



Redressing Inequities in America's Drug Policies: An Evidence-Grounded Call for Bold Action

Brief prepared for the Biden-Harris Administration

The Biden-Harris Administration has an unprecedented mandate to advance equity, which it has identified as a key priority. The advancement of equity cannot be meaningfully achieved without bold action in the domain of drug policy, as recognized by the Office of National Drug Control Policy (ONDCP) by including racial equity among its priorities for the first year of the Biden-Harris Administration.¹ For decades, current policy approaches to drug use and addiction have been amplifying inequities across racialized and economically marginalized Americans. This is the direct result of an overreliance on the criminal justice system and supply-side enforcement (collectively described as drug prohibition) to control drug-related harms. This continues to be the status quo despite clear scientific evidence that this approach is ineffective. To address emerging and long-standing drug-related crises, the United States needs drug policies grounded in the best available scientific evidence. This is critical to addressing three interrelated issues: the opioid overdose epidemic, the disproportionate harms of the criminal justice among racialized Americans, and the potential opportunities presented by drug decriminalization and regulation.

Below, we outline five key drug policy issues that require immediate, bold, and evidence-grounded action. These are:

1. Reforming cannabis policy;
2. Removing obstacles to harm reduction for overdose and infectious disease prevention;
3. Increasing access to medication for opioid use disorder;
4. Evolving drug courts; and
5. Elevating the use of discretion in drug law enforcement.

1. Reforming Cannabis Policy

Prohibition has failed to control the demand and supply of cannabis, with widespread use and availability continuing unabated based on data from the United Nations Office on Drugs and Crime, and other sources.²⁻⁴ Beyond its failure to achieve these goals, the prohibition of cannabis has caused significant harms including disproportionate criminalization for low-level offences (6.1 million cannabis arrests in the United States between 2010 and 2018),⁵ especially among Black, Indigenous, and Latinx communities, barriers to access of medical cannabis,⁶ and impediments to cannabis research.⁷ For these and other reasons, cannabis policy reform for medical and adult use has continued to gain momentum internationally and nationally. Moreover, public support for cannabis reform is now at 68%, the highest proportion recorded,⁸ and there are growing calls to reallocate resources from enforcing low-level cannabis offences towards health and social services instead.

Against this backdrop, there is an opportunity to modernize cannabis policy at the federal level and to support states in their continued development of regulated markets for medical and adult cannabis use.

Key Actions

- Remove cannabis from Schedule I of the *Controlled Substances Act (CSA)*, such as by adopting the *Marijuana Opportunity Reinvestment and Expungement (MORE) Act (H.R.*



3884/S. 2227). This federal legislation would not only remove cannabis from the CSA, but also begin to address persisting racial inequities by allowing for the expungement and resentencing of cannabis convictions, providing financial support to communities most harmed by criminalization, and diversifying the regulated cannabis industry.

- Put an end to the negative impacts of cannabis criminalization in other sectors including, but not limited to, child welfare, housing, education, employment, and immigration.
- Prioritize equity in established and emerging regulated cannabis markets by formally ensuring diversity in access to cannabis production, processing, and sales licences, supporting people in the transition from the illegal to legal markets, and providing broadly available capital and banking solutions.
- Invest profits from regulated cannabis markets into supporting the public good, such as equity initiatives, harm reduction, evidence-based education and treatment on substance use, and research.

2. Removing Obstacles to Harm Reduction for Overdose and Infectious Disease Prevention

An estimated 75,500 Americans died of overdose between March 2019 and March 2020 and preliminary data indicate that overdose deaths will reach an all-time high in 2020.⁹ In cities such as St. Louis¹⁰ and Philadelphia,¹¹ Black and Latinx communities are being disproportionately impacted by the opioid overdose epidemic, alongside well-publicized racial disparities in the COVID-19 pandemic. Multiple outbreaks of HIV and Hepatitis C infection related to injection drug use have occurred in urban and rural areas across the United States since 2015.¹² Many evidence-based strategies that are the most effective at preventing these adverse health outcomes are rooted in harm reduction.

