



Center For
POLICING EQUITY

REDESIGNING PUBLIC SAFETY

Substance Use

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Introduction

Nationally, at least 12% of all police arrests are for possessing, selling, or making illicit drugs.¹ Despite using and selling illicit drugs at similar rates as White people do, Black people are more likely to be arrested,² incarcerated,³ and reported to law enforcement by medical professionals⁴ for substance use. Decades of criminalizing certain substances as a crime-control tactic has failed to achieve its goal of eliminating drug use and instead contributed to profound stigma and fear of punishment that prevents people from accessing treatment and support. It has also resulted in the proliferation of smaller, more potent versions of illicit drugs—like fentanyl—which have exacerbated the opioid crisis in recent years. In 2021, drug overdose deaths reached a record high of 106,699 people,⁵ and overdose from synthetic opioids such as fentanyl is now a leading cause of death for adults ages 18 to 45.⁶ Because of systemic inequities, including in health care access and the criminal legal system, Black and Native people are experiencing even higher increases in overdose rates than White people are.⁷ A public safety approach to substance use, in contrast, means ending the widespread, racist, arbitrary, and ineffective criminalization of certain drugs. It requires fully investing instead in equitable and accessible systems of care to prevent and reduce the harms associated with substance use, including consistently offering services that recognize continued, moderated use as a common and acceptable feature of recovery.

Laws prohibiting the use of certain drugs (including alcohol at one time) have been repeatedly enacted, fueled by racist narratives about the dangerous behavior of particular groups of people due to their substance use, including German, Irish, and Chinese immigrants; Black men; and communists.⁸ The Controlled Substances Act of 1970 created the current framework stipulating which substances are deemed illicit under federal law. It also established categories for regulating substances based on the perception about potential for abuse and whether the substance has any medical benefits. Notably, alcohol and tobacco were excluded despite high potential for dependency.⁹ The enforcement of drug laws increased dramatically after 1971, when President Nixon declared the war on drugs,¹⁰ which an advisor later said was an effort to criminalize and vilify Black people and war protesters.¹¹ After this announcement, the government embarked on a decades-long trend of prioritizing and increasing funding for enforcement that is still ongoing. For example, the U.S. government spent approximately \$2.8 billion on drug enforcement in 1981,¹² adjusted for inflation, compared to \$19.3 billion in 2023.¹³

This immense federal funding has enabled wide and inequitable enforcement of drug laws by local law enforcement agencies, funneling millions of people—especially Black and Latino men—into carceral systems and saddled them with criminal records that affect their future eligibility for housing, employment, voting, and education while undermining community health.¹⁴ In 2022, law enforcement made more than 600,000 arrests for drug possession nationally.¹⁵ Black people are almost twice as likely as White people to be arrested for drug offenses.¹⁶ The war on drugs is widely recognized as a primary contributor to mass incarceration, racial disparities in incarceration rates, and militarized policing tactics.¹⁷ From 1980 to 2011, the average federal prison sentence for a drug offense increased 36%, and similarly, the state incarceration rate for drug offenses increased nearly tenfold.¹⁸ As of 2019, Black people were 3.6 times more likely than White people to be incarcerated in state prisons for a drug offense.¹⁹

In addition to being a primary driver of mass incarceration, these efforts have failed to eliminate drug use—and its associated harms—from our society. Instead, over the past several decades of heavy enforcement, illegal drug prices have declined²⁰ and the annual number of overdose deaths has risen fivefold since 1999.²¹ From 2019 to 2020, the latest year of data, drug overdose rates rose 22% among White people, 39% among Native people, and 44% among Black people.²² These disparities are not fully explained by differences in substance use patterns.²³ Instead, Black communities face heightened barriers to accessing care due to reasons including criminalization, mistrust of the medical system, and lack of access to certain evidence-based treatments.²⁴ According to recent data, Black people who died from overdose had the lowest rate of previous substance use treatment.²⁵

AS OF 2019, BLACK PEOPLE WERE 3.6 TIMES MORE LIKELY THAN WHITE PEOPLE TO BE INCARCERATED IN STATE PRISONS FOR A DRUG OFFENSE

Instead of making communities healthier and safer, heavy-handed drug enforcement has created a pernicious system of punishment across both criminal and civil systems, extending even to housing, child welfare, and access to social services—which also disproportionately harms Black people. Many experts²⁶ and members of the public²⁷ have concluded that enforcement has had unintended consequences that work against its goals: In response to drug control tactics that focus heavily on reducing the supply of drugs rather than the demand for them, the market for illegal drugs has shifted to produce fentanyl and other smaller, powerful versions of popular drugs that are easier to transport across borders and more deadly.²⁸

Promisingly, new funding opportunities—including through opioid lawsuit settlements—have the potential to help shift from an enforcement-based to a public health response based in harm reduction. Harm reduction is a philosophy and set of strategies focused on ensuring that all people who use substances receive help that focuses on living a healthy life, not eliminating drug use.²⁹ These approaches have been shown to reduce drug-related fatalities and increase engagement in substance use treatment and other services that improve the lives of people who use drugs.³⁰

The recommendations in this report guide communities and policymakers on how to leverage this change to work effectively toward an effective public health-based approach to substance use response and prevention. They are grounded in the reality that police and criminal legal systems should not be the default response to overdose emergencies or used as a threat to force people into treatment. They acknowledge and aim to remedy the deep racism in criminal legal systems, health care systems, and social services that has made Black people who use substances more likely to be arrested, harmed by police, jailed, and denied access to appropriate healthcare. They also recognize the pervasive racism and stigma, rather than science, that has led to certain categories of drugs being categorized as more dangerous than others and prioritized abstinence from those drugs. Finally, the recommendations in this report recognize that excessive criminalization of drug use and sales undermines public safety and is ultimately counterproductive to a public health response to substance use disorder and related emergencies.



Decriminalize Personal Substance Use and Street-Level Selling

Research has documented that racism shapes how Black people are treated for drug-related offenses at virtually every level of the criminal legal system. A study on drug arrests, for example, found that racial disparities cannot be explained by differences in drug offending or non-drug-related lawbreaking—or even by residing in the kinds of neighborhoods likely to have heavier police presence. Instead, police discretion plays a significant role in racial disparities in drug arrests.³¹ An analysis of 300 St. Louis police reports from 2009 to 2013 found that drug arrests in predominantly White neighborhoods mostly came from policing to meet community concerns, such as responding to calls for service, while drug arrests in predominantly Black and racially mixed neighborhoods mostly came from officer-initiated policing, like pedestrian or vehicle stops.³²

For several decades, research has also repeatedly demonstrated that the disproportionate outcomes faced by Black people at subsequent stages of the criminal legal system cannot be explained by these higher arrest rates—and that the unexplained disparity is highest for drug-related offenses.³³ A recent analysis of exoneration data found that innocent Black people are 19 times more likely to be convicted of drug crimes than innocent White people, which was the largest disparity for any crime analyzed.³⁴

The war on drugs has failed to curb the harms of drug use, and may exacerbate these harms, including overdose. A recent analysis found that law enforcement seizures of opioid and stimulant substances are associated with increased overdose; researchers hypothesized that this was due to people losing their ability to obtain a substance they can safely dose and needing to turn to a new supply.³⁵ Enforcement of illegal drugs also may worsen violence in some communities.³⁶ Multiple studies and systematic reviews, for example, have found that increasing drug law enforcement is unlikely to reduce drug market violence, and that disrupting drug markets can actually increase violence by ending the relationships and agreements that keep them peaceful.³⁷

Meaningfully addressing the harms from substance use requires a significant shift away from enforcement or “supply-side” approaches, which have resulted in more potent illegal drugs, at enormous financial and human costs. A range of stakeholders support this sea change. For example, a 2021 report calling for an end to drug prohibition by the Global Commission on Drug Policy, led by former world leaders, concluded that “despite decades of costly drug enforcement, the supply and production of illegal drugs continues to flourish, as does the number of people who use drugs around the world.”³⁸ Instead, promising approaches to limiting and preventing substance use and its harms include access to housing,³⁹ employment,⁴⁰ and evidence-based treatment options,⁴¹ as well as addressing systemic racism⁴² and improving people’s socioeconomic status.⁴³

The following recommendations provide initial steps that policymakers and communities can take to stem the tide of counterproductive and racially biased drug enforcement.

1. End arrests for offenses that criminalize illicit substance use, including drug paraphernalia, drug possession, and street-level drug selling.

In light of the serious harms that stem from widespread enforcement of substance use, some police departments and prosecutors’ offices have enacted policies to restrict certain drug-related charges. In March 2020, for example, the Baltimore City State’s Attorney’s Office stopped prosecuting drug possession and drug paraphernalia possession (including possession of tools—such as clean needles, clean syringes, and test strips to check drugs for unknown chemicals like fentanyl—that minimize the risk of disease or overdose during drug use). Importantly, this policy applies to sex work—which, like being unsheltered, is frequently criminalized along with drug use. In the 14 months following the policy change, an estimated 448 drug-related arrests were averted. According to historical data, 78% of these arrests would likely have been Black people.⁴⁴ Additionally, 911 call analysis did not find an increase in public complaints related to drug use.⁴⁵

While policymakers work to decriminalize or legalize the use of drugs, police departments have an immediate and significant role to play in reducing enforcement of drug laws by implementing policies to not enforce drug possession, drug paraphernalia possession, and any drug sales charge other than those that involve selling or distribution for extensive financial gain. In other words, police should deprioritize “street-level” sellers. Decades of enforcing laws against street-level drug selling has shown that removing a seller at this level is ineffective to stem the flow of drugs into communities: such sellers will be replaced as long as the basic conditions that drive drug use and sales—including poverty—remain unchanged.⁴⁶ Additionally, laws that criminalize drug sales often ensnare people in need of a public health response themselves: a 2012 survey found that 43% of people who had recently sold drugs had a substance use disorder.⁴⁷

To maximize implementation and reduce potential for bias, do-not-arrest policies related to drug laws should not rely on an inflexible and arbitrary threshold (for example, drug weight) to define which behavior falls under the umbrella of categories such as personal substance use. Rather, departments should stipulate which specific charges related to drug use *do* remain enforceable and clearly articulate that any other charge related to drug laws is *not* enforceable.

