

Whole of Government and Harm Reduction

THE LEGAL PATH TO A WHOLE OF GOVERNMENT OPIOIDS RESPONSE: PART 5

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Executive Summary

Harm reduction is beset by law and stigma. Stigma powers the urge to be punitive and law provides the means. The effects ripple through every harm reducing action the government does at all levels. To achieve its full potential in reducing the toll of overdose and dangerous drug use, harm reduction must be allowed to do its job without undue interference from contrary federal policies, inconsistent state laws, and structural barriers. Using a whole-of-government (W-G) approach, this paper details the challenges, current policy misalignments and legal barriers to implementing harm reduction strategies for drug use. The recommendations that follow articulate a series of opportunities for governments at all levels to realign and recommit to harm reduction.

The federal government needs to do more to make hard reduction work. The Centers for Disease Control and Prevention and the National Institutes of Health should fund the research that further demonstrates its cost-effectiveness. Those and other health and human services agencies together with the Office of National Drug Policy (ONDC) and the Drug Enforcement Agency (DEA) must better align their horizontal whole-of-government policy levers. Harm reduction requires not only positive policy signals but a far more sophisticated approach to federal funding to avoid funding gaps, insecurity, and siloes. Congress can make progress on vertical whole-of-government (W-G) by endorsing a new financing framework (“braiding”) where multiple mandatory and discretionary funding sources that flow vertically from the federal government to the states can be coordinated. Congress must also intervene to remove numerous legal roadblocks such as those that impede the funding of access to clean syringes and the establishment of Overdose Prevention Centers.

State governments must move beyond the “war on drugs” (such as eliminating drug induced homicide charges against street-level dealers and people sharing drugs with others)

and address the legal rules that create persistent barriers to harm reduction, such as state drug paraphernalia laws that impede federal-funded initiatives such as naloxone distribution, fentanyl test strips, and syringe services programs. State executives also must ask themselves whether they are making sufficient progress on structural barriers such as the attitudes of local prosecutors to people who use drugs, the links between homelessness and drug-taking, and efforts to reduce stigma. State governments must also find a consistent institutional “home” for harm reduction. There must be aligned appropriations from the federal and state budget (and opioid lawsuit settlements) that are both big and flexible enough to allow states and localities to construct a true “harm reduction system,” one that is tailored to local needs, but with a firm floor of decriminalization, destigmatizing, non-discrimination elements that nudge states towards a public health and non-punitive approach to Opioid Use Disorder.

Introduction

Harm reduction emphasizes working directly with people who use drugs in a non-judgmental and non-coercive manner (National Harm Reduction Coalition, 2020b) to prevent overdose and infectious disease transmission and, overall, to improve their well-being (The White House Executive Office of the President, 2022). While the Council of Economic Advisers has estimated the cost of the opioid overdose crisis at 3.4 percent of the US GDP (\$2.5 trillion from 2015 to 2018) (Council of Economic Advisers, 2019), a Cato Institute analysis observed, “harm reduction has a success record that prohibition cannot match” (Singer, 2018). Notwithstanding, this track record and an excellent return on investment (Harm Reduction International, 2020), harm reduction is beset by horizontal and vertical whole-of-government (W-G) challenges.

Ignoring the evidence-base underpinning harm reduction strategies, many of its critics (who frequently will have influence or control over some level of government) see harm reduction engagement as encouraging or

perpetuating unlawful drug use. This is not news for those involved in harm reduction. Indeed, many of those who staff harm reduction services such as syringe services programs (SSPs) are themselves people in recovery, surviving not only the physical and mental challenges but also rampant stigma (Birtel et al., 2017; Pytell et al., 2022). Historically, many programs have started underground. Today, in many cities overdose prevention centers (OPCs) operate “off the grid” (“Dozens and dozens’ of underground safe injection sites in Seattle,” 2018) and, no doubt, safe supply services will follow, only to emerge once law and policy catch up with the evidence-base their underground activities inevitably help to establish.

