

**We are
the Drug
Policy
Alliance.**

Drug Policy Alliance 2020 Roadmap

Drug Policy Alliance envisions a just society in which the use and regulation of drugs are grounded in science, compassion, health, and human rights and advances policies and attitudes that best reduce the harms of both drug use and drug prohibition.

Here, we provide a roadmap for the 2020 Administration to meaningfully address the need for drug policy reform. Specifically, this document provides recommendations for federal drug policy reform addressing criminal legal reform and ending the war on drugs, police reform, drug decriminalization, marijuana reform, and harm reduction and substance use disorder treatment. It also provides an outline of federal bills the next Administration should support. These recommendations take into account the ongoing COVID-19 national emergency.

Criminal Legal Reform & Ending the War on Drugs

The United States not only imprisons more people than any other nation in the world, but also criminalizes entire communities with aggressive drug war policing and other criminal legal tools to solve social and public health issues such as drug addiction. This system causes a great deal of harm to individuals, families, and communities, impacting many people who have never been charged or even arrested. People with a drug conviction, or even a drug arrest record, face lifelong barriers to housing, employment, education, parental rights, and permanent immigration status. The consequences of drug war enforcement have become even more glaring in the face of the global pandemic, as infection rates surge in incarcerated settings and people struggle to get by once released. Drug Policy Alliance is committed to identifying and promoting health-centered alternatives to harmful, punitive drug laws.

Policy Recommendations

End mandatory minimums, retroactively reduce drug sentences for those currently in prison, and expunge prior criminal records for those who have already been released. According to the U.S. Sentencing Commission and the Congressional Research Service, mandatory minimums have significantly contributed to overcrowding and racial disparities in the Bureau of Prisons (BOP). The BOP operates over capacity – and more than half of the prisoners in the BOP are serving time for a drug law violation. Even though Black Americans are no more likely than white people to use or sell drugs, evidence shows they are far more likely to be prosecuted for drug law offenses and far more likely to receive longer sentences than white people. With less than 5% of the world’s population – but nearly 25% of the

world’s prison population – the U.S. leads the world in the incarceration of its own citizens. Given the rate of incarceration in this country, expungement is a crucial mechanism to ensure people can successfully rebuild their lives after contact with the criminal legal system.

Oppose the movement to codify harsher penalties that would place fentanyl analogs permanently into Schedule 1. Harsh penalties for fentanyl are detrimental to public health and exacerbate the overdose crisis. Tougher penalties create perverse incentives for drug manufacturers. Underground chemists have found new ways of evading enhanced penalties by modifying the structure of a substance to create something that is similar to fentanyl, yet chemically distinct and, often, carries myriad unknown risks. This has led to more potent forms of fentanyl and other synthetic opioids that are even more likely to cause overdose deaths. Further criminalization of fentanyl also drives people who use drugs away from health services and encourages them to engage in riskier drug-using behavior to avoid detection and prosecution. Public health centered approaches to fentanyl steer clear of these adverse consequences of punitive approaches and focus instead on reducing fentanyl-related overdose deaths and other harms through education, harm reduction, and evidence-based treatment.

Establish and fund “community-based alternatives programs.” One essential component of any strategy for reducing contacts with the criminal legal system is to divert more people from it, preferably avoiding any police contact at all. To the extent that funding is provided for state and local law enforcement grants in any further stimulus appropriations bills, funds should be made available for “community-based alternatives to policing,” and such programs should be included as a permissible use of state and local law enforcement grants.

Shift criminal legal funding to reentry services. People are being released from federal, state, and local incarceration settings, but without the support they need to make a successful reentry

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and reintegration into the community. This is even more concerning because they are returning home in a time of decreased community services based on stay-at-home orders and the COVID-19 pandemic. Funding should be redirected from high-cost incarceration systems to community-based prevention and support programs, including transitional “housing first” programs for people with histories of substance use disorders.

Repeal the Medicaid “inmate exclusion” to facilitate continuity of care post-release. The next Administration must work to immediately repeal Section 1905(a)(A) of the Social Security Act (commonly referred to as the “inmate exclusion” provision) to ensure seamless healthcare coverage for people involved in the criminal legal system. Individuals are nearly 130 times more likely to experience overdose in the first two weeks post-release than non-justice involved members of the community in that same timeframe. Ensuring proper Medicaid enrollment prior to release facilitates smoother transition to community-based treatment and health providers and continuation of health care.

