

Contents lists available at [ScienceDirect](#)

Journal of the American Pharmacists Association

journal homepage: www.japha.org

COMMENTARY

Support, don't punish: Drug decriminalization is harm reduction

Jeffrey P. Bratberg*, Adrienne Simmons, Vibhuti Arya, Aneesha Bhatia, Sheila P. Vakharia

ARTICLE INFO

Article history:

Received 15 July 2022

Accepted 15 December 2022

Available online 20 December 2022

ABSTRACT

Despite large investments in and policy support for harm reduction including naloxone, syringes, and medications for opioid use disorder, people who use drugs continue to experience unprecedented rates of mortality from overdose and morbidity from infectious diseases. The criminalization of drug use has disproportionately exacerbated these drug-related harms and imposed short- and long-term burdens on already marginalized and vulnerable populations. Pharmacy professionals and students are not immune to the effects of drug criminalization, where one conviction can lead to the loss of their license, employment, or educational progress. Communities become less healthy and stagnate in punitive criminalization systems, further reducing opportunities for growth. Decriminalization of drug use and possession is an urgently needed and effective approach to drug use that shifts resources from punishment to public health, thereby reducing the negative impacts of drug use and keeping communities safe and healthy. Pharmacists play essential roles in the prevention and management of drug misuse and use disorders. As policy makers consider and implement drug decriminalization, pharmacists must actively advocate for these policies and educate community and organizational partners on the individual, professional, and community benefits of this harm reduction strategy.

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The overdose crisis

Overall drug overdose deaths reached a record-breaking 107,000 deaths in 2021, according to preliminary data from the Centers for Disease Control and Prevention.¹ From 1999 to 2021, more than 650,000 people have died of opioid overdose. In the next decade, it is predicted that 1.2 million individuals will die of opioid-related overdose.² In recent years, illegally manufactured fentanyl has been implicated most frequently in recent deaths, followed by methamphetamine and cocaine,

whereas overdose deaths involving heroin and opioid analgesics have remained relatively stable.¹

Beyond overdose risk, substance use is associated with several other health risks. Among people who inject drugs (PWID), sharing injection equipment is the driving factor for hepatitis C virus (HCV) infections and remains a risk factor for human immunodeficiency virus (HIV) infections. Although HIV infections declined from 2015 to 2019, HCV infection rates have increased for more than a decade.^{3,4} In addition to HCV and HIV, there have been increases in endocarditis, osteomyelitis, hepatitis B virus, and other infectious diseases among people who use drugs (PWUD).^{5–8} These preventable health outcomes are the result of multiple decades of inaccessible public health interventions, outdated drug laws that disproportionately criminalize some PWUD, and attitudes among policy makers, the public, and health care providers rooted in racism and stigma.

Most people use drugs without criminal penalty and without developing a substance use disorder (SUD). According to data from the 2020 National Survey on Drug Use and Health, approximately 1 in 5 people older than 12 years in the United States used an illicit drug in the past year—totaling more than 59 million people. Less than a third of this group, 18.4 million

Disclosure: The authors declare no relevant conflicts of interest or financial relationships.

Funding: The authors declare that this work was not funded.

* **Correspondence:** Jeffrey P. Bratberg, PharmD, FAPhA, Clinical Professor of Pharmacy Practice, University of Rhode Island College of Pharmacy, 7 Greenhouse Rd., 244J, Kingston, RI 02881.

E-mail address: jefbratberg@uri.edu (J.P. Bratberg).

ORCID

Jeffrey P. Bratberg: <http://orcid.org/0000-0002-2240-5768>Adrienne Simmons: <http://orcid.org/0000-0003-1135-4851>Vibhuti Arya: <http://orcid.org/0000-0001-7820-2030>Sheila P. Vakharia: <http://orcid.org/0000-0003-0892-071X>

Key Points**Background:**

- People who use drugs face health risks including infections, overdose, and death.
- The criminalization of drug use and often subsequent incarceration disproportionately worsens the morbidity and mortality of marginalized populations.
- The American Pharmacists' Association (APhA) has enacted several evidence-based policies supporting harm reduction of drug use and resolution of racial and socioeconomic health inequities at the root of marginalization.