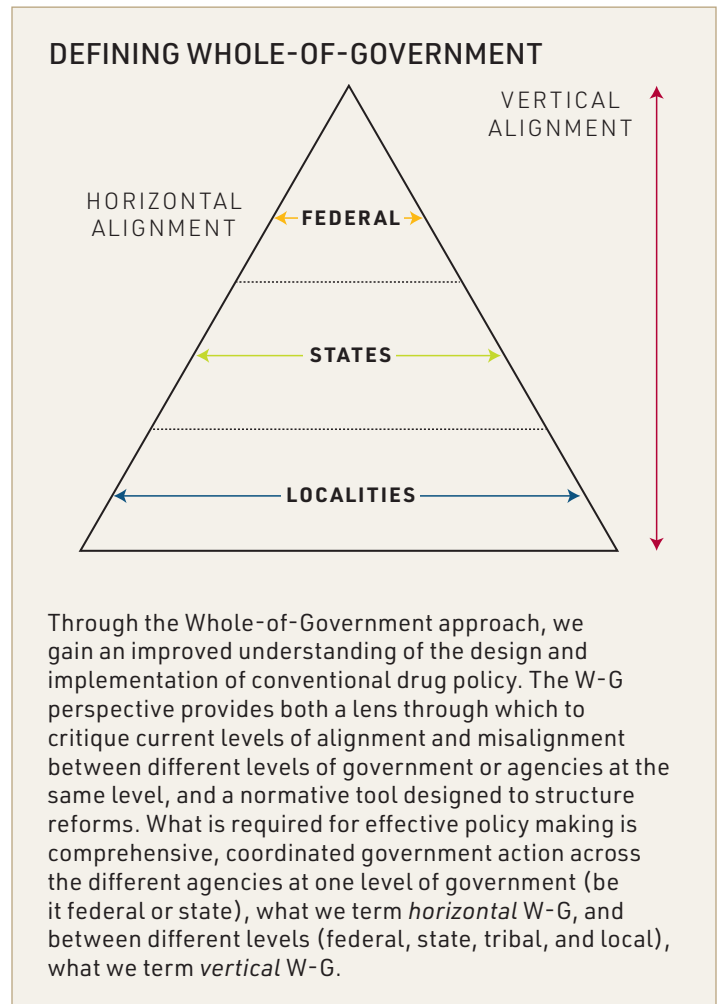
Blunt disagreements over harm reduction policies and implementation strategies exist at every level of government and between government and citizens. Take, for example, OnPoint’s community outreach teams (mobile SSPs) and its OPC in New York that have provoked anger from civic groups who feel overburdened by drug use in their locales even as the programs increasingly reduce deaths and illness (Interlandi, 2023).

To achieve its full potential reducing the toll of overdose and dangerous drug use, harm reduction must be allowed to do its job without undue interference from contrary federal policies, inconsistent state laws, and structural barriers (including those sometimes erected by local law enforcement). Getting there will require not only rethinking health care and its interface with public health strategies but also the role of law enforcement. Public safety initiatives that provide amenity in civil spaces, team up with social services and gain behavioral health skills must replace arrests and incarceration. To paraphrase Justice Douglas in *Robinson v. California*, we can no longer allow sickness to be viewed as a crime or sick people punished for being sick (*Robinson v. California*, 82 S.Ct. 1417, 1426 (1962)).

This paper details the W-G challenges, current policy misalignments and legal barriers faced by harm reduction and offers recommendations for all levels of government.

Harm Reduction’s Whole-of-Government Failure

Even the Biden administration’s signature harm reduction program designed to channel \$30 million into harm reduction strategies (Substance Abuse and Mental Health Services Administration, 2021) has attracted controversy. The Substance Abuse and Mental Health Services Administration (SAMHSA) grants for harm reduction announced pursuant to the American Rescue Plan Act can be used to fund products such as infectious-disease testing kits, condoms, and hepatitis vaccinations (Substance Abuse and Mental Health Services Administration, 2021). The



list of covered products (including “safe smoking kits” containing, for example, alcohol swabs and lip balm) led to a political storm, fueled by conservative news outlets, accusing the US Department of Health and Human Services (HHS) of funding and distributing “crack pipes” (Jones, 2022). Before long, legislation was introduced to further restrict products that could be purchased with federal funds (Preventing Illicit Paraphernalia for Exchange Systems Act, 2022), with one of its sponsors proclaiming, “We need to do more, but sending drug paraphernalia to addicts is not the answer” (Rubio, 2022).

Syringe services, while finally granted a funding stream under the Consolidated Appropriations Act of 2018, remain hampered by a congressional federal rider contained in continuing appropriations legislation (Centers for Disease Control and Prevention, 2019) that prohibits federal funds being used to purchase syringes. As if to highlight the confusion and friction that can flow from these restrictions, a September 2022 letter to state agencies from SAMHSA opined that it was permissible

to use federal funds for the purchase of syringes for the intramuscular administration of the overdose reversal drug naloxone. These inconsistencies reflect a government that is not serious about harm reduction, allowing pervasive internal barriers at all levels of government to hamper the use of the proven, effective strategy.

The interaction of harm reduction and government is fraught, strewn with legal barriers that make the job of saving lives harder. A broad W-G approach is necessary to harness diverse sources of funding but exposes harm reduction strategies to actors who frequently initiate or defend horizontal and vertical misalignments and barriers.

Federal Horizontal Whole-of-Government Issues

Harm reduction is institutionally under-represented at the federal agency level and currently lacks an advocate agency that can harness and promote the necessary W-G solutions.

Of our public health agencies, the US Centers for Disease Control and Prevention (CDC) is focused on testing, education, surveillance, and data. SAMHSA, the lead federal body and one of the few that self-describes as a public health agency, is currently focused on providing “access to a comprehensive continuum of mental and substance use disorder services, including high-quality, evidence-based prevention, treatment, and recovery support services” (Substance Abuse and Mental Health Services Administration, 2022). Other than a commitment to improving access to naloxone, the strategies advocated by SAMHSA arguably are more aligned with improving the treatment continuum than public health interventions such as syringe services or overdose preventions centers. This treatment orientation is consistent with its origin story and its advocacy and support for treating mental health illnesses (Duff, 2020). But is it conducive to an effective harm reduction strategy? The country’s lead agency on funding state OUD strategies should be front and center in promoting and funding effective harm reduction. In contrast, laws and policies that create misalignments and barriers (whether intended or not) have strong advocates in DEA and among congressional criminal justice hawks. SAMHSA and the Office of National Drug Control Policy (ONDCP) both had their origins in the early years of the “war on drugs.”