Harm reduction refers to a set of interventions to reduce the negative consequences of substance use. Harm reduction interventions are often described as “meeting people where they are at,” and do not require abstinence, which is not always a realistic or desired goal. Harm reduction interventions include the provision of sterile injecting equipment, naloxone, and education for opioid overdose reversal, supervised consumption sites, and clinical approaches to reduce barriers to addiction treatment access. Over thirty years of evidence supports the use of harm reduction

strategies to prevent overdose and infectious disease transmission. However, current federal policies and enforcement decisions limit the ability of states and municipalities to implement these proven, life-saving interventions. These barriers to life-saving harm reduction interventions must be removed to save lives. We are encouraged by the explicit inclusion of harm reduction in the priorities of ONDCP,¹ as well as the first dedicated funding stream for harm reduction by the United States Congress.¹³

Key Actions

- Support state and local efforts to pilot and evaluate supervised consumption sites (SCSs) in the United States. Immediately drop the lawsuits against potential SCS operators in Philadelphia, and do not levy the “crack house statute” against them or other possible SCS operators. Over 120 SCSs¹⁴ exist globally and they have been found to reduce overdose mortality and infectious disease risk, and increase access to treatment and other health services.¹⁵ The “crack house statute” currently stands in the way of this intervention.¹⁶
- Eliminate the ban on federal funding for syringe service programs (SSPs). Although the ban was modified in the Consolidated Appropriations Act in 2016 to permit funding from the Department of Health and Human Services for some SSPs, the continued ban on purchasing injection equipment with federal funds and the need to seek special permission from federal authorities place undue burden on SSPs, which are recognized by the World Health Organization as the primary strategy to prevent infectious disease transmission related to injection drug use.
- Pass mandates to increase access to naloxone to prevent overdose deaths. This includes (a) mandating coverage in public and private insurance plans, (b) requiring that federally-funded drug treatment programs and correctional settings provide naloxone upon release, and (c) negotiating with manufacturers for reduced bulk pricing of naloxone.
- Pass federal mandates to allow for the implementation of voluntary drug checking services (e.g., fentanyl test strips, infrared spectrometry, mass spectrometry) in response to the unacceptably high level of overdose mortality stemming primarily from unknown high-potency opioids in the unregulated drug market.¹⁷



3. Increasing Access to Medication for Opioid Use Disorder

An estimated 2.4 million Americans are eligible for opioid agonist therapies to address opioid dependence.¹⁸ These therapies, which are dubbed Medication for Opioid Use Disorder, or MOUD, are pharmaceutical medications such as methadone, buprenorphine/naloxone, and other formulations that can manage opioid withdrawal symptoms and help stabilize individuals' drug use and lives. Extensive research has identified these medications as the gold standard in treating opioid addiction.¹⁹⁻²¹ For that reason, both methadone and buprenorphine are included on the World Health Organization's List of Essential Medicines.²² Evidence from the United States and elsewhere demonstrates that they are also effective in preventing overdose and drug-related recidivism.^{23,24} Despite this medical consensus on the effectiveness of MOUD, however, under 20% of eligible Americans have access to these life-saving treatments. To prevent the cycle of untreated addiction, overdose death, and criminal justice involvement, the Biden-Harris Administration must prioritize access to these life-saving treatments. We are encouraged by the priority of ONDCP to expand access to evidence-based treatment, including by removing unnecessary barriers to MOUD.¹

Scaling up access to MOUD requires four parallel actions. First, create an MOUD stockpile sufficient to cover all eligible Americans. Second, address gaps in the provision of MOUD for incarcerated and recently-incarcerated people that contributes to a high prevalence of overdose post-release.²⁵ Third, provide training and education for clinicians to increase their capacity to prescribe these medications. Fourth, respond to misinformation about the effectiveness of these medicines, which has critically hampered their rollout. This "MOUD hesitancy," much like vaccine hesitancy, undermines the delivery of life-saving medicines to people who need it and the response to the ongoing opioid overdose epidemic.

