate	No change	↓↓↓↓	↑↑(v)	↓↓	↑↑↑	Low	Low

V= voluntary access.

The table shows that while all the approaches examined have advantages and disadvantages, all decrease the burden on the criminal-legal system. A few approaches increase voluntary access to treatment and harm reduction services. Almost all decrease drug-related health harms and increase social integration. The risks of net-widening and differential application are variable, as are start-up costs.[311]

Regulation

Decriminalization schemes like those described above do not fully account for all negative effects of the drug trade.[324] For example, as discussed above, the harms associated with drugs increase when they are sold and consumed in an unregulated environment. Drugs are sold without quality controls. They are of unknown strength and are cut with adulterants. Regulating agencies could reduce these harms significantly.[288]

Regulating potentially harmful human activities is the crux of public health and government, as with tobacco and alcohol (a substance that generated immense harms during Prohibition–harms that were diminished under the regulatory periods that preceded and followed Prohibition).[1,288] Regulating drugs would recognize that illicit drug use is a fact of life that requires an evidence-based approach.

Establishing a regulatory system for legal access to all controlled substances has been recommended by:

- The Johns Hopkins-Lancet Commission on Drug Policy and Health: Countries should "move gradually toward regulated drug markets and apply the scientific method to their assessment."[1]
- The UN High Commissioner for Human Rights, which recommends that member countries should "take control of illegal drug markets through responsible regulation, to eliminate profits from illegal trafficking" and "consider developing a regulatory system for legal access to all controlled substances."[297]
- The Global Commission on Drug Policy, a body composed of former presidents and UN leaders: "In order to fully mitigate the harms caused by ineffective and dangerous punitive responses to drugs, governments must ultimately regulate illicit drugs, from production through to distribution."[324]

While there is no one-size-fits-all approach, Figure 5 (next page) depicts a spectrum where the control of drugs shifts from unregulated criminal markets to government agencies. Government oversight could be applied to all aspects and levels of the drug market: the licensing of producers and vendors; price, potency, and packing; branding and promotion; access and availability, including medical prescriptions; and more.[288] Sales to children, inaccurate packaging, or other deviations from the parameters could still be prohibited and sanctioned. Riskier drugs like injectable heroin may require more government intervention than cannabis. Figure 5 illustrates that societal harms are at their lowest with robust government regulation; unregulated access in either criminal markets or legal markets increases harms.

A regulated legal market could take any of the following forms, all of which have been applied to other products: medical prescription (heroin-assisted treatment clinics in Switzerland are one example);[325] specialist pharmacies; licensed retail outlets; licensed premises, like bars or cannabis "coffee shops,"; and unlicensed retail, for low-risk drugs like coffee. Any policy movements toward regulation should be rigorously studied.[288]

Figure 5. Regulation reduces harm to health and society

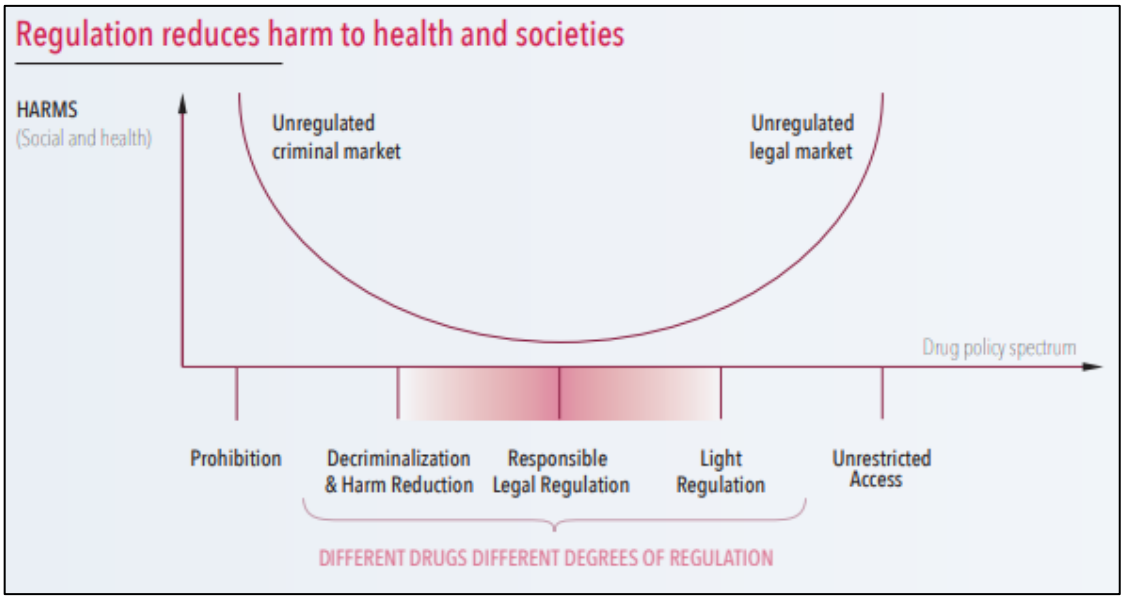


Image Source: Global Commission on Drug Policy (2018) "Regulation: The Responsible Control of Drugs." Available at https://www.globalcommissionondrugs.org/wp-content/uploads/2018/09/ENG-2018_Regulation_Report_WEB-FINAL.pdf

Incremental change

Other jurisdictions have experimented with smaller-scale adjustments to the criminalization approach to drug policy. These include legalizing or decriminalizing drug paraphernalia (Minnesota and Maine respectively), which recognizes that these policies do not dissuade drug use but do lead to riskier drug use behaviors.[326]

Defelonization is another incremental alternative approach: drug possession penalties are reduced from felonies to misdemeanors, with the intended outcomes of avoiding prison time and the specific collateral consequences that can follow from a felony conviction.[327] At least 18 states and the District of Columbia treat possession as a misdemeanor, including California, Iowa, Oklahoma, and Wisconsin.[328] An evaluation of California's Proposition 47, which reduced penalties from felonies to misdemeanors in 2014, found that it significantly reduced the likelihood that people convicted of drug offenses would go to jail or prison. One evaluation found a small increase in crimes against persons associated with the change;[329] another found the policy change had no impacts on homicide, rape, aggravated assault, robbery, or burglary and that while property crimes increased moderately, the evidence was not strong enough to link them conclusively to Proposition 47.[330] State prison and local jail populations declined, and the state saved $68 million in prison expenses in the first year of implementation.[331]

The success or failure of alternatives to criminalization rest on multiple interlocking factors:[14] the availability of health and social services like housing and drug treatment, social values, the nature of

the legal system, the scale and nature of the illicit drug market,[332] and the culture of police and prosecutors. It is difficult to isolate the effects of the legal framework separate from these confounding factors. It also means that alternatives to criminalization should be designed for specific contexts and with involvement from all impacted groups.

Nevertheless, there is a clear consensus among key drug policy governance bodies and policymakers about the need for an alternative to criminalization for simple possession of illicit drugs. For example, the United Nations High Commissioner for Human Rights encourages member countries to take up a public health and human rights approach to drug policy, "including by decriminalizing drug possession for personal use."[297]

Other groups recommending some form of decriminalization include the American Society for Addiction Medicine, the American Public Health Association, the Johns Hopkins-Lancet Commission on Public Health and International Drug Policy, the International Center for Human Rights and Drug Policy, and the Global Commission on Drug Policy.[1,53,110,153,214]

Off-ramps

After describing the evidence associated with a law enforcement approach to the drug possession and sales and reviewing alternative legal frameworks to criminalization, we will now review a few "off-ramps" from the criminal-legal system available to people involved in the illicit drug market. These off-ramps can be and are implemented in jurisdictions that employ a criminalization approach to simple possession and sales. They are also associated with some of the alternative legal frameworks described earlier in this section.

Off-ramps discussed here include community responder models, retroactive expungement, and sentence commutation, though others exist that are not covered in this report.

Community responder models

For many people who use drugs, police are their first contact with the criminal legal system.[10] But police often lack the training to support people who are using drugs, or an armed police response is unwarranted, as in "quality of life" issues related to houselessness. Police response substantially increases adverse outcomes for communities of color and people with behavioral health disorders and disabilities. Additionally, sending law enforcement to respond to behavioral health or disturbance calls takes them away from addressing serious crime.[333] For all these reasons, preventing contact with the criminal-legal system has been identified as particularly important in the context of the overdose crisis.[334] In this sense, the first off-ramp from the system is preventing any contact at all.

The Community Responder model aims to address certain situations with health or social services professionals or community members rather than police–for example, substance use or mental health

crises, overdose response, or social disturbances. These models have been shown to improve outcomes for people in need and to reduce reliance on police.[333,335,336]

One analysis of 911 calls in eight US cities found that Community Responders could respond to a sizable portion of calls, ranging from a low of 21% in Detroit to a high of 38% in Seattle.[333] Community Responders could be paramedics, clinicians, or peer workers.[333] The CAHOOTS (Crisis Assistance Helping Out On The Streets) model, from Eugene, Oregon, has been in place since 1989. In 2019, it responded to 24,000 calls, or about one-fifth of the calls dispatched by 911. They called for police back-up just 250 times (1%).[335] Community Responder programs like CAHOOTS also have been shown to reduce reports of crime and thus contact with the criminal-legal system.[336]

Case study: Rhode Island

In 2021, Rhode Island became the first state in the country to authorize overdose prevention sites.[337] The Department of Health established rules for their licensing and operation in 2022,[338] and it was recently announced that the first state-regulated center will open in Providence in early 2024. The first year of operations will be funded with $2.6 million in opioid settlement funds.[339] A rigorous evaluation will be conducted by Brown University.

Rhode Island has led the nation in implementing evidence-based approaches to reduce overdose in other areas, as well: in 2016, it became the first state to establish a corrections system-wide approach to treating opioid use disorder (OUD), including screening all individuals for opioid use disorder, offering access to the three FDA-approved medications for OUD (methadone, buprenorphine, and naltrexone), and providing linkage to community care upon release.[340] The monthly average number of people receiving MOUD rose from 80 to 303 following implementation.[341]

In the first year following implementation, the interventions resulted in a 12% drop in statewide overdose deaths and an "astounding" 61% drop in post-incarceration overdose deaths.[30,341,342]

At the outset of the COVID-19 pandemic and leveraging flexibilities in telehealth issued by the DEA and SAMHSA, Rhode Island created a buprenorphine "hotline" accessible 24 hours a day, seven days a week. People with opioid use disorder could be connected to a prescriber for assessment and initiation in real time.[343] Research has found that people who were linked to buprenorphine via the hotline had high rates of medication initiation that were comparable to treatment linkage rates at in-person bridge clinics and emergency department-based programs. They also had low rates of complications.[344] On-demand care allows people to access care at the moment of peak motivation and to overcome barriers associated with in-person appointment for people with low incomes, caregiving duties, limited transportation options, and restricted mobility.[344]

In May 2023, the US Departments of Justice and Health and Human Services issued guidance for states, local governments, and tribes regarding people experiencing behavioral health crises. It

acknowledges that "jurisdictions should not assume that the proper response to a crisis is always to send law enforcement," and that unarmed, behavioral health practitioners should be dispatched "whenever appropriate." The guidance recommends integrating tools like those described above, including diverting 911 calls related to behavioral health to non-police supports and mobile response teams comprised of health providers and peer workers to respond to behavioral health crises.[345]

In January 2024, the state of New Jersey established a Community Crisis Response Advisory Council and allocated $12 million to community groups to implement pilot programs in six counties.[346]

Alternatives to incarceration and diversion programs

Alternatives to incarceration and diversion programs aim to ease the burden on the criminal-legal system by moving PWUD out of the system.[347] These programs are increasingly employed by states for people who are not involved with drug trafficking and are understood to be less deserving of punitive responses.[63] A 2018 study found that 39 states had such programs, and while many predated the overdose crisis, they have been employed more frequently since its start.[348]

There are generally two types of these programs, with some overlap: programs that aim to provide access to drug treatment for people who need it, and programs that aim to provide an alternative response for low-risk PWUD.[349] The former might divert someone who commits a crime to support their substance use disorder via evidence-based treatment; the latter might entail a judge suspending a sentence or positing their decision if the person meets certain conditions.

The Sequential Intercept Model (SIM)

The Sequential Intercept Model maps the paths of people with mental health and substance use disorders through the criminal-legal system, from community services and law enforcement through to jails and prisons and community corrections.[334] The model has been successfully applied by communities seeking to address the impact of the overdose crisis by helping community partners identify places where people can access health and social services supports to increase prevention, treatment for opioid use disorder, reduce overdose, and disentangle people from the criminal-legal system.[352,353]

Alternatives to incarceration and diversion programs can provide an "off-ramp" at multiple points in the Sequential Intercept Model (SIM) (see text box). Earlier, this section reviewed diversion programs that occur at the law enforcement level. They can also be implemented at the charge/pre-trial stage, at trial and sentencing, and post-sentencing.[350] At all levels, court actors should be aware that opting for treatment or another alternative should not compromise people's due process rights; for example, a requirement to plead guilty to become eligible for alternatives could be seen as eroding due process rights.[351]

Drug Courts

Drug courts are perhaps the most studied alternative to traditional criminal-legal system involvement. Drug courts are specialized courts within the criminal-legal system meant to provide alternatives to jail or prison for people charged with drug possession, sale, or use.[354] The number of drug courts in the US has ballooned over the last thirty years as a response to the huge increase in drug-related arrests and the recognition that traditional criminal-legal system tools like incarceration, probation, or parole have not been effective in reducing drug use or drug-related crime. A 2005 review of the evidence found that drug courts "positively affected[ed] the criminal-legal system" by lowering rates of recidivism compared with people who did not receive court-supervised treatment.[355–357]

More recently, however, drug courts have been criticized for restricting access to quality drug treatment for people who need it, and mandating drug treatment for people who do not. A review by Physicians for Human Rights of drug courts in three states found that the punitive approach of the criminal-legal system and the purported therapeutic approach of the drug court situated within it were at odds. Among other findings, researchers found that:

- Despite the chronic nature of substance use disorder, with the known outcome of return to use after periods of cessation, drug court participants were punished for return to use, missing therapy appointments, and other failing to follow court rules.
- Diagnosis and treatment plans were developed by people without medical training and without oversight.
- The refusal, delay, or tapering of medications for opioid use disorder, despite evidence that these medications are the gold standards of care for people with opioid use disorder.
- Drug courts pose human rights concerns when participants are asked to waive their rights to patient confidentiality and privacy in order to access treatment.
- Drug courts at times mandate people to treatment for crimes like drug possession that don't necessarily imply problematic drug use. When people in the community seek to access treatment without a court mandate, they face long waiting lists, creating a perverse incentive to commit a crime in order to access treatment.[354]

Studies have shown racial disparities within the drug court system, both by excluding racial and ethnic minorities from a system meant to provide an alternative to incarceration, and by over-targeting them, mandating treatment for people without problematic drug use behavior.[358] For example, one study found that Black people referred to drug treatment for cannabis use from the criminal-legal system tend to have less serious problems with cannabis use than white people. This placed more Black people under government control.[359]

Another study found that Black people were less likely to be referred or admitted to drug court programs in almost all jurisdictions covered, and had lower graduation rates in more than half. Graduation disparities may have been driven by a lack of cultural competency among staff; failure to address needs related to housing, employment, mental health, and the like; and other factors.[360] The federal government's National Drug Control Strategy calls for racially equitable implementation across all aspects of the criminal-legal's system response to drug offenses, including drug courts.[32]

The "success" of drug courts depends on the outcomes of interest. Policymakers should know that while evidence finds that they reduce recidivism, they also result in racial disparities, can impede access to medications for opioid use disorder, and pose ethical and legal questions related to due process, right to privacy, and more.[358,361,362]

Testing participants for drug use is a common feature of diversion programs. Intended to monitor compliance with the programs' mandates, it is also employed during probation and parole, and in prison and treatment settings. However, there is a lack of evidence showing that drug testing (and the punishments that follow a positive drug screen) is effective in reducing crime. Instead, research has shown that it increases costs to the criminal-legal system through expenses related to drug testing and increased imprisonment.[363–366]

Diversion to treatment is effective in reducing substance use and recidivism when the treatment is tailored to the individual. SAMHSA and the WHO echo that treatment should match the needs of the individual and should be evidence-based.[351,367] Importantly, not all people who use drugs require treatment.[350]

In addition, research has found that people recidivate almost 50% less after community service than after imprisonment.[368] Other research has found that imprisonment makes people more likely to reoffend than non-custodial alternatives.[369] Electronic monitoring has been shown to be more effective in reducing future incarceration than imprisonment.[370]

Alternative measures like these are endorsed by the federal Office of National Drug Control Strategy, the Substance Abuse and Mental Health Services Administration, the UN Common Position on Drugs, Human Rights Watch, the Johns Hopkins-Lancet Commission on Public Health and International Drug Policy, and the Global Commission on Drug Policy.[1,32,110,112,152,154]

Sentence commutations

Decriminalization is forward looking: it does not provide relief to people who committed the same drug crimes in the past.[371] Sentence commutation is designed to alleviate harms of the policies that criminalize possession or other drug crimes to people previously or currently incarcerated.

The logic supporting commuting (or reducing) sentences is that policies to decriminalize possession or other drug crimes should apply retroactively to people who are currently incarcerated or under community supervision. Retroactivity in the context of changing drugs laws in especially important because of the considerable number of people charged and incarcerated on drug-related crimes, and it reflects an understanding that the old laws and sentences were unjust.[152]

There are various forms of sentence commutation and reduction polices. The American Society for Addiction Medicine asks policymakers to consider "new clemency efforts" that would encourage people incarcerated for non-violent drug offenses, many of whom are people of color, to petition for sentence commutations or reductions.[151] This would put the onus on the individual to seek relief. In contrast, the Drug Policy Alliance advises states to establish "second look" processes for people

incarcerated only on drug offenses,[h] create procedures to re-open sentencing proceedings for people convicted of drug offenses, and to establish immediate "set asides" and release people convicted of offenses that subsequently have been decriminalized.[372,i]

Sentence reduction or commutation is also supported by Human Rights Watch, which recommends that states "include a retroactivity provision in all future reforms to drug use and possession laws, and, to the extent possible, apply the terms of already enacted reforms to decrease the drug sentences of individuals sentenced for the same offenses prior to the reforms."[152]

In sum, there is little evidence that a law enforcement-based, punitive approach to the simple possession and sales is effective in producing positive health or public safety outcomes. In fact, evidence indicates that these policies often do the opposite, degrading public health and public safety.