Overall, harm reduction needs stronger leadership within the federal government to raise its profile and offer a counterbalance to supply-side strategies. Both agencies should be advocates for harm reduction and forcefully argue against FDA over-caution and DEA/Department of Justice (DOJ) over-regulation. Although the Biden administration has publicly supported harm reduction (The White House, 2022), the ONDCP Director is still not

a member of his cabinet (Choi, 2023). Arguably the most effective counterpoints to agencies that have not committed to harm reduction are, within HHS, the evidence-driven National Institute on Drug Abuse and, outside of government, national advocacy organizations such as the Drug Policy Alliance (DPA) (Drug Policy Alliance, 2022a), the National Harm Reduction Coalition (National Harm Reduction Coalition, 2020a), and the Network for Public Health Law (The Network for Public Health Law, 2023b).

Spending on harm reduction has increased during the Biden administration, and the American Rescue Plan Act of 2021 included \$30 million for harm reduction (American Rescue Plan Act, 2021 § 2706; Substance Abuse and Mental Health Services Administration, 2021). In September 2022, HHS announced \$1.6 billion in funding to be distributed by SAMHSA’s State Opioid Response (SOR) and Tribal Opioid Response (TOR) grant programs and the Health Resources and Services Administration (HRSA) rural communities opioid response programs (US Department of Health and Human Services, 2022). This overall increase in funding is positive. However, these funding programs are spread across prevention, harm reduction, treatment and recovery support. Indeed, historically they have skewed towards treatment and, as far as harm reduction goes, naloxone distribution. Even with overall funding increases harm reduction struggles to maintain current levels of service, let alone expanding to meet unmet need.

Because of harm reduction’s emphasis on survival over abstinence and its acceptance (but not necessarily approval) of illicit conduct, its strategies can face strong push-back. At the federal agency level, harm reduction frequently attracts friendly fire from other agencies or Congress that for political, policy, or social (stigma) reasons lean toward “moral defect” explanations of drug use and illnesses. It is all too easy for critics to beat the drum of criminalization, arguing that harm reduction helps deviant people do illegal things.

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State Horizontal Whole-of-Government Issues

In response to the sharp increase in heroin and fentanyl overdoses from 2016 through 2018 (Baumgartner & Radley, 2021), many states appointed study commissions or task forces to create state action plans. Most of these state initiatives addressed the familiar prevention/early intervention, harm reduction, treatment, and recovery domains. Harm reduction tended to concentrate on naloxone distribution and training, with limited receptiveness to establishing syringe services. Some more recent state-level initiatives have addressed additional strategies such as drug-checking, OPCs, and joint public safety-public health programs. However, there has been only limited willingness to address the legal rules that create persistent barriers to harm reduction (Davis et al., 2019). Federal funding for the overdose reversal drug naloxone or fentanyl test strips frequently are impeded by state drug paraphernalia laws (Singer, 2023) (albeit with a growing number of exceptions (New Mexico Department of Health, 2022)) or the attitudes of local prosecutors to people who use drugs (Chernoby & Terry, 2020).

Like the federal government, harm reduction does not have a consistent institutional “home” in state governments. Many programs have found homes alongside infectious disease programs within public health agencies, in the same divisions that deal with HIV, STDs, and viral hepatitis (California Department of Public Health, 2022; Indiana Department of Health). In other states the programs appear to be less programmatic and more communications oriented (Georgia Department of Public Health, 2023) or narrowly focused on licensing private harm reduction

organizations such as SSPs (West Virginia Bureau for Public Health, 2018). And, of course, there are still other states without any harm reduction programs, having committed themselves to the continued criminalization of the possession and distribution of supplies for drug use and drug testing (Dey, 2022). Several governors have appointed cabinet level officials to “drug czar” positions such as a director of recovery (Governor of Ohio) or a director for drug prevention, treatment and enforcement (NextLevel Recovery Indiana). However, some clearly have been appointed to further a drug policing strategy rather than harm reduction agenda (Bailey, 2023). Most states rely on the federal government to fund harm reduction (state appropriations for harm reduction are rare (Co. HB22-1326 Fentanyl Accountability And Prevention, 2022)) and community organizations to provide it (Coalition; North America Syringe Exchange Network (NASEN)).

The conventional (and quite modest) state law harm reduction playbook features laws relaxing syringe possession and distribution, improved naloxone access (including statewide standing orders) and some variant on “Good Samaritan” overdose protections (The Network for Public Health Law, 2023a). However, not every state has legalized SSPs (Kaiser Family Foundation, 2022b) and (as discussed below) there are considerable variations in syringe laws. Naloxone distribution is frequently burdened by incomplete immunity provisions, lack of insurance or out-of-pocket charges (Legislative Analysis and Public Analysis Association, 2020; New York State Department of Health AIDS Institute), while few states have enacted naloxone-opioids co-prescribing laws (Ariz. Rev. Stat. § 32-3248.01(D); Cal. Bus. & Prof. Code § 741).