DO-NOT-ARREST POLICIES RELATED TO DRUG LAWS SHOULD NOT RELY ON AN INFLEXIBLE AND ARBITRARY THRESHOLD

2. Decriminalize the personal use of all drugs, as well as tools that provide safety for drug users, such as syringes and testing strips.

Policymakers in the United States are increasingly taking steps to allow the personal use of some drugs: From 2012 to 2023, 24 states and the District of Columbia passed laws to regulate marijuana for nonmedical use,⁴⁸ and at least one state has regulated hallucinogenic mushrooms.⁴⁹ While working toward legalized drug markets that equitably and effectively allow for recreational drug use, policymakers should immediately decriminalize the personal use of drugs. In doing so, they should ensure that appropriate investments in health care and harm reduction services are required as part of legislation and promptly administered. Additionally, any thresholds set to determine what “personal drug use” means legally should be realistic measures of actual use, as informed by community members and harm reduction organizations. Federal policymakers should also reclassify drugs that states currently regulate, including removing marijuana from the Controlled Substances Act.

As of 2022, every state except Alaska had a law restricting possession of safe drug use tools, known as drug paraphernalia laws.⁵⁰ In 39 states the definition of “drug paraphernalia” includes syringes, and in 44 it includes testing materials.⁵¹ Policymakers should fully repeal drug paraphernalia laws that criminalize safe drug-use tools.

IN 39 STATES THE DEFINITION OF “DRUG PARAPHERNALIA” INCLUDES SYRINGES

Legalizing personal drug use and funding health care

In 2001, Portugal became the first country to enact laws making the possession of small amounts of all drugs a civil citation rather than a criminal offense. People who are found in possession of drugs are referred to a “dissuasion commission,” where they receive information and, if necessary, non-compulsory customized referrals to a variety of services.⁵² A 2010 study assessing the impact of the change nine years later found that decriminalization accomplished its goals: the number of people in treatment increased by 63% and the number of drug-related deaths decreased significantly, with no observed major increase in overall drug use.⁵³ The average number of people arrested on drug-related offenses, including trafficking, dropped from 14,000 a year to around 5,000.⁵⁴ But in 2012, Portugal cut funding for the government’s drug oversight body by about 80%, and the main architect of the policy believes that as a result, the model has lost some efficacy.⁵⁵

In 2020, Oregon became the first state nationwide to enact a similar change through a ballot initiative known as Measure 110.⁵⁶ Implementation of the groundbreaking law—expanding and connecting people to needed services with \$300 million every two years—faced serious challenges.⁵⁷ People who were issued citations had to either pay a fine of \$100 or call a hotline⁵⁸ to be screened for a substance use disorder, but few people called the hotline in part because officials did not create a standard ticket or train law enforcement on the change.⁵⁹ And there have been significant delays in funding: decriminalization went into effect in February 2021, but the majority of grants were not issued until late 2022.⁶⁰ At the same time, an already significant opioid overdose crisis was growing worse because of the influx of fentanyl, as well as pandemic-related factors such as reduced access to healthcare, increased isolation, and significant upticks in evictions and homelessness.⁶¹

In short, high-risk drug use in Oregon was likely increasing at the same time that it was decriminalized without the planned support yet in effect. Many media articles have alleged that public concern about crime and public disorder, such as public drug use, increased following the reform; however, early studies have found that 911 call volume did not change after Measure 110.⁶² Rather, data suggest that it resulted in significant reductions in arrests, even after accounting for decreases during the first year of COVID-19.⁶³ Finally, even while funding for treatment has been delayed, more than 16,000 people accessed services with the initial \$31 million allocated for services through the law, and approximately 60% of those were harm reduction services, which traditionally lack a stable funding source.⁶⁴

In February 2024, state legislators partially rolled back Measure 110 by passing a law that once again creates misdemeanor-level penalties, including jail sentences of up to 6 months, for possession of certain drugs (the penalties are less severe than pre-Measure 110).⁶⁵ The new law funds treatment and encourages the use of various alternatives to incarceration, indicating that lawmakers still recognize the positive effect of investment in support and services for people who use drugs.⁶⁶

Together, the Oregon and Portugal experiences indicate that while a meaningful shift from a punitive to a public health approach to drug use is possible, it will not happen quickly and progress may not be linear. Like many bold policy changes, it requires sustained support, effort, and funding to achieve its intended effects.

3. Implement pre-arrest diversion programs (that are not contingent on treatment) for offenses that are motivated by or related to substance use but not covered by decriminalization policies.

People who use drugs may frequently be arrested for offenses—such as theft to acquire drugs or fighting while intoxicated—that are motivated by or related to substance use but would not be covered by a non-arrest policy on substance use possession.⁶⁷ In such cases, diversion programs can help connect people who use drugs to appropriate supportive care instead of incarcerating them, which does not address their underlying needs. But when these programs target low-level violations (such as vagrancy or substance use possession) or direct people to treatment who are not ready for or in need of it, they can be highly coercive, presenting a “choice” between arrest or treatment when optional community-based support would be more appropriate. Therefore, programs may funnel people into the criminal legal system who otherwise would not be there—a risk that is disproportionately borne by Black and other communities who experience burdensome policing.

Any diversion program used to address substance use should be restricted to certain categories of offenses that would otherwise lead to jail time when there is evidence that the person committed the offense as a result of their drug use. Rather than using disqualifying criteria (factors that prevent someone from being eligible, such as being on probation or having committed certain types of crimes) programs should use mandatory inclusion criteria outlining factors that automatically qualify someone for diversion or would at least require the consideration of diversion. For example, mandatory inclusion criteria could require officers to consider diversion for someone who is perceived to have committed a crime not covered by decriminalization policies and to have an identified substance use issue.

Law Enforcement Assisted Diversion (LEAD) is a widely adopted pre-booking program in which people who would otherwise be arrested on low-level charges (such as shoplifting) are identified by police officers or community partners and diverted to intensive community-based case management.⁶⁸ Currently, about 73 jurisdictions operate the program to some degree, including the cities of Seattle, Los Angeles, Atlanta, Denver, New Orleans, Baltimore, Minneapolis, and St. Louis.⁶⁹ The program focuses on connecting participants to appropriate services that would meet their needs, including but not limited to treatment services and supportive housing. Evaluations have found that LEAD participants are 58% less likely to be arrested in the long term than people who did not participate⁷⁰ and are more likely to have housing and employment than they were before the program.⁷¹ But studies have also shown significant racial disparities in some LEAD programs.⁷² Researchers have identified several factors that may have contributed to this disparity, including bias from police referrals, program criteria, and distrust of law enforcement,⁷³ which may be addressed in part by using mandatory diversion criteria.

Ending coercive and involuntary treatment

Many people who use drugs and encounter the criminal legal system are presented with the choice to begin treatment supervised by that system as an alternative to traditional punishment, including arrest or incarceration. This includes people who use drugs recreationally and may not need such treatment, or those who have a substance use disorder but who would not benefit from the kind of treatment offered. People with substance use disorder who break laws often have a need for basic support—including but not limited to nonpunitive, noncoercive treatment—that would help them live healthier lives. These needs can be met with voluntary community-based and evidence-based treatment options that are fundamentally centered in public health rather than the criminal legal system, as described in “Invest in Public Health Approaches to Substance Use” on page 19.

People who use drugs and interact with the criminal legal system often enter treatment through drug courts. Drug courts require someone who would otherwise be convicted of a criminal offense to participate in court-mandated, supervised treatment, often involving frequent court appearances and drug tests, as well as sanctions for certain setbacks and rewards for meeting goals toward recovery.⁷⁴ Drug courts too often do not offer evidence-based treatment options, including medication for opioid use disorder, and routinely terminate participants for continued moderate drug use—which is frequently part of the recovery journey.⁷⁵ As a U.N. expert analysis of drug courts concluded in 2019, “access to quality treatment is hampered by the inherent tension between a punitive criminal justice logic and therapeutic concern for participants as patients.”⁷⁶ Because of these and other issues, the evidence on drug courts in achieving their goals of reduced recidivism is mixed: a 2013 meta-analysis showed that they significantly reduced the likelihood of incarceration for participants, but did not reduce the *time* spent in incarceration because when participants did not complete the program, they received longer sentences than if they hadn’t chosen the treatment option to begin with.⁷⁷ **Jurisdictions with drug courts should end the use of these programs as a pathway to treatment.** People who would normally enter court-supervised treatment through drug courts should either have their charges dismissed and offered voluntary services, or, if the charge is more serious and related to substance use, be diverted at the point of arrest to noncoercive, harm reduction-based programs that offer a broader range of support than treatment.