Conversations about an enforcement, prohibition-based approach to simple possession and drugs sales are bound up with the broader national conversation around "right sizing" the role of police in everyday life. For example, policing tactics like SWAT teams and stop-and-frisk that are deployed for purposes of drug policing have been associated with police violence against communities, and they have also been the subject of reforms that have criticized their inequitable use in communities of color. (These approaches also are ineffective in reducing street-level drug activity.)[230,373]

As policymakers examine the evidence associated with drug policing, we encourage them to view drug policy and policing in conversation with broader questions about the appropriate scope of police practice in the lives of Minnesotans.

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[h] Second-look laws provide an opportunity for courts to re-examine a sentence after a set period of time, to determine if it continues to serve its original purpose. These laws, which exist in a handful of states in different forms, also recognize that evidence about best practices for addressing drug crimes continue to evolve and intentionally build in a review period to integrate new findings.[431]

[i] In general, a "set aside" laws allow courts to vacate a conviction, with the goal of signaling a person's rehabilitation—which may or may not be signaled by a sealed record.[432]

SPECIAL POPULATIONS

Several groups require special responses from any drug policy regime. The categories below are not exclusive, and people who live in their intersections often experience enhanced vulnerability.[374] For example, Black and Native American women face higher rates of child removal for drug use than white women, highlighting how notions of race, gender, and caretaking are inextricably entangled.[375,376]

Racial and ethnic minorities

It is hard to overstate the overwhelming negative consequences that a punitive approach to simple possession and drug sales has caused for communities of color. Racial and ethnic minorities are overrepresented at every stage of the criminal-legal system, despite using drugs at the same rate as white people. They face disparate health outcomes in every health area related to drugs. Access to housing, employment, and education is also stratified by race.

Thus, policymakers have a special duty to center the voices of these groups in every discussion about how to improve the system. Communities of color require health and harm reduction services that are tailored to their needs, and this requires disaggregating data by race and ethnicity to understand groups' needs. Communities of color also require intentional investments in housing, employment, and other social determinants of health to restore communities that have been overpoliced and overincarcerated.[j]

The UN has recognized that governments must address the unjust impact of drug policy on people of African descent and on Indigenous peoples and asks governments to address racial discrimination in the enforcement of drug laws and sharp disparities in prosecution and incarceration.[377] The UN also reminds governments that Indigenous people have the right to traditional medicines, including psychoactive plants, and advises that laws or policies that restrict access to these medicines should be repealed or amended.[153]

People in detention settings

People in detention settings, despite having proportionately greater rates of substance use disorders and being at higher risk for overdose death, have extremely limited access to evidence-based care and treatment.[27,29,378] One study found that less than 5% of people referred to SUD treatment by the

[j] Minnesota provided funding for culturally specific recovery communities during the 2023 legislative session.

criminal-legal system received any medication as part of their care.[379] All people in detention settings should be able to access treatment voluntarily, and treatment should be evidence-based and provided by qualified medical personnel.

Increasingly, evidence shows that the use of MOUD - specifically methadone and buprenorphine - in carceral settings not only reduces drug use, injecting, and injection-related morbidities while people are incarcerated,[31] it has protective effects against overdose mortality after release.[380,381] In some states, the failure to provide access to MOUD within prisons has been recognized as a violation of federal law.[30] As a recent example, in December 2023, the Department of Justice filed a statement of interest asserting that a Pennsylvania county jail violated the Americans with Disabilities Act (ADA) by failing to provide a person with methadone to treat their OUD.[382]

A number of local, national, and global bodies have recommend requiring access to MOUD in detention settings, including the US Office of National Drug Control Policy, the American Public Health Association, the Minnesota Medical Association, and the United Nations.[32,82,111,153]

People experiencing houselessness

The growing population of people experiencing houselessness has broad implications for drug policy.[383]

Unhoused people with substance use disorders are at increased risk of associated morbidities and mortalities and have increased rates of emergency department visits and hospitalizations.[384,385] Houselessness is also associated with drug overdose mortality; one study found that people experiencing houselessness die of overdose at a rate that is 16 to 24 times higher than the general population.[386,387] Evictions are positively associated with substance-related mortality.[388] Involuntary displacement of people experiencing houselessness, or "sweeps," can lead to increased levels of overdose deaths, increased hospitalizations, and fewer initiations of medications for opioid use disorder compared to no displacement.[389]

Reforms that improve access to affordable housing are, in this light, drug policy reforms. A recent study found that by helping place people experiencing houselessness with SUD in supportive housing, SUD-related hospitalizations and ED visits decreased significantly.[384] Substance use disorders are often a predictor of houselessness, but the reverse is also true: the chronic stress of houselessness is a predictor of SUD.[390] The most powerful predictor of increases in houselessness, however, is an increase in housing cost. At the population level, a $100 increase in rent is linked to a 9% increase in houselessness.[391]

Houselessness is not evenly distributed across the population; important disparities exist that predispose Blacks and Native Americans to houselessness, including barriers to housing and economic mobility, racism and discrimination within services for people experiencing houselessness, and involvement in

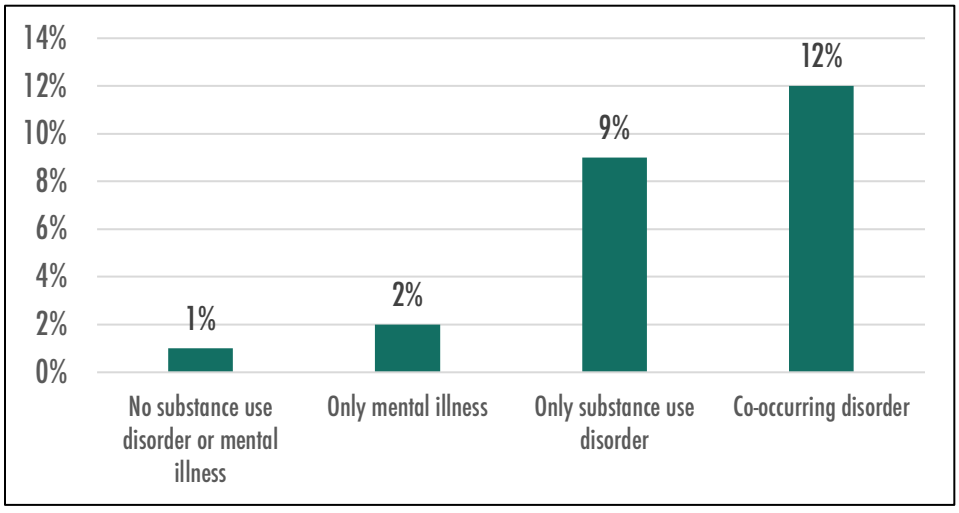
multiple systems, including the criminal-legal system.[392] People of color, especially Black people, are overrepresented in the houseless population, putting them at heightened risk of arrest for "quality of life" behaviors, which is compounded by racially targeted law enforcement practices.[393] (Laws criminalizing "qualify of life" behaviors, such as trespassing, disorderly conduct, and public urination, disproportionately impact unhoused people, and these issues often have root causes in mental health and substance use disorders.)[393]

People with severe mental health disorders

Many individuals with substance use disorders also have diagnosed mental health conditions. Specifically, evidence shows high rates of comorbidity with anxiety disorders, depression, schizophrenia, bipolar disorder, and attention-deficit hyperactivity disorder (ADHD), among others.[394] The overlap is especially significant between SUD and serious mental illness (SMI), defined as "at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities."[394] Roughly one quarter of individuals with SMI also have SUD.

People with comorbid substance use and mental health disorders experience poorer outcomes than individuals with one diagnosis alone.[395,396] Treatment requires communication and collaboration between providers, including medical and supportive service providers, and across settings, including criminal-legal settings.

Figure 6.Percentage of adults arrested annually by behavioral health type, 2017-2019



Source: Pew analysis of data from the National Survey on Drug Use and Health, 2017-2019.

Individuals with both SUD and mental health disorders are also much more likely to be exposed to the criminal-legal system: more than 1 in 9 individuals with comorbid SUD and mental illness are arrested annually, a number 12 times higher than someone with neither SUD or menta illness, and 6 times higher than someone suffering from only mental illness.[397] This underscores the critical importance of law enforcement training on both mental illness and substance use and presents a critical opportunity for engaging people in needed medical and social support services.

Case study: Portugal

Portugal was not the first country to decriminalize drugs, but it has been one of the most influential.[398] It is therefore critical to examine the policy change and outcomes in detail.

In the 1980s and 1990s, law enforcement, health providers, and the general population were increasingly concerned about the social exclusion and marginalization of people who used drugs, including rates of HIV, AIDS, TB, and hepatitis C that were among the highest in Europe.[399,400] This concern led to the publication of Portugal's first national drug control strategy, a document produced by an expert commission with the goal of implementing a comprehensive, evidence-based approach to drug policy.[320]

Based on recommendations in the report, in 2001, Portugal decriminalized the public and private use, acquisition, and possession of small amounts of illicit drugs. Rather than facing the criminal-legal system, a person using illicit drugs instead would face administrative sanctions and would be mandated to meet with the Commission for the Dissuasion of Drug Addiction, commonly known as Dissuasion Committees. The regionally located Commissions are governed by the Ministry of Health with goals to encourage treatment adherence and abstinence from drug use.

Importantly, drug decriminalization was only one part of the country's reform package. The country also expanded access to harm reduction services and treatment for problematic drug use that recognized the necessity of a health-based approach to drugs.

Despite the decriminalization policy, penalties and law enforcement continued to play key roles. Police who encounter people using or possessing drugs confiscate them, issue an administrative citation, and send the citation to the Dissuasion Committee, after which the person is mandated to appear before the Committee. The Committee then assesses the person and the situation and decides on the nature of sanctions, considering criteria like the severity of the offense and the person's economic circumstances, among others.

Sanctions may include monetary fines, warnings, suspension of licenses, regular reporting to the Committee, and others. The Dissuasion Committees may not mandate treatment, but they can encourage it by removing sanctions for people with drug dependence issues who enter and complete treatment. Similarly, they can lift sanctions for people who use drugs recreationally who fulfill certain conditions, like agreeing not to reoffend. The possession of more than ten days' worth of drugs continues to be met with criminal sanctions.

Evaluating the decriminalization policy has been complicated by a few factors, including the lack of a matched control country, inconsistent implementation on the ground, and challenges with data availability and interpretation. It is therefore impossible to make explicit causal links between the policy change and public safety and public health outcomes.[320]

Still, researchers have established some key findings from the available data.

- Drug-related mortality rates are among the lowest in Europe – 6 deaths per million among people aged 15 – 64 years, compared to 23.7 per million in the European Union in 2019.[401]
- The portion of people in prison in Portugal for drug offenses has fallen from over 40% in 2001 to 15.7% in 2019. The average for Europe has increased from 14% to 18% over the last twenty years.[402]

Case study: Portugal

- Levels of drug use have been below the European average for the past twenty years; among 15 – 34 year olds, it has among the lowest drug use rates in the region.[401]
- "High risk" opioid use declined between 2001 and 2015 but remains above the European average.[401,403,404]
- New HIV diagnoses associated with injection drug use fell precipitously after reform. In 2001, Portugal had 50% of all such cases in the EU. In 2019, it had 1.68% of the total. Portugal's trends were stronger than the rest of Europe, which also saw a decline in new HIV diagnoses.[398,405,406]
- The number of new hepatitis C infections dropped consistently over the last twenty years.[401]
- The number of outpatient treatment units grew from 50 to 70 from 2000 to 2009.[404] However, the number of people in treatment declined from 2009 to 2018, which may be linked to the reduction of health and social services budgets following the global financial crisis.[407] It also may be tied to the reduction in problematic use.[404]

Clearly, there have been positive public safety and health outcomes associated with the drug strategy implemented in 2021.

At the same time, community groups and researchers have raised important considerations about the policy change. A few key points include:

- While the policy was originally created to support people with entrenched drug use disorders, the reality is that most people referred to the Dissuasion Committees are non-dependent cannabis users. This has had the unintended consequence of net-widening, bringing more people into contact with the government.[408]
- Many of the harm reduction services recommended in the 2001 report, including overdose prevention sites (or drug consumption rooms, as they are commonly called in Europe), were not implemented until the last few years.[409]
- Portugal replaced criminal sanctions with administrative sanctions, which means that drug use and possession continue to be stigmatized under the law. Researchers and organizations led by people who use drugs have called for an approach to drugs rooted in human rights and autonomy, and they note that health-based approaches like Dissuasion Committees can continue to enforce stigma and modes of penalization.[322,410]
- Cuts to the health budget have been significant and increases in overdose and crime have followed (though there are no causal links between the two established in research). Specifically, Portugal decentralized its drug oversight program in 2012, following the global economic crisis. Funding dropped from the equivalent of $82.7 million to $17.4 million. João Goulão, the director of Portugal's drug's agency and the architect of the reform plan, blames depleted funding for the decline in people entering drug treatment (from 1,150 in 2015 to 352 in 2021).[411]

The media and Portuguese law enforcement have made much of an increase in overdose rates in Lisbon and increased crime in Porto, tying them to the decriminalization of drugs in 2001, without evidence.[411,412] In fact, drug use and overdose rose globally in the context of COVID-19.[413]

Women, pregnant and parenting persons, and caregivers

Among many substance use and treatment utilization metrics, both nationally and in Minnesota, men constitute the majority.[3,414] Women, however, can be pre-disposed to substance use due to gender violence, economic marginalization, and persistent poverty, as well as degrading and sexist interactions with social institutions. This is often compounded by a medical and drug treatment system that often neglects the specific needs of women, including those during pregnancy and while parenting. Women of color experience the intersection of both racism and sexism and experience compounding risk for substance use and its effects.[415]

A key related trend is the increasing rates of arrest and incarceration of women in the US. In the past few decades, women in the US have been incarcerated at twice the rate of men.[416] Women who are incarcerated reflect a more disadvantaged, impoverished, and marginalized experience than women in the general population. They report high rates of trauma, houselessness, joblessness, and physical and mental health conditions. Often due to gender biases in drug policy, the proportion of women detained on drug infractions in prisons and jails is higher than that of men.[1] Importantly, over half of incarcerated women meet criteria for substance use disorders.[31]

There are a few areas of specific concern for women when it comes to drug policy. First, gender-sensitive substance use disorder treatment, harm reduction services, and health care should be accessible to all women who want it and tailored to meet women's specific needs. All these services, in addition to other supportive services, need to account for the needs of people who are solo or primary caretakers of children and other family members. People who use drugs who are parenting should never face removal of a child in their care solely due to the use of drugs; evidence shows that this has detrimental effects on people accessing needed care and treatment. Pregnant people should not be penalized or criminalized for drug use during pregnancy, another strong deterrent to seeking prenatal care.[417] Evidence-based treatment, including MOUD, should be made accessible to people during pregnancy.[153]

In Minnesota, laws state that substance abuse during pregnancy is child abuse, and pregnant people have been prosecuted for exposing their unborn children to drugs. It is also one of only three states where substance use during pregnancy can be grounds for involuntary commitment to a treatment program, and one of only four states that require hospitals to drug test people at the time of childbirth if there are drug-related complications at birth.[418] A task force established during the 2023 legislative session will present recommendations on when drug tests should be administered to the pregnant person and the infant, how to support families to access appropriate drug treatment and remain together in instances of caregiver drug misuse, and involuntary civil commitments in pregnancy.

People who engage in sex work

People who use drugs and people engaged in sex work face similar barriers: imprisonment, denial of health care, and stigma. Both groups are at increased risk of HIV. They are also, often, the same people. The medical journal *The Lancet* found that decriminalizing consensual sex work would avert 33-46% of new HIV infections in sex workers and clients over the course of a decade. Criminalizing sex work has also been found to increase the odds of sex without condoms, sexually transmitted infections, and sexual or physical violence perpetrated by clients against sex workers.[419] The evidence-based policies included in this report, like access to harm reduction services and overdose prevention policies, will benefit people engaged in sex work; they would benefit them more if sex work were decriminalized.[420] In the future, state governments should consider the evidence associated with decriminalizing sex work and look at implementation in Belgium and New Zealand and the European Union's deliberations on the policy.[421]

Youth

Just like other special populations, youth deserve access to evidence-based prevention education, protection from punitive responses to drug offenses in school (which can lead youth to enter the school-to-prison pipeline), access to evidence-based and voluntary treatment that suits them, and higher education. The American Academy of Pediatrics, the American Society for Addiction Medicine, and international guidance agree that youth have the right to accurate information about drugs and drug-related harm, the right to protection from harmful misinformation, and the right to privacy.[153,422,423]

However, access to medications for opioid use disorder is even more limited for adolescents and young adults than is it in the general population.[424] Barriers to care include a lack of pediatrician provider training to treat overdose and opioid use disorder, a lack of youth-specific programs, insurance barriers like prior authorizations, and requirements to enroll in behavioral health services before utilizing medication options.[425] Other environmental barriers discussed above, including policies that restrict access to methadone and buprenorphine broadly, also apply to youth.[424] Governments should develop accessible, child-sensitive prevention, drug treatment, and harm reduction services.[153]

In cases where there is concern about drug-related criminality, governments should try to divert youth away from the criminal-legal system and promote rehabilitation over punishment. Youth should not be criminalized for drug use or personal possession of drug.[153]

Despite the widespread implementation of DARE (Drug Abuse Resistance Education), a school-based curriculum, meta-analyses show that the program is ineffective at reducing drug use.[40,426]

DATA COLLECTION AND EVALUATION

Across all areas of drug policy, improvements must be driven by data, and the successes (or failures) of reform must be evaluated with data. Effectively measuring the impacts of drug policy reform is not an impossible task, but it has rarely been done well. For example, the most predominant metric used to measure drug policy is prevalence of use, despite its limited clinical significance and minimal association with policy change.[16] More clinically relevant, and potentially alterable, metrics include the prevalence of drug-related risk behaviors, the prevalence of substance use disorders, and access to and utilization of evidence-based treatments.