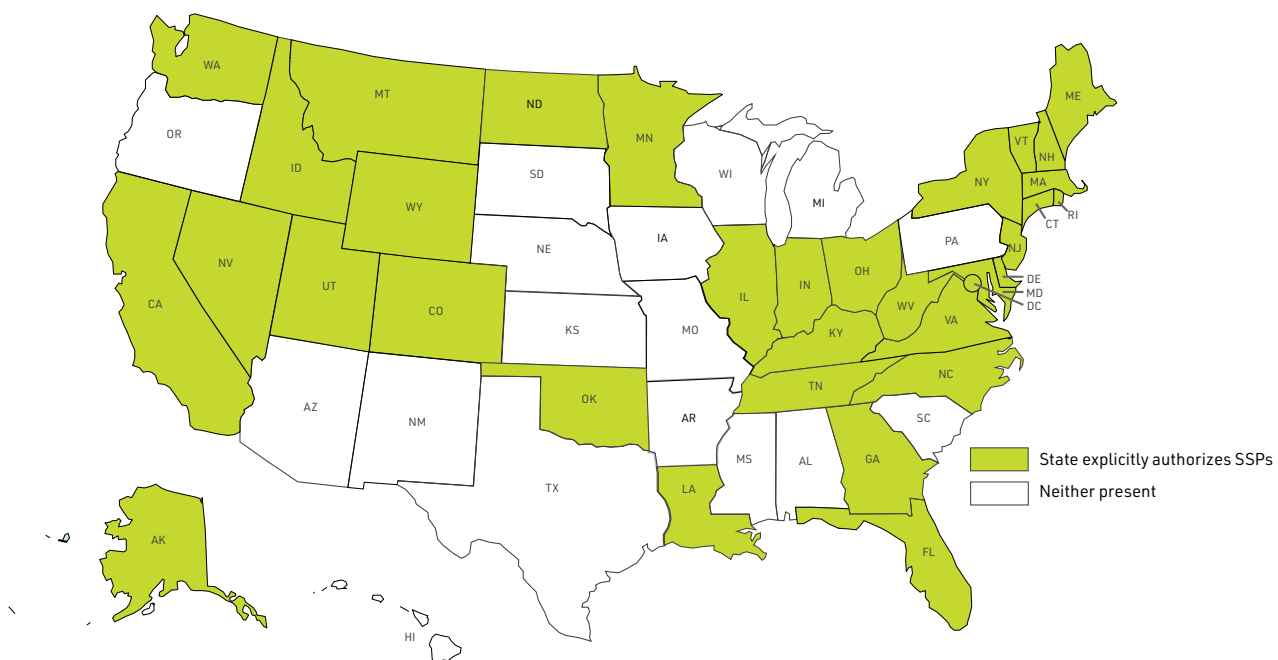


Figure 1: 34 states explicitly authorize syringe service programs as of August 1, 2021 (PDAPS, 2021).

A prevailing sense of criminalization with harm reduction and treatment exceptionalism reappears in state government. The criminalization fault line generally is replicated across state government with legislatures leaning toward more conservative positions while many state public health and Medicaid agencies push for harm reduction and treatment policies. Some state legislatures, such as Georgia, have gone so far as to propose legislation allowing centralized or concurrent jurisdictions designed to thwart local prosecutors who have decided not to bring minor drug cases (Blakinger, 2022). There are, however, few consistent patterns. For example, in 2019, 39 attorneys general acting through the National Association of Attorneys General sent a letter to congressional leaders requesting the federal government correct vertical misalignments such as the federal over-regulation of buprenorphine and restrictions on Medicaid funding of some residential treatment facilities (National Association of Attorneys General, 2019).

Vertical Whole-of-Government Issues

Few harm reduction strategies illustrate the W-G misalignments and barriers more vividly than strongly evidence-based SSPs (Bartholomew et al., 2021). One horizontal federal misalignment, the syringe rider, is discussed above. Additional signs of vertical friction are found in other appropriations language that makes eligibility for SSP funds dependent on a state, local, tribal, or territorial health departments satisfying a CDC Certificate of Need. This Certificate of Need is premised on a “risk for significant increases in hepatitis infections or an HIV outbreak (Centers for Disease Control and Prevention, 2022).

Once this obstacle is scaled (as it has been by 44 states and the District of Columbia, one tribal nation, and on territory (Centers for Disease Control and Prevention, 2022)), additional legal and policy barriers or, at best, friction are found downstream in state legislatures or agencies. Most, but not all, states now allow SSPs (Kaiser Family Foundation, 2022b). However, some SSP-enabling legislation itself can lead to further direct barriers. For example, some states push additional approval processes even further downstream to local public health officials who must certify a hepatitis C or HIV risk causes by intravenous drug use (Ind. Code §16-41-7.5-5, 2021; Fla. Stat. § 381.0038(4)(a), 2018). Other state statutes have potentially onerous requirements for programs, such as requiring the presence of a licensed health care provider (W. Va. Code § 16-64-3(a), 2021) or “one-for-one” syringe exchange (Bartholomew et al., 2021; Fla. Stat. § 381.0038(4)(b)(3), 2018; W. Va. Code §16-64-3(a), 2021).