Findings:

- Drug decriminalization offers advantages over failed punitive measures, potentially breaking the cycle of despair caused by each step of the justice system for both pharmacists and their patients.
- As more drug decriminalization policies are enacted, pharmacists should educate the public and their peers on their positive impact, and advocate for their implementation, evaluation, and expansion.

people, met criteria for a SUD relating to their drug use in the past year. Meanwhile, there were 1.5 million drug-related arrests⁹ in the United States in 2019 and they were disproportionately among black, indigenous, and Latinx people.¹⁰

People who are marginalized, poor, black, indigenous, or people of color are more likely to experience punishment for drug use, develop SUD, and experience health care discrimination including receiving less treatment.^{11–18} As pharmacists, we play a critical role in providing access to health care for all PWUD and our advocacy must acknowledge how our current policies and structures exacerbate drug-related harms. The following commentary examines the impact of criminalization and incarceration on health outcomes and the concept of decriminalization as a harm reduction strategy for improved patient and community health.

The history of the drug war

Until the early 20th century, Americans had relatively easy access to drugs such as heroin, cocaine, alcohol, and marijuana. These substances were commonly used by middle- and upper-class white Americans both recreationally and medicinally. The first restrictive drug law in the United States was passed in San Francisco in 1875, which banned opium smoking that was commonly associated with Chinese immigrants. Over the next several years, fears among white people were stoked to ban and restrict more drugs at the state and federal level, often depicting drug-intoxicated racialized minorities as threats to white communities. A New York Times headline in 1914 decried that “Negro Cocaine Fiends were a new southern menace” (“[The Negro Cocaine Fiend](#)”)¹⁹ which helped garner support for a federal anticocaine law. Later on, federal anticannabis laws were directed at people of Mexican descent.²⁰

The Harrison Narcotics Tax Act of 1914 initiated 2 dramatic changes in drug policy. First, by requiring registration and taxation of the import of opium and coca derivatives, it was the first law to criminalize drug possession and use. Second, the Act defined opioid use disorder as “not a medical condition,” preventing physicians from treating it and laying the foundation for society to view drug use as a moral failing, PWUD as menaces to society, and complete abstinence as the only solution to drug use so that physicians could not prescribe opioids to these patients to keep them stable.²¹

By 1971, President Nixon declared a “war on drugs” through passing the Controlled Substances Act, increasing and intensifying policing, arrests, sentencing, and incarceration of people for the manufacturing, sale, use and possession of certain drugs. Although ostensibly enacted to increase the health and safety of all Americans because it was the first federal law to allocate funding to drug prevention, treatment, and research, it was also politically motivated to control and surveil groups that posed a threat to his administration—the antiwar left and the civil rights activists. Decades later, a now infamous interview with Nixon’s advisor John Ehrlichman confirmed this when he said they wanted to associate hippies with marijuana and black people with heroin through criminalization.²²

Since then, several federal laws were passed that resulted in an explosive increase in people imprisoned, often for long sentences, for nonviolent drug offenses. In 1991, the U.S. Supreme Court ruled that a mandatory life sentence is not a “cruel and unusual” punishment for a first-time drug possession conviction.²³ Supporters of punitive approaches to drug use often believe that arrests and incarceration motivate PWUD to stop using and commit fewer crimes. In fact, researchers recently published a retrospective observational study of the effects of traditional policing for drug-related crimes and discovered an association of policing with an increased risk of fatal overdoses and no change in the rate of future arrests nor incarceration.²⁴

America now has the highest number of incarcerated people in the world, 2.3 million people, and 1 in 5 is incarcerated for a drug offense. Between 1980 and 2016, there was a 10-fold increase in the number of incarcerations owing to drug possession.²⁵ Although black and white people use and sell drugs at the same rates, black people convicted of drug crimes represent 3 times their share of the overall population.²⁶ Although most people arrested for drug charges do not end up incarcerated, a drug-related arrest record can have lifelong impacts for people and their families including poverty, un- or underemployment, and homelessness.^{27,28}

Background checks are often a routine hiring practice and can be required for some housing applications. Some professional licensing or credentials disqualify candidates with a criminal background, thereby excluding people from well-paying and fulfilling careers, including pharmacy. In addition, a criminal record can negatively affect child custody decisions and can affect one’s ability to vote. Given that this nation ties health care access to employment, the health ramifications of criminalization can be particularly damaging as well.