The evaluation of drug policy reform also frequently suffers from a lack of alignment between the stated goal of the policy change and the outcomes measured.[16] For example, if a jurisdiction removes or reduces criminal sanctions with the goal of preventing negative sequalae of criminal-legal system involvement, drug-related criminal-legal system involvement following policy change must be measured. Similarly, if improving the health and wellness of people who use drugs is a policy goal, physical and mental health outcomes of PWUD need to be systematically measured, beyond just prevalence of use. Other important metrics include access to care and treatment and infectious disease transmission and acquisition.[16]

The Drug Policy Alliance, in its report "Dismantling the Drug War in the States: A Comprehensive Drug Decriminalization Framework" offers a few data collection recommendations for state and local jurisdictions. States and localities should be required to make available important types of criminal justice data, in order to assess the success of drug policy. These include arrests for drug possession and distribution offenses, possession of paraphernalia, public use and intoxication, loitering, and other drug-related violations. Additionally, law enforcement should collect and make publicly available details about the tactics used leading to arrests, such as any use of force, alleged substances, quantities recovered, and sociodemographic characteristics of the individuals arrested. Last, states and localities should make public all expenditures related to drug offense enforcement.[372]

When the right types are collected and findings are disseminated quickly and accessibly to non-medical, non-academic audiences, data can be a tool to improve health and wellbeing. They can also identify racial, ethnic, and other inequities and reduce disparities. For a thorough examination of how health data can be used to advance equity, see Urban Institute's Principles for Advancing Equitable Data Practice.

We recommend seven principles to guide the ethical collection and oversight of data that can be applied to the evaluation of drug policy:

1. The entire data life cycle, from conceptualization of metrics to collection, analysis, and dissemination should be informed by people with lived and living experience. People who use

drugs, people who have utilized treatment and harm reduction services, and people impacted by the criminal-legal system are closest to the problem and can play key roles in clearly identifying process and outcome measures, interpreting results, and disseminating findings to stakeholder communities.

2. Use data to identify racial inequities and assist in driving policy change. Data can be used strategically to identify key disparities and gaps in treatment access and utilization, morbidity and mortality outcomes, social determinants of health outcomes, and public safety outcomes. Data should be specifically and intentionally collected and stratified to illuminate the experiences of disproportionately affected communities, primarily BIPOC communities, women, and people impacted by houselessness. These data can help fill important gaps in public health data.[1,32,53]

3. Particular attention should be paid to measuring access (and the lack thereof), as well as specific barriers to access. Outcomes such as MOUD availability by county, as well as the policy and administrative restrictions put in place by local authorities and clinics, can provide valuable information to guide policy and practice.

4. Findings, and the data they are based on, should be communicated transparently. Data is a public good, and should be owned, at a maximum, and accessible, at a minimum, by the communities that produce it.

5. Protect individual privacy and confidentiality. It is important to balance the principle of transparency with the principle of individual privacy, in order to reduce any risk of re-identification and minimize the ways in which sensitive data can impact people and communities. One way to ensure this is to minimize the collection of personally identifiable data whenever possible.

6. We know that there are often unintended consequences of policy change, and this is true in the criminal-legal and drug policy arena, just as it is elsewhere. Where there is historical precedent of policy changes inadvertently impacting communities disparately, evidence should be collected pro-actively to track them. Examples of unintended consequences include but are not limited to net widening, up-charging, other areas where there's judicial discretion.

7. Publicly place value on data-driven practice by encouraging and incentivizing evidence-based practices in licensing, accrediting, reimbursement structures. For example, outpatient clinics could be required to regularly report on the modalities of treatment employed, stratified by sociodemographic indicators, with extra documentation required when non-evidence-based treatments are given.

CONCLUSION

Drug use is pervasive: most US adults use legal drugs, and about one-fifth of all adults in the US use illegal drugs.[427] People have always used drugs: they bring pleasure and ease pain and anxiety. They are also associated with personal and public health risks, and these risks are not always tightly correlated to their legality or illegality. Alcohol, for example, with its many known health harms, has long been regulated in a legal market by the government; cannabis, with comparatively few serious health harms, remains illegal under federal law.[428]

Policies/interventions with a strong evidence base

At the outset of this research, we defined successful drug policies as policies and interventions that are associated with:

- Improved health outcomes, as evidenced by measures of morbidity and mortality at the individual level and the population level, as well as improved access to health care and treatment.
- Improved safety outcomes, which we define as decreased violent crime and decreased drug-related health harms.[14]
- Improved socioeconomic outcomes, such as employment, education, poverty, and housing.

After reviewing the evidence, we concluded that the following key policies and interventions **meet these criteria**; see the Results subsections for detailed information about the policies and interventions and their outcomes. (Note that health outcomes, safety outcomes, and socioeconomic outcomes are described across the Results domains. For example, pharmacy access to syringes, described in the Harm Reduction subsection, is associated with positive health outcomes and also does not increase drug-related crime in the area, a safety outcome.)

Health Care

- Medications for opioid use disorder, and telehealth flexibilities that increase their accessibility
- Substance use disorder treatment that is voluntary, available on demand, culturally appropriate, and geographically accessible
- Medicaid coverage for treatment for SUD
- Peer support/recovery coaching
- Across provider types, increased competency working with people who use drugs, including harm reduction techniques and expanding training and education curricula

Harm Reduction

- Safer drug use supplies
- Access to naloxone, including distribution directly to people who use drugs.
- Overdose prevention centers
- Fentanyl test strips

Social Determinants of Health

- Housing First and other programs that ease access to housing for people who use drugs
- Criminal record expungement
- Supporting families to remain together in cases of caretaker drug misuse
- Ensuring access to employment opportunities, public benefits, higher education for people with criminal histories

Drug Policing

- Decriminalization with targeted diversion to health/social services
- Defelonization
- Diversion to drug treatment for people who need it and that is tailored to the individual
- Sentence commutations

Policies/interventions with a mixed or limited evidence base

Evidence is mixed or limited for the following bulleted policies and interventions. See the Subsections for more detail.

Health Care

- Prescription drug monitoring programs

Harm Reduction

- 911 Good Samaritan laws

Drug Policing

- Depenalization
- *De facto* and *de jure* police diversion
- Decriminalization with civil or administrative penalties
- Decriminalization with no sanctions attached
- Regulation

Policies/interventions that do not meet criteria for successful drug policies

We concluded that the following prevalent bulleted policies and interventions **do not meet the criteria for successful drug policies**; see the Results subsections for detailed information about the policies and interventions and their outcomes.

Health Care

- Compulsory treatment
- Involuntary civil commitment
- Policies requiring prior authorization, abstinence, drug screening, and/or counseling before initiating HIV or HCV or SUD treatment
- Prescription drug take-back programs
- Residential rehabilitation houses

Social Determinants of Health

- Restricting access to housing based on criminal history
- Removing children to the foster care system for parental drug misuse
- Policy barriers to employment, education, and public benefits based on criminal history or drug use
- Laws that prohibit public behaviors associated with houselessness, like sleeping or camping in public, begging, and loitering
- Fines, fees, and debt associated with criminal-legal system involvement

Drug Policing

- Arresting people for drug use and criminal repercussions for simple possession
- Imprisoning people for drug use
- Drug paraphernalia laws
- Drug-induced homicide laws
- Opioid-related drug seizures

The failure of contemporary drug policy represents a complex systems problem. Responses to substance use made by one arm of government undermine the responses made by other arms of government. Consider one example of Minnesota taxpayers paying twice for oppositional interventions: until August 2023, the effective date of drug paraphernalia legalization, an individual at an encampment of people experiencing houselessness in Minneapolis could receive evidence-based harm reduction supplies, paid for in part by taxpayer dollars, while law enforcement, also funded by

taxpayer dollars, shut down the encampment and confiscate the same supplies. Similar examples abound across state agencies.

Solving this problem requires not only excising a prohibition-based law enforcement response but replacing it with a new approach. Such a complex systems problem requires a cooperative, cohesive, "whole of government" solution – one that eliminates situations in which agency policies undermine each other and instead work together to make better use of scarce resources and maximize the health and safety of all Minnesotans.

Government bodies have the ability to choose among different policy approaches to respond to products and behaviors associated with risk, like riding motorcycles and consuming tobacco products. They can try to suppress these activities by creating criminal penalties for deterrence, or they can acknowledge their existence and put protections in place to reduce the associated harms.

We have a great deal evidence about the many ways a prohibition-based approach to drug policy does not work. Globally, countries have been implementing alternative models for decades. In the US, states are learning from the experiences of legalizing cannabis and are experimenting with new ways of regulating illicit drug use and possession. We urge lawmakers in Minnesota to follow the evidence.

This report is the first of two commissioned by the Minnesota Legislature, which aimed to (1) review current policies, practices and funding; and (2) describe alternative approaches utilized effectively in other jurisdictions. On March 1, 2025, the research team will present the second and final report on illicit drug use in Minnesota. The final report will be based on the evidence presented in this report and address the third goal of the legislative appropriation: "to make policy and funding recommendations toward a drug policy that reduces and, where possible, prevents harm and expands individual and community health, safety, and autonomy."

APPENDIX A. POLICY RECOMMENDATIONS FOR THE 2024 LEGISLATIVE SEASON.

This table provides a "sneak peek" of insights from the report's data collection phase, specifically from qualitative interviews with Minnesota-based subject matter experts. While these insights will be integrated more formally in the final report in 2025, we provide them here so as not to miss any opportunities for legislative action.

Theme	Policy problem	Potential policy fix	Effort Required[1]	Resource
Health Care	People under age 18 lack access to peer support services.	Remove the age minimum for reimbursement for peer recovery services	Small	
Health Care	Lack of access to medications for opioid use disorder and peer support for people experiencing non-fatal overdose in Emergency Departments.	In all Emergency Departments, create access to buprenorphine and peer recovery support for people being seen for non-fatal overdose.	Large	https://www.nyc.gov/site/doh/about/press/pr2023/relay-overdose-prevention-program-expands-to-15th-nyc-hospital.page
Health Care	Some SUD treatment providers do not want to provide evidence-based medications for opioid use disorder.	Mandate that all substance use disorder treatment providers must offer evidence-based medications for opioid use disorder.	Large	
Health Care	Not all private insurers cover buprenorphine.	None offered.	Medium	
Health Care	State support for non-evidence based care, especially in prevention/education and treatment, is not a good use of taxpayer dollars.	None offered.	Large	
Health Care	Lack of access to MOUD in jails and prisons and continuity of care at community re-entry. Related to this, people in detention settings lose access to Medicaid coverage, which poses barriers to continuity of care at release.	Application (and approval) for a Medicaid Re-entry Section 1115 waiver. See detailed recommendations in the Year-end Report from the Governor's Advisory Council on Opioids, Substance Use, and Addiction.	Large	https://mn.gov/mmb/assets/gacosua-year-end-report-2023_tcm1059-607070.pdf
Health Care	Ongoing shortages in behavioral health workforce limit access to services.	Invest in behavioral health workforce, especially peers. See also detailed recommendations regarding peer recovery specialists in jails and prison in the Year-end Report from the Governor's Advisory Council on Opioids, Substance Use, and Addiction.	Medium	https://mn.gov/mmb/assets/gacosua-year-end-report-2023_tcm1059-607070.pdf
Health Care	Lack of access to evidence-based treatment for substance use disorder in rural areas.	Scale use of ECHO model.	Medium	

Theme	Policy problem	Potential policy fix	Effort Required[1]	Resource
Health Care	Lack of access to medications for opioid use disorder.	Increase the number of providers providing buprenorphine and methadone.	Medium	
Health Care	Behavioral health workforce shortage restricts access to services	Offer trainings for peer workers	Small	
Health Care	Need for transparency around what therapy modalities doctors are providing.	None offered.	Large	
Health Care	Significant uptick in requests for prior authorizations from insurers, including for medications to treat hepatitis C, pose barriers to healthcare treatment.	None offered.	Small	
Health Care	Healthcare providers avoid seeking needed treatment for substance use disorder for fear of losing their licenses.	Changes to licensure questionnaire to encourage providers to seek drug treatment.	Small	
Health Care	Lack of funding for translation services at SUD treatment facilities.	State Medicaid dollars should fund translation services	Small	
Health Care	Great deal of variability in outcomes and modalities among substance use disorder treatment providers.	Bring evidence-based standards to all SUD treatment providers, including credentialing and accountability.	Large	
Health Care	Need for culturally specific substance use disorder treatment programs.	Support culturally competent modes of recovery in addition to MOUD. See also detailed recommendations in the Year-end Report from the Governor's Advisory Council on Opioids, Substance Use, and Addiction.	Medium	https://mn.gov/mmb/assets/gacosua-year-end-report-2023_tcm1059-607070.pdf
Health Care	Statutes governing methadone go above and beyond the federal government's standards.	Align Minnesota's statues with the federal standards for methadone.	Small	
Health Care, Harm Reduction	Room to better integrate state's harm reduction services, housed primarily within MDH, and state's treatment and recovery services, housed primarily within DHS.	The Governor's Office of Addiction and Recovery is working on coordination and integration through a National Governors Association Policy Academy. This is also part of the Crossroads to Justice Plan from the Minnesota Interagency Council on Homelessness.	Large	https://mich.mn.gov/crossroads-justice-minnesotas-new-pathways-housing-racial-and-health-justice-people-facing-0
Harm Reduction	Minnesota's Good Samaritan law does not provide adequate protection from criminal or civil repercussions to people who witness an overdose, discouraging them from calling for help.	Add protections to "Steve's Law," Minnesota's Good Samaritan law.	Small	
Harm Reduction	Lack of access to the opioid overdose antidote naloxone.	All drug formularies should cover the purchase of over-the-counter naloxone.	Medium	

Theme	Policy problem	Potential policy fix	Effort Required[1]	Resource
Harm Reduction	High rates of fatal overdose.	Continue to support naloxone saturation across the state. Investigate State of California's naloxone portal as a model for increasing access to the opioid overdose antidote.	Medium	https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx
Harm Reduction	Budget allocation for "safe recovery spaces" during 2023 session opened the door for safe consumption sites, but more protective language is required for organizations to feel safe opening such spaces.	Statutory language allowing for the existence of "safe recovery sites."	Medium	
Social Determinants of Health	Criminal records restrict access to housing, employment, and other basic needs.	Automatic or simple record expungement for non-violent drug offenses. [Authors' note: the Clean Slate Act, passed during the 2023 session, goes into effect on January 1, 2025. Eligibility rules are TBD.)	Small	https://dps.mn.gov/divisions/bca/expungements/Pages/default.aspx
Social Determinants of Health	Lack of safe, affordable permanent housing and shelter options for people who use drugs and with substance use disorders.	None offered. See recommendations in Crossroads to Justice: Minnesota's New Pathways to Housing, Racial, and Health Justice for People Facing Homelessness	Large	https://mich.mn.gov/crossroads-justice-minnesotas-new-pathways-housing-racial-and-health-justice-people-facing-0
Social Determinants of Health	A punitive response to drug use has led to a large number of children of color being removed from their homes.	None offered.	Large	
Social Determinants of Health	DHS licensure rules that disqualify people for drug offenses are inequitable and pose barriers to employment.	See detailed recommendations in the Year-end Report from the Governor's Advisory Council on Opioids, Substance Use, and Addiction.	Medium	https://mn.gov/mmb/assets/gacosua-year-end-report-2023_tcm1059-607070.pdf
Social Determinants of Health	Ongoing sweeps of encampment of people living outside exacerbate overdose and health harms.	Cities require oversight from state in regards to encampment sweeps. See recommendations in Crossroads to Justice: Minnesota's New Pathways to Housing, Racial, and Health Justice for People Facing Homelessness	Large	https://mich.mn.gov/crossroads-justice-minnesotas-new-pathways-housing-racial-and-health-justice-people-facing-0
Social Determinants of Health	Sober homes may exclude people for using prescribed medications, including medications for opioid use disorder.	Prevent sober homes from excluding people on the basis of the medications they take.	Medium	
Drug Policing	Lack of proactive, intentional, evidence-based review of drug scheduling tables.	None offered.	Medium	
Drug Policing	People continue to be prosecuted for drug residue if the residue is contained in other than drug paraphernalia, outside the spirit of the law changed in the 2023 session.	Amend the definition of residue in § 152.025, Subd. 2 to close this loophole.	Small	

Theme	Policy problem	Potential policy fix	Effort Required[1]	Resource
Special Populations	Lack of state funding for Black-led organizations working on drug use in Black communities.	State agencies should fund Black-led organizations directly, as funding distributed via RFP do not reach these groups. In addition, see detailed recommendations in the Year-end Report from the Governor's Advisory Council on Opioids, Substance Use, and Addiction.	Medium	https://mn.gov/mmb/assets/gacosua-year-end-report-2023_tcm1059-607070.pdf
Special Populations	Lack of perspective from people with lived or living experience at OERAC. One or two representatives from these communities is not enough.	Consider forming councils of people lived or living experience to advise OERAC.	Small	
Special Populations	Lack of perspective from and dedicated services for Hmong and East African people who use drugs.	None offered.	Medium	
Special Populations	Large gap in services (housing, shelter, SUD treatment) for women who use drugs and are trying to leave violent situations.	None offered. See recommendations in Crossroads to Justice: Minnesota's New Pathways to Housing, Racial, and Health Justice for People Facing Homelessness	Large	https://mich.mn.gov/crossroads-justice-minnesotas-new-pathways-housing-racial-and-health-justice-people-facing-0

[1]Effort required = The authors' best guess as to the level of effort required to promulgate a policy solution, implement the policy solution, or both.

APPENDIX B. SUMMARY OF GUIDANCE AND RECOMMENDATIONS ISSUED BY GOVERNMENT, MEDICAL, AND OTHER EXPERT BODIES.