In addition to offering the “choice” of entering court-supervised treatment instead of incarceration, the criminal legal system in some states offers the ability for stakeholders, including police, to force people into involuntary substance use treatment. This means that they are taken into treatment against their will, rather than coerced to go as an alternative to other sanctions. As of 2018, 38 states authorized involuntary commitment for substance use.⁷⁸ Similar to drug courts, the quality of treatment provided is inconsistent, and may result in worse health outcomes. While data on the use of involuntary commitment is scarce, in Massachusetts, for example, records show that people committed to involuntary treatment were 2.2 times as likely to die of opioid overdose and 1.9 times as likely to die of any cause compared to those who had received only voluntary treatment.⁷⁹ **Jurisdictions should end any use of involuntary treatment and instead fund wider access to voluntary treatment and harm reduction services.**

DRUG COURTS TOO OFTEN DO NOT OFFER EVIDENCE-BASED TREATMENT OPTIONS INCLUDING MEDICATION FOR OPIOID USE DISORDER



Do Not Use Overdose Emergencies for Criminal Investigation

Many people who experience or witness a drug overdose do not seek medical help because they assume that police will respond to a 911 call.⁸⁰ Involving police at a scene where someone has been using drugs opens the door to a wide range of harms beyond arrest for possession of drugs or drug-use tools, such as arrest for a warrant or violation of parole conditions or the unnecessary involvement of child welfare authorities. One study of overdose emergencies reported to 911 found that 10% resulted in arrest and incarceration.⁸¹ And research indicates that people who live in communities with a high burden of police enforcement are less likely to seek help during an overdose.⁸²

Most states have laws that aim to encourage reporting of overdose by stipulating that people who call 911 will not be charged with certain crimes, such as low-level drug possession. But research indicates that many people are unaware of these protections,⁸³ and even when they know about them, they may not call because they fear arrest for other offenses.⁸⁴ Additionally, a recent study showed that just 26% of surveyed officers could correctly report what protections from arrest such laws in their state offer.⁸⁵

Overdose emergencies are medical emergencies and should be treated as such. Evidence indicates that a more comprehensive approach is needed for people who use substances—especially Black people—to overcome the pervasive fear of how police will respond. Dispatching police to the scene of an overdose not only has a chilling effect on future emergencies, but is not an effective use of resources. Medical responders, not law enforcement, are equipped to make decisions at an overdose scene about what care is needed. Lawmakers and police departments should implement policies to ensure that people experiencing or witnessing overdose emergencies are empowered to ask for and receive prompt, safe, and appropriate treatment. They should also implement and enforce policies to prevent the disproportionate and serious harms that police contact routinely causes to people who use drugs.

4. Assign overdose calls for service to medical responders.

A growing body of research shows that fear of police strongly deters bystanders from calling emergency services for help during an overdose.⁸⁶ Some U.S. jurisdictions already default to dispatching EMS (without police) to the scene of an overdose unless police are needed for an explicit reason. Other dispatch systems should adopt similar practices and dispatch police to the scene of an overdose only if they are requested by EMS because of a specific threat of violence.

New systems for community-based mental health crisis response, including through the national 988 hotline, present an opportunity to build in call diversion practices specific to substance use emergencies.⁸⁷ In July 2022, 988 was launched nationally as a universal 24/7 hotline, replacing the previous 10-digit National Suicide Prevention Lifeline.⁸⁸ Any call to 988 will be answered by someone trained in mental health crisis response who can either help resolve the situation over the phone or dispatch crisis services. It is critical that local and state policymakers meet the opportunity of 988 by educating community members about its availability, ensuring and communicating that personal information about callers will be kept confidential and not shared with law enforcement, and providing enough funding to ensure an adequate response to increased calls—including for co-occurring substance use needs.

POLICE CAN PLAY A LIFESAVING ROLE BY ADMINISTERING THE OPIOID OVERDOSE MEDICATION NALOXONE

5. Require police to carry and administer naloxone when they encounter a person who may be experiencing an overdose—and to call for assistance from medics or any available community-based alternative crisis response program.

Police may be first to the scene of an overdose or encounter someone experiencing a substance use emergency. Officers should therefore be trained on how to identify and stabilize people who may be experiencing such an emergency and the environment around them until a specialized community-based or emergency medical response team arrives. They should also be trained to use guidance from available medics or community-based health responders as soon as they get in contact by phone, radio, or in person. Unless police are needed due to a specific threat of violence, they should transfer control of a scene to those responders.

Police who encounter someone experiencing an opioid-related overdose can play a lifesaving role by administering the opioid overdose medication naloxone (commonly referred to by the brand name Narcan; for more on naloxone, see page 24). But evidence shows that police frequently require the revived individual to go to the hospital or go to jail.⁸⁹ The administration of naloxone by an officer should not be accompanied by further police intervention in a health emergency. Whenever possible, in the rare event that hospital transfers are necessary after an overdose, the decision should be made by patients or at the discretion of medical services (such as EMS), not by police.

In case alternative response services are unavailable to come to the scene, police should be trained to provide information on optional harm reduction-based services, whether for immediate or follow-up care (for example, offering to take the person to a harm reduction or crisis stabilization center and leaving behind naloxone kits with information on such services). The SHIELD program (Safety & Health Integration in the Enforcement of Laws on Drugs) is an evidence-based training program that helps inform law enforcement about the options available in their community when responding to people who experience overdose, therefore improving officers' effectiveness in these interactions.⁹⁰

6. Ban police who respond to overdoses from investigating or arresting anyone at the scene unless it is related to a serious violent crime.

Police who respond to overdoses routinely look for evidence of drug selling or unrelated crimes. This also happens when police follow up after an overdose incident, often by pairing with a public health professional in “post-overdose response team” programs. A study of post-overdose response teams in Massachusetts, for example, found that 57% of such programs check warrants of people involved in the overdose prior to visiting them.⁹¹ Checking for warrants, searching, or interrogating people who have experienced or witnessed an overdose communicates that police officers are a threat to people who use drugs and undermines the opportunity to connect people who are at risk of another overdose to lifesaving resources that can prevent such future harm.

In order to support harm reduction practices, departments should restrict officers responding to overdoses or participating in post-overdose response teams from checking warrants, conducting searches, asking investigatory questions, or taking any other action that is not medically necessary or recommended by medical services unless it is related to evidence of a serious violent crime. Departmental policies should specifically state that people involved in confirmed overdoses, including those who report or are present, should not be charged with any drug-related offenses. Additionally, any contraband found at the scene by police should be confiscated and destroyed, not used for prosecution.

7. Encourage reporting by families, friends, and bystanders who witness people experiencing overdose by passing or strengthening 911 drug immunity laws and repealing drug-induced homicide laws.

A patchwork of state laws govern how to treat people who are witnessing an overdose and could seek emergency help. On one hand, 911 drug immunity laws (sometimes known as “Good Samaritan” laws) aim to encourage people to seek medical attention or follow-up services related to an overdose they experience or witness by explicitly protecting them from arrest or prosecution for drug-related offenses.⁹² As of 2021, the District of Columbia and every state except Kansas and Texas had some form of 911 drug immunity law, though they vary widely in the protections they offer.⁹³ Florida’s comprehensive 911 drug immunity law shields people (including those on probation or parole) who seek medical attention from arrest, charges, and prosecution for both drug and drug paraphernalia possession. It also makes reporting an overdose a mitigating factor in sentencing for other offenses.⁹⁴ Even when laws are comprehensive, research shows that people who use drugs as well as paramedics and police have limited knowledge of these laws,⁹⁵ limiting their efficacy.⁹⁶

On the other hand, drug-induced homicide laws serve the opposite purpose. These laws make the act of giving or selling drugs that are taken in a fatal overdose a criminal homicide. In other words, it allows for severe punishment of people—typically street-level dealers or even friends and family members of the deceased—who do not know what may be in the drugs they are providing. As of 2019, at least 24 states and the District of Columbia have a specific drug-induced homicide law.⁹⁷ While data on these prosecutions are sparse, an analysis of media articles mentioning them from 2000 to 2016 found that approximately half of the people charged were not traditional sellers, but friends and partners of the deceased.⁹⁸ Of the remaining cases where a traditional dealer was involved, a disproportionate amount were Black or Latine people who sold to White people,⁹⁹ despite the fact that White and Black people sell drugs at similar rates.¹⁰⁰ Even in states where drug-induced homicide laws do not exist, an individual can still face a homicide conviction if they provide or sell drugs to someone who then dies from an overdose—and this may exacerbate a resistance to calling for help among people who witness an overdose. In July 2023, prosecutors in Placer County, California secured the state’s first homicide conviction related to a fatal fentanyl overdose: the defendant was convicted of second-degree murder for supplying fentanyl, despite the fact that no drug-induced homicide state law exists.¹⁰¹

To encourage critical help-seeking behavior among people who use drugs and their friends and family, policymakers should repeal drug-induced homicide laws and, in consultation with impacted community members, enact or expand 911 drug immunity laws to include an expansive range of protections. For example, laws should include immunity from drug-related charges such as possession, paraphernalia possession, and probation or parole violations. Laws should also include safeguards against eviction, protection of government benefits, and preservation of student aid. Policymakers, criminal justice stakeholders, social service providers, and others should widely communicate these laws to ensure that they serve their purpose. Police departments should make sure officers are aware of the protections that 911 drug immunity laws provide in their communities by using evidence-based training programs such as SHIELD.