Repeal the drug felony ban on TANF and SNAP assistance. Federal policies enacted during the misguided “tough on crime” era of the 1990s bar people with drug felony convictions from receiving Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) benefits. This is especially important in light of the COVID-19 pandemic when federal and state officials should be taking actions to provide relief from regulations and other barriers that otherwise impose undue hardship on people struggling to get by during the epidemic. The ban on people with criminal convictions who would otherwise be eligible to receive need-based supports should be repealed immediately.

Repeal legal barriers to higher education on account of a criminal conviction. Congress should reinstate Pell Grants for incarcerated students and repeal a policy known as the Aid Elimination Penalty that denies federal student aid to people

who were convicted of a drug law violation while they were receiving student aid in the past. In recent years strong bipartisan efforts have gained momentum to repeal these retrograde policies as counterproductive to the goals of supporting access to education and reducing recidivism. Restoring access to Pell Grants supports effective reentry of people who are better equipped through education to find employment while promoting improved quality of life and a safer environment for people who are incarcerated and staff in facilities that host prison education. The Aid Elimination Penalty disproportionately impacts Black and Brown students who apply for federal student aid. Although no more likely to use drugs than other students, people of color are more likely to be convicted of a drug law violation that results in suspension of student aid. The Aid Elimination Penalty threatens to disrupt access to higher education for students who need federal student aid to maintain enrollment at a time when the stabilizing and enriching environment that higher education provides can be most helpful to the student getting back on track. Students who do not receive financial aid, including more affluent students, are not impacted by the penalty.

Eliminate deportations for drug possession. The criminalization of drugs is closely linked to the criminalization of immigrants, especially those without American citizenship. For noncitizens, possession of any amount of any drug can trigger automatic detention and deportation – often without the possibility of return. No one should be deported for drug possession.

Eliminate drug testing. Drug testing as a condition of federal probation and parole should be eliminated. A negative drug test while on probation or parole can send a person to a correctional facility as punishment, but a drug test does not diagnose or treat a substance use disorder or facilitate access to care. Instead of receiving merely punishment, people should be connected to evidence-based treatment for drug use should they want it.

Criminal Legal Reform & Ending the War on Drugs

Release people from federal prison who are especially vulnerable to contracting COVID-19 while protecting those who remain incarcerated. Already, more than 100,000 incarcerated people have tested positive for COVID-19. This is unsurprising given that it is all but impossible to follow the CDC guidelines on COVID-19 in jails and prisons. What is more, incarcerated people suffer from underlying medical conditions at a rate much greater than the general population. This includes higher rates of respiratory disease, diabetes, substance use disorder, and other infectious diseases that make them more susceptible to COVID-19. Protecting these especially vulnerable individuals means protecting the broader community, including correctional staff and people who live in the surrounding communities where the facilities are located. And it's a critical step in ensuring our hospitals do not become overwhelmed. This next Administration must support depopulating jails and prisons and ensuring those that remain incarcerated have adequate support to withstand the pandemic.

Federal Legislation

- **Restoring Education And Learning (REAL) Act (H.R. 2168/S. 1074):** This bill would reinstate Pell Grant eligibility for incarcerated individuals by repealing the prohibition in the 1994 Crime Bill.
- **Financial Aid Fairness for Students Act (H.R. 4584):** This bill would repeal the Aid Elimination Penalty that denies federal student aid to individuals convicted of a drug law violation while they were receiving federal student aid in the past.
- **Medicaid Reentry Act (H.R. 1329):** This bill would lift the current prohibition on Medicaid payments for incarcerated people up to 30 days prior to release. Lifting the Medicaid “inmate exclusion” during this timeframe enables eligible individuals to enroll in Medicaid and establish patient relationships with community based health providers prior to their release. This is critical for ensuring smooth physical and mental health coverage during this transition as well as helping to ensure smooth transition into medication assisted treatment.
- **New Way Forward Act (H.R. 5383):** This bill detangles the immigration and criminal legal systems and works to end the mass incarceration and mass deportation of non-citizens by strengthening due process protections. It would also disallow local police from collaborating with Immigration Customs Enforcement (ICE) and provide a pathway for previously deported people to return home.
- **Emergency Community Supervision Act of 2020 (S. 3579/H.R. 6400):** This bill would help reduce dangerous overcrowding in federal prisons by transferring into community supervision individuals who are medically vulnerable, people over 50 years of age, and people within 12 months of release from incarceration from federal custody. The bill would also limit pre-trial detention.
- **COVID-19 Correctional Facility Emergency Response Act of 2020 (H.R. 6414):** This bill incentivizes state and local officials to reduce jail and prison populations and curtail pre-trial detention during the pandemic. The language of the bill that was included in the House-passed HEROES Act (“CARES 2”) should be adopted.
- **Federal Immigrant Release for Safety and Security Together Act (“FIRST Act”) (H.R. 6537):** This measure provides urgent and critical restrictions on immigration detention and enforcement during this unprecedented national emergency. The Act requires the release of people at heightened risk of contracting COVID-19 (with some exceptions) and mandates individual reviews of all detained people with a presumption of release. The Act also requires DHS to provide basic health and sanitary supplies and telephone access to those who remain in custody.