US/Global	Title	Source	Date	Conclusion	URL
US	Drug Overdose: Promising Strategies	Center for Disease Control and Prevention	n.d.	To prevent overdose and enhance health, improve prescribing practices, increased access to evidence-based treatment, expand access to naloxone, consider Good Samaritan laws, and more.	https://www.cdc.gov/drugoverdose/strategies/index.html
US	A Transformative Whole-of-Government Model to Reduce Opioid Use Harms and Deaths	Center for Public Health Law Research, Temple University Beasley School of Law	2023	Different arms of the government are working in opposition to one another in traditional drug policy approaches. Recommends drug decriminalization as the key component of transforming drug policy.	https://phlr.org/sites/default/files/uploaded_images/CPHLR-WGDrugPolicy_Pt1-WGModelandRecs.pdf
US	Harm Reduction Framework	Substance Abuse and Mental Health Services Administration	2023	The first document to comprehensively outline harm reduction and its role within the federal government's Department of Health and Human Services. Defines harm reduction six principles, twelve supporting pillars, and core practice areas.	https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf
US	Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies	National Academy of Medicine	2023	A socioecological approach to prevention identifies additional structural factors that can contribute to the development of substance use disorder and overdose risk, including housing, welfare, and criminal-legal system policies.	https://nam.edu/primary-secondary-and-tertiary-prevention-of-substance-use-disorders-through-socioecological-strategies/
US	Reduction of Public Health Consequences and Public Health Consequences of Drug Use	American Medical Association	2023	Recommends expanding harm reduction measures, medications for opioid use disorder, removing laws that restrict access to syringe services programs, and fully evaluating US state-based drug legalization models.	https://policysearch.ama-assn.org/policyfinder/detail/*?uri=%2FAMADoc%2FHOD.xml-0-5333.xml
US	Support, don't punish: Drug decriminalization is harm reduction	American Pharmacists Association	2023	Decriminalization of drug use and possession is urgently needed. Decriminalization will reduce the negative impacts of drug use and keep communities healthy and safe.	https://pubmed.ncbi.nlm.nih.gov/36682855/#:~:text=Decriminalization%20of%20drug%20use%20and,keeping%20communities%20safe%20and%20healthy.

US	Decriminalization of Simple Possession of Illicit Drugs Policy	Minnesota Medical Association	2022	Remove criminal penalties associated with simple possession, release people who are currently incarcerated for simple possession, and expunge criminal records associated with simple possession. Expand statewide access to harm reduction and medications for opioid use disorder.	https://www.mnmed.org/application/files/3916/8676/6277/MMA_Decriminalization_HR_Policies.pdf
US	National Drug Control Strategy	Office of National Drug Control Policy	2022	The federal government's drug strategy document focuses on seven key areas, among them expanding access to evidence-based treatment, particularly medications for opioid use disorder; advancing racial equity; enhancing harm reduction efforts; reducing the supply of illicit substances; and expanding access to recovery services.	https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf
US	Public Policy Statement on Racial Justice Beyond Health Care: Addressing the Broader Structural Issues at the Intersection of Racism, Drug Use, and Addiction	American Society of Addiction Medicine	2022	Highlighting racial disparities in the criminal response, recommends shifting the national response to personal drug use away from criminality and toward health and wellness. ASAM recommends policy responses to address the social determinants of health, like removing bans on TANF and SNAP and housing for people who commit drug offenses.	https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/advocacy/racial-justice/2022-pps-recs-on-adv-rj-beyond-health-care.pdf?sfvrsn=f4e11c74_5
US	Addiction Should Be Treated, Not Penalized	National Institute on Drug Abuse	2021	Substance use disorder should be treated with high quality care and compassion. A punitive approach is ineffective and exacerbates racial disparities.	https://nida.nih.gov/about-nida/noras-blog/2021/05/addiction-should-be-treated-not-penalized
US	Advancing Public Health Interventions to Address the Harms of the Carceral System	American Public Health Association	2021	To advance the public's health, calls for evidence-based policies that reduce the number of people who are incarcerated, invest more in social determinants of health like housing and employment, explore restorative and transformative justice, and investing in community-based mental health care.	https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Advancing-Public-Health-Interventions-to-Address-the-Harms-of-the-Carceral-System
US	Collateral Consequences: The Crossroads of Punishment, Redemption, and the Effects on Communities	US Civil Rights Commission	2019	Racial discrimination in collateral consequences constitutes a civil rights issues. Recommends that policymakers roll back and avoid punitive mandatory consequences that don't serve public safety, are not connected to the offense committed, and impede people from entering and contributing to society. This includes restrictions on TANF and SNAP, housing, student loans, and employment.	https://www.usccr.gov/files/pubs/2019/06-13-Collateral-Consequences.pdf
US	Four Decades and Counting: The Continued Failure of the War on Drugs	Cato Institute	2017	Drug criminalization is associated with significant economic costs. Decriminalization and legalization should be considered at the state, federal, and international levels.	https://www.cato.org/sites/cato.org/files/pubs/pdf/pa-811-updated.pdf

US	Every 25 Seconds: The Human Toll of Criminalizing Drug Use in the United States	Human Rights Watch	2016	Criminalizing drug use does not prevent problematic use. Recommends instead that governments end criminalization of simple possession, as well as expand access to prevention education and evidence-based treatment available outside the court and prison system.	https://www.hrw.org/sites/default/files/report_pdf/usdrug1016_web_0.pdf
US	Defining and Implementing a Public Health Response to Drug Use and Misuse	American Public Health Association	2013	Finds that a criminal-legal system response to drug use and misuse is ineffective and leads to other public health problems. Recommends ending the criminalization of drugs and people who use drugs and prioritizing health and harm reduction approaches, and asks all stakeholders to pivot toward a health approach and examine promising practices implemented in other jurisdictions.	https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse
Global	HIV, Hepatitis & Drug Policy Reform	Global Commission on Drug Policy	2023	Calls for countries to make several policy changes to reduce HIV and Hepatitis C, including decriminalizing drug use, drug possession for personal use, and the possession of drug paraphernalia; ensure that health and harm reduction services are widely available; and consider legal regulation of drugs as a way to combat illicit drug markets.	https://www.globalcommissionondrugs.org/reports/hiv-hepatitis-drug-policy-reform
Global	Human rights challenges in addressing and countering all aspects of the world drug problem	United Nations Office of the High Commissioner for Human Rights	2023	Offers roughly twenty recommendations for developing effective drug policies rooted in human rights, including considering decriminalization of drug use and developing regulatory systems for legal access to all controlled substances, ensuring that drug treatment is voluntary, protecting against discrimination, and funding harm reduction services.	https://www.ohchr.org/en/documents/thematic-reports/ahrc5453-human-rights-challenges-addressing-and-countering-all-aspects
Global	The 8 March Principles for a Human Rights-Based Approach to Criminal Law Proscribing Conduct Associated with Sex, Reproduction, Drug Use, HIV, Homelessness and Poverty	International Commission of Jurists	2023	Addresses the harmful human rights impacts of criminal laws targeting vulnerable groups, among them people who use drugs, sell sex, are living with HIV, and are experiencing homelessness and poverty - with many intersections among them. Criminal laws targeting these groups punish, stigmatize, and deny services and rights to individuals.	https://share-netinternational.org/wp-content/uploads/2023/03/8-MARCH-Principles-FINAL-printer-version-1-MARCH-2023.pdf
Global	Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances	Health Canada Expert Task Force on Substance Use	2021	End criminal penalties related to simple possession, and end all coercive measures related to simple possession and consumption.	https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf

Global	Time to End Prohibition	Global Commission on Drug Policy	2021	Recommends replacing prohibition with increased focus on health and safety outcomes, focusing enforcement on organized crime, and regulating all drugs using cannabis as a model.	https://www.globalcommissionondrugs.org/wp-content/uploads/2021/12/Time_to_end_prohibition_EN_2021_report.pdf
Global	International Guidelines on Human Rights and Drug Policy	International Centre for Human Rights in Drug Policy, UNAIDS, UN Development Program, World Health Organization	2019	The Guidelines apply existing human rights law to drug control laws and policies.	https://www.humanrights-drugpolicy.org/about/
Global	United Nations Common Position on Drugs	United Nations System Chief Executives Board for Coordination	2018	A joint commitment of all relevant United Nations bodies to protect human rights in international drug control policies. Promotes alternatives to conviction and punishment, including decriminalization of drug possession for personal use. Calls for changes in drug laws and policies that threaten people's health and human rights.	https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf
Global	Public health and international drug policy	Johns Hopkins-Lancet Commission on Drug Policy and Health	2016	Recommends an evidence-based approach to drug policy that includes decriminalization of minor drug offenses; reducing violence associated with drug policing; easy access to harm reduction services and evidence-based and voluntary treatment; and moving gradually toward regulated drug markets with rigorous evaluation.	https://linkinghub.elsevier.com/retrieve/pii/S0140673616006 19X
Global	The Drug Problem in the Americas	Organization of American States	2013	A public health approach is needed to address drug use, and decriminalization of drug use should be a core element of any public health strategy. Adequate funding is needed to make treatment accessible.	https://www.oas.org/documents/eng/press/introduction_and_analytical_report.pdf

BIBLIOGRAPHY

1. Csete, J. *et al.* Public health and international drug policy. *The Lancet* **387**, 1427–1480 (2016).
2. National Center for Health Statistics. Minnesota. https://www.cdc.gov/nchs/pressroom/states/minnesota/mn.htm (2023).
3. Minnesota Department of Health. Drug Overdose Dashboard. https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html (2023).
4. Opioids Overdose Dashboard Data.
5. Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health. (2022).
6. 2022 Uniform Crime Report. (2022).
7. Minnesota Department of Corrections. *Individuals Incarcerated for Drug Offenses*. https://mn.gov/doc/assets/Individuals%20Incarcerated%20for%20Drug%20Offenses_tcm1089-419995.pdf (2024).
8. Moriearty, P. *Racial Disparities in the Minnesota Criminal Justice System*. https://www.house.mn.gov/comm/docs/b5447814-8afe-4898-b491-61c0b7fb6a28.pdf (2020).
9. Harrington, J., Evans, D., Gotz, D. & Rush, K. State of Minnesota Minnesota Crime Information - 2020. (2020).
10. Terry, N. P. & Burris, S. C. A 'Whole of Government' Approach to Reforming Opioid Use Disorder Legal and Policy Strategies. *SSRN Electron. J.* (2023) doi:10.2139/ssrn.4650706.
11. Ollila, E. Health in All Policies: from rhetoric to action. *Scand. J. Public Health* **39**, 11–18 (2011).
12. Pan American Health Organization/World Health Organization. Social Determinants of Health. https://www.paho.org/en/topics/social-determinants-health.
13. Terry, N., Johnson, S., Larsen, J. & Burris, S. *The Legal Path to a Whole-of-Government Opioids Response: Part 1*. https://phlr.org/sites/default/files/uploaded_images/CPHLR-WGDrugPolicy_Pt1-WGModelandRecs.pdf (2023).
14. Stevens, A., Hughes, C. E., Hulme, S. & Cassidy, R. Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. *Eur. J. Criminol.* **19**, 29–54 (2022).
15. International Narcotics Control Board. *Report of the International Narcotics Board for 2014*. https://www.incb.org/incb/en/publications/annual-reports/annual-report-2014.html (2015).
16. Scheim, A. I. *et al.* Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review. *BMJ Open* **10**, e035148 (2020).
17. Schuler, M. S., Griffin, B. A., Cerdá, M., McGinty, E. E. & Stuart, E. A. Methodological challenges and proposed solutions for evaluating opioid policy effectiveness. *Health Serv. Outcomes Res. Methodol.* **21**, 21–41 (2021).
18. Heimer, R. *et al.* Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016–17. *Drug Alcohol Depend.* **254**, 111040 (2024).
19. MacArthur, G. J. *et al.* Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. *BMJ* **345**, e5945 (2012).

20. Mattick, R. P., Breen, C., Kimber, J. & Davoli, M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database Syst. Rev.* (2009) doi:10.1002/14651858.CD002209.pub2.

21. Sordo, L. *et al.* Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ* **357**, j1550 (2017).

22. Mauro, P. M., Gutkind, S., Annunziato, E. M. & Samples, H. Use of Medication for Opioid Use Disorder Among US Adolescents and Adults With Need for Opioid Treatment, 2019. *JAMA Netw. Open* **5**, e223821 (2022).

23. Williams, A. R. *et al.* Retention and critical outcomes among new methadone maintenance patients following extended take-home reforms: a retrospective observational cohort study. *Lancet Reg. Health – Am.* **28**, (2023).

24. Netherland, J. & Hansen, H. White opioids: Pharmaceutical race and the war on drugs that wasn't. *BioSocieties* **12**, 217–238 (2017).

25. Schuler, M. S., Dick, A. W. & Stein, B. D. Growing racial/ethnic disparities in buprenorphine distribution in the United States, 2007–2017. *Drug Alcohol Depend.* **223**, 108710 (2021).

26. Binswanger, I. A., Blatchford, P. J., Mueller, S. R. & Stern, M. F. Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009. *Ann. Intern. Med.* **159**, 592–600 (2013).

27. Merrall, E. L. C. *et al.* Meta-analysis of drug-related deaths soon after release from prison: Drug-related deaths after release from prison. *Addiction* **105**, 1545–1554 (2010).

28. Binswanger, I. A. *et al.* Release from prison–a high risk of death for former inmates. *N. Engl. J. Med.* **356**, 157–165 (2007).

29. Cerdá, M. *et al.* A Critical Review of the Social and Behavioral Contributions to the Overdose Epidemic. *Annu. Rev. Public Health* **42**, 95–114 (2021).

30. Davis, C., Green, T., LaSalle, L. & Beletsky, L. State Approaches to Addressing the Overdose Epidemic: Public Health Focus Needed. *J. Law. Med. Ethics* **47**, 43–46 (2019).

31. Stallwitz, A. & Stöver, H. The impact of substitution treatment in prisons - A literature review. *Int. J. Drug Policy* **18**, 464–74 (2007).

32. Office of National Drug Control Policy. *National Drug Control Strategy*. https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf (2022).

33. Kaltenbach, K., Berghella, V. & Finnegan, L. Opioid dependence during pregnancy. Effects and management. *Obstet. Gynecol. Clin. North Am.* **25**, 139–151 (1998).

34. Jones, H. E., Finnegan, L. P. & Kaltenbach, K. Methadone and Buprenorphine for the Management of Opioid Dependence in Pregnancy. *Drugs* **72**, 747–757 (2012).

35. Phillippi, J. C. *et al.* Reproductive-Age Women's Experience of Accessing Treatment for Opioid Use Disorder: "We Don't Do That Here". *Womens Health Issues* **31**, 455–461 (2021).

36. Martin, C. E., Longinaker, N. & Terplan, M. Recent trends in treatment admissions for prescription opioid abuse during pregnancy. *J. Subst. Abuse Treat.* **48**, 37–42 (2015).

37. Henkhaus, Buntin, Henderson, Lai, & Patrick. Disparities in Receipt of Medications for Opioid use Disorder among Pregnant Women. *Subst. Use Addict.* **43**, 508–513 (2022).

38. Schiff, D. M. *et al.* Assessment of Racial and Ethnic Disparities in the Use of Medication to Treat Opioid Use Disorder Among Pregnant Women in Massachusetts. *JAMA Netw. Open* **3**, e205734 (2020).

39. Angelotta, C., Weiss, C. J., Angelotta, J. W. & Friedman, R. A. A Moral or Medical Problem? The Relationship between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women. *Womens Health Issues* **26**, 595–601 (2016).

40. Strang, J. *et al*. Drug policy and the public good: evidence for effective interventions. *The Lancet* **379**, 71–83 (2012).

41. Babor, T. F. *et al*. Drug Policy and the Public Good: a summary of the second edition. *Addiction* **114**, 1941–1950 (2019).

42. Gossop, M., Stewart, D. & Marsden, J. Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: a 5-year follow-up study. *Addiction* **103**, 119–125 (2008).

43. Humphreys, K. & Moos, R. Can Encouraging Substance Abuse Patients to Participate in Self-Help Groups Reduce Demand for Health Care? A Quasi-Experimental Study. *Alcohol. Clin. Exp. Res.* **25**, 711–716 (2001).

44. National Collaborating Centre for Mental Health (UK). *Drug Misuse: Psychosocial Interventions*. (British Psychological Society (UK), Leicester (UK), 2008).

45. Prendergast, M., Podus, D., Finney, J., Greenwell, L. & Roll, J. Contingency management for treatment of substance use disorders: a meta-analysis. *Addict. Abingdon Engl.* **101**, 1546–1560 (2006).

46. Ronsley, C. *et al*. Treatment of stimulant use disorder: A systematic review of reviews. *PLOS ONE* **15**, e0234809 (2020).

47. Center for Substance Abuse Treatment. Brief Interventions in Substance Abuse Treatment. in *Brief Interventions and Brief Therapies for Substance Abuse* (Substance Abuse and Mental Health Services Administration (US), Rockville, MD, 1999).

48. Kelly, J. F., Bergman, B. G., Hoeppner, B. B., Vilsaint, C. & White, W. L. Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy. *Drug Alcohol Depend.* **181**, 162–169 (2017).

49. Carver, H., Ring, N., Miler, J. & Parkes, T. What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography. *Harm. Reduct. J.* **17**, 10 (2020).

50. Drug Policy Alliance. *Protecting Our Communities*. https://drugpolicy.org/wp-content/uploads/2023/09/2023.09.13_Communities_Toolkit_FINAL.pdf (2023).

51. Ali, R. & Stevens, M. Moving toward Voluntary Community-Based Treatment for Drug Use and Dependence. *Health Hum. Rights* **24**, 183–187 (2022).

52. Werb, D. *et al*. The effectiveness of compulsory drug treatment: A systematic review. *Int. J. Drug Policy* **28**, 1–9 (2016).

53. American Society of Addiction Medicine. *Public Policy Statement on Racial Justice Beyond Healthcare: Addressing the Broader Structural Issues at the Intersection of Racism, Drug Use, and Addiction*. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/advocacy/racial-justice/2022-pps-recs-on-adv-rj-beyond-health-care.pdf?sfvrsn=f4e11c74_5 (2022).

54. Forati, A. M., Ghose, R. & Mantsch, J. R. Examining Opioid Overdose Deaths across Communities Defined by Racial Composition: a Multiscale Geographically Weighted Regression Approach. *J. Urban Health* **98**, 551–562 (2021).

55. Hyder, A. *et al*. Opioid Treatment Deserts: Concept development and application in a US Midwestern urban county. *PLOS ONE* **16**, e0250324 (2021).

56. Joudrey, P. J., Edelman, E. J. & Wang, E. A. Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States. *JAMA* **322**, 1310–1312 (2019).