Key Actions

- Direct the Department of Health and Human Services to create a stockpile of opioid agonist therapy to cover all eligible individuals.
- Direct the Federal Bureau of Prisons to scale up access to MOUD to ensure continuation of medication during and post-incarceration for eligible individuals, and work

with state authorities to improve access for individuals incarcerated in state and municipal prisons and jails.

- Direct the National Institute on Drug Abuse to develop and fund clinical training programs on the prescribing of opioid agonist therapy to address low dispensation of these life-saving medications.
- Direct the Office of National Drug Control Policy to develop a public education campaign to dispel myths contributing to MOUD hesitancy.
- Remove the "X" waiver requirement for the clinical prescribing of buprenorphine as MOUD,²⁶ along with disproportionate restrictions on methadone prescribing.²⁷

These recommendations are in line with guidance from incoming United States Surgeon-General Dr. Vivek H. Murthy, MD, who wrote that clinicians must "ensure that the recognition and treatment of opioid use disorder is a universal aspect of training and part of every clinician's toolbox." Dr. Murthy further identified that, "[e]radicating the bias against addiction that too many people — including some clinicians — still harbor" is critical to addressing the severely limited provision of MOUD for eligible Americans.²⁸

4. Evolving Drug Courts

For people charged with eligible drug-related offenses, drug courts offer a treatment-based alternative to incarceration.²⁹ However, drug courts leave most of the harms of drug criminalization untouched.³⁰ Even with more than 4,000 problem-solving courts in the United States, people who use drugs remain over-policed, over-incarcerated, under-housed, and, with respect to healthcare delivery, under-served.³¹ Traditional drug court practices also create their own unnecessary harms, including those associated with "shock" jail sanctions, abstinence-only treatment mandates, the overuse of in-patient care, and intrusive drug-testing protocols.³² Despite being one of the few diversion programs scaled up across the United States, drug courts have had no demonstrable impact on incarceration rates³⁰ or the opioid overdose epidemic. They have also only reproduced the racialized legal and healthcare disparities generated by drug prohibition. People of color are admitted, retained, and graduated from drug courts at significantly lower rates than their White counterparts.³³



Drug courts must be re-designed as a non-coercive, non-punitive, trauma-informed, and evidence-based intervention.³⁴ To become less coercive – and closer to the voluntary option they aim to be – drug courts must become pre-plea across the board. To become non-punitive and more humane, the common practice of sanctioning participants for not achieving abstinence must be prohibited. To further reduce participant harms – particularly to victims of sexual violence – drug courts need to implement trauma-informed alternatives to observed urine-testing protocols.³⁵ To be considered an evidence-based intervention, drug courts must provide full access to life-saving opioid medications, not prohibit the use of prescribed psychiatric medications, and not otherwise intervene in any doctor/patient relationship.³⁶ Lastly, to become a more racially equitable and historically-responsive intervention, drug courts must interrogate their admission and community engagement practices, as well as shift their focus away from one-size-fits-all treatment mandates towards addressing key health determinants such as housing, primary healthcare, education, and employment.³³

Key Actions

- Immediately end the use of jail holds as sanction for substance use or program non-compliance.³⁷
- Immediately end the use of extended jail holds under the guise of “keeping participants safe from overdose.”³⁸
- Immediately end the use of mandated treatment for first-time offenders and cannabis offences.³⁹
- Expand successful completion criteria to include non-abstinence-based outcomes.
- Expand program eligibility to include higher-level offenses or cases involving lengthier prison terms.⁴⁰
- Allow federal funds from the Bureau of Justice Assistance to be used to support drug court participants with charges involving violence.⁴¹
- Expand access to, and funding for, culturally-responsive treatment options.⁴²
- Partner with community-based harm reduction organizations and provide education on harm reduction to clients.
- Implement a low-barrier “housing first” accessibility model for unhoused participants.⁴³
- Prioritize funding for jurisdictions facing transportation challenges and treatment deserts.⁴⁴
- Provide non-judicially-intensive deflection and diversion options for low-level charges.