911 DRUG IMMUNITY LAWS SHOULD INCLUDE SAFEGUARDS AGAINST EVICTION, PROTECTION OF GOVERNMENT BENEFITS, AND PRESERVATION OF STUDENT AID



Invest in Community-Based Programs to Prevent and Respond to Substance Use Emergencies

People who experience overdose and other substance use emergencies deserve a nonjudgmental, noncoercive, and non-carceral response that provides a pathway to treatment and services. Research shows that police—like many other people without training in substance use issues—harbor negative views about those who use drugs, misperceptions about the nature of substance use disorder, and a lack of support for its treatment.¹⁰² A 2020 study, for example, found that 43% of surveyed officers believe that the number of times someone can receive the opioid antidote naloxone should be limited.¹⁰³ And a 2018 study found strong police support for punishment over treatment for people who use substances but also found that just 11% of surveyed officers believe the war on drugs is reducing drug use.¹⁰⁴

Substance use disorder is a chronic, complex, and deeply stigmatized health issue. Too often, responses to substance use that are based in the criminal legal system take a legally coercive approach, so people may feel as if they have to take recommended help or face punishment (for more, see “Ending Coercive and Involuntary Treatment” on page 8). What’s more, police officers are not equipped to recognize the difference between someone who may be intoxicated from using substances and someone who is either experiencing a mental health or physical health crisis (such as a seizure). When witnessing someone who uses substances, they and other actors in the criminal legal system are not typically equipped to determine whether a person is in need of treatment.

Communities should develop alternative community-based responses to substance use that incorporate the philosophy of harm reduction to meet people where they are—regardless of whether they are willing and able to stop using drugs—to connect them with the support that can help them lead a healthier life. Communities should also take steps to mitigate stigma about substance use and incorporate evidence-based practices in all their crisis response systems in order to better connect people experiencing substance use emergencies with appropriate support and services—including but not limited to any treatment programs they might consider, now or in the future.

8. Invest in and study community-based models for responding to substance use emergencies.

Several communities have demonstrated the effectiveness of investing in **unarmed alternative response programs** that aim to better support the health and well-being of people experiencing substance use emergencies, including overdose or other crises related to co-occurring substance use and mental health issues. Many of these programs respond to people experiencing either mental health or substance use emergencies, as an estimated 40% of adults with serious mental illness also have a substance use disorder. (Another report in this series, [Redesigning Public Safety: Mental Health Emergency Response](#), provides specific recommendations on responding to mental health emergencies.) Jurisdictions have used a variety of approaches to fund these programs, including ballot initiatives increasing sales tax,¹⁰⁵ Medicaid funding, and American Rescue Plan Act funding¹⁰⁶ (for more on funding opportunities, see “Maximizing the potential of opioid settlement funding” on page 20).

Emerging research from community-based alternative response models for crisis situations involving substance use shows positive effects on crime and cost savings.¹⁰⁷ For example, a study of Denver’s STAR program, which serves people experiencing mental health or substance use emergencies, estimated that in a six-month period the program prevented nearly 1,400 criminal offenses.¹⁰⁸ Communities developing crisis response systems—which typically focus on mental health emergencies—should incorporate the perspectives and needs of people with co-occurring diagnoses as well as those who have only substance use diagnoses.

Communities have also developed innovative **outreach programs**, sometimes known as street outreach or mobile outreach programs, to engage people at high risk of overdose.¹⁰⁹ These programs may aim to reach overdose survivors by following up with people who are revived by law enforcement or by emergency medical services.¹¹⁰ For example, in Seattle, where the fire department responds to overdose-related calls, a new pilot program aims to provide follow-up referrals to treatment.¹¹¹ Programs might also seek to connect with people who are unsheltered and using drugs in public spaces such as parks or campsites and are at high risk of overdose.¹¹² The nonprofit Homeless Health Care Los Angeles sends out trained teams daily to Skid Row to intervene in overdoses with naloxone and oxygen.¹¹³

PEER SUPPORT CAN HELP PEOPLE WHO USE DRUGS OVERCOME BARRIERS TO ACCESSING HELP

Communities are also creating **places where people in crisis can go for help**, such as crisis stabilization units or walk-in crisis services. These centers can provide a more appropriate option than an emergency room for community responders (or law enforcement officers where such programs do not exist yet) to take someone in need of help.¹¹⁴ For example, in addition to resolving crises over the phone and deploying mobile crisis response teams, Philadelphia has opened five Crisis Response Centers, which take substance use related emergency cases and can connect people with evidence-based treatment options.¹¹⁵

Some of these programs provide support from peers who have also experienced substance use disorder. **Peer support** can help mitigate the pervasive stigma faced by people who use drugs that acts as a barrier to seeking help. The relationships built through peer outreach—from a “trusted messenger” rather than an authority figure—can also help overcome other barriers to accessing help, including fear of the criminal legal system and distrust of social services.¹¹⁶

9. Train all crisis responders in evidence-based practices for substance use disorders.

Despite the fact that a significant share of people with serious mental illness also have substance use disorder, only 9.3% of those people report receiving treatment for both conditions.¹¹⁷ People with co-occurring needs may experience heightened bias from and distrust of service providers. Their substance use may worsen mental health symptoms and make it more difficult for them to engage in treatment.¹¹⁸ Evidence shows a lack of service provider training and understanding to correctly identify co-occurring diagnoses, particularly among substance use disorder professionals.¹¹⁹

One opportunity to improve accurate diagnoses and service provision for people with co-occurring needs is through the recent expansion of unarmed alternative response programs.¹²⁰ Community-based alternative response program staff, as well as dispatchers who triage mental health and substance use crisis calls, should be trained in substance use disorder risk assessment. For example, the Georgia Department of Behavioral Health and Developmental Disabilities uses dispatch to screen individuals in crisis related to substance use about the type of substance(s) used, the amount, and any withdrawal symptoms. Then they may deploy an alternative response team to help connect someone in opioid withdrawal to medication-based treatment or emergency medical services to provide medical care to an individual in withdrawal from other substances, including alcohol.¹²¹



Align Criminal Legal Systems with Public Health Approaches to Substance Use

The war on drugs enshrined wide-reaching policies that increased punishment for drug use throughout not only criminal systems of punishment, but also civil systems. For example, policymakers enacted long automatic, or mandatory, sentences for drug-related offenses and automatically excluded people who use drugs from gaining employment or housing. In recent years, public opinion and policies toward people who use drugs have shifted significantly. Media coverage of the opioid crisis—where certain communities had high numbers of impacted White people—has helped produce a more sympathetic response from the public and policymakers than was seen for previous substance disorder epidemics, including the crack cocaine panic of the 1980s, which predominantly involved Black people and was met almost universally with punitive criminal justice responses.¹²²

Despite increasing support for an approach to drug use that is based in public health rather than punishment, many harsh systems and policies put in place during the war on drugs remain, reinforcing the stigma about drug use that often prevents people in need of treatment and support from seeking help. These policies are not only philosophically misaligned with new approaches, but can conflict with new laws or medical treatment. For example, local public housing authorities can exclude people for marijuana use, even in states where it is recreationally legal, because it is still illegal at the federal level.¹²³ This means that new laws, such as ones legalizing marijuana, are not experienced equitably. For example, due to systemic racism, Black people are more likely to live in public housing and are therefore also more likely to be at risk of losing or being denied housing, even in cases where recreational marijuana use is legal. And because some employers even discriminate against people who use methadone as part of their recovery from opioid use disorder, the federal Department of Justice has recently taken steps to prosecute such discrimination as a violation of the Americans with Disabilities Act.¹²⁴

The continued surveillance, discrimination, and punishment of people who use drugs—or are suspected of using them—disproportionately harms Black people. The following recommendations offer a starting point for aligning criminal and civil systems with a public health approach to drug use.

10. Legalize marijuana and other drugs with measures that address racialized harm.

Although data indicate similar rates of marijuana use across racial groups, enforcement of marijuana and other drug offenses has been disproportionately punitive toward Black communities.¹²⁵ For example, Black people are more likely to be arrested for marijuana possession than their White counterparts in every state, with an average disparity of 3.64 times higher arrest rates.¹²⁶ In some states, a Black person is nine times as likely to be arrested for marijuana possession as a White person is.¹²⁷ Evidence shows that in states where marijuana is legal for recreational purposes, total arrests for marijuana possession have decreased significantly, but racial disparities in such arrests have decreased only slightly.¹²⁸ Arrests and convictions for marijuana-related offenses have resulted in widespread collateral consequences, including denied employment opportunities, education advancement, and career growth; exclusion from professional licensing organizations;¹²⁹ difficulty in securing affordable housing and health benefits; loss of voting rights; inability to serve on juries; risk of deportation; and difficulty establishing or retaining child custody.¹³⁰

BLACK PEOPLE ARE MORE LIKELY TO BE
ARRESTED FOR MARIJUANA POSSESSION
THAN THEIR WHITE COUNTERPARTS

3.64_x

In recognition of the widespread racialized harm that came from decades of criminalizing drugs that are now legal, the legalization of substances such as marijuana should not only reflect present-day public opinion of social acceptability, but also aim to address the unremedied consequences of the racially disproportionate past enforcement of drug offenses.