Police Reform

The war on drugs fuels militarized policing that terrorizes communities of color primarily. For decades, police departments have been rewarded with funding and equipment for pursuing drug investigations. Through legal mechanisms such as civil asset forfeiture and government programs like the Edward Byrne Memorial Justice Grant Program and the 1033 Program, police departments have been armored with military-grade equipment and other weapons that endanger the communities they are sworn to protect and serve. Moreover, militarized responses to drug investigations, such as SWAT-style raids where no-knock and quick-knock warrants are routine, are disproportionately used against people of color in drug investigations and have contributed to many deaths, including that of Breonna Taylor in March 2020. At the same time, the Drug Enforcement Administration (DEA), a massive federal law enforcement agency, continues to act with impunity, misuse government funds, and jeopardize human rights at home and abroad. Law enforcement in this country must be reined in and funding streams must be re-evaluated.

Policy Recommendations

End militarized policing practices in pursuit of the drug war. The transfer of Department of Defense (DOD) equipment to local police departments must be terminated by ending programs like 1033 and 1122 that allow military equipment transfers for counter-narcotic activities. The 1033 Program has resulted in the transfer of approximately \$7.4 billion worth of surplus military equipment to state, local and tribal law enforcement agencies since its creation in 1990. It has equipped law enforcement agencies with military-grade equipment

such as armored vehicles, military-style assault rifles, and explosives, and has funded the creation of special tactical teams for drug investigations. The increased transfer of equipment through the 1033 Program has been shown to increase the number of police killings in communities. It has paved the way for militarized police responses to protests against police violence, like we witnessed in the summer of 2014 in Ferguson, Missouri when people protesting the killing of Michael Brown at the hands of a police officer were met with law enforcement equipped with tanks and riot gear. Moreover, the 1033 Program has been notoriously mismanaged. A 2017 federal government oversight report found that the program could not prevent fraudulent applications from acquiring weapons of war from the program.

Prohibit no-knock warrants and quick-knock raids. Law enforcement must also be banned from using no-knock warrants and quick-knock techniques that are often used by police in militarized drug investigations, endangering the lives of civilians and police personnel. Thousands of “no-knock” warrants are issued to law enforcement every year, allowing law enforcement to forcibly enter a person’s home without announcing who they are or their intent. Judges rarely deny these warrants and they have been increasingly permitted by courts in pursuit of the drug war. No-knock warrants are often used in conjunction with SWAT team deployments and have led to numerous tragic killings. Similar to no-knock warrants, “quick-knocks” are also used in SWAT responses to drug cases. Like no-knock warrants, quick-knock raids do not give people much time to respond to police presence and can lead to deadly outcomes. According to a 2014 report by the American Civil Liberties Union, the use of SWAT teams to execute search warrants in drug cases has disproportionately targeted African American and Latino individuals, who make up 61% of the total number of individuals impacted by SWAT raids for drug cases.

Re-examine funding streams for law enforcement and counter-narcotic activities. Federal grant programs like the Edward Byrne Memorial Justice Assistance Grant (JAG) Program and the Office of Community Oriented Policing Services (COPS Office)

grant program have for years funded militarized policing and counter-narcotic activities that have decimated communities of color and contributed to mass incarceration. Rather than continuing to fund policing, grants should be repurposed for social services and infrastructure that can strengthen communities hardest hit by drug war enforcement as well as drug addiction. Civil asset forfeiture is also a significant funding stream that must end. Through civil asset forfeiture, law enforcement is able to legally confiscate the property of people merely suspected of criminal activity. Civil asset forfeiture impedes the due process of individuals and is responsible for transferring billions of dollars to police departments across the country.