State laws also create indirect barriers to the successful implementation of SSPs. For example, while states have passed legislation curtailing law enforcement from arguing probable cause merely because someone attended an SSP

(Ind. Code § 16-41-7.5-9, 2021), possession of syringes may still create jeopardy under outdated paraphernalia laws (Ga. Code Ann. § 16-13-32.2, 2021). Even states that seek to exclude only SSP-obtained syringes or drug residue left in exchanged syringes can muddy the waters by placing the burden on the person who injects drugs to establish proof that a particular syringe was exchanged at an SSP (N.C. Gen. Stat. § 90-113.27(c), 2020). Additional indirect barriers can involve broad structural determinants (such as law enforcement harassment of drug users) (Tempalski et al., 2007) as well as more explicit NIMBYism such as zoning laws to keep SSPs from opening in a neighborhood in the first place (Sawicki, 2022; Strike & Miskovic, 2017).

SSPs illustrate primarily downstream W-G barriers and misalignments. In contrast, overdose prevention centers (OPCs), safe spaces for the consumption of drugs under medical supervision (Drug Policy Alliance), currently trigger upstream vertical issues. Underground, unsanctioned OPCs have shown considerable potential for harm reduction (Armbrecht et al., 2021) as have studies on a large number of sites outside the United States (Drug Policy Alliance, 2022b). An NIH/NIDA report noted, “drug use supervision and overdose management have the potential to provide health benefits to at-risk [people who inject drugs] as well as economic advantages to the larger community,” concluding that “the evidence suggests these sites are able to provide sterile equipment, overdose reversal, and linkage to medical care for addiction, in the virtual absence of significant direct risks like increases in drug use, drug sales, or crime” (National Institutes of Health, 2021, p. 11). Notwithstanding, in 2019 after the City of Philadelphia approved an OPC to be opened by a non-profit, the federal government successfully sued to block the opening, arguing that it was unlawful under the Anti-Drug Abuse Act of 1988 (referred to as the “Crack House Law”) a position endorsed by the Third Circuit Court of Appeals, which noted, “Although Congress passed § 856 to shut down crack houses, its words reach well beyond them. Safehouse’s benevolent motive makes no difference” (United States v. Safehouse, 2021). The Biden administration has signaled a less combative approach than its predecessor (Peltz J, 2022). However, the “Crack House Law” remains on the books and could well be enforced again by a subsequent administration that is less inclined to favor harm reduction.

States have been slow to follow the Biden administration’s example. The governors of California (Cowan, 2022) and Vermont (Vermont governor vetoes safe injection sites for drug users, 2022) vetoed bills that were favorable to OPCs. However, a comprehensive 2023 bill introduced in New Mexico (House Bill 263, 56th Legislature (Lujan & Hochman-Vigil), 2023) may find approval from the governor, and similar legislation is being considered in Colorado (Young, 2023). Rhode Island has passed legislation allowing a pilot program (dependent on

downstream municipal approval (R.I. Gen. Laws § 23-12.10-1, 2022) but, with no OPC yet opened, is running into the sunset date for the pilot program (Smollen, 2023)). Although New York City has opened two OPCs (Khurshid, 2022), funding is running out (Wernau, 2023), and the governor of New York has refused to use opioid settlement moneys to fund OPCs, citing state and federal laws (Lombardo, 2022).

Even where federal/state/locality misalignments can be navigated, the friction they generate burns resources and hinders harm reduction strategies from getting to scale. Small breakthroughs such as the establishment of 402 SSPs scattered across 43 states (Kaiser Family Foundation, 2022b) represents a disproportionate use of resources, including lobbying and advocacy. Yet even that is a hollow victory. Only 13 states have 10 or more SSPs and they account for 253 of the 402 nationwide. The remaining 149 SSPs are spread across 31 states and the District of Columbia. Similar questions arise regarding OPCs. There may now be two open in New York City (NYC Health) but what about the rest of the state that has an opioid burden event (opioid overdose deaths, non-fatal outpatient ED visits and/or hospital discharges involving opioid overdose, abuse, dependence and unspecified use) at a rate of 250.5 per 100,000 population (New York State Department of Health, 2021, p. 41)?

The harm reduction strategy that logically will follow on from SSPs and OPCs are safe supply programs that have been piloted in Ontario (Lew et al., 2022) and British

Columbia (Tyndall, 2020). An array of federal barriers (the Controlled Substance Act, off-label prescribing, DEA sanctions against physicians) would be complemented by state and local laws such as those that have slowed the adoption of SSPs.

In short, as Herd and Moynihan (2019) note, “federalism... creates opportunities for different levels of government to work at cross-purposes.” Regulators and legislatures manipulate here policy misalignments and legal barriers to calibrate their views of policies or strategies. Thus, passing or enforcing a broad drug paraphernalia law heightens their control over harm reduction, or vice versa. Worryingly, the vertical misalignment in health and public health has been hardened by political polarization over the last few decades and, in particular, during the COVID-19 pandemic (Findling et al., 2022; Hegland et al., 2022). What is becoming clear is that some states will reject federal funding of evidence-based health or public health strategies because they disapprove of the conditions imposed by the federal government (such as non-discrimination policies), as exemplified by Tennessee’s recent rejection \$9 million destined for HIV/AIDS prevention (Cha & Nirappil, 2023) and more generally by a small government vision of public health precipitated by the COVID-19 pandemic (NACCHO & The Network for Public Health Law, 2021).