- Develop a model of federal oversight that includes directing courts to not interfere with medical mandates in the drug court context.
- Shift drug court data collection priorities beyond recidivism to include broader public health outcomes.⁴⁵

5. Elevating the Use of Discretion in Drug Law Enforcement

Law enforcement leaders often invoke the mantra, “we don’t make the laws,” to signal that the scope of their role in policymaking is limited to its implementation. Yet decisions relating to prioritization and modes of law enforcement by police, prosecutors, and other actors within the criminal legal system are absolutely critical to shaping the policy environment on-the-ground. How that enforcement discretion is communicated also has a powerful impact on people’s understanding of their legal environment.

In the drug policy sphere, one major example of the leverage of enforcement discretion is in the area of cannabis. Although major legislative and regulatory reform is still needed, the cannabis sector in the United States has emerged as a product of enforcement discretion on the federal level.⁴⁶

Using enforcement restraint to encourage local innovation in cannabis policy is certainly relevant to other spheres of federal drug policy, where discretion can be leveraged to prevent deaths and promote recovery. Especially at a time of intersecting national public health crises, federal law enforcement must not stand in the way of state and local drug policy experimentation. Without necessitating legislative or regulatory shifts, decisive and coordinated changes in enforcement priorities can rapidly transform the drug policy landscape. In fact, enforcement discretion could be crucial to rapidly achieving many of the priorities outlined above.

Key Actions

- Make federal statements of commitment not to prosecute agencies, staff, and clients of above-ground SCSs.
- Commit to relax enforcement of draconian monitoring and other regulations on prescribers and healthcare institutions to reduce access barriers to MOUD.



- Make a statement of non-prosecution for harm reduction-focused diversion to promote access to non-prescribed buprenorphine.⁴⁷
- Deprioritize regulatory and street-level enforcement targeting injectable and other emerging modalities (including safer supply⁴⁸), in line with the evidence of public health benefits of safer supply and other novel treatment approaches.^{49,50}
- Wind down aggressive drug law enforcement done under the banner of disrupting street supplies, especially when it comes to arrest and prosecution of low-level dealers in drug delivery resulting in death investigations.⁵¹

Although restraint is warranted in a number of areas, more *aggressive* federal law enforcement is warranted in other areas to address the addiction and opioid overdose crises. These are multifactorial issues that have numerous structural drivers, where legal intervention can produce public health benefit. This includes scaling up federal law enforcement in the following areas:

- Adopt consumer protection to address fraud, abuse, and discrimination in drug treatment and other health services, including inside correctional settings.
- Promote access to housing, employment, and other supportive systems through enforcement of anti-discrimination, parity, and other provisions.
- Oppose discriminatory and unhealthy zoning provisions that block access to harm reduction, treatment, housing, and other services.

Conclusion

Moving the United States beyond the opioid overdose epidemic, the inequity crisis in drug law enforcement, and the unacceptably low levels of access to quality, evidence-based addiction treatment requires bold, innovative solutions. The recommendations listed herein offer a roadmap to addressing the current challenges in drug policy. The United States has the opportunity to be a global leader in developing evidence-based, effective drug policies. We urge the Biden-Harris Administration to immediately begin implementing these recommendations to advance equity, health, and the social well-being of all Americans.