57. Advisory: Low Barrier Models of Care for Substance Use Disorders.

58. Hood, J. E. *et al*. Engaging an Unstably Housed Population with Low-Barrier Buprenorphine Treatment at a Syringe Services Program: Lessons Learned from Seattle, Washington. *Subst. Abuse* **41**, 356–364 (2020).

59. Aronowitz, S. V., Behrends, C. N., Lowenstein, M., Schackman, B. R. & Weiner, J. Lowering the Barriers to Medication Treatment for People with Opioid Use Disorder.

60. Latimore, A. D. *et al*. Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies. *NAM Perspect.* (2023) doi:10.31478/202309b.

61. Kravitz-Wirtz, N. *et al*. Association of Medicaid Expansion With Opioid Overdose Mortality in the United States. *JAMA Netw. Open* **3**, e1919066 (2020).

62. Centers for Disease Control and Prevention. *Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States*. https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf (2018).

63. Parker, A. M., Strunk, D. & Fiellin, D. A. State Responses to the Opioid Crisis. *J. Law. Med. Ethics* **46**, 367–381 (2018).

64. Dowell, D., Zhang, K., Noonan, R. K. & Hockenberry, J. M. Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates. *Health Aff. (Millwood)* **35**, 1876–1883 (2016).

65. Popovici, I., Maclean, J. C., Hijazi, B. & Radakrishnan, S. The effect of state laws designed to prevent nonmedical prescription opioid use on overdose deaths and treatment. *Health Econ.* **27**, 294–305 (2018).

66. Adams, N., Gundlach, E. & Cheng, C.-W. An Analysis of State-Level Policies and Opioid Overdose Deaths. *West. J. Nurs. Res.* **42**, 535–542 (2020).

67. Ansari, B., Tote, K. M., Rosenberg, E. S. & Martin, E. G. A Rapid Review of the Impact of Systems-Level Policies and Interventions on Population-Level Outcomes Related to the Opioid Epidemic, United States and Canada, 2014-2018. *Public Health Rep.* **135**, 100S-127S (2020).

68. Fink, D. S. *et al*. Association Between Prescription Drug Monitoring Programs and Nonfatal and Fatal Drug Overdoses. *Ann. Intern. Med.* **168**, 783–790 (2018).

69. Mauri, A. I., Townsend, T. N. & Haffajee, R. L. The Association of State Opioid Misuse Prevention Policies With Patient- and Provider-Related Outcomes: A Scoping Review. *Milbank Q.* **98**, 57–105 (2020).

70. Dowell, D., Haegerich, T. M. & Chou, R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. *JAMA* **315**, 1624–1645 (2016).

71. Trooskin, S. B., Dore, G. & Kostman, J. We Must Do Better: Addressing HCV Treatment Barriers in Persons Who Inject Drugs in the United States. *J. Infect. Dis.* **222**, S773–S781 (2020).

72. U.S. Department of Justice Civil Rights Division. Opioid Use Disorder. *ADA.gov* https://www.ada.gov/topics/opioid-use-disorder/ (2024).

73. Medications for the Treatment of Opioid Use Disorder. *Federal Register* https://www.federalregister.gov/documents/2024/02/02/2024-01693/medications-for-the-treatment-of-opioid-use-disorder (2024).

74. Shatterproof Treatment Atlas. National Principles of Care. https://treatmentatlas.org/national-principles-care.

75. Substance Abuse and Mental Health Services Administration. The 42 CFR Part 8 Final Rule Table of Changes. https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/42-cfr-part-8/final-rule-table-changes (2024).

76. Dennis, C.-L. Peer support within a health care context: a concept analysis. *Int. J. Nurs. Stud.* **40**, 321–332 (2003).

77. du Plessis, C., Whitaker, L. & Hurley, J. Peer support workers in substance abuse treatment services: A systematic review of the literature. *J. Subst. Use* **25**, 225–230 (2020).

78. Eddie, D. *et al.* Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching. *Front. Psychol.* **10**, (2019).

79. Mercer, F. *et al.* Peer Support and Overdose Prevention Responses: A Systematic 'State-of-the-Art' Review. *Int. J. Environ. Res. Public. Health* **18**, 12073 (2021).

80. Myrick, K. & Del Vecchio, P. Peer support services in the behavioral healthcare workforce: State of the field. *Psychiatr. Rehabil. J.* **39**, 197–203 (2016).

81. Biancarelli, D. L. *et al.* Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug Alcohol Depend.* **198**, 80–86 (2019).

82. American Public Health Association. Defining and Implementing a Public Health Response to Drug Use and Misuse. *Policy Statements and Advocacy* https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse (2013).

83. Office of National Drug Control Policy. *Plan to Address Methamphetamine Supply, Use, and Consequences*. https://www.whitehouse.gov/wp-content/uploads/2022/05/ONDCP-Plan-to-Address-Methamphetamine-Supply-Use-and-Consequences.pdf (2022).

84. Wild, T. C. Compulsory Substance-User Treatment and Harm Reduction: A Critical Analysis. *Subst. Use Misuse* **34**, 83–102 (1999).

85. Christopher, P. P., Anderson, B. & Stein, M. D. Civil Commitment Experiences among Opioid Users. *Drug Alcohol Depend.* **193**, 137–141 (2018).

86. Wodak, A. & Lurie, P. A Tale of Two Countries: Attempts to Control HIV among Injecting Drug Users in Australia and the United States. *J. Drug Issues* **27**, 117–134 (1997).

87. Stimson, G. V. Aids and injecting drug use in the United Kingdom, 1987–1993: The policy response and the prevention of the epidemic. *Soc. Sci. Med.* **41**, 699–716 (1995).

88. Ritter, A. & Cameron, J. A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drug Alcohol Rev.* **25**, 611–624 (2006).

89. Werb, D. *et al.* Interventions to prevent the initiation of injection drug use: a systematic review. *Drug Alcohol Depend.* **133**, 669–676 (2013).

90. Coyle, S. L., Needle, R. H. & Normand, J. Outreach-based HIV prevention for injecting drug users: a review of published outcome data. *Public Health Rep.* **113**, 19–30 (1998).

91. Centers for Disease Control and Prevention. Injection Drug Use. https://www.cdc.gov/hiv/risk/drugs/index.html (2022).

92. Centers for Disease Control. Hepatitis C Surveillance 2021. https://www.cdc.gov/hepatitis/statistics/2021surveillance/hepatitis-c.htm (2023).

93. Aspinall, E. J. *et al.* Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *Int. J. Epidemiol.* **43**, 235–248 (2014).

94. Jakubowski, A., Fowler, S. & Fox, A. D. Three decades of research in substance use disorder treatment for syringe services program participants: a scoping review of the literature. *Addict. Sci. Clin. Pract.* **18**, 40 (2023).

95. Lambdin, B. H. *et al.* Overdose Education and Naloxone Distribution Within Syringe Service Programs — United States, 2019. *Morb. Mortal. Wkly. Rep.* **69**, 1117–1121 (2020).

96. Peiper, N. C. *et al*. Fentanyl test strips as an opioid overdose prevention strategy: Findings from a syringe services program in the Southeastern United States. *Int. J. Drug Policy* **63**, 122–128 (2019).

97. Latkin, C. A., Davey, M. A. & Hua, W. Needle Exchange Program Utilization and Entry into Drug User Treatment: Is There a Long-Term Connection in Baltimore, Maryland? *Subst. Use Misuse* **41**, 1991–2001 (2006).

98. Strathdee, S. A. *et al*. Needle-exchange attendance and health care utilization promote entry into detoxification. *J. Urban Health* **76**, 448–460 (1999).

99. Patel, M. R. *et al*. Reduction of Injection-Related Risk Behaviors After Emergency Implementation of a Syringe Services Program During an HIV Outbreak. *JAIDS J. Acquir. Immune Defic. Syndr.* **77**, 373 (2018).

100. Kuehn, B. M. Restrictive Policies Threaten Efforts to Stop 2 West Virginia HIV Outbreaks. *JAMA* **325**, 2238–2240 (2021).

101. Tookes, H. E. *et al*. A comparison of syringe disposal practices among injection drug users in a city with versus a city without needle and syringe programs. *Drug Alcohol Depend.* **123**, 255–259 (2012).

102. Marx, M. A. *et al*. Trends in crime and the introduction of a needle exchange program. *Am. J. Public Health* **90**, 1933–1936 (2000).

103. Galea, S., Ahern, J., Fuller, C., Freudenberg, N. & Vlahov, D. Needle Exchange Programs and Experience of Violence in an Inner City Neighborhood. *JAIDS J. Acquir. Immune Defic. Syndr.* **28**, 282 (2001).

104. Minnesota Department of Health. *Minnesota Syringe Service Programs: Fall 2021 Evaluation & Impact Summary on MDH-Funded Syringe Service Programs*. https://www.health.state.mn.us/communities/injury/pubs/documents/sspevaluationreport.pdf (2022).

105. Fuller, C. M. *et al*. Impact of Increased Syringe Access: Preliminary Findings on Injection Drug User Syringe Source, Disposal, and Pharmacy Sales in Harlem, New York. *J. Am. Pharm. Assoc. 1996* **42**, S77–S82 (2002).

106. Green, T. C. *et al*. Examining nonprescription syringe sales in Massachusetts and Rhode Island community pharmacies. *J. Am. Pharm. Assoc.* **61**, e237–e241 (2021).

107. Janulis, P. Pharmacy nonprescription syringe distribution and HIV/AIDS: A review. *J. Am. Pharm. Assoc.* **52**, 787–797 (2012).

108. Jones, L., Pickering, L., Sumnall, H., McVeigh, J. & Bellis, M. A. Optimal provision of needle and syringe programmes for injecting drug users: A systematic review. *Int. J. Drug Policy* **21**, 335–342 (2010).

109. Tapper, A., Ahern, C., Graveline-Long, Z., Newberger, N. G. & Hughto, J. M. W. The utilization and delivery of safer smoking practices and services: a narrative synthesis of the literature. *Harm. Reduct. J.* **20**, 160 (2023).

110. Global Commission on Drug Policy. *HIV, Hepatitis & Drug Policy Reform*. https://www.globalcommissionondrugs.org/reports/hiv-hepatitis-drug-policy-reform (2023).

111. Minnesota Medical Association. *Harm Reduction of Illicit Drug Use*. https://www.mnmed.org/application/files/3916/8676/6277/MMA_Decriminalization_HR_Policies.pdf (2022).

112. SAMHSA. *Harm Reduction Framework*. https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf (2023).

113. National Institute on Drug Abuse. Drug Overdose Death Rates. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates (2023).

114. McDonald, R. & Strang, J. Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. *Addict. Abingdon Engl.* **111**, 1177–1187 (2016).

115. Schuler, M. S. *et al*. The state of the science in opioid policy research. *Drug Alcohol Depend*. **214**, 108137 (2020).

116. Walley, A. Y. *et al*. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *The BMJ* **346**, f174 (2013).

117. Wheeler, E., Davidson, P. J., Jones, T. S. & Irwin, K. S. Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010. *MMWR Morb. Mortal. Wkly. Rep*. **61**, 101–105 (2012).

118. Lieberman, A. Addressing the Inequitable Distribution of the Life-Saving Overdose Drug Naloxone: Could Vending Machines be an Answer? *Network for Public Health Law* https://www.networkforphl.org/news-insights/addressing-the-inequitable-distribution-of-the-life-saving-overdose-drug-naloxone-could-vending-machines-be-an-answer/.

119. Scharf, B. M., Sabat, D. J., Brothers, J. M., Margolis, A. M. & Levy, M. J. Best Practices for a Novel EMS-Based Naloxone Leave behind Program. *Prehosp. Emerg. Care* **25**, 418–426 (2021).

120. Bell, A., Bennett, A. S., Jones, T. S., Doe-Simkins, M. & Williams, L. D. Amount of naloxone used to reverse opioid overdoses outside of medical practice in a city with increasing illicitly manufactured fentanyl in illicit drug supply. *Subst. Abuse* **40**, 52–55 (2019).

121. Carpenter, J. *et al*. Naloxone Dosing After Opioid Overdose in the Era of Illicitly Manufactured Fentanyl. *J. Med. Toxicol.* **16**, 41–48 (2020).

122. Smart, R., Pardo, B. & Davis, C. S. Systematic review of the emerging literature on the effectiveness of naloxone access laws in the United States. *Addict. Abingdon Engl.* **116**, 6–17 (2021).

123. Coffin, P. O. *et al*. Nonrandomized Intervention Study of Naloxone Coprescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain. *Ann. Intern. Med.* **165**, 245–252 (2016).

124. Maxwell, S., Bigg, D., Stanczykiewicz, K. & Carlberg-Racich, S. Prescribing naloxone to actively injecting heroin users: a program to reduce heroin overdose deaths. *J. Addict. Dis.* **25**, 89–96 (2006).

125. Dwyer, K. *et al*. Opioid education and nasal naloxone rescue kits in the emergency department. *West. J. Emerg. Med.* **16**, 381–384 (2015).

126. Kennedy, M. C., Karamouzian, M. & Kerr, T. Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review. *Curr. HIV/AIDS Rep.* **14**, (2017).

127. Marshall, B. D., Milloy, M.-J., Wood, E., Montaner, J. S. & Kerr, T. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *The Lancet* **377**, 1429–1437 (2011).

128. Ng, J., Sutherland, C. & Kolber, M. R. Does evidence support supervised injection sites? *Can. Fam. Physician* **63**, 866–866 (2017).

129. Harocopos, A. *et al*. First 2 Months of Operation at First Publicly Recognized Overdose Prevention Centers in US. *JAMA Netw. Open* **5**, e2222149 (2022).

130. American Medical Association. Pilot Implementation of Supervised Injection Facilities H-95.295. *PolicyFinder* https://policysearch.ama-assn.org/policyfinder/detail/Supervised%20injection?uri=%2FAMADoc%2FHOD.xml-H-95.925.xml (2023).

131. McClellan, C. *et al*. Opioid-overdose laws association with opioid use and overdose mortality. *Addict. Behav.* **86**, 90–95 (2018).

132. Jakubowski, A., Kunins, H. V., Huxley-Reicher, Z. & Siegler, A. Knowledge of the 911 Good Samaritan Law and 911-Calling Behavior of Overdose Witnesses. *Subst. Abuse* **39**, 233–238 (2018).

133. Moallef, S. & Hayashi, K. The effectiveness of drug-related Good Samaritan laws: A review of the literature. *Int. J. Drug Policy* **90**, 102773 (2021).

134. Ondocsin, J. *et al.* Insights from Drug Checking Programs: Practicing Bootstrap Public Health Whilst Tailoring to Local Drug User Needs. *Int. J. Environ. Res. Public. Health* **20**, 5999 (2023).

135. Maghsoudi, N. *et al.* Drug checking services for people who use drugs: a systematic review. *Addiction* **117**, 532–544 (2022).

136. Park, J. N. *et al.* Evaluation of fentanyl test strip distribution in two Mid-Atlantic syringe services programs. *Int. J. Drug Policy* **94**, 103196 (2021).

137. Human Impact Partners. A Framework Connecting Criminal Justice and Public Health. *Human Impact Partners* https://humanimpact.org/a-framework-connecting-criminal-justice-and-public-health/ (2016).

138. Vallas, R. & Dietrich, S. *One Strike and You're Out: How We Can Eliminate Barriers to Economic Security and Mobility for People with Criminal Records*. https://cdn.americanprogress.org/wp-content/uploads/2014/12/VallasCriminalRecordsReport.pdf (2014).

139. U.S. Commission on Civil Rights. *Collateral Consequences: The Crossroads of Punishment, Redemption, and the Effects on Communities*. https://www.usccr.gov/files/pubs/2019/06-13-Collateral-Consequences.pdf (2019).

140. Ehman, Merf & Reosti, Anna. *Tenant Screening in an Era of Mass Incarceration: A Criminal Record Is No Crystal Ball*. https://roominate.com/blogg/fair_chance_housing/crystal_ball.pdf (2015).

141. Tran-Leung, M. C. *When Discretion Means Denial: A National Perspective on Criminal Records Barriers to Federally Subsidized Housing*. https://www.povertylaw.org/wp-content/uploads/2019/09/WDMD-final.pdf (2019).

142. Bauman, Tristia. *No Safe Place; The Criminalization of Homelessness in U.S. Cities*. https://homelesslaw.org/wp-content/uploads/2019/02/No_Safe_Place.pdf (2019).

143. Metraux, S., Roman, C. G. & Cho, R. S. Incarceration and Homelessness. in (2007).

144. Allard K. Lowenstein International Human Rights Clinic. *'Forced into Breaking the Law': The Criminalization of Homelessness in Connecticut*. https://law.yale.edu/sites/default/files/area/center/schell/criminalization_of_homelessness_report_for_web_executive_summary.pdf (2016).

145. Herbert, C. W., MORENOFF, J. D. & HARDING, D. J. Homelessness and Housing Insecurity Among Former Prisoners. *Russell Sage Found. J. Soc. Sci. RSF* **1**, 44–79 (2015).

146. Lutze, F. E., Rosky, J. W. & Hamilton, Z. K. Homelessness and Reentry: A Multisite Outcome Evaluation of Washington State's Reentry Housing Program for High Risk Offenders. *Crim. Justice Behav.* **41**, 471–491 (2014).

147. Peng, Y. *et al.* Permanent Supportive Housing With Housing First to Reduce Homelessness and Promote Health Among Homeless Populations With Disability: A Community Guide Systematic Review. *J. Public Health Manag. Pract.* **26**, 404–411 (2020).

148. SDOH: Housing First Programs | The Community Guide. https://www.thecommunityguide.org/findings/social-determinants-health-housing-first-programs.html (2023).

149. Davidson, C. *et al.* Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use. *Psychiatr. Serv. Wash. DC* **65**, (2014).

150. Larimer, M. E. *et al.* Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *JAMA* **301**, 1349–1357 (2009).

151. American Society of Addiction Medicine. *Public Policy Statement on the Use of Naloxone for the Prevention of Opioid Overdose Deaths*. https://www.asam.org/docs/default-source/public-policy-statements/use-of-naloxone-for-the-prevention-of-opioid-overdose-deaths-final.pdf (2021).

152. Borden, T. *Every 25 Seconds - The Human Toll of Criminalizing Drug Use in the United States*. https://www.hrw.org/sites/default/files/report_pdf/usdrug1016_web_0.pdf (2016).