Legalization efforts with this kind of focus—known as *reparative justice*—can help stop perpetuating the harm long endured by Black communities. To achieve equity, legalization must be retroactive, seeking to repair the damages caused by past unjust enforcement.¹³¹ One essential such measure is automatic and expansive criminal record expungement, which means that documentation of an arrest and/or conviction is permanently erased from official records.¹³² Criminal record expungement should be automatic, so that the affected person does not need to take any steps to have their record cleaned. Research demonstrates that expungement is associated with improvements in employment rates and wages for recipients.¹³³ It can also help people gain access to housing, social services, and education, all of which are known to help reduce their likelihood of future lawbreaking. Policymakers should follow the lead of states like California and Illinois, which have taken steps toward reparative justice by combining marijuana legalization with criminal record expungement.¹³⁴

In addition to expungement, a comprehensive reparative justice framework should encompass automatic resentencing, which involves systematically reviewing and revising sentences not covered by expungement to align with new approaches. Additionally, the framework should also include the restoration of voting rights, debt forgiveness for related offenses, and targeted reinvestment in Black communities.¹³⁵ Legalization efforts should prioritize people who have had drug-related convictions and those from disproportionately impacted communities for participation in the legal drug industry, as has been done in New York.¹³⁶

CRIMINAL RECORD EXPUNGEMENT SHOULD
BE AUTOMATIC, SO THAT THE AFFECTED
PERSON DOES NOT NEED TO TAKE ANY
STEPS TO HAVE THEIR RECORD CLEANED

11. End systems of surveillance that undermine safety and support for people who use drugs.

A wide range of systems beyond law enforcement participate in monitoring, reporting, and punishing suspected or confirmed substance use, including prenatal healthcare, schools, social work, employers, and public and private housing.¹³⁷ These systems stigmatize substance use, including legal use, making people who use substances less likely to trust public services, receive needed treatment, or meet their basic needs.

Widespread restrictions on housing, public benefits, and employment based solely on suspected drug use, a positive drug test, or a drug-related arrest should be eliminated. Such policies are not only ineffective at minimizing harms related to substance use, but are counterproductive to that goal by often denying people the very things that would help them minimize or manage their substance use disorder. And in the case of policies that punish people for legal recreational drug use, these racist systems deliberately limit opportunities for Black people, even as others profit from the legalization of marijuana and other drugs.

Fortunately, policymakers are taking steps to unwind drug-based restrictions on various public and private benefits and services. For example, in 2023, the federal government removed questions about drug convictions from federal student aid applications.¹³⁸ But a wide range of policies still support systems of drug surveillance. **Policymakers should eliminate drug testing as a standard requirement for people on parole and probation,¹³⁹ remove drug testing and drug-sniffing dogs from K-12 schools,¹⁴⁰ and end policies that automatically detain people without residency status for drug possession.¹⁴¹** They should dismantle the following surveillance systems, which are especially harmful to Black people:

- **Housing:** Federal law permits local public housing authorities to evict residents if a member of the household or their guests engage in drug-related criminal activity on or off public housing premises.¹⁴² Private landlords can also enforce similar provisions: In more than 2,000 cities private landlords can obtain a crime-free certification for their property that would allow for the immediate eviction if a tenant, a member of their family, or guest engage in drug-related criminal activity on or off the premises.¹⁴³ The results of this surveillance and eviction can include housing instability or homelessness, both of which are associated with a range of adverse health outcomes, including infectious disease and overdose.¹⁴⁴ Unhoused people who also use drugs are often forced into increasingly unsafe, unsanitary, and riskier drug-using practices to avoid detection and they are at an increased risk of drug-related harms such as overdose and infectious diseases.¹⁴⁵
- **Public benefits:** Applicants for public benefits are often subjected to criminal background checks, drug screening questionnaires, and drug tests as a condition of receiving assistance. The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, and Temporary Assistance for Needy Families (TANF), which provides cash assistance to families with children experiencing poverty, can impose a lifetime ban for people with felony drug convictions unless their state either modified or opted out of such a ban.¹⁴⁶ Denying children and families food or financial assistance based on one member's past drug use does nothing to help address these programs' fundamental goals of minimizing child hunger and addressing systemic inequality. As of 2022, 21 states had implemented a modified SNAP ban and 17 states had implemented a modified TANF ban for people with felony drug convictions,¹⁴⁷ but these modifications include conditions like mandatory drug treatment, drug testing, satisfactorily serving probation or parole, and a post-conviction ineligibility period.¹⁴⁸ Evidence shows that in states that have scaled back these bans, people with felony drug convictions who can access public benefits are less likely to commit new crimes.¹⁴⁹

- Pregnancy and family separation:** Pregnant people are routinely tested for illicit drug use on the basis of a medical professional's discretion and, if the test comes back positive, reported to authorities for child endangerment.¹⁵⁰ Experts have concluded that illicit drug use is not universally harmful to fetal health, and that screening for these substances is not justified by their risk level or prevalence. They note that other substances, like tobacco or alcohol, are equally risky or more risky, and used far more often during pregnancy, but are not routinely tested for.¹⁵¹ Any harms that may result from prenatal drug use are exacerbated by screening, which makes pregnant people less likely to seek prenatal and other forms of health care.¹⁵² Parental substance use, similarly, is an underlying factor in approximately 40% of foster care cases,¹⁵³ even though there is little evidence that substance use alone is predictive of neglect.¹⁵⁴ Furthermore, surveillance and criminalization of pregnant people who use drugs differs by race: despite evidence that suggests Black women and White women use drugs at a similar rates,¹⁵⁵ pregnant Black women are more often tested for drug use, reported to child protective services and police, and subjected to punishment, including removal of their child.¹⁵⁶

PREGNANT BLACK WOMEN ARE MORE OFTEN TESTED FOR DRUG USE, REPORTED TO CHILD PROTECTIVE SERVICES AND POLICE, AND SUBJECTED TO PUNISHMENT

12. **Revise excessive mandatory sentencing laws.**

Mandatory sentencing laws stipulate fixed minimum and maximum penalties for specific crimes, including substance use. These laws have driven racial disparities in sentencing: Researchers have found that federal prosecutors are 65% more likely to charge Black people with offenses that contain mandatory sentences.¹⁵⁷ But little evidence demonstrates that these laws achieve their goals of deterring crime and substance use.¹⁵⁸ Evidence shows that people are often unaware of the mandatory punishment for specific offenses¹⁵⁹ and that incarceration does not reduce drug-related recidivism¹⁶⁰ but instead may exacerbate it.¹⁶¹ For example, Florida experienced a 50% upsurge in crime after enacting drug-related mandatory sentencing laws.¹⁶² And a 50-state study conducted by the Pew Charitable Trusts found no statistically significant relationship between drug imprisonment and drug use, drug arrest, or overdose death.¹⁶³

One of the most overtly racist examples of mandatory sentencing laws is the disparity between sentences for crack cocaine and powder cocaine, which has fueled imprisonment of Black drug users. The 1986 Anti-Drug Abuse Act established a 100:1 sentencing disparity between crack cocaine and powder cocaine.¹⁶⁴ This disparity was also applied unequally: Although White people are about equally likely to use crack cocaine as Black people are,¹⁶⁵ from 1991 to 2016, Black people served time in federal prison seven times more often for crack cocaine offenses than White people did.¹⁶⁶ In the same years, among drug offenders with minimal or no prior criminal history, Black people on average served 40 months longer than White people did for crack cocaine possession and distribution.¹⁶⁷ In 2010, the Fair Sentencing Act partially reduced the sentencing disparity between crack and powder cocaine from 100:1 to 18:1.¹⁶⁸ Because there is no scientific basis for treating crack cocaine differently from powder cocaine—and because treating them differently perpetuates racial inequity in sentencing—law-makers should fully eliminate the sentencing disparity.

65%

FEDERAL PROSECUTORS ARE MORE LIKELY TO CHARGE BLACK PEOPLE WITH OFFENSES THAT CONTAIN MANDATORY SENTENCES

Federal policymakers should also end the Drug Enforcement Administration’s emergency scheduling of “synthetic” opioids. This policy change in 2018 placed fentanyl and other synthetic opioids in a category of Schedule I illicit drugs, allowing them to be prosecuted under mandatory minimum sentencing.¹⁶⁹ Even trace amounts of fentanyl can now result in lengthy mandatory sentences, even if the person accused was unaware of its presence in their drug supply.¹⁷⁰ Ending emergency scheduling of synthetic opioids can reduce the racial disparities in sentencing that are already present in prosecutions of these cases.¹⁷¹ In 2019, 75% of federal fentanyl prosecutions were of non-White people.¹⁷²

Finally, policymakers should expand the “safety valve exception,” a legal mechanism for people convicted of low-level, nonviolent drug charges that allows the court to disregard mandatory sentencing laws for cooperative defendants with minimal criminal history.¹⁷³ This tool does not currently apply to all drug charges that carry mandatory sentencing. For example, drug trafficking is defined as the manufacturing, selling, transporting, or importing of controlled substances for commercial purposes and therefore encompasses street-level dealing.¹⁷⁴ Because drug trafficking within 1,000 feet of a playground, school, or public housing facility is not eligible for the safety valve, many drug-related charges have inflexible mandatory minimum sentences.¹⁷⁵ To reduce the harms of mandatory minimum sentencing, this tool should be available to criminal legal stakeholders in all drug-related cases.

EVEN TRACE AMOUNTS OF FENTANYL CAN NOW RESULT IN LENGTHY MANDATORY SENTENCES

13. Limit use of fines and fees for offenses related to substance use.

Many people who use drugs have to pay fines and fees to the criminal legal system, either as a result of arrest or in order to be diverted from it. Fines are intended to deter and punish people for drug-related crimes, and the amount is usually based on the weight and type of drug. The amount of fees, in contrast, have no relation to the offense committed and instead are intended solely to raise revenue for the government.¹⁷⁶ People may be issued fees after receiving a fine or in order to participate in a diversion program.