The war on drugs has led to overall poorer health outcomes and increased morbidity and mortality.²⁹ Incarcerated individuals are 3 times more likely to have HIV/acquired immunodeficiency syndrome (AIDS) and other sexually transmitted infections than nonincarcerated individuals. They are also less likely to receive vaccines for preventable diseases

like influenza and coronavirus disease 2019 (COVID-19).²⁵ In addition to infectious disease related issues, most detention centers leave individuals with SUD untreated. Although 2 of every 3 incarcerated people have a diagnosis for an alcohol or other SUD, only approximately 11% of these individuals are treated with evidence-based therapies.^{25,30} The relative risk of all-cause mortality was 12 times higher for incarcerated individuals than nonincarcerated individuals.³¹

The impact of the war on drugs on pharmacists

Within the first few years of the passage the Controlled Substances Act, the Drug Enforcement Administration (DEA) was formed. The DEA was granted the authority to enforce federal drug laws and to monitor the prescribing and dispensing of certain controlled substances. The involvement of this law enforcement entity in medical treatment and decision making entrenched the war on drugs into American health care and pharmacy practice in an unprecedented manner.

Most notably, the early years of the overdose crisis were characterized by high levels of opioid prescriptions being written and dispensed in Appalachia and other parts of the nation, as pain became the fifth vital sign. However, as overdose deaths increased and there was recognition of the role of overprescribing, pressure was placed on pharmacists to monitor their dispensing practices and their inventories to avoid diversion, to verify prescriptions for controlled substances, and to use prescription drug monitoring programs to identify overprescribing or drug interaction risks. Many pharmacists became cautionary tales as they were targeted by the DEA and other authorities for their dispensing practices, and several pharmacy chains have been found liable for their role in the overdose crisis. This fear has affected the older and new generation of pharmacists alike, who all now share a heightened awareness (and fear) that they are being monitored and could be at risk for their practices. As expected, these fears have had a chilling effect in opioid prescribing and dispensing and prescribers and pharmacists alike.

Unfortunately, fears of DEA intervention and wholesaler limits have now had an impact on the availability of buprenorphine, a gold standard treatment for opioid use disorder that cuts the risk of lethal overdose in half.^{32,33} Research suggests that pharmacists may not stock buprenorphine, may not accept prescriptions from new patients, or may impose other limits.³⁴ On the one hand, this tragic example shows how DEA involvement in pharmacy practice led to reduced opioid dispensing in an attempt to address the overdose crisis; on the other hand, those very policies have now instilled fear in pharmacists to dispense a lifesaving medication that could save lives.

The history of the American Pharmacists Association (APhA) harm reduction–related policies

APhA is the largest national pharmacy organization in the United States and is “the pharmacy voice at the table in developing national guidelines, policies, and best practices that advance the profession and patient care.”³⁵ Over more than 4 decades, the APhA House of Delegates (HOD) has passed a series of policies related to drug control laws and

research, access to medications for opioid overdose and opioid use disorder treatment, harm reduction, and social determinants of health (SDOH), with a focus on racism.

In 1980, HOD supported a policy on medical marijuana research, yet opposed state legislation intended to circumvent federal laws restricting “substances having a recognized hazard of abuse.” This was followed up with several policies passed in 2015, supporting patient-centered care of people who use cannabis for medicinal use. In 1983, they supported classifying heroin as a Schedule I controlled substance, but also research exploring medicinal uses of Schedule I substances. In 2012, HOD passed policies encouraging close collaborations between pharmacists, DEA, and the U.S. Department of Justice to update and harmonize controlled substance laws, while prioritizing patient care in the revision and enforcement of these laws. HOD voted to approve policies on controlling access to methamphetamine precursors in 2016, emphasizing patient access for legitimate medical needs, but also supporting “stringent enforcement of criminal laws against individuals who engage in drug trafficking.”