Finally, the mechanisms by which the federal government appropriates funding and states apply for funds for harm reduction strategies are flawed. The federal

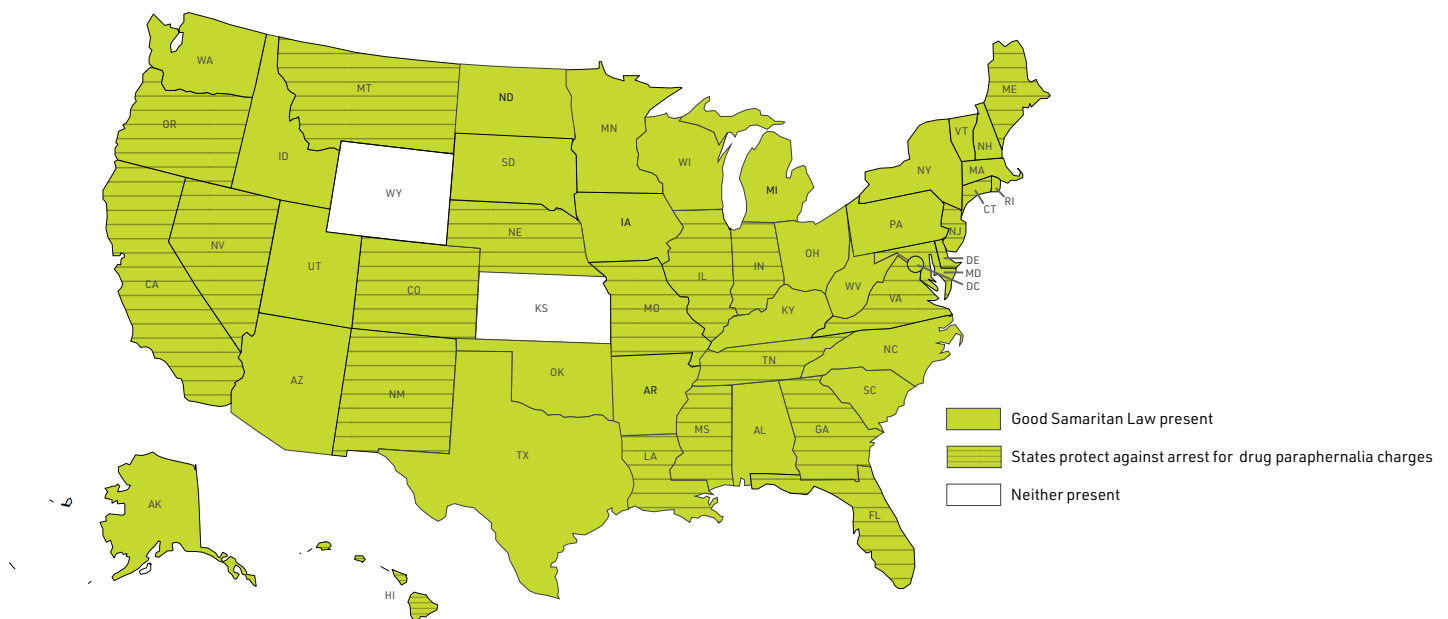


Figure 2: GSLs are now in 48 states and the District of Columbia, that encourage bystanders to call first responders during an overdose. 3 jurisdictions protect against arrest for controlled substance possession charges. (PDAPS, 2023).

government defaults to a “feast or famine” model for discretionary spending. States will be starved of resources until a change in administration or policies triggers a substantial appropriation. As a result, states and the harm reduction organizations they support receive episodic and inconsistent funding with short spending horizons that discourage spending on staffing, long term plans, or infrastructure. This phenomenon occurred during the Ebola and Zika outbreaks and was vividly illustrated during the COVID-19 public health emergency. In all cases, the federal government adopted the same type of grant-based funding; state public health agencies were underfunded as the pandemic began but, by the time federal funding arrived, the emergency was past its peak with grant funds unspent (LaFraniere, 2023).

Meeting the Whole-of-Government Challenges

Bringing the W-G approach to bear on a complex problem depends on several components, including agreement as to the problem, understanding the problem, and the causes of the problem (Worzala et al., 2018). For many involved in government at all levels, the harm reduction challenge unfortunately falls at the first of those hurdles. *Implicitly*, harm reduction recognizes that the predominant component of the “war on drugs,” the criminalization of drug use, has been a failure and that the future depends on demand-side strategies, such as harm reduction and treatment. *Explicitly*, harm reduction characterizes the addictive use of drugs, whether alcohol, tobacco, or opioids, as a public health problem, not a justice system issue. These challenges to the criminalization fault line create a barrier to the adoption (sometimes even the mere toleration) of harm reduction strategies. These challenges must be met with a reduction in legal and policy barriers, including: (1) an overhaul of funding mechanisms, (2) the removal of criminal justice barriers to harm reduction, and (3) the construction of a harm reduction system.