153. International Centre for Human Rights in Drug Policy, United Nations Human Rights, UNAIDS, World Health Organization, UN Developement Program. *International Guidelines on Human Rights and Drug Policy*. https://www.humanrights-drugpolicy.org/about/ (2019).

154. United Nations System Chief Executives Board for Coordination. *United Nations System Common Position Supporting the Implementation of the International Drug Control Policy through Effective Inter-Agency Collaboration*. https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf (2018).

155. Russoniello, K. *et al*. Decriminalization of drug possession in Oregon: Analysis and early lessons. *Drug Sci. Policy Law* **9**, 20503245231167407 (2023).

156. Hager, E. Debtors' Prisons, Then and Now: FAQ. *The Marshall Project* https://www.themarshallproject.org/2015/02/24/debtors-prisons-then-and-now-faq (2015).

157. Davis, C. S., Joshi, S., Rivera, B. D. & Cerdá, M. Changes in arrests following decriminalization of low-level drug possession in Oregon and Washington. *Int. J. Drug Policy* **119**, 104155 (2023).

158. Doherty, E. E., Green, K. M. & Ensminger, M. E. Long-term Consequences of Criminal Justice System Intervention: The Impact of Young Adult Arrest on Midlife Health Behaviors. *Prev. Sci. Off. J. Soc. Prev. Res.* **23**, 167–180 (2022).

159. Joshi, S. *et al*. One-Year Association of Drug Possession Law Change With Fatal Drug Overdose in Oregon and Washington. *JAMA Psychiatry* (2023) doi:10.1001/jamapsychiatry.2023.3416.

160. Kral, A. H., Oviedo, S., Humphrey, J. L. & Lambdin, B. H. Impact of Fentanyl on Overdose Mortality in Oregon before and after Measure 110. (2024).

161. LaForge, K. *et al*. Knowledge, attitudes, and behaviors related to the fentanyl-adulterated drug supply among people who use drugs in Oregon. *J. Subst. Abuse Treat.* **141**, 108849 (2022).

162. Ciccarone, D. Fentanyl in the US heroin supply: A rapidly changing risk environment. *Int. J. Drug Policy* **46**, 107–111 (2017).

163. Ciccarone, D. The Rise of Illicit Fentanyls, Stimulants and the Fourth Wave of the Opioid Overdose Crisis. *Curr. Opin. Psychiatry* **34**, 344–350 (2021).

164. Shover, C. L. *et al*. Steep increases in fentanyl-related mortality west of the Mississippi River: Recent evidence from county and state surveillance. *Drug Alcohol Depend.* **216**, 108314 (2020).

165. Unick, G. J. & Ciccarone, D. US regional and demographic differences in prescription opioid and heroin-related overdose hospitalizations. *Int. J. Drug Policy* **46**, 112–119 (2017).

166. Public Health Division. Fentanyl Facts. *Oregon.gov* https://www.oregon.gov/oha/ph/preventionwellness/substanceuse/opioids/pages/fentanylfacts.aspx.

167. Kral, A. H. *et al*. Transition from injecting opioids to smoking fentanyl in San Francisco, California. *Drug Alcohol Depend.* **227**, 109003 (2021).

168. RTI International. *Understanding the Impact of Drug Decriminalization in Oregon*. https://www.rti.org/impact/building-evidence-understanding-impacts-drug-decriminalization-oregon (2022).

169. Joint Office of Homeless Services. *2022 Point In Time Report: Count of People Experiencing HUD Homelessness in Portland/Gresham/Multnomah County*. https://multco-web7-psh-files-usw2.s3-us-west-2.amazonaws.com/s3fs-public/2022%20Point%20In%20Time%20Report%20-%20Full.pdf (2022).

170. Multnomah County. NEWS RELEASE: Chronic homelessness number falls across tri-county region in 2023 Point in Time Count. *Multnomah County* https://www.multco.us/multnomah-county/news/news-release-chronic-homelessness-number-falls-across-tri-county-region-2023 (2023).

171. Oregon Health Authority and Oversight and Accountability Council. *Funding and Delivery of Measure 110 Substance Use Disorder Services Shows Progress, but Significant Risks Remain*. https://sos.oregon.gov/audits/Documents/2023-39.pdf (2023).

172. Donheffner, Kristen. Measure 110: One Year of Implementation. (2024).

173. VanderHart. Oregon Democrats unveil bill to recriminalize drug possession, step up access to treatment. *Oregon Public Broadcasting* (2024).

174. National Inventory of Collateral Consequences of Criminal Conviction. Collateral Consequences Inventory. https://niccc.nationalreentryresourcecenter.org/consequences (2024).

175. Clark, L. D. A Civil Rights Task: Removing Barriers to Employment of Ex-Convicts. *Univ. San Franc. Law Rev.* (2004).

176. Bell, S. D. The Long Shadow: Decreasing Barriers to Employment, Housing, and Civic Participation for People with Criminal Records will Improve Public Safety and Strengthen the Economy. *West. State Law Rev.* **42**, 1 (2014).

177. Duane, La Vigne, Reimal, & Lynch. *Criminal Background Checks: Impact on Employment and Recidivism*. https://www.urban.org/research/publication/criminal-background-checks-impact-employment-and-recidivism (2017).

178. Travis, Solomon, & Waul. *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry*. https://www.urban.org/sites/default/files/publication/61571/410098-From-Prison-to-Home-The-Dimensions-and-Consequences-of-Prisoner-Reentry.PDF (2001).

179. Economy League of Greater Philadelphia. *Economic Benefits of Employing Formerly Incarcerated Individuals in Philadelphia* |. https://www.economyleague.org/sites/default/files/legacy/712279713790016867-economic-benefits-of-employing-formerly-incarcerated-full-report.pdf (2011).

180. National Employment Law Project. *Seizing the "Ban the Box" Momentum to Advance a New Generation of Fair Chance Hiring Reforms*. https://www.nelp.org/wp-content/uploads/2015/03/Seizing-Ban-the-Box-Momentum-Advance-New-Generation-Fair-Chance-Hiring-Reforms.pdf (2014).

181. Consumer Financial Protection Bureau. *Justice-Involved Individuals and the Consumer Financial Marketplace*. https://files.consumerfinance.gov/f/documents/cfpb_jic_report_2022-01.pdf (2022).

182. Fines and Fees Justice Center. Free to Drive: End driver's license suspensions for unpaid fines and fees. *Fines and Fees Justice Center* https://finesandfeesjusticecenter.org/campaigns/national-drivers-license-suspension-campaign-free-to-drive/.

183. Harper, A. *et al*. Debt, Incarceration, and Re-entry: a Scoping Review. *Am. J. Crim. Justice* **46**, 250–278 (2021).

184. McCarty, M. *Drug Testing and Crime-Related Restrictions in TANF, SNAP, and Housing Assistance*. https://sgp.fas.org/crs/misc/R42394.pdf (2016).

185. Batie, R. & Wentworth, G. *Drug Testing Unemployment Insurance Applicants: An Unconstitutional Solution in Search of a Problem*. https://www.nelp.org/publication/drug-testing-unemployment-insurance-applicants/ (2017).

186. Centers for Medicare & Medicaid Services. *HHS Releases New Guidance to Encourage States to Apply for New Medicaid Reentry Section 1115 Demonstration Opportunity to Increase Health Care for People Leaving Carceral Facilities*. https://www.cms.gov/newsroom/press-releases/hhs-releases-new-guidance-encourage-states-apply-new-medicaid-reentry-section-1115-demonstration (2023).

187. Federal Student Aid. Eligibility for Students With Criminal Convictions. *U.S. Department of Education* https://studentaid.gov/understand-aid/eligibility/requirements/criminal-convictions.

188. Wheelock, D. & Uggen, C. Race, Poverty and Punishment: The Impact Of Criminal Sanctions On Racial, Ethnic, and Socioeconomic Inequality. (2005).

189. Ma, Jennifer, Pender, Matea, & Welch, Meredith. *Education Pays 2016: The Benefits of Higher Education for Individuals and Society. Trends in Higher Education Series*. https://www.getmidegree.org/wp-content/uploads/2018/08/education-pays-2016-full-report.pdf (2016).

190. U.S. Department of Education. *Beyond the Box: Increasing Access to Higher Education for Justice-Involved Individuals*. https://www.aacrao.org/docs/default-source/signature-initiative-docs/disciplinary-notations/ed-guidance.pdf?sfvrsn=61d160cc_4 (2016).

191. Allen, Elizabeth. College Applications Shouldn't Ask About Conviction History. *Vera Institute of Justice* https://www.vera.org/news/college-applications-shouldnt-ask-about-conviction-history (2023).

192. Office of Career, Technical, and Adult Education. *Beyond the Box 2023*. https://lincs.ed.gov/sites/default/files/2023-04/beyond-the-box.pdf (2023).

193. A Child Welfare Timeline. *National Coalition For Child Protection Reform* https://nccpr.org/a-child-welfare-timeline/ (2017).

194. Pelton, L. H. *For Reasons of Poverty: A Critical Analysis of the Public Child Welfare System in the United States*. xvii, 203 (Praeger Publishers, New York, NY, England, 1989).

195. Roberts, D. Shattered Bonds: The Color of Child Welfare. *Fac. Scholarsh.* (2001).

196. Minoff, Elisa. *Entangled Roots: The Role of Race in Policies That Separate Families*. https://cssp.org/wp-content/uploads/2018/11/CSSP-Entangled-Roots.pdf (2018).

197. Movement for Family Power. *"Whatever They Do, I'm Her Comfort, I'm Her Protector.": How the Foster System Has Become Ground Zero for the U.S. Drug War*. https://static1.squarespace.com/static/5be5ed0fd274cb7c8a5d0cba/t/5eead939ca509d4e36a89277/1592449422870/MFP+Drug+War+Foster+System+Report.pdf (2020).

198. Banwell, C. & Bammer, G. Maternal habits: Narratives of mothering, social position and drug use. *Int. J. Drug Policy* **17**, 504–513 (2006).

199. Hogan, T. M. S., Myers, B. J. & Elswick, R. K. Child abuse potential among mothers of substance-exposed and nonexposed infants and toddlers. *Child Abuse Negl.* **30**, 145–156 (2006).

200. Kearney, M. H., Murphy, S. & Rosenbaum, M. Mothering on crack cocaine: a grounded theory analysis. *Soc. Sci. Med. 1982* **38**, 351–361 (1994).

201. Kepple, N. J. Does parental substance use always engender risk for children? Comparing incidence rate ratios of abusive and neglectful behaviors across substance use behavior patterns. *Child Abuse Negl.* **76**, 44–55 (2018).

202. Doyle Jr., J. J. . Child Protection and Child Outcomes: Measuring the Effects of Foster Care. *Am. Econ. Rev.* **97**, 1583–1610 (2007).

203. Doyle, J. J. Causal effects of foster care: An instrumental-variables approach. *Child. Youth Serv. Rev.* **35**, 1143–1151 (2013).

204. Lawrence, C. R., Carlson, E. A. & Egeland, B. The impact of foster care on development. *Dev. Psychopathol.* **18**, 57–76 (2006).

205. Turney, K. & Wildeman, C. Mental and Physical Health of Children in Foster Care. *Pediatrics* **138**, e20161118 (2016).

206. Ahrens, K. R., Garrison, M. M. & Courtney, M. E. Health Outcomes in Young Adults From Foster Care and Economically Diverse Backgrounds. *Pediatrics* **134**, 1067 (2014).

207. Thumath, M. *et al*. Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. *Int. J. Drug Policy* **91**, 102977 (2021).

208. Restoration of Rights Project. 50-State Comparison: Pardon Policy & Practice. https://ccresourcecenter.org/state-restoration-profiles/50-state-comparisoncharacteristics-of-pardon-authorities-2/ (2023).

209. Eagly & Shafer. *Access to Counsel*. https://www.americanimmigrationcouncil.org/sites/default/files/research/access_to_counsel_in_immigration_court.pdf (2016).

210. Ispa-Landa, Simone & Loeffler, Charles. Indefinite Punishment and the Criminal Record: Stigma Reports Among Expungement-Seekers in Illinois. *Criminology* **54**, 387–412 (2016).

211. Adams, E. B., Chen, E. Y. & Chapman, R. Erasing the mark of a criminal past: Ex-offenders' expectations and experiences with record clearance. *Punishm. Soc.* **19**, 23–52 (2017).

212. Prescott, J. J. & Starr, S. B. The Power of a Clean Slate. *Regulation* **43**, 28–34 (2020).

213. Selbin, J., Mccrary, J. & Epstein, J. Unmarked? Criminal Record Clearing and Employment Outcomes. *J. Crim. Law Crimonology* **108**, (2018).

214. American Public Health Association. Advancing Public Health Interventions to Address the Harms of the Carceral System. *Policy Statements and Advocacy* https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Advancing-Public-Health-Interventions-to-Address-the-Harms-of-the-Carceral-System (2021).

215. Caulkins, J. P. Local Drug Markets' Response to Focused Police Enforcement. *Oper. Res.* **41**, 848–863 (1993).

216. Introduction: Illegal Drug Markets, Research and Policy. in *Illegal Drug Markets: From Research to Prevention Policy* (eds. Hough & Natarajan) vol. 11 1–17 (Criminal Justice Press, 2000).

217. Kleiman. Neither Prohibition Not Legalization: Grudging Toleration in Drug Control Policy. in *Drug Use and Drug Policy: Contemporary Literature in Theory and Practice* (Garln, 1992).

218. Lee, M. London: 'Community Damage Limitation' through Policing? in *European Drug Policies and Enforcement* (eds. Dorn, N., Jepsen, J. & Savona, E.) 33–54 (Palgrave Macmillan UK, London, 1996). doi:10.1007/978-1-349-24619-9_3.

219. Murji, Karim. *Policing Drugs*. (Routledge Revivials, 2000).

220. Weatherburn & Lind. Crime Prevention: The Role of Economic and Social Support. *Agenda* **6**, 309 (1999).

221. Zimmer, Lynn. Proactive Policing Against Street-Level Drug Trafficking. *Am. J. Police* **9**, 43 (1990).

222. Bewley-Taylor, D. *Towards Metrics That Measure Outcomes That Matter*. https://www.swansea.ac.uk/media/Towards-Metrics-that-Measure-Outcomes-that-Matter.pdf (2016).

223. Neocleous, M. *A Critical Theory of Police Power: The Fabrication of the Social Order*. (Verso Books, 2021).

224. Bass. Policing Space, Policing Race: Social Control Imperatives and Police Discretionary Decisions. *Soc. Justice* **28**, (2001).

225. Alexander. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. (The New Press, New York, 2010).

226. Bailey, Z. D. *et al.* Structural racism and health inequities in the USA: evidence and interventions. *Lancet* **389**, 1453–1463 (2017).

227. Werb, D. *et al.* A call to reprioritise metrics to evaluate illicit drug policy. *The Lancet* **387**, 1371 (2016).

228. Nougier & Cots Fernandez. *Global Drug Policy Index 2021*. https://globaldrugpolicyindex.net/wp-content/themes/gdpi/uploads/GDPI%202021%20Report%20EN.pdf (2021).

229. Mazerolle, L. & Eggins, E. *Street-Level Drug Law Enforcement: An Updated Systematic Review*. (Australian Institute of Criminology, 2020). doi:10.52922/ti04640.

230. Werb, D. *et al.* Effect of drug law enforcement on drug market violence: a systematic review. *Int. J. Drug Policy* **22**, 87–94 (2011).

231. Coyne, C. J. & Hall, Abigail R. *Four Decades and Counting: The Continued Failure of the War on Drugs*. https://www.cato.org/sites/cato.org/files/pubs/pdf/pa-811-updated.pdf (2017).

232. Bless, R., Korf, D. J. & Freeman, M. Open Drug Scenes: A Cross-National Comparison of Concepts and Urban Strategies. *Eur. Addict. Res.* **1**, 128–138 (2009).

233. Edmunds, M., Hough, M. & Uriquia, N. Tackling local drug markets. in (1996).

234. Johnson, B. D. Emerging Models of Crack Distribution. in (2011).

235. May, T. & Hough, M. Illegal Dealings: The Impact of Low-Level Police Enforcement on Drug Markets. *Eur. J. Crim. Policy Res.* **9**, 137–162 (2001).

236. LaSalle. *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane*. https://drugpolicy.org/wp-content/uploads/2023/05/Overdose_Death_Is_Not_Murder_Report.pdf (2017).

237. Friedman, S. R. *et al.* Drug Arrests and Injection Drug Deterrence. *Am. J. Public Health* **101**, 344–349 (2011).

238. Latimore, A. D. & Bergstein, R. S. 'Caught with a body' yet protected by law? Calling 911 for opioid overdose in the context of the Good Samaritan Law. *Int. J. Drug Policy* **50**, 82–89 (2017).

239. Knight, J. H. The First Hit's Free . . . Or Is It? Criminal Liability for Drug-Induced Death in New Jersey. *SETON HALL LAW Rev.* **34**, (2004).

240. Beletsky, L. America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis. *Utah Law Rev.* **2019**, 833 (2019).

241. David Dixon, P. C. Zero tolerance policing of illegal drug markets. *Drug Alcohol Rev.* (1999).

242. Global Initiative Against Transnational Organized Crime. *The Global Illicit Economy: Trajectories of Transnational Organized Crime*. https://globalinitiative.net/wp-content/uploads/2021/03/The-Global-Illicit-Economy-GITOC-Low.pdf (2021).

243. Zhang, A. *et al.* The relationship between police contacts for drug use-related crime and future arrests, incarceration, and overdoses: a retrospective observational study highlighting the need to break the vicious cycle. *Harm. Reduct. J.* **19**, 67 (2022).

244. Eggins, E. & Hine, L. *The Impact of Arrest and Seizure on Drug Crime and Harms: A Systematic Review*. (Australian Institute of Criminology, 2020). doi:10.52922/ti04688.

245. Volkow, N. D. Addiction should be treated, not penalized. *Neuropsychopharmacology* **46**, 2048–2050 (2021).

246. More Imprisonment Does Not Reduce State Drug Problems. http://pew.org/2tszeZl (2018).

247. Mital, S., Wolff, J. & Carroll, J. J. The relationship between incarceration history and overdose in North America: A scoping review of the evidence. *Drug Alcohol Depend.* **213**, 108088 (2020).