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References

1. The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. Washington, DC: Office of National Drug Control Policy; 2021.
2. Fries A, Anthony RW, Cseko Jr. A, Gaither CC, Schulman E. The price and purity of illicit drugs: 1981 - 2007. Alexandria, VA: Institute for Defense Analyses, 2008.
3. Werb D, Kerr T, Nosyk B, Strathdee S, Montaner J, Wood E. The temporal relationship between drug supply indicators: an audit of international government surveillance systems. *BMJ Open* 2013; **3**: 8.
4. UNODC. World Drug Report 2020. Vienna: United Nations Office on Drugs and Crime, 2020.
5. ACLU. A tale of two countries: Racially targeted arrests in the era of marijuana reform. New York: American Civil Liberties Union, 2020.
6. Valencia CI, Asaolu IO, Ehiri JE, Rosales C. Structural barriers in access to medical marijuana in the USA—a systematic review protocol. *Systematic Reviews Journal* 2017; **6**(1): 1-8.
7. Walker I, Netherland J. Developing a transformative drug policy research agenda in the United States. *Contemporary Drug Problems* 2019; **46**(1): 3-21.
8. Brennan M. Support for Legal Marijuana Inches Up to New High of 68%. Gallup, Inc., 2020.
9. Stephenson J. Drug Overdose Deaths Head Toward Record Number in 2020, CDC Warns. *JAMA Health Forum*; 2020: American Medical Association; 2020. p. e201318-e.
10. Rehwald J. Opioid overdose deaths decline statewide in 2019, but rise for Black men. *Springfield News-Leader*. 2020 July 20.
11. Whelan A. Philadelphia may be on the way to a record for fatal drug overdoses in 2020, another COVID-19 consequence. *The Philadelphia Inquirer*. 2020 December 6.
12. Lyss SB, Buchacz K, McClung RP, Asher A, Oster AM. Responding to Outbreaks of Human Immunodeficiency Virus Among Persons Who Inject Drugs—United States, 2016–2019: Perspectives on Recent Experience and Lessons Learned. *Journal of Infectious Diseases* 2020; **222**(Supplement_5): S239-S49.
13. Rosenberg S. Congress Responds to NCHRF's Request with First Ever Federal Funding Solely Dedicated to Harm Reduction. National Campaign for Harm Reduction Funding; 2021.
14. BCCSU. Supervised Consumption Services. Vancouver: British Columbia Centre on Substance Use, 2017.
15. Kennedy MC, Karamouzian M, Kerr T. Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review. *Current HIV/AIDS Reports* 2017; **14**(5): 161-83.
16. Burns J. Court Blocks PA Safe Injection Again Despite Data, Citing Federal 'Crack House' Statute. *Forbes*. 2021 January 14.
17. Peppin JF, Coleman JJ. CDC's Efforts to Quantify Prescription Opioid Overdose Deaths Fall Short. *Pain and Therapy* 2021: 1-14.
18. Florence C, Luo F, Rice K. The economic burden of opioid use disorder and fatal opioid overdose in the United States, 2017. *Drug Alc Depend* 2020; **218**: 108350.
19. Mattick RP, Kimber J, Breen C, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev* 2008; **2**(2).
20. Nielsen S, Larance B, Degenhardt L, Gowing L, Kehler C, Lintzeris N. Opioid agonist treatment for pharmaceutical opioid dependent people. *Cochrane Database Syst Rev* 2016; (5).
21. Amato L, Davoli M, Ferri M, Ali R. Methadone at tapered doses for the management of opioid withdrawal. *Cochrane Database Syst Rev* 2002; (1): CD003409.
22. World Health Organization. WHO Model List of Essential Medicines: 20th Edition: World Health Organization; 2017.
23. Stone AC, Carroll JJ, Rich JD, Green TC. Methadone maintenance treatment among patients exposed to illicit fentanyl in Rhode Island: Safety, dose, retention, and relapse at 6 months. *Drug Alc Depend* 2018; **192**: 94-7.
24. Westerberg VS, McCrady BS, Owens M, Guerin P. Community-based methadone maintenance in a large detention center is associated with decreases in inmate recidivism. *J Subst Abus Treat* 2016; **70**: 1-6.
25. Brinkley-Rubinstein L, McKenzie M, Macmadu A, et al. A randomized, open label trial of methadone continuation versus forced withdrawal in a combined US prison and jail: Findings at 12 months post-release. *Drug Alc Depend* 2018; **184**: 57-63.
26. Fiscella K, Wakeman SE, Beletsky L. Buprenorphine deregulation and mainstreaming treatment for opioid use disorder: X the X waiver. *JAMA Psychiatry* 2019; **76**(3): 229-30.