APhA HOD has passed several policies specifically addressing harm reduction. In 1999, HOD supported state policies to permit unrestricted sales or distribution of sterile syringes by pharmacists. This was followed up with policies in 2014 to increase pharmacy-based patient access to opioid reversal agents (e.g., naloxone); in 2016, expanded access to injectable medications for addiction treatment; and, in 2022, independent prescribing authority for medications for opioid and other SUDs. The most comprehensive harm reduction policy statements were approved in 2019, “Patient-centered Care of People who Inject Non-Medically Sanctioned Psychotropic or Psychotropic Substances.” The priority statement encouraged state authorities to revise laws to support PWUD. These statements also supported pharmacists’ roles in providing consistent and unrestricted access to evidence-based harm reduction interventions (e.g., safe injection equipment, immunizations, use of overdose prevention sites, pre-exposure prophylaxis for HIV), embracing harm reduction principles for PWID, and referring people to solutions for their primary care, behavioral health, and SDOH needs and other recovery supports.

In 2021, amidst the racial and socioeconomic disparities brought to light by COVID-19 pandemic, HOD discussed and approved policies on antiracism and SDOH. In addition to denouncing racism, APhA policy also affirmed that racism is a SDOH, and urged organizations to evaluate their policies for their effect on racial inequities. Another HOD policy supported pharmacists to universally screen for SDOH that affect patient outcomes, but also “create opportunities for community engagement to best meet the needs of the patients they serve.” In 2022, APhA passed a policy urging pharmacists to use SDOH to address health inequities in practice and advocacy.

Decriminalizing drug use and possession

A strategy to reduce the number of people who are arrested, convicted, and incarcerated for drug-related offenses is to eliminate criminal penalties for drug use and possession, possession of drug use supplies such as syringes, and low-level drug sales. Drug decriminalization is different from legalization in that it does not establish a legally regulated market or