Criminal justice systems often rely on fines and fees collected from defendants to fund the operations of courts, prosecutors, diversion programs, and more.¹⁷⁷ Fines and fees are therefore a regressive tax imposed on low-income people who often find themselves trapped in a cycle of debt, punishment, and collateral consequences if they are unable to pay. According to one study, the average amount spent for conviction and court-related costs was \$13,607, which is approximately one year’s income for those earning the federal minimum wage, or \$15,000 per year.¹⁷⁸ Research has also shown that jurisdictions that rely heavily on revenue generated from fines and fees also have higher than average Black and Latine populations.¹⁷⁹ While fines can be a less intrusive form of deterrence than incarceration for some offenses, research has shown that they do not decrease—and may even increase—the likelihood of recidivism for drug use or possession.¹⁸⁰

Jurisdictions should remove all fees from substance use-related testing, supervision, treatment, and diversion programming. If fines are used as a criminal sanction, jurisdictions should ensure that they are reasonable, automatically based on a defendant’s income and ability to pay, and issued only when incarceration is not also being imposed or as an option to avoid incarceration.



Invest in Public Health Approaches to Substance Use

Current public safety approaches to substance use-related issues, including substance use disorders and overdose emergencies, fail to recognize drug use as a complex and multifaceted issue that requires a variety of potential supports. A public health approach, in contrast, recognizes that people who use drugs have different and varied needs. For example, some people may use drugs in a way that requires safe practices and tools, but they are able to manage their use and do not want or need treatment. Other drug users have a substance use disorder, a condition in which people keep using a substance despite repeated harmful consequences (such as a decreased ability to manage day-to-day functions). The most severe form of a substance use disorder is commonly known as addiction.¹⁸¹ Not everyone who uses the same substance, even repeatedly, develops a substance use disorder, because many individual and environmental factors shape the relationship between a person and their drug use. For example, taking drugs while living in difficult circumstances such as lacking shelter may increase the desire to continue using drugs.¹⁸² People with substance use disorders, therefore, may need basic support such as stable housing or transportation before they are able to engage with treatment to address their drug use.

Surveys of people with substance use disorder show that not being ready to stop using substances is a top reason for not being in treatment, even among those who recognize a need for treatment.¹⁸³ Because of the widespread influence of Alcoholics Anonymous since the early 20th century, most substance use treatment in the United States centers around a goal of abstinence from substances and can be punitive toward those who do not meet that goal (for example, through policies that see any use as “failing” treatment programs).¹⁸⁴ Research shows that the goal for many people struggling with substance use is not abstinence, however, but to control or reduce their use, improve their health and quality of life, and meet their basic needs.¹⁸⁵ Evidence in the case of alcohol dependency also shows that a disproportionate focus on explicit abstinence-based recovery goals can leave people in recovery ill-equipped to deal with using again, broadly considered a relapse.¹⁸⁶ Even among people who seek abstinence, substance use disorder is a chronic condition and relapse is a common feature of recovery.¹⁸⁷

One important facet of a public health approach to drug use is harm reduction. Harm reduction programs aim to “meet people where they are” rather than require them to display a certain relationship to drug use. While there is no one-size-fits all approach to practicing harm reduction, the National Harm Reduction Coalition outlines several principles that can be used to develop and manage such services, including the recognition that social inequalities, including racism, impact people’s ability to deal with drug-related harm.¹⁸⁸ In recent years, the United States has increasingly supported a harm reduction approach to the overdose crisis.¹⁸⁹ But because substance use is largely criminalized, harm reduction remains the exception rather than the rule for addressing drug use.

The following evidence-informed, public health-based strategies are grounded in principles of harm reduction and have been shown to reduce negative consequences associated with drug use. They can be used as a starting point to understand which kinds of investments are most likely to reduce the unwanted individual and community-level consequences of substance use, including overdose, public drug consumption, and crimes committed to support drug use. At the same time, these interventions can reduce the unwarranted and unproductive involvement of police and other systems of punishment in responding to substance use.

HARM REDUCTION PROGRAMS AIM TO “MEET PEOPLE WHERE THEY ARE” RATHER THAN REQUIRE THEM TO DISPLAY A CERTAIN RELATIONSHIP TO DRUG USE

Maximizing the potential of opioid settlement funding

In 2022, four U.S. pharmaceutical companies agreed to pay approximately \$26 billion to support communities in nearly every state as a response to the effects of the opioid crisis. Since then, other settlements, including by Purdue Pharma¹⁹¹ and the retailers Walgreens and CVS,¹⁹² have brought the amount of money to be distributed to approximately \$50 billion over the next 18 years.¹⁹³

The distribution of these funds to local and state governments represents a significant opportunity to invest equitably in systems of care. These agreements outline what specific strategies funds can be used for, and typically include public health-based approaches such as the ones identified in this report.¹⁹⁴ But the way funds are to be distributed, spent, and accounted for varies widely by state. Just 15 states as of 2023 had committed to publicly reporting the entirety of their opioid settlement spending.¹⁹⁵ And there are many approved uses for settlement funds, including strategies—such as media campaigns aimed at discouraging opioid use or funding for law enforcement diversion programs—that may be less effective and are less urgently needed than, for example, expanding community-based harm reduction services.

Community advocates can play an important role in engaging with the settlement spending process by calling on their policymakers to allocate spending for services that are based in scientific evidence, grounded in harm reduction, and that prioritize the needs of people affected by opioid use disorder who have historically not received adequate or equitable services, including Black communities, older people, and pregnant people. To support community members in this work, Vital Strategies and Christine Minhee of OpioidSettlementTracker.com have published guides for all 50 states and the District of Columbia outlining how much money a state is receiving, how much is allocated to local governments, who is in charge of decision-making about spending, and how to engage in that process.¹⁹⁶ Similarly, the National Association of Counties' Opioid Solutions Center supports local policymakers to maximize the impact of settlement funding by prioritizing and implementing effective strategies.¹⁹⁷ The Brandeis Opioid Resource Connector has also highlighted innovative ways communities are addressing factors like lack of employment and housing that frequently are barriers to recovery from opioid use disorder.¹⁹⁸

14. Address barriers to equitable expansion of medications for opioid use disorder.

Medications for opioid use disorder (or MOUD, also known as *medication-assisted treatment* and *opioid agonist treatment*) are a gold standard of care. The medications—including buprenorphine, methadone, and naltrexone—work by reducing opioid cravings and withdrawal, which helps the patient engage in therapy and other activities that support their recovery.¹⁹⁹ But access to MOUD is limited: In 2021, only 22% of people with opioid use disorder received MOUD,²⁰⁰ and Black patients are significantly less likely than White patients to access MOUD because of widespread systemic barriers.²⁰¹ One study, for example, showed that following a nonfatal opioid overdose, Black patients were less likely than White patients to obtain MOUD as follow-up treatment.²⁰² Another recent study found that Black and Latine patients stay in medication-assisted treatment for shorter periods than their White counterparts do.²⁰³ People who are incarcerated—who are disproportionately Black and Latine people—rarely receive access to MOUD, forcing painful withdrawals and leaving them at higher risk for overdose.²⁰⁴ Research has found that in the first two weeks following release from incarceration, people are at up to 40 times greater risk of overdose than people in the general population,²⁰⁵ and one study of Marion County (Indianapolis), Indiana, found that 21% of people who died of overdose had been in the county jail within the past two years.²⁰⁶

To help close the treatment gap between patients who need MOUD and those who receive it, in January 2023, the federal government eliminated a licensing requirement that prevented many doctors from being able to prescribe buprenorphine. The change dramatically increased the number of health providers who are able to prescribe the medication for opioid use disorder, from 130,000 to an estimated 2 million.²⁰⁷ But these providers still may not be able to—or be incentivized to—reach and help eligible patients.

Federal policymakers should take steps to ensure that the goals of the buprenorphine licensing change are met, including: funding cultural competency training in opioid use disorder treatment (through professional organizations and in medical school); removing administrative hurdles to prescribing buprenorphine, like prior authorization requirements for insurance; and creating financial incentives such as loan forgiveness for providers of buprenorphine treatment in underserved areas. They should also permanently allow providers to prescribe buprenorphine and other MOUD via telemedicine, which was temporarily allowed during the COVID-19 pandemic²⁰⁸ and has shown positive results for treatment outcomes.²⁰⁹

Methadone was placed under strict controls at the start of the war on drugs when policymakers began to link heroin and methadone with crime.²¹⁰ As a result, it is typically available only by going to a treatment provider daily at a specific time, which may be a long distance away. Policymakers should expand access to methadone by piloting more take-home²¹¹ and delivery programs²¹² with the ultimate goal of offering methadone in pharmacies.²¹³

PROVIDERS SHOULD BE PERMANENTLY ALLOWED TO PRESCRIBE MEDICATION FOR OPIOID USE DISORDER THROUGH TELEMEDICINE

To help address racial disparities in access to MOUD, policymakers should also aim to make these medications widely available in more settings where providers may interact with underserved people who have opioid use disorder. Policymakers and practitioners should develop programs that encourage the provision of MOUD in emergency departments; syringe services programs; prenatal and postpartum care; and through inpatient and outpatient substance use and mental health care.²¹⁴ Programs that operate with mobile vans can help make contact with hard-to-reach groups, such as encampments of unhoused people or other communities that traditionally lack comprehensive healthcare access, such as those in rural areas.²¹⁵ Importantly, policymakers should take steps to ensure that people are able to receive whichever medication works best for them in their recovery. Incarcerated patients, patients in court-mandated treatment, and patients on parole are frequently prescribed only certain medications or aren't prescribed enough medication due to practitioner bias about specific medications.²¹⁶ The U.S. Justice Department recently filed lawsuits on the basis of the Americans with Disability Act to ensure that people in criminal justice settings have access to the full range of medications available.²¹⁷