248. Flam-Ross, J. M. *et al.* Factors associated with opioid-involved overdose among previously incarcerated people in the U.S.: A community engaged narrative review. *Int. J. Drug Policy* **100**, 103534 (2022).

249. Ray, B. *et al.* Spatiotemporal Analysis Exploring the Effect of Law Enforcement Drug Market Disruptions on Overdose, Indianapolis, Indiana, 2020–2021. *Am. J. Public Health* **113**, 750–758 (2023).

250. United States General Accountability Office. *Drug Offenders: Various Factors May Limit the Impacts of Federal Laws That Provide for Denial of Selected Benefits*. https://www.gao.gov/assets/gao-05-238.pdf (2005).

251. Bailey, Z. D., Feldman, J. M. & Bassett, M. T. How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities. *N. Engl. J. Med.* **384**, 768–773 (2021).

252. Rivara, F. P. *et al.* Structural Racism and JAMA Network Open. *JAMA Netw. Open* **4**, e2120269 (2021).

253. Broadhead, R. S., Kerr, T. H., Grund, J.-P. C. & Altice, F. L. Safer Injection Facilities in North America: Their Place in Public Policy and Health Initiatives. *J. Drug Issues* **32**, 329–355 (2002).

254. Darke, S. G. & Ross, Joanne. *Heroin-related Deaths in South-western Sydney: 1992-1996.* https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/T.R.%20052.pdf (1998).

255. McGregor, C., Darke, S., Ali, R. & Christie, P. Experience of non-fatal overdose among heroin users in Adelaide, Australia: circumstances and risk perceptions. *Addict. Abingdon Engl.* **93**, 701–711 (1998).

256. Aitken, C., Moore, D., Higgs, P., Kelsall, J. & Kerger, M. The impact of a police crackdown on a street drug scene: evidence from the street. *Int. J. Drug Policy* **13**, 193–202 (2002).

257. Maher, L. & Dixon, D. The Cost of Crackdowns: Policing Cabramatta's Heroin Market. *Curr. Issues Crim. Justice* **13**, 5–22 (2001).

258. Dixon, D. & Maher, L. Anh Hai: Policing, Culture and Social Exclusion in a Street Heroin Market. *Polic. Soc.* **12**, 93–110 (2002).

259. Small, W., Kerr, T., Charette, J., Schechter, M. T. & Spittal, P. M. Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation. *Int. J. Drug Policy* **17**, 85–95 (2006).

260. Murphy *et al.* Risk factors for skin and soft-tissue abscesses among injection drug users: a case-control study. *Clin Infect Dis* **33**, 35–40 (2001).

261. DeBeck, K. *et al.* HIV and the criminalisation of drug use among people who inject drugs: a systematic review. *Lancet HIV* **4**, e357–e374 (2017).

262. Kerr, T., Small, W. & Wood, E. The public health and social impacts of drug market enforcement: A review of the evidence. *Int. J. Drug Policy* **16**, 210–220 (2005).

263. Celentano, D. D. *et al.* Risk factors for shooting gallery use and cessation among intravenous drug users. *Am. J. Public Health* **81**, 1291–1295 (1991).

264. Des Jarlais, D. C. & Friedman, S. R. Shooting galleries and AIDS: infection probabilities and 'tough' policies. *Am. J. Public Health* **80**, 142–144 (1990).

265. Schneider, C. L. Racism, Drug Policy, and AIDS. *Polit. Sci. Q.* **113**, 427–446 (1998).

266. Battjes, R. J., Pickens, R. W., Haverkos, H. W. & Sloboda, Z. HIV risk factors among injecting drug users in five US cities. *AIDS Lond. Engl.* **8**, 681–687 (1994).

267. Chaisson, R. E., Moss, A. R., Onishi, R., Osmond, D. & Carlson, J. R. Human immunodeficiency virus infection in heterosexual intravenous drug users in San Francisco. *Am. J. Public Health* **77**, 169–172 (1987).

268. Chitwood, D. D. *et al.* Risk factors for HIV-1 seroconversion among injection drug users: a case-control study. *Am. J. Public Health* **85**, 1538–1542 (1995).

269. Zolopa, A. R. *et al.* HIV and tuberculosis infection in San Francisco's homeless adults. Prevalence and risk factors in a representative sample. *JAMA* **272**, 455–461 (1994).

270. Bluthenthal, RickyN., Lorvick, J., Kral, AlexH., Erringer, ElizabethA. & Kahn, JamesG. Collateral damage in the war on drugs: HIV risk behaviors among injection drug users. *Int. J. Drug Policy* **10**, 25–38 (1999).

271. Curtis, R. *et al.* Street-level drug markets: Network structure and HIV risk. *Soc. Netw.* **17**, 229–249 (1995).

272. Rhodes, T. *et al.* Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment. *Soc. Sci. Med. 1982* **57**, 39–54 (2003).

273. Wood, E. *et al*. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *CMAJ Can. Med. Assoc. J.* **171**, 731–734 (2004).

274. Wood, E. *et al*. Displacement of Canada's largest public illicit drug market in response to a police crackdown. *CMAJ Can. Med. Assoc. J.* **170**, 1551–1556 (2004).

275. Bastos, F. I. & Strathdee, S. A. Evaluating effectiveness of syringe exchange programmes: current issues and future prospects. *Soc. Sci. Med. 1982* **51**, 1771–1782 (2000).

276. Bourgois, P. The moral economies of homeless heroin addicts: confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments. *Subst. Use Misuse* **33**, 2323–2351 (1998).

277. Des Jarlais, D. C. Structural interventions to reduce HIV transmission among injecting drug users. *AIDS Lond. Engl.* **14 Suppl 1**, S41-46 (2000).

278. Milliken, D. Death by restraint. *CMAJ Can. Med. Assoc. J.* **158**, 1611–1612 (1998).

279. Pollanen, M. S., Chiasson, D. A., Cairns, J. T. & Young, J. G. Unexpected death related to restraint for excited delirium: a retrospective study of deaths in police custody and in the community. *CMAJ Can. Med. Assoc. J. J. Assoc. Medicale Can.* **158**, 1603–1607 (1998).

280. Brownstein, H. H., Crimmins, S. M. & Spunt, B. J. A Conceptual Framework for Operationalizing the Relationship between Violence and Drug Market Stability. *Contemp. Drug Probl.* **27**, 867–890 (2000).

281. Maher, L. & Dixon, D. POLICING AND PUBLIC HEALTH: Law Enforcement and Harm Minimization in a Street-level Drug Market. *Br. J. Criminol.* **39**, 488–512 (1999).

282. CDC WONDER. https://wonder.cdc.gov/.

283. Jones, C. M., Einstein, E. B. & Compton, W. M. Changes in Synthetic Opioid Involvement in Drug Overdose Deaths in the United States, 2010-2016. *JAMA* **319**, 1819–1821 (2018).

284. Carroll, J. J., Marshall, B. D. L., Rich, J. D. & Green, T. C. Exposure to fentanyl-contaminated heroin and overdose risk among illicit opioid users in Rhode Island: A mixed methods study. *Int. J. Drug Policy* **46**, 136–145 (2017).

285. Wakeman, S. E. 'Policies that Punish the Powerless' in a supply-led illicit fentanyl market. *Addiction* **114**, 781–782 (2019).

286. Mars, S. G., Rosenblum, D. & Ciccarone, D. Illicit fentanyls in the opioid street market: desired or imposed? *Addict. Abingdon Engl.* **114**, 774–780 (2019).

287. Rothberg, R. L. & Stith, K. Fentanyl: A Whole New World? *J. Law. Med. Ethics* **46**, 314–324 (2018).

288. Global Commission on Drug Policy. *Regulation: The Responsible Control of Drugs*. https://www.globalcommissionondrugs.org/wp-content/uploads/2018/09/ENG-2018_Regulation_Report_WEB-FINAL.pdf (2018).

289. Sewell, A. A. & Jefferson, K. A. Collateral Damage: The Health Effects of Invasive Police Encounters in New York City. *J. Urban Health* **93**, 42–67 (2016).

290. Sewell, A. A., Jefferson, K. A. & Lee, H. Living under surveillance: Gender, psychological distress, and stop-question-and-frisk policing in New York City. *Soc. Sci. Med.* **159**, 1–13 (2016).

291. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Incarceration. *Healthy People 2030* https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration#:~:text=Studies%20have%20shown%20that%20when,%2C%20hepatitis%20C%2C%20and%20HIV. (2024).

292. Binswanger, I. A., Redmond, N., Steiner, J. F. & Hicks, L. S. Health Disparities and the Criminal Justice System: An Agenda for Further Research and Action. *J. Urban Health Bull. N. Y. Acad. Med.* **89**, 98–107 (2012).

293. Camplain, R. *et al*. Epidemiology of incarceration: Characterizing jail incarceration for public health research. *Epidemiol. Camb. Mass* **30**, 561–568 (2019).

294. Kochel. Effect of Suspect Race on Officers' Arrest Decisions. *Crimonology* **49**, 473–512 (2011).

295. Rosenberg, A., Groves, A. K. & Blankenship, K. M. Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming. *J. Drug Issues* **47**, 132–142 (2017).

296. Drug Policy Alliance. *The Drug War, Mass Incarceration and Race*. https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf (2015).

297. UN Office of the High Commissioner of Human Rights. *Human Rights Challenges in Addressing and Countering All Aspects of the World Drug Problem: Report to the Office of the United Nations High Commissioner for Human Rights*. https://www.ohchr.org/en/documents/thematic-reports/ahrc5453-human-rights-challenges-addressing-and-countering-all-aspects (2023).

298. DeLeon. *Left Coast City*. (University Press of Kansas, 1992).

299. Grossman, L. A. Life, Liberty, (and the Pursuit of Happiness): Medical Marijuana Regulation in Historical Context. *SSRN Electron. J.* (2018) doi:10.2139/ssrn.3299678.

300. San Francisco AIDS Foundation. The Long View on Harm Reduction in San Francisco. *San Francisco AIDS Foundation* https://www.sfaf.org/collections/status/the-long-view-on-harm-reduction-in-san-francisco/ (2022).

301. Suen, L. W. *et al*. Evaluating oxygen monitoring and administration during overdose responses at a sanctioned overdose prevention site in San Francisco, California: A mixed-methods study. *Int. J. Drug Policy* **121**, 104165 (2023).

302. Amaral, D. J. Who Banishes? City Power and Anti-homeless Policy in San Francisco. *Urban Aff. Rev.* **57**, 1524–1557 (2021).

303. Anthony, K., Modi, K., Rajgopal, K. & Yu, G. *Homelessness in the San Francisco Bay Area: The Crisis and a Path Forward*. https://www.mckinsey.com/industries/social-sector/our-insights/homelessness-in-the-san-francisco-bay-area-the-crisis-and-a-path-forward#/ (2019).

304. Colliver. California Statewide Study Investigates Causes and Impacts of Homelessness. https://www.ucsf.edu/news/2023/06/425646/california-statewide-study-investigates-causes-and-impacts-homelessness (2023).

305. Applied Survey Research. *San Francisco Homeless Count and Survey: 2022 Comprehensive Report*. https://hsh.sfgov.org/wp-content/uploads/2022/08/2022-PIT-Count-Report-San-Francisco-Updated-8.19.22.pdf (2022).

306. Assaf, R. D., Gorbach, P. M. & Cooper, Z. D. Changes in medical and non-medical cannabis use among United States adults before and during the COVID-19 pandemic. *Am. J. Drug Alcohol Abuse* **48**, 321–327 (2022).

307. Roberts, A. *et al*. Alcohol and other substance use during the COVID-19 pandemic: A systematic review. *Drug Alcohol Depend.* **229**, 109150 (2021).

308. Vo, A. T., Patton, T., Peacock, A., Larney, S. & Borquez, A. Illicit Substance Use and the COVID-19 Pandemic in the United States: A Scoping Review and Characterization of Research Evidence in Unprecedented Times. *Int. J. Environ. Res. Public. Health* **19**, 8883 (2022).

309. Wainwright, J. J. *et al*. Analysis of Drug Test Results Before and After the US Declaration of a National Emergency Concerning the COVID-19 Outbreak. *JAMA* **324**, 1674–1677 (2020).

310. National Institute on Drug Abuse. COVID-19 and Substance Use. *National Institute on Drug Abuse* https://nida.nih.gov/research-topics/covid-19-substance-use (2023).

311. Hughes, D.C., Stevens, Alex, Hulme, S., & Cassidy, Rebecca. *Models for the Decriminalisation, Depenalisation and Diversion of Illicit Drug Possession: An International Realist Review*. https://harmreductioneurasia.org/wp-content/uploads/2019/07/Hughes-et-al-ISSDP-2019-Models-for-the-decriminalisation-depenalisation-and-diversion-of-illicit-drug-possession-FINAL.pdf (2019).

312. Blais, E., Brisson, J., Gagnon, F. & Lemay, S.-A. Diverting people who use drugs from the criminal justice system: A systematic review of police-based diversion measures. *Int. J. Drug Policy* **105**, 103697 (2022).

313. Belenko, S. The challenges of integrating drug treatment into the criminal justice process. *Albany Law Rev.* **63**, 833–833 (2000).

314. Broner, N., Borum, R. & Gawley, K. Criminal justice diversion of individuals with co-occurring mental illness and substance use disorders: An overview. (2002).

315. Schiff, D. M. *et al.* A police-led addiction treatment referral program in Gloucester, MA: Implementation and participants' experiences. *J. Subst. Abuse Treat.* **82**, 41–47 (2017).

316. Barberi, D. & Taxman, F. S. Diversion and Alternatives to Arrest: A Qualitative Understanding of Police and Substance Users' Perspective. *J. Drug Issues* **49**, 703–717 (2019).

317. Alang, S., McAlpine, D., McClain, M. & Hardeman, R. Police brutality, medical mistrust and unmet need for medical care. *Prev. Med. Rep.* **22**, 101361 (2021).

318. Frankham, E., Jacobi, C. & Vaidyanathan, B. Race, Trust in Police, and Mental Health Crisis Support. *Contexts* **20**, 60–62 (2021).

319. Grucza, R. A. *et al.* Cannabis decriminalization: A study of recent policy change in five U.S. states. *Int. J. Drug Policy* **59**, 67–75 (2018).

320. Hughes, C. & Stevens, A. What Can We Learn From The Portuguese Decriminalization of Illicit Drugs? *Br. J. Criminol. - BRIT J CRIMINOL* **50**, (2010).

321. Pombo, S. Heroin addiction patterns of treatment-seeking patients, 1992-2013: comparison between pre- and post-drug policy reform in Portugal. *Heroin Addict. Relat. Clin. Probl.* **18**, 51–60 (2016).

322. Madden, Annie, Tanguay, Pascal, & Chang, Judy. *Drug Decriminalisation: Progress or Political Red Herring?* https://inpud.net/wp-content/uploads/2022/01/INPUD_Decriminalisation-report_online-version-2.pdf (2021).

323. Health Canada Expert Task Force on Substance Use. *Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances*. https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf (2021).

324. Global Commission on Drug Policy. *Advancing Drug Policy Reform: A New Approach to Criminalization*. https://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf (2016).

325. Strang, Groshkova, & Metrebian. *New Heroin-Assisted Treatment: Recent Evidence and Current Practices of Supervised Injectable Heroin Treatment in Europe and Beyond*. https://www.emcdda.europa.eu/publications/insights/heroin-assisted-treatment_en (2012).

326. Davis, C. S., Carr, D. H. & Samuels, E. A. Paraphernalia Laws, Criminalizing Possession and Distribution of Items Used to Consume Illicit Drugs, and Injection-Related Harm. *Am. J. Public Health* **109**, 1564–1567 (2019).

327. Elderbroom, Brian & Durnan, Julia. *Reclassified: State Drug Law Reforms to Reduce Felony Convictions and Increase Second Chances*. https://www.urban.org/sites/default/files/publication/99077/reclassified_state_drug_law_reforms_to_reduce_felony_convictions_and_increase_second_chances.pdf (2018).

328. Drug Policy Alliance. *Defelonization: Reducing Rug Penalties for Use and Possession from Felonies to Misdemeanors*. https://www.nmlegis.gov/handouts/CCJ%20110817%20Item%203%20Drug%20Policy%20Alliance%20-%20Defelonization.pdf.

329. Bird, M., Nguyen, V. & Grattet, R. Impact of defelonizing drug possession on recidivism. *Criminol. Public Policy* **19**, 591–616 (2020).

330. Bartos. Can We Downsize Our Prisons and Jails Without Compromising Public Safety? *Criminol. Public Policy* **17**, 693–715 (2018).

331. Californians for Safety and Justice. *Second Chances and System Change: How Proposition 47 Is Changing California*. https://safeandjust.org/wp-content/uploads/P47_Report_Final.pdf (2017).

332. Caulkins, J. P. & Kleiman, M. Lessons to be Drawn from U.S. Drug Control Policies. *Eur. J. Crim. Policy Res.* **24**, 125–144 (2018).

333. Irwin, A. & Pearl, B. *The Community Responder Model*. https://www.americanprogress.org/wp-content/uploads/sites/2/2020/10/Alternatives911-report.pdf (2020).

334. The Sequential Intercept Model (SIM). https://www.samhsa.gov/criminal-juvenile-justice/sim-overview (2020).

335. *Crisis Assistance Helping Out on the Street (CAHOOTS): Media Guide 2020*. https://whitebirdclinic.org/wp-content/uploads/2020/07/CAHOOTS-Media.pdf (2020).

336. Dee, T. S. & Pyne, J. A community response approach to mental health and substance abuse crises reduced crime. *Sci. Adv.* **8**, eabm2106 (2022).

337. Prevent Overdose, RI. Overdose Prevention Centers. https://preventoverdoseri.org/overdose-prevention-centers/.

338. *Harm Reduction Centers*. vols 216-RICR-40-10–25 (2022).

339. Project Weber/RENEW. The Country's First State-Regulated Overdose Prevention Center. *Project Weber/RENEW* https://weberrenew.org/overdose-prevention-center/.