Drug decriminalization

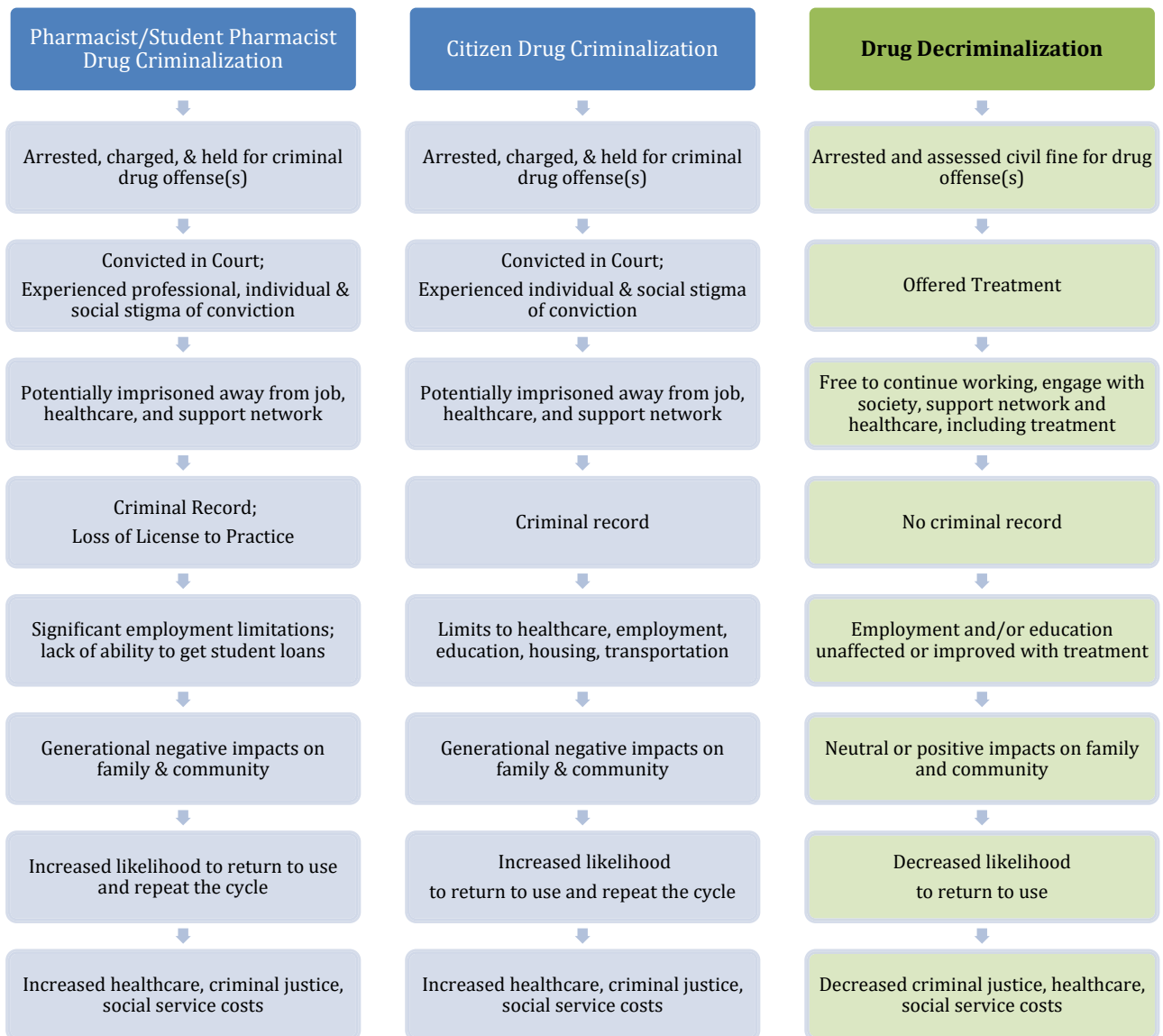


Figure 1. Comparison of experiences in criminalized versus decriminalized circumstances.

supply chain for the cultivation, production, or sale of drugs.³⁶ At its core, drug decriminalization is a harm reduction strategy, much like wearing seatbelts, the human papillomavirus vaccine, and naloxone. Harm reduction strategies aimed at reducing the negative consequences associated with drug use “have demonstrated effectiveness in reducing HIV and HCV transmission, do not increase rates of community drug use, help individuals engage in treatment, and are cost-effective.”³⁷ Benefits of drug decriminalization include reduction in jail and prison populations, better law enforcement resource utilization, decreased drug use stigma, and removal of barriers to evidence-based harm reduction practices.³⁶

A common concern is that decriminalizing drugs would lead to higher rates of drug use and crime. However, data from the United States and across the globe suggest that treating problematic drug use as a health issue, rather than a criminal

issue, helps keep communities healthy and safe. Numerous countries have eliminated criminal penalties for drug use and possession without increased societal harm.³⁸ In 2000, Portugal decriminalized drugs and increased access to sterile syringes, methadone, and other drug therapies. Since then, Portuguese officials have observed no major increase in drug use, reduced rates of adolescent drug use, decreased incidence of HIV/AIDS, reduced drug-related deaths, and an increase in the number of patients receiving SUD treatment.^{39,40}

In 2020, Oregon became the first U.S. state to decriminalize drug possession and expand access to evidence-based harm reduction services. Advocates in the state worked to secure \$302 million in funding for harm reduction and substance use treatment services such as overdose prevention; access to naloxone, methadone, and buprenorphine; and drug education and outreach. By removing criminal penalties for drug

possession, the Oregon Criminal Justice Commission estimated that there would be a 95% reduction in racial disparities in drug arrests. Decriminalization is widely supported, including the American Public Health Association, the World Health Organization, and the National Association for the Advancement of Colored People, and the public. A recent poll by Drug Policy Alliance and the American Civil Liberties Union finding that 66% of Americans now support decriminalization.⁴¹ Now is the time for other states to reimagine their approach to substance use and incorporate decriminalization as a key component of health care and harm reduction.