POLICYMAKERS SHOULD ENSURE THAT PEOPLE ARE ABLE TO RECEIVE WHICHEVER MEDICATION WORKS BEST FOR THEM IN THEIR RECOVERY

15. Increase access to and quality of services for substance disorder treatment through Medicaid.

Lack of accessible health insurance is a huge barrier to mental health and substance use care: People who are uninsured are significantly less likely to receive treatment.²¹⁸ Among adults with substance use disorder who sensed a need for treatment but did not get it, financial barriers were among the most frequently reported reasons, especially among people without insurance.²¹⁹

Medicaid aims to fill health insurance gaps by providing coverage for tens of millions of people who do not have jobs that provide health insurance and cannot afford insurance on their own.²²⁰ More than 8.3 million adults covered under Medicaid in 2021 had a drug use disorder.²²¹ After the passage of the Affordable Care Act (ACA), the share of people who had health insurance increased, especially among Latine, Black, Asian, and Indigenous people.²²² This was due in part to the expansion of Medicaid coverage included in the ACA.²²³ But as of 2020, about 28 million people remained uninsured nationally.²²⁴ Although all states report data on the racial groups of Medicaid enrollees to federal agencies, a lack of uniform data collection standards prevents complete, up-to-date national monitoring of racial and other inequities in Medicaid access.²²⁵

State-level expansions in Medicaid coverage have been shown to increase participation in substance use treatment.²²⁶ The uninsured rate for people with opioid-related hospitalizations dropped significantly in states that elected to expand Medicaid, from 13.4% in 2013 to 2.9% in 2015.²²⁷ Medicaid expansion was also associated with a 50% increase in specialty treatment for opioid use disorder, most of which was for MOUD treatment.²²⁸ Emerging research has also shown that Medicaid expansion is associated with lower rates of police contact and decreases in crime.²²⁹ Similarly, expanding access to substance use treatment through more treatment centers is associated with reduced crime.²³⁰ Despite the success of state Medicaid expansion, lawmakers in 11 states (Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming) have decided against it,²³¹ restricting access for a combined 2.1 million low-income adults.²³² As of 2021, uninsured rates for Black people in these states are twice as high compared to the rest of the country.²³³

MEDICAID EXPANSION IS ASSOCIATED WITH LOWER RATES OF POLICE CONTACT AND DECREASES IN CRIME

In addition to expanding the number of people eligible for Medicaid, access to care for substance use disorder can be improved by increasing provider participation in Medicaid. When Virginia increased provider payments for addiction and recovery treatment services, the number of providers offering outpatient services covered by Medicaid more than doubled.²³⁴ In particular, increasing the number of specialists who are equipped and trained to provide substance use diagnoses (beyond just general physicians) are vital to address this issue. Policymakers can also include funding for student loan forgiveness programs for providers who work in communities that lack sufficient substance use care, expand the types of therapies and care Medicaid covers (such as contingency management programs; see page 25), and offer technical assistance to providers to assist in complying with Medicaid requirements.

Access to substance use treatment can also be improved by making sure insurance plans adequately cover it. The ACA requires Medicaid and private insurers to cover substance disorder treatment in a no more restrictive way than for medical and surgical services.²³⁵ But compliance has been uneven, and significant caps in coverage remain. To achieve parity between substance use treatment and other medical services, policymakers can strengthen enforcement measures and remove remaining exemptions, including for small businesses that self-insure; federal, state, and local governments; and Medicare plans.

16. Establish and expand syringe services programs and overdose prevention centers.

Community-based syringe service programs (SSPs)^{236*} reduce the harms of drug use by providing services that facilitate safe drug use, such as clean drug use tools or fentanyl testing strips. SSPs are often led by people who have experience with drug use and who can connect other people who use drugs—and may otherwise face barriers to accessing care—to a range of other information and services, including referrals to treatment, medical care, or overdose recognition and response training. SSPs have operated for decades, and evidence shows that they reduce the transmission of infectious diseases like hepatitis and HIV²³⁷, are associated with safer drug tool disposal,²³⁸ and help connect clients to treatment.²³⁹ Despite the fact that SSPs have been successful in the United States for decades and have garnered bipartisan support,²⁴⁰ they are limited in scope due to significant legal and budgetary barriers. Thirty-six states make possession of drug use tools, including syringes, illegal through “drug paraphernalia” laws.²⁴¹ And while the majority of these states have created exemptions for SSPs,²⁴² a patchwork of requirements is often in place, such as limiting clients’ visits or the number of needles provided, requiring clients to have proof of residency, or restricting SSPs’ authorization or funding to those with state or local government approval.²⁴³ In California, Colorado, and Ohio, SSPs must receive local law enforcement approval to operate.²⁴⁴ In light of these barriers, states are taking steps to expand access to SSPs. For example, in 2022, New Jersey—which previously had only seven SSPs—removed the ability of municipalities to approve or terminate SSPs, allocated \$5 million to fund them, and decriminalized the possession of syringes.²⁴⁵

Overdose prevention centers (OPCs)^{**} are similar to SSPs but also provide a space for people to use pre-acquired drugs under the supervision of staff or peers trained to monitor for overdose, instead of requiring the drug use to happen elsewhere.²⁴⁶ Nearly 200 OPCs are active in 14 countries,²⁴⁷ generating a strong body of evidence showing that they reduce the likelihood of overdose and infectious disease,²⁴⁸ increase access to treatment,²⁴⁹ decrease public order concerns such as open drug use,²⁵⁰ and are not associated with an increase in neighborhood crime.²⁵¹ By providing a safe environment without judgment or requirements where visitors can repeatedly engage with supportive staff or peers, OPCs can be instrumental in reaching people living with high risk of overdose or infectious disease who have not been able to access other services and support.²⁵² Several studies have found that OPCs help increase engagement with treatment and reduce drug use.²⁵³ For example, one study of an OPC in Vancouver, Canada, found that the center’s opening was associated with a 30% increase in detoxification services, which in turn was associated with increased long-term treatment rates and reduced injecting at the center.²⁵⁴ OPCs also help increase visibility of bad batches of drugs (for example, heroin containing fentanyl) among drug users likely to be affected by them.

Some argue that OPCs are illegal in the United States under federal law enacted during the crack cocaine panic.²⁵⁵ But cities and states are piloting them in an attempt to bring an evidence-based solution to rising overdoses²⁵⁶ as well as public drug use. An unsanctioned, undisclosed site, for example, has been operating since 2014 and has been studied, showing averted overdoses as well as a significant reduction in emergency department visits and hospitalization.²⁵⁷ In 2021, New York City became the first city to openly pilot two OPCs through the harm reduction service provider OnPoint NYC.²⁵⁸ As of February 2024, the pilot had served 4,486 clients and intervened in 1,339 overdoses since November 2021.²⁵⁹ In July 2021, Rhode Island legally authorized OPCs, and its first center—which will be the nation’s first state-regulated OPC—is scheduled to open in 2024 with funding from the state’s opioid settlement.²⁶⁰ In May 2023, Minnesota became the second state to legally authorize and fund OPCs. At least 16 other states and several cities are authorizing or have considered authorizing OPCs.²⁶¹ To support states in opening OPCs,²⁶² federal policymakers should repeal the federal “crack house” statute.

* Also known as harm reduction centers or syringe access programs.

** Also known as safe injection sites or supervised consumption sites.

17. Invest in programs to widely distribute the opioid reversal medication naloxone (Narcan).

Naloxone—commonly known by the brand name Narcan—is a medication that can reverse opioid overdoses when given in time.²⁶³ It can be safely and easily administered by anyone, is non-addictive, does not encourage increased drug use, and does not have harmful effects if the person did not experience an opioid overdose.²⁶⁴ In March 2023, the Food and Drug Administration authorized nasal spray Narcan for over-the-counter sales, an important step in expanding access to the medication for people who need it.²⁶⁵ But barriers still exist, including the cost of doses.²⁶⁶

Research has demonstrated that funding naloxone training and doses for people likely to witness an overdose can help reduce overdose fatalities.²⁶⁷ And naloxone training has other positive effects, such as reducing stigma about opioid use.²⁶⁸ To reach people most likely to witness or experience a future overdose, policymakers should prioritize funding free naloxone kits and training in high-risk communities where public overdose is frequent, with the goal of making naloxone available to any bystander witnessing a potential overdose, not just emergency responders. For example, communities have added naloxone dispensers on sidewalks²⁶⁹ and in parks, libraries, court buildings, medical centers, coffee shops, and churches.²⁷⁰ Policymakers should also prioritize funding for walk-in community-based harm reduction services (including SSPs and OPCs), as well as for people leaving jails, prisons, hospitals and detox programs.²⁷¹ Any funding for equipping and training first responders such as police in using naloxone should include community-based alternative response pilots and provide kits for responders called to substance use emergencies to leave behind for future use.²⁷²

NALOXONE TRAINING CAN HELP REDUCE OVERDOSE FATALITIES

18. Pilot and study harm reduction-based drug education programs.

The vast majority of drug education in schools and through public media campaigns is based on abstinence and is often characterized by scare tactics and fear, substance use refusal training, and incomplete, inaccurate information about prohibited substances.²⁷³ But evidence shows that programs such as D.A.R.E. are not effective at reducing substance use.²⁷⁴ Abstinence-only drug education often fails to recognize the complexity of substance use, the spectrum of strategies to address it, and ways to achieve the greatest public health impact. Because people with less severe substance use disorder are especially likely to not want to stop using, abstinence-based drug education fails to engage people who could benefit from education about drug use before their disorder and associated harms become more serious.