Overhaul Funding Mechanisms

After establishing effective leadership, the next step is funding. Harm reduction properly led and with workable strategies, deserves a proper funding mechanism. Not only has there been chronic underinvestment in harm reduction strategies (Baumgartner et al., 2022) but also the financing mechanisms are awash in funding insecurity (Jaramillo et al., 2019); periodic grant applications, limitations on use, spending horizons. Funding mechanisms must be overhauled to promote long-term state strategies, building out necessary infrastructure, and coordinated spending. Recently the Bipartisan Policy Center (BPC) recommended that Congress revisit the State Opioid Response Grants and Substance Abuse Prevention

and Treatment Block Grants overseen by SAMHSA, revisit its funding formula, and allow multiyear authorizations (Bipartisan Policy Center, 2022).

In addition to funding insecurity, states and other organizations that rely on federal and other funds for harm reduction (and treatment) must cope with funding siloes. Funds may be provided from different SAMHSA “buckets,” as well as from the Centers for Medicare and Medicaid Services (CMS), CDC, HRSA, NIH, and FDA; 70 opioid-related discretionary funding streams. (Bipartisan Policy Center, 2022, p. 35). This is the financial equivalent of the horizontal W-G fail (fragmentation and lack of coordination) across the federal government. Thereafter, this fragmentation and lack of coordination across the federal horizontal plane means states and their public and private dependents face difficulties analogous to vertical W-G barriers as they seek to apply funds to various harm reduction and treatment purposes (Butler et al., 2020, p. 6-8). Budget flexibility and coordination of funding sources are improved by either braiding together grants or other sources into a virtual fund or actually blending them into a single pool (Butler et al., 2020, p. 8-9). BPC has recommended the braiding approach to improve OUD funding. First, SAMHSA and CMS should provide states with a braiding framework whereby multiple mandatory and discretionary funding sources can be coordinated to support similar objectives and align programs. (Bipartisan Policy Center, 2022, p. 41-42). BPC did not go so far as to recommend the federal government blend their funding sources (presumably because of the mandatory-discretionary divide) it did recommend braiding discretionary funding through close cooperation across agencies and recommended that Congress should add instructions that agencies better coordinate their spending and braid funding from multiple programs (Bipartisan Policy Center, 2022, p. 41-42).

Finally, funding gaps must be addressed. Large numbers of people with OUD, particularly those in non-expansion states (Kaiser Family Foundation, 2023), do not have health insurance. While more of a treatment than harm reduction issue at this time, it will become more important as harm reduction programs (SSPs and OPCs) begin to blend into treatment programs. As such attention should be paid to designing a reimbursement model for OUD services modeled on the “payer of last resort” used in the Ryan White HIV/AIDS Program; a program specifically designed to fill funding gaps (Kaiser Family Foundation, 2022a).

Remove Criminal Justice Barriers to Harm Reduction

Nationally, law enforcement officials exacerbate rather than ameliorate the harms associated with drug use, confiscating naloxone, opposing SSPs, and prosecuting

syringe possession or drug-induced homicides (Fair and Just Prosecution, 2019, p. 4). Harm reduction must be allowed to do its job with sharply reduced interference from contrary federal policies, inconsistent state laws, and structural barriers. A recent editorial in the *Journal of the American Medical Association* summarized our current state: “Studies have demonstrated that intensified drug enforcement laws have little deterrent effect on substance use and may worsen health outcomes” (Jurecka & Barocas, 2023). Leaders at all levels, federal agencies, Congress, state legislatures, the National Governors Association, and others must provide a final, transparent assessment of the “war on drugs” and recalibrate the criminalization fault line to exclude most people who use drugs, making harm reduction and treatment the dominant systems they encounter. This is not legalization, nor is it the capitulation of the country to the cartels. Neither does it follow that public safety should be sacrificed; that itself is an essential part of everyone’s right to public health.

Congress should not only commit more strongly to long-term harm reduction funding but also resist calls to maintain impediments such as carve-outs for syringes. The Biden administration’s harm reduction strategies must (along with steadily improving treatment initiatives) become the dominant themes in a freshly framed “war on death and disease” with all the federal agencies pulling together in the same direction. Although the FDA has approved its first OTC naloxone product (FDA News Release, 2023), but itself that will not cure and may even exacerbate fundamental cost-based, access problems (Bowman, 2023; Lovelace Jr., 2023). Federal agencies also must reach consensus on repealing or at least limiting the “Crack-House” law and fund innovative public safety/public health partnerships. States and localities must examine their own laws and policies to remove barriers to drug testing and SSPs, while encouraging public safety/public health partnerships such as law enforcement deflection and community mobile crisis intervention programs.

A recent *New York Times* editorial (2023) said,

Criminal justice still has a role to play in tackling addiction and overdose. The harm done by drugs extends far beyond the people who use them, and addictive substances — including legal ones like alcohol — have always contributed to crime. There is a better balance to strike, nonetheless, between public health and law enforcement.

Striking that balance is not without difficulty but there is some low-hanging fruit that will further harm reduction. Approximately half the states have drug-induced homicide laws (PDAPS, 2019) that primarily ensnare family members and friends rather than hardened criminals, create barriers to calling for help, and are “perhaps the

most vivid illustration of a larger structural problem” (Beletsky, 2019). Next, states need to reassess their overbroad approach to drug paraphernalia. For example, Colorado no longer includes drug-testing products (CO Rev. Stats. Title 18. Criminal Code § 18-18-426) and New York has decriminalized the possession or sale of hypodermic needles or syringes (NY SB 2523 (2021-22)).