27. Del Pozo B, Beletsky L. No “back to normal” after COVID-19 for our failed drug policies. *International Journal of Drug Policy* 2020; **83**: 102901.
28. Murthy VH. Ending the Opioid Epidemic — A Call to Action. *New England Journal of Medicine* 2016; **375**(25): 2413-5.
29. U.S. Department of Justice. Drug Courts: Overview. 2020. <https://www.ojp.gov/feature/drug-courts/overview> (accessed February 23 2021).
30. Sevigny EL, Fuleihan BK, Ferdik FV. Do drug courts reduce the use of incarceration?: A meta-analysis. *Journal of Criminal Justice* 2013; **41**(6): 416-25.
31. Cooke M. Exploring the Divestment/Reinvestment Approach to Policing. ACLU-WA Blog Series. Washington: American Civil Liberties Union; 2021.
32. Möllmann M, Mehta C. Neither Justice Nor Treatment: Drug Courts in the United States. New York: Physicians for Human Rights, 2017.
33. National Association of Drug Court Professionals. Journal for Advancing Justice Volume I: Identifying and Rectifying Racial, Ethnic, and Gender Disparities in Treatment Courts. 2018.
34. Drug Policy Alliance. Moving away from drug courts: Toward a health-centered approach to drug use, 2014.
35. Trauma Informed Oregon. Trauma Informed Urine Drug Screenings. Portland, OR, 2020.
36. National Association of Drug Court Professionals. Journal for Advancing Justice Volume II: Best Practices in the Justice System for Addressing the Opioid Epidemic. 2018.
37. Rabuy B. The life-threatening reality of short jail stays. Northampton, MA, 2016.
38. Joudrey PJ, Khan MR, Wang EA, et al. A conceptual model for understanding post-release opioid-related overdose risk. *Addiction Sci & Clin Prac* 2019; **14**(1): 1-14.
39. Werb D, Kamarulzaman A, Meacham M, et al. The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy* 2016; **28**: 1-9.
40. Sevigny EL, Pollack HA, Reuter P. Can drug courts help to reduce prison and jail populations? *Annals Am Acad Pol & Soc Sci* 2013; **647**(1): 190-212.
41. Sacco LN. Federal support for drug courts: In brief. Washington, DC: Congressional Research Service, 2018.
42. Acevedo A, Garnick DW, Dunigan R, et al. Performance measures and racial/ethnic disparities in the treatment of substance use disorders. *J Stud Alc & Drugs* 2015; **76**(1): 57-67.
43. Edens EL, Mares AS, Tsai J, Rosenheck RA. Does active substance use at housing entry impair outcomes in supported housing for chronically homeless persons? *Psychiatric Services* 2011; **62**(2): 171-8.
44. Baldwin JM. Drug courts review: Rural treatment court programs. Washington, DC: National Drug Court Research Center, 2019.
45. Joudrey PJ, Howell BA, Nyhan K, et al. Reporting of substance use treatment quality in United States adult drug courts. *International Journal of Drug Policy* 2021; **90**: 103050.
46. Mead A. Legal and regulatory issues governing cannabis and cannabis-derived products in the United States. *Frontiers in Plant Science* 2019; **10**: 697.
47. Pozo Bd, Krasner LS, George SF. Decriminalization of diverted buprenorphine in Burlington, Vermont and Philadelphia: An intervention to reduce opioid overdose deaths. *Journal of Law, Medicine & Ethics* 2020; **48**(2): 373-5.
48. Letter from the Minister of Health regarding treatment and safer supply. Ottawa, Canada; 2020.
49. Eydt E, Glegg S, Sutherland C, et al. Service delivery models for injectable opioid agonist treatment in Canada: 2 sequential environmental scans. *CMAJ Open* 2021; **9**(1): E115-E24.
50. Fairgrieve C, Fairbairn N, Samet JH, Nolan S. Nontraditional alcohol and opioid agonist treatment interventions. *Medical Clinics* 2018; **102**(4): 683-96.
51. Beletsky L. America’s favorite antidote: drug-induced homicide in the age of the overdose crisis. *Utah L Rev* 2019: 833.