The comparisons between the steps experienced by pharmacists and citizens in the status quo environment of drug criminalization versus one of drug decriminalization are outlined in Figure 1. A cascade of short- and long-term impacts on the person's SDOH and overall health is activated after arrest, conviction, and especially incarceration. Individual, social, and professional stigmatization may result.^{42,43} Within the pharmacy profession, pharmacists with a conviction, especially one involving drug laws, face stigma and discrimination in their personal and professional communities. Even if maintained on medications in recovery, using without consequences, or not using at all, the pharmacy professional community, like other health professions, is not comprehensively "recovery friendly." Socially, what is normally a higher level of professional admiration, trust, and respect given to pharmacists is lost with a drug conviction. Even in established professional recovery communities, convicted pharmacists face often permanent ridicule and disrespect. Criminalization makes our patients, colleagues, students, and communities less healthy and requires resources to be redirected from a punitive, failed approach to a public health approach.

Advocating for decriminalization

Although APhA has taken steps to support providing care to PWUD, such as access to naloxone, nonprescription syringes, and medications for opioid use disorder (MOUD), the association has a contradictory position on the legalization and decriminalization of drugs.⁴⁴ First approved in 1990, the policy originally stated that "APhA opposes legalization or decriminalization of the possession, sale, distribution, or use of illicit drug substances for non-medical uses." In 2016, HOD approved a change in the policy to remove decriminalization and add 2 more statements:

APhA supports the use of drug courts or other evidence-based mechanisms—when appropriate as determined by the courts—to provide alternate pathways within the legal criminal justice system for the treatment and rehabilitation of individuals who are charged with drug-related offenses and who have substance use or other related medical disorders.

APhA supports criminal penalties for persons convicted of drug-related crimes, including but not limited to drug trafficking, drug manufacturing, and drug diversion, whenever alternate pathways are inappropriate as determined by the courts.

Although these changes were ostensibly intended to improve care for people with SUDs, their flaw is that they call on courts, not clinicians, to make medical decisions, which are often not centered on evidence-based practice. The additional dissonance of these policy statements is further highlighted by

the association's advocacy to position pharmacists as key leaders in addressing the opioid overdose crisis. To fortify our role as providers of compassionate, humane, and equitable health care, APhA must (1) urgently amend these policies to more explicitly support decriminalization at the state and federal level and (2) support the Drug Policy Reform Act (HR 4020), which would dismantle the drug war through drug decriminalization.⁴⁵

As the overdose crisis worsens and pharmacists' role in public health increases, it is imperative to position pharmacists as advocates for drug decriminalization. Education, service, advocacy, and policy change are needed to live up to our professional duty to do no harm and meet people where they are at. Examples of ways to support decriminalization as a pharmacist include the following:

- Educate peers, policy makers, law enforcement, pharmacy organizations, and community members about the benefits of decriminalization and other harm reduction practices and the harms of the war on drugs.
- Support interprofessional harm reduction advocacy education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
- Provide unrestricted harm reduction services and services that address SDOH.
- Advocate for decriminalization and harm reduction legislation and policy changes at state and federal levels, including within the pharmacy profession and its organizations, led by pharmacists with lived experience.
- Expand access to evidence-based SUD treatments as decriminalization efforts succeed.

To assist pharmacists with policy education and advocacy, they can find policies on topics ranging from syringe distribution to drug decriminalization to naloxone and MOUD access at the following websites:

- The Drug Policy Alliance: <https://drugpolicy.org/>
- Prescription Drug Abuse Policy System: <https://pdaps.org>
- Network for Public Health Law Harm Reduction Legal Project: <https://www.networkforphl.org/resources/topics/projects/harm-reduction-legal-project/>

Not until pharmacists publicly declare our support for decriminalization will pharmacists be viewed as health care providers for all patients, providing care where it is most needed, justifying an increased scope of practice to enhance and sustain more access points for the full scope of addiction treatment services.

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- Jeffrey P. Bratberg, PharmD, FAPhA**, Clinical Professor of Pharmacy Practice, University of Rhode Island College of Pharmacy, Kingston, RI
- Adrienne Simmons, PharmD**, Director of Programs, National Viral Hepatitis Roundtable, Washington, DC
- Vibhuti Arya, PharmD, MPH**, Professor, St. John's University College of Pharmacy and Health Sciences, Queens, NY
- Aneesa Bhatia, PharmD**, PGY-1, Capital Health Regional Medical Center, Trenton, NJ
- Sheila P. Vakharia, PhD**, MSW, Department of Research and Academic Engagement, Drug Policy Alliance, New York, NY