The next question that must be addressed is whether it is sound policy to continue prosecuting drug users. Some cities are approaching this with prosecutorial discretion. For example, Baltimore’s decision to stop prosecuting low-level offenses such as drug possession did not seem to pose a threat to public safety or result in increased public complaints about drug use (Rouhani et al., 2021), and there is similar evidence coming out of Oregon (RTI International, 2023). A more advanced model, and illustrative of a W-G success in Canada, has been the granting of an exception to the federal Controlled Drugs and Substances Act (1996) to the province of British Columbia that decriminalizes possession of up to 2.5 grams of certain illegal drugs for personal use (Health Canada, 2023). In the words of a former mayor of Vancouver, “it gets the police out of the lives of drug users...” (Ling, 2023).

In the United States, Washington and Oregon have come closest to the British Columbia model. In 2021, the Supreme Court of Washington ruled the state’s felony strict liability drug possession law was unconstitutional (State v. Blake, 2021). Subsequently, the legislature replaced that law with a misdemeanor provision but also enacted a substance use recovery services plan and a preference for diversion rather than arrest (WA SB 5476 (2021-22)). Following the approval of a ballot initiative Oregon went further, decriminalizing low-level drug possession and instituting a “ticketing” system of fines that are waived if a health assessment is completed (OR SB 755 (2021 Regular Session)).

Construct Harm Reduction Systems

Currently OUD harm reduction is defined by W-G barriers and misalignments — but what happens if you take those away? What’s left? The federal government funneling money to state purchases of naloxone? States supporting non-profit community SSPs and eventually OPCs? However, a collection of programs is not a system. Neither is it sufficient to nominate (our still inadequate) access to treatment and recovery services. Of course, harm reduction services (syringes, HIV-testing, police deflection programs, etc.) increasingly are recognized as non-stigmatizing entry points for some health care services and products and as pathways into treatment (US Department of Homeland Security, 2022). Some harm reduction programs such as syringe services are becoming increasingly medicalized, providing naloxone and buprenorphine, and engaging

their clients in support services. Parallel lessons have been learned by those rooted in the treatment domain. First responders now carry and administer naloxone and, increasingly, emergency department interventions are being reevaluated as being more than lifesaving but as opportunities to move patients toward treatment with, for example, early initiation of buprenorphine. Providers are also acting more like harm reduction services, meeting those who need treatment outside of traditional health care facilities through the use of community mobile crisis intervention or rapid response teams (Weiner, 2022).

However, fundamentally a harm reduction frame is different and accepts that the treatment gap between those with SUD and those being treated is not simply or even primarily caused by unaffordable or unavailable treatment services. People who use drugs are exercising choices. Modern harm reduction was founded during the identification of HIV/AIDS in the 1980s. Then, as now with OUD, treatment access or prevention were not the only priorities, with illicit conduct, stigma, and a lack of trust muddying the waters. OUD harm reduction strategies can mitigate or reverse those concerns, including but not requiring nudging people who use drugs towards treatment (The White House Executive Office of the President, 2022). Harm reduction also rejects the binaries that populate treatment (recovery vs. relapse) or the justice system (lawful vs. unlawful). The lessons learned from HIV/AIDS are that harm reduction should not be judgmental about drug use and must be prepared to meet people who use drugs where they are, psychologically and geographically. Today, we should design coordinated services that “[e]nsure and improve the health and wellness of people who use opioids and other drugs” (Washington State Health Care Authority).

According to a recent *New York Times* (2023) editorial:

In the United States, syringe service programs and would-be supervised consumption sites have largely been left on their own, forced to design vital public health programs from scratch, then operate them in a legal morass, with little guidance or support. The Office of National Drug Control Policy could help if it worked to stitch organizations together into a national network, bound to a set of standards and guided by the same policies and procedures.

Indications of what a national harm reduction system could look like have come from jurisdictions that have moved the closest to decriminalization. Washington State has favored a system designed to move people toward treatment and recovery through a substance use recovery services plan designed to pull together existing and newly funded state resources. Although treatment and recovery oriented, the plan is notable for its emphasis on inclusion and lived lives together with plans for recovery housing,

transport assistance, and education and employment pathways (WA SB 5476 (2021-22)). Oregon's reforms have gone further with a network of Behavioral Health Resource Networks (BHRNs), entities or groups of entities to be established in every county and tribal area (OR SB 755 (2021 Regular Session); Russoniello et al., 2023). Services are provided free of charge using a payer of last resort model and include screening, individualized intervention plans, case management, harm reduction, peer support, and housing (Oregon Health Authority, 2023). We must radically increase our funding of harm reduction, embracing increased and additional services such as OPCs and pathways to treatment and make progress against persistent social determinants of health such as homelessness and unemployment.

Conclusion

It's time to end the blunt disagreements over harm reduction policies and implementation strategies that exist at every level of government and between government and citizens to enable horizontal and vertical W-G in the harm reduction space. Public safety and public health must cease being confrontational. The overwhelming priority is to allow harm reduction to do its job without undue interference from contrary federal policies, inconsistent state laws, and structural barriers. However, in parallel, additional consideration must be given to more effective leadership, far more responsive funding mechanisms, and the construction of harm reduction systems. ♦

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