340. Clarke, J. G., Martin, R. A., Gresko, S. A. & Rich, J. D. The First Comprehensive Program for Opioid Use Disorder in a US Statewide Correctional System. *Am. J. Public Health* **108**, 1323–1325 (2018).

341. Green, T. C. *et al*. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. *JAMA Psychiatry* **75**, 405–407 (2018).

342. Martin, R. A. *et al*. Post-incarceration outcomes of a comprehensive statewide correctional MOUD program: a retrospective cohort study. *Lancet Reg. Health – Am.* **18**, (2023).

343. Clark, S. A. *et al*. Using telehealth to improve buprenorphine access during and after COVID-19: A rapid response initiative in Rhode Island. *J. Subst. Abuse Treat.* **124**, 108283 (2021).

344. Wunsch, C. *et al*. Thirty-day Treatment Continuation After Audio-only Buprenorphine Telehealth Initiation. *J. Addict. Med.* **17**, 206–209 (2023).

345. *Department of Justice and Department of Health & Human Services Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities*.

346. Department of Human Services. Governor Murphy Signs Seabrooks-Washington Community-Led Crisis Response Act. *Official Site of the State of New Jersey* https://www.nj.gov/humanservices/news/pressreleases/2024/approved/20240112.shtml (2024).

347. Mazerolle, L., Soole, D. W. & Rombouts, S. Street-level drug law enforcement: A meta-analytical review⋆. *J. Exp. Criminol.* **2**, 409–435 (2007).

348. National Conference of State Legislatures. The Legislative Primer Series for Front-End Justice. https://www.ncsl.org/civil-and-criminal-justice/the-legislative-primer-series-for-front-end-justice (2023).

349. Closing the Revolving Door?: Substance Abuse Treatment as an Alternative to Traditional Sentencing for Drug-Dependent Offenders - Tara D. Warner, John H. Kramer, 2009. https://journals.sagepub.com/doi/10.1177/0093854808326743.

350. Tomaz, V., Moreira, D. & Souza Cruz, O. Criminal reactions to drug-using offenders: A systematic review of the effect of treatment and/or punishment on reduction of drug use and/or criminal recidivism. *Front. Psychiatry* **14**, (2023).

351. *Substance Abuse Treatment*. (Substance Abuse and Mental Health Services Administration (US), 2005).

352. Bonfine, N., Munetz, M. R. & Simera, R. H. Sequential Intercept Mapping: Developing Systems-Level Solutions for the Opioid Epidemic. *Psychiatr. Serv.* **69**, 1124–1126 (2018).

353. Brinkley-Rubinstein, L. *et al.* Criminal justice continuum for opioid users at risk of overdose. *Addict. Behav.* **86**, 104–110 (2018).

354. Mollman, Marianne & Mehta, Christine. *Neither Justice Nor Treatment: Drug Courts in the United States*. https://phr.org/wp-content/uploads/2017/06/phr_drugcourts_report_singlepages.pdf (2017).

355. Mitchell, O., Wilson, D. B., Eggers, A. & MacKenzie, D. L. Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *J. Crim. Justice* **40**, 60–71 (2012).

356. Sanford, J. S. & Arrigo, B. A. Lifting the Cover on Drug Courts: Evaluation Findings and Policy Concerns. *Int. J. Offender Ther. Comp. Criminol.* **49**, 239–259 (2005).

357. Shaffer, D. K. Looking Inside the Black Box of Drug Courts: A Meta-Analytic Review. *Justice Q.* **28**, 493–521 (2011).

358. Marlowe, D. B. Achieving Racial and Ethnic Fairness in Drug Courts. *Court Rev. J. Am. Judges Assoc.* **49**, 40 (2013).

359. McElrath, K., Taylor, A. & Tran, K. K. Black–White Disparities in Criminal Justice Referrals to Drug Treatment: Addressing Treatment Need or Expanding the Diagnostic Net? *Behav. Sci.* **6**, 21 (2016).

360. Cheesman II, F. L., Marlowe, D. B. & Genthon, K. J. Racial differences in drug court referral, admission, and graduation rates: findings from two states and eight counties. *J. Ethn. Crim. Justice* **21**, 80–102 (2023).

361. Center for Justice Innovation & All Rise. *A Practitioner's Guide to Constitutional and Legal Issues in Adult Drug Courts*. https://www.innovatingjustice.org/sites/default/files/media/document/2023/Constitutional-and-Legal-Issues.pdf (2023).

362. Farago, F. *et al.* Medication-Assisted Treatment in Problem-solving Courts: A National Survey of State and Local Court Coordinators. *J. Drug Issues* **53**, 296–320 (2023).

363. Deaton, Stuart. *On-Charge Drug Testing: Evaluation of Drug Testing in the Criminal Justice System*. https://www.ojp.gov/ncjrs/virtual-library/abstracts/charge-drug-testing-evaluation-drug-testing-criminal-justice-system (2004).

364. Goldkamp, J. S. & Jones, P. R. Pretrial drug-testing experiments in Milwaukee and Prince George's County: The context of implementation. *J. Res. Crime Delinquency* **29**, 430–465 (1992).

365. Haapanen, R. & Britton, L. Drug Testing for Youthful Offenders on Parole: An Experimental Evaluation*. *Criminol. Public Policy* **1**, 217–244 (2002).

366. Turner, S., Petersilia, J. & Deschenes, E. P. Evaluating Intensive Supervision Probation/Parole (ISP) for Drug Offenders. *Crime Delinquency* **38**, 539–556 (1992).

367. United Nations Office on Drugs and Crime & World Health Organization. *Treatment and Care for People with Drug Use Disorders in Contact with the Criminal Justice System: Alternatives to Conviction or Punishment*. https://www.unodc.org/documents/UNODC_WHO_Alternatives_to_conviction_or_punishment_ENG.pdf (2019).

368. Wermink, H., Blokland, A., Nieuwbeerta, P., Nagin, D. & Tollenaar, N. Comparing the effects of community service and short-term imprisonment on recidivism: a matched samples approach. *J. Exp. Criminol.* **6**, 325–349 (2010).

369. Bales, W. D. & Piquero, A. R. Assessing the impact of imprisonment on recidivism. *J. Exp. Criminol.* **8**, 71–101 (2012).

370. Robert, L., Maes, E., Blokland, A. & Wermink, H. 'Virtual' versus 'real' prison: Which is best? Comparing the re-incarceration rates after electronic monitoring and imprisonment in Belgium. in *The Routledge international handbook of life-course criminology* 417–435 (Routledge/Taylor & Francis Group, New York, NY, US, 2017). doi:10.4324/9781315747996-23.

371. Wakefield, T., Bialous, S. & Apollonio, D. E. Clearing cannabis criminal records: A survey of criminal record expungement availability and accessibility among US States and Washington DC that decriminalized or legalized cannabis. *Int. J. Drug Policy* **114**, 103983 (2023).

372. Drug Policy Alliance. *Dismantling the Drug War in the States: A Comprehensive Framework for Drug Decriminalization and Shifting to a Public Health Approach*. https://drugpolicy.org/resource/dismantling-drug-war-states-comprehensive-framework-drug-decriminalization-and-shifting (nd).

373. Cooper, H. L. War on Drugs Policing and Police Brutality. *Subst. Use Misuse* **50**, 1188–1194 (2015).

374. Crenshaw, K. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Rev.* **43**, 1241–1299 (1991).

375. Harp, K. L. H. & Bunting, A. M. The Racialized Nature of Child Welfare Policies and the Social Control of Black Bodies. *Soc. Polit.* **27**, 258–281 (2020).

376. Meinhofer, A., Onuoha, E., Angleró-Díaz, Y. & Keyes, K. M. Parental drug use and racial and ethnic disproportionality in the U.S. foster care system. *Child. Youth Serv. Rev.* **118**, 105336 (2020).

377. Fight against world drug problem must address unjust impact on people of African descent, say UN rights experts. *OHCHR* https://www.ohchr.org/en/news/2019/03/fight-against-world-drug-problem-must-address-unjust-impact-people-african-descent-say.

378. Aronowitz, S. V. & Laurent, J. Screaming Behind a Door. *J. Correct. Health Care* **22**, 98–108 (2016).

379. Krawczyk, N., Picher, C. E., Feder, K. A. & Saloner, B. Only One In Twenty Justice-Referred Adults In Specialty Treatment For Opioid Use Receive Methadone Or Buprenorphine. *Health Aff. (Millwood)* **36**, 2046–2053 (2017).

380. Lim, S. *et al.* Association between jail-based methadone or buprenorphine treatment for opioid use disorder and overdose mortality after release from New York City jails 2011–17. *Addiction* **118**, 459–467 (2023).

381. Haas, A. *et al.* Post-incarceration outcomes for individuals who continued methadone treatment while in Connecticut jails, 2014–2018. *Drug Alcohol Depend.* **227**, 108937 (2021).

382. Office of Public Affairs | Justice Department Files Statement of Interest in Case Alleging Pennsylvania Jail Unlawfully Denied Access to Medication to Treat Opioid Use Disorder | United States Department of Justice. https://www.justice.gov/opa/pr/justice-department-files-statement-interest-case-alleging-pennsylvania-jail-unlawfully (2023).

383. State of Homelessness: 2023 Edition. *National Alliance to End Homelessness* https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/.

384. Miller-Archie, S. A., Walters, S. C., Singh, T. P. & Lim, S. Impact of supportive housing on substance use–related health care utilization among homeless persons who are active substance users. *Ann. Epidemiol.* **32**, 1-6.e1 (2019).

385. Bradford, W. D. & Lozano-Rojas, F. Higher Rates Of Homelessness Are Associated With Increases In Mortality From Accidental Drug And Alcohol Poisonings. *Health Aff. (Millwood)* **43**, 242–249 (2024).

386. Bauer, L. K., Brody, J. K., León, C. & Baggett, T. P. Characteristics of Homeless Adults Who Died of Drug Overdose: A Retrospective Record Review. *J. Health Care Poor Underserved* **27**, 846–859 (2016).

387. Cano, M. & Oh, S. State-level homelessness and drug overdose mortality: Evidence from US panel data. *Drug Alcohol Depend.* **250**, 110910 (2023).

388. Bradford, A. C. & Bradford, W. D. The effect of evictions on accidental drug and alcohol mortality. *Health Serv. Res.* **55**, 9–17 (2020).

389. Barocas, J. *et al.* Population-Level Health Effects of Involuntary Displacement of People Experiencing Unsheltered Homelessness Who Inject Drugs in US Cities. *JAMA* **329**, (2023).

390. Sinha, R. Chronic Stress, Drug Use, and Vulnerability to Addiction. *Ann. N. Y. Acad. Sci.* **1141**, 105–130 (2008).

391. U.S. Government Accountability Guide. *Homelessness: Better HUD Oversight of Data Collection Could Improve Estimates of Homeless Population*. https://www.gao.gov/products/gao-20-433 (2020).

392. Olivet. Racial Inequity and Homelessness: Findings from the SPARC Study. *Ann. Am. Acad. Pol. Soc. Sci.* **693**, 82–100 (2021).

393. Natapoff, A. *Punishment without Crime: How Our Massive Misdemeanor System Traps the Innocent and Makes America More Unequal*. (Basic Books, New York, NY, 2018).

394. Abuse, N. I. on D. Part 1: The Connection Between Substance Use Disorders and Mental Illness | National Institute on Drug Abuse (NIDA). https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness (–).

395. Torrens, M., Rossi, P. C., Martinez-Riera, R., Martinez-Sanvisens, D. & Bulbena, A. Psychiatric Co-Morbidity and Substance Use Disorders: Treatment in Parallel Systems or in One Integrated System? *Subst. Use Misuse* **47**, 1005–1014 (2012).

396. Kelly, T. M., Daley, D. C. & Douaihy, A. B. Treatment of substance abusing patients with comorbid psychiatric disorders. *Addict. Behav.* **37**, 11–24 (2012).

397. More Than 1 in 9 Adults With Co-Occurring Mental Illness and Substance Use Disorders Are Arrested Annually. https://pew.org/3HWryCL (2023).

398. Slade, Harvey. *Drug Decriminalisation in Portugal: Setting the Record Straight*. https://transformdrugs.org/blog/drug-decriminalisation-in-portugal-setting-the-record-straight (2021).

399. European Monitoring Centre for Drugs and Drug Addiction. *2000 Annual Report on the State of the Drugs Problem in the European Union*. https://www.emcdda.europa.eu/html.cfm/index37279EN.html_en (2000).

400. Instituto Português da Droga e da Toxicodependência. *Portugal Drug Situation 2000: Report to the EMCDDA*. https://www.emcdda.europa.eu/system/files/publications/148/NR2000Portugal_65264.PDF (2000).

401. European Monitoring Centre for Drugs and Drug Addiction. *Statistical Bulletin 2020 – Prevalence of Drug Use*. https://www.emcdda.europa.eu/data/stats2020/gps_en (2020).

402. Universite de Lausanne. Council of Europe Annual Penal Statistics. *Council of Europe* https://wp.unil.ch/space/space-i/annual-reports/.

403. European Monitoring Centre for Drugs and Drug Addiction. *Portugal, Country Drug Report 2019*. https://www.emcdda.europa.eu/publications/country-drug-reports/2019/portugal_en (2019).

404. Stevens, A. & Hughes, C. Dépénalisation et santé publique : politiques des drogues et toxicomanies au Portugal. *Mouvements* **86**, 22–33 (2016).

405. Harm Reduction International. *The Global State of Harm Reduction 2020*. https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2020/ (2020).

406. Sante publique France. *HIV/AIDS Surveillance in Europe. End year report 2004*. https://www.santepubliquefrance.fr/maladies-et-traumatismes/infections-sexuellement-transmissibles/vih-sida/hiv-aids-surveillance-in-europe.-end-year-report-2004 (2005).

407. General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD). *Statistical Bulletin 2018: Illicit Substances*. https://www.sicad.pt/BK/EstatisticaInvestigacao/Documents/2020/sinopses/SinopseEstatistica18_substanciasIlicitas_EN.pdf (2020).

408. Laqueur, H. Uses and Abuses of Drug Decriminalization in Portugal. *Law Soc. Inq.* **40**, 746–781 (2015).

409. Taylor, H. *et al*. Prospective client survey and participatory process ahead of opening a mobile drug consumption room in Lisbon. *Harm. Reduct. J.* **16**, 49 (2019).

410. Rêgo, X., Oliveira, M.J., Lameira, C., & Cruz, O.S. 20 years of Portuguese drug policy - developments, challenges and the quest for human rights. *Subst. Abuse Treat. Prev. Policy* **16**, 59 (2021).

411. Faiola & Fernandes Martins. Once hailed for decriminalizing drugs, Portugal is now having doubts. *Washington Post* (2023).

412. Singer, Jeffrey A. My Washington Post Letter to the Editor about Portugal's Drug Decriminalization. *Cato Institute* https://www.cato.org/blog/washington-post-letter-editor-about-portugals-drug-decriminalization (2023).

413. United Nations Office on Drugs and Crime. *World Drug Report 2021*. https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html (2021).

414. Hospital – Treated Overdose and Acute Substance Misuse In MNDOSA.

415. Richie, B. E. Women and Drug Use: The Case for a Justice Analysis. *Women Crim. Justice* **17**, 137–143 (2006).

416. Kajstura & Sawyer. *Women's Mass Incarceration: The Whole Pie 2023*. https://www.prisonpolicy.org/reports/pie2023women.html (2023).

417. American College of Obstetricians and Gynecologists. *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist*. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy-the-role-of-the-obstetrician-gynecologist (2011).

418. Miranda, L., Dixon, V., September, C. R. P. on, 30, & 2015. How States Handle Drug Use During Pregnancy. http://projects.propublica.org/graphics/maternity-drug-policies-by-state.

419. Shannon, K. *et al*. Global epidemiology of HIV among female sex workers: influence of structural determinants. *The Lancet* **385**, 55–71 (2015).

420. Johnson. Interventions to improve health and the determinants of health among sex workers in high-income countries: a systematic review. *Lancet Public Health* **8**, E141-154 (2023).

421. Noichl, Maria. DRAFT REPORT on the regulation of prostitution in the EU: its cross-border implications and impact on gender equality and women's rights. (2023).

422. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J. Addict. Med.* **14**, 1–91 (2020).

423. Committee on Substance Use and Prevention. Medication-Assisted Treatment of Adolescents With Opioid Use Disorders. *Pediatrics* **138**, e20161893 (2016).

424. McCarty, D. *et al*. Effectiveness of and Access to Medications for Opioid Use Disorder for adolescents and young adults: A scoping review. *J. Addict. Med.* **16**, e157–e164 (2022).

425. Alinsky, R., Hadland, S., Matson, P., Cerda, M. & Saloner, B. Adolescent-Serving Addiction Treatment Facilities in the United States and the Availability of Medications for Opioid Use Disorder. *J. Adolesc. Health* **67**, (2020).

426. Stevens, A., Trace, M. & Bewley-Taylor, D. *Reducing Drug-Related Crime: An Overview of the Global Evidence*. https://www.beckleyfoundation.org/wp-content/uploads/2016/04/BF_Report_05.pdf (2005).

427. Center for Behavioral Health Statistics and Quality. *Results from the 2020 National Survey on Drug Use and Health: Detailed Tables*. https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020.htm (2021).

428. Weissenborn, R. & Nutt, D. J. Popular intoxicants: what lessons can be learned from the last 40 years of alcohol and cannabis regulation? *J. Psychopharmacol. (Oxf.)* **26**, 213–220 (2012).

429. Collateral Sanctions Committee. *DHS Background Studies, Disqualifications, and Set-Asides: Report and Recommendations of the 2007 Collateral Sanctions Committee*. Minnesota Sentencing Guidelines Commission (2008).

430. Minnesota Sentencing Guidelines Commission. *Controlled Substance Offenses: Sentencing Practices for Offenses Sentenced in 2019*. Minnesota Sentencing Guidelines Commission (2021).

431. Murray, J., Hecker, S., Skocpol, M., & Elkins, M. *Second Look = Second Chance: Turning the Tide through NACDL's Model Second Look Legislation*. Federal Sentencing Reporter 33(5), (2021).

432. Collateral Consequences Resource Center. Expungement, sealing & set-aside convictions: A national survey. https://ccresourcecenter.org/2020/09/01/expungement-sealing-set-aside-of-convictions-a-national-survey/. (2020).