Harm reduction-based drug education programs, in contrast, incorporate practical strategies and ideas aimed at preventing harms and negative consequences associated with substance use in a nonjudgmental and culturally relevant way.²⁷⁵ Harm reduction-based drug education acknowledges that legal and illegal substance use is prevalent and therefore the aim of information-sharing should be to inform people about how to reduce the risks of substance use, improve their health, and prevent overdose.

To guide people who use drugs or witness drug use in making healthy decisions and seeking help in case of an emergency, policymakers should pilot and study drug education programs based on harm reduction. For example, the Drug Policy Alliance developed and distributed the nation's first harm reduction-based drug education program for high school students called Safety First: Real Drug Education for Teens.²⁷⁶ An independent study of the program found a significant increase in students' knowledge and behaviors related to harm reduction, an increase in student detection of and response to an overdose, and a decrease in overall substance use.²⁷⁷

19. Expand evidence-based incentives for treatment (contingency management programs).

Contingency management programs are an underused type of therapy for substance use disorders that provides small rewards (such as cash) for positive steps toward treatment goals (such as attending a therapy session). Unlike involuntary or coercive treatment through the criminal legal system, an approach that forces people to enter treatment before they are ready—and to face *punishment* if they don't meet treatment goals—contingency management is an evidence-based practice that provides a way to encourage people to begin or continue treatment goals through *rewards*. It is especially helpful for treating people struggling with the use of stimulant drugs such as cocaine or methamphetamine, for which there is no approved medication treatment option.²⁷⁸

Decades of evidence have shown that contingency management is highly effective at increasing engagement with substance use disorder treatment,²⁷⁹ with no adverse effects.²⁸⁰ And as psychologist Dr. Carl Hart notes, people who use drugs tend to choose the cash over using because it's an alternate source of small, temporary pleasure—one they may not have previously had.²⁸¹ This therapy remains underutilized because of several barriers, including federal and state laws that limit how much money can be paid to patients as incentives (often a lower amount than what is effective in contingency management).²⁸²

In 2022, the Biden administration clarified that contingency management programs paying patients higher amounts would not violate federal law.²⁸³ To expand access to contingency management, policymakers should take steps to educate providers about this change. They should also remove state-level legal barriers to these programs and ensure that Medicaid covers them.²⁸⁴



Improve Data Collection and Transparency

Data analysis is a powerful tool to assess the effectiveness and equity of substance use interventions. It can also ensure that new programming, services, and interventions are grounded in evidence. Data can deepen understanding of the problems that affect a community, shedding light on gaps in service or changes in the unique needs of a community that may require the redirection of resources.

Designing effective and equitable responses to substance use requires accurate, comprehensive, and timely data from several sources. Knowing where overdoses are occurring at higher rates, for example, helps officials deploy responsive resources (such as naloxone or alerts about fentanyl in the local drug supply) and monitor the effectiveness of such interventions.²⁸⁵ Data on interactions between law enforcement and people experiencing substance use emergencies can reveal opportunities for building alternative response systems. Building robust data collection and analysis practices is essential to enable communities to effectively serve people experiencing substance use emergencies.

20. Collect and share up-to-date data on overdoses.

Many fatal overdoses are not categorized as such in medical examiners' death records due to issues like inadequate testing, inconsistent procedures, and a lack of training.²⁸⁶ For example, one study found that from 1999 to 2016, there were 28% more opioid deaths than were officially reported.²⁸⁷ Research also shows that overdose deaths of Black people are disproportionately underreported compared to deaths of White people: 26% of heroin-related deaths among Black women were accurately identified by standard procedures, compared to 58% among White men.²⁸⁸

To improve data collection and analysis on overdoses, local policymakers should pursue opportunities to enhance overdose data collection and sharing that involves public health entities such as the CDC's Overdose Data to Action initiative, which supports jurisdictions in collecting comprehensive, high-quality overdose data, and using that data to inform public health-based responses.²⁸⁹ Localities should aim to have non-police agencies, such as the public health department, collect information on all overdose incidents that are reported to officials in line with a shift away from involving police as the default responder to overdose emergencies.

These efforts should include tracking potential overdoses to inform a public health response. Prescription Drug Monitoring Programs (PDMPs) are used by every state to track prescriptions of controlled substances.²⁹⁰ However, the substances monitored and the ways in which law enforcement are allowed to use these electronic databases (oftentimes without a warrant) vary widely.²⁹¹ Research has shown PDMPs may have had unintended consequences including underprescribing certain substances due to fear of enforcement²⁹² or patients turning to non-prescription opioid sources such as heroin after their prescription supply is disrupted.²⁹³ To guard against these risks, states are taking steps to ensure that these data are managed and used by public health entities. For example, after a medical provider is identified as over-prescribing through PDMP data, the Pennsylvania Department of Health notifies their patients' insurers so that they can identify another source of pain management or opioid treatment and reduce the risk of future overdose.²⁹⁴

LOCALITIES SHOULD AIM TO HAVE NON-POLICE AGENCIES, SUCH AS THE PUBLIC HEALTH DEPARTMENT, COLLECT INFORMATION ON ALL OVERDOSE INCIDENTS

21. Collect and analyze data on substance-use related calls for service.

Data about calls for service (such as 911, 988, or 311 calls) allow stakeholders to measure community requests related to public safety. Analysis of these data, along with data recorded by first responders, can help communities understand when and where callers are reporting substance use emergencies. It can also reveal the barriers people face in calling for service when they experience these types of emergencies. With this information, communities can make more informed decisions about where they should invest resources in emergency dispatch systems to maximize public safety, and about potential opportunities for a community-based public health response.

In order to analyze outcomes of substance use calls for service, first responder records must be linked to calls for service data. First responders should update the call-type information after a call is completed as needed to make sure it is accurately recorded as related to substance use. All data collection systems should make it possible to tell which emergency responses are related to which calls for service. This can be accomplished either by using the same unique identifier (or number) to label a specific incident; or, if systems use different identifiers, including a column in the stop dataset that shows the calls for service incident number associated with each substance use emergency response.

22. Analyze outcomes of community-based response systems, diversion programs, decriminalization efforts, and drug legalization.

Jurisdictions should compare the outcomes of community-based response systems to outcomes of police responses and assess any racial or other demographic disparities to gauge their effectiveness. Demonstrating outcomes of innovative pilot programs is necessary to maintain and increase funding and can spur other jurisdictions to adopt similar programs. Outcomes analyzed in the data should include:

- Use of force;
- Arrests;
- Calls for police backup;
- Community-based referrals made by responders, including but not limited to treatment, harm reduction services, and other supports. Data should specify the type of service referred and whether or not it was accepted.

Jurisdictions should also collect and analyze data to determine the effectiveness of any diversion programs used. They should specifically examine outcomes related to health and well-being (such as hospitalization rates and stability of housing), in addition to rearrest rates.

Finally, jurisdictions should measure the impact of decriminalization and legalization efforts to ensure that such changes are advancing their goals, such as reducing arrests for certain offenses and racial disparities. Outcomes analyzed in the data should include community-level reported rates of drug use, arrests by offense category, and calls for service related to those changes in drug policies (such as public drug use). All data on arrests and other criminal legal system outcomes should include racial and other demographic data, such as age.

23. Collect analyzable data on all police stops and uses of force.

Police should record data for every stop or use of force incident. Stop records should be stored electronically in a spreadsheet or database format. For data to be analyzed for patterns of police contact with people experiencing substance use emergencies, officers should record whether anyone—law enforcement, dispatch personnel, or people at the scene—perceived the person to be experiencing a mental health or substance use emergency. Forms for recording data should distinguish, from the officer's perception, mental health crises from substance use crises. Data should also include information about the outcome of the call and whether the officer was part of a co-response team or other specialized mental health response team. A complete list of the information needed to collect meaningful data on all stops is available on CPE's [Justice Navigator platform](#). For more detailed guidance on stop data, including how to address common technical limitations to data collection, see CPE's report [Collecting, Analyzing, and Responding to Stop Data: A Guidebook for Law Enforcement Agencies, Government, and Communities](#).

JURISDICTIONS SHOULD MEASURE THE IMPACT OF DECRIMINALIZATION AND LEGALIZATION EFFORTS TO ENSURE THEY ARE ADVANCING THEIR GOALS

Conclusion

The United States has long treated substance use as a crime rather than a public health issue, resulting in a system of mass incarceration with stark racial inequities in who is punished for drug use. It has also resulted in the availability of smaller, more dangerous drugs and skyrocketing rates of overdose and substance use disorder. The recommendations in the report offer many starting points for responding to substance use in a way that promotes safety, equity, and health.

Communities embarking on redesigning how their public health and safety systems respond to substance use should gather information to prioritize their next steps. This might include answering questions such as these:

- What are the most pressing needs of people who have substance use disorder?
- Which community-based alternative response models should be developed or expanded to respond to those needs?
- Is dispatch effectively diverting calls related to substance use to these and other specialized responders?
- Do police departments have clear and enforced policies as to what they can and cannot do when responding to substance use emergencies?
- What barriers to high-quality diagnoses and treatment exist in public health systems for people with unmet substance use disorder needs, particularly Black people?

Meaningful redesign of substance use response relies on engaging with and listening to the needs of the people who are most affected by disparities and harm in the current systems. Systemic racism in the criminal legal system and deep stigma surrounding substance use play significant roles in driving disparities in who has been punished for using substances and who has instead received healthcare. The expertise of people who are impacted by such factors is fundamental to understanding and redesigning systems that can deliver safety for all people who are affected by illicit substance use.

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