Dismantle the DEA. The DEA has a long history of violating human rights, misusing government funds, behaving unethically, and acting outside its intended scope, yet it has never been held accountable nor has there been extensive oversight of the law enforcement agency. The DEA was created to eradicate illegal drug markets, but it has made no progress in this area as the illegal drug market continues to thrive. Rather, the DEA has helped usher in an era of mass incarceration as its investigations have focused on people on the lower levels of drug distribution chains. The DEA needs greater oversight and lawmakers should consider restructuring or altogether eliminating the agency.

Federal Legislation

- **Demilitarizing Local Law Enforcement Act of 2020 (H.R.7143):** This bill would end the DOD 1033 Program.
- **Fifth Amendment Integrity Restoration (FAIR) Act (H.R. 1895):** This bill would end the profit incentives that police departments have to conduct civil asset forfeiture by eliminating the “equitable sharing program,” which allows state law enforcement officers to turn seized property over to federal officials for forfeiture—and get up to 80% of the proceeds of the forfeited property. The FAIR Act ends this practice and ensures that law enforcement cannot ignore state law.

In 2018, there were more than 1.6 million drug arrests in the United States. More than 86% of these arrests were for possession only. Twenty-six states plus the District of Columbia have already decriminalized the possession of small amounts of marijuana. Other jurisdictions are experimenting with de facto decriminalization through Law Enforcement Assisted Diversion (LEAD) programs. LEAD directs people to drug treatment or other supportive services instead of arresting and booking them for certain drug law violations, including possession and low-level sales. These are important steps in the right direction, but they are not enough. Criminalizing drug use and possession merely exacerbates the harms associated with the criminal legal system and diverts scarce resources from effective treatment options for those who want it. Drug Policy Alliance supports eliminating criminal penalties for personal use and possession of all drugs, not just marijuana.

Policy Recommendations

Eliminate criminal penalties and decarcerate. Repeal penalties for possession of personal-use quantities of a controlled substance, possession of equipment used to ingest controlled substances, and possession with intent to distribute personal use quantities of a controlled substance. Mandate the automatic reopening of sentencing proceedings for people convicted solely of offenses related to the possession of personal use quantities of controlled substances; require immediate release pending resentencing and dismissal proceedings for all qualifying individuals.

Marijuana Reform

Defund the federal drug enforcement apparatus and shift regulatory authority. Shift federal resources away from enforcement strategies to supportive initiatives to protect the public health and safety. Transfer authority from the DEA to the National Institutes of Health (NIH) as the agency responsible for classifying drugs pursuant to the Controlled Substances Act (CSA).

Prohibit funding to states for drug enforcement. Prohibit the use of grant funding to states provided through any federal program for the investigation, arrest, prosecution or incarceration in relation to alleged drug possession violations.

Federal Legislation

- **The BREATHE Act (bill number forthcoming):** This visionary bill divests taxpayer dollars from discriminatory policing and invests in a new vision of public safety. It includes a plan to decriminalize drugs and end the collateral consequences of the war on drugs.

Marijuana prohibition is an utter failure. There is more public support for marijuana law reform than ever before with polls showing two-thirds of the country is in favor of legalizing marijuana. Prohibitionist laws waste billions of dollars criminalizing people who use marijuana, even for low-level offenses. Black and Latinx people are disproportionately arrested for marijuana even though white people use marijuana at similar rates. One of the most egregious outcomes of marijuana prohibition is that many sick people cannot legally access the medicine that works best for them. Drug Policy Alliance believes marijuana should be removed from the criminal legal system and regulated like alcohol and tobacco. There are several million state-licensed medical cannabis patients in the U.S., in addition to people who use cannabis to increase their quality of life and personal wellbeing. We believe that patients must have safe and immediate access to medical marijuana, including the ability to cultivate it in their own homes, and that barriers unique to marijuana research must be eliminated. We are committed to legalizing marijuana at the state and federal levels and improving medical marijuana programs to better protect patients' rights and access to medicine.

Policy Recommendations

Remove marijuana from Schedule I of the CSA. Marijuana has limited potential for abuse and established medical uses. De-scheduling marijuana will facilitate medical research, ensure patient access, and remove federal criminal penalties.

Address the harmful collateral consequences of prohibition. Resolve the devastating impacts of marijuana prohibition in the fields of immigration, housing, employment, child welfare, and other lifelong consequences of criminalization.

Ensure an equitable and diverse industry. Federal policies should support farmers, small businesses, and directly-impacted people over large corporations, providing real banking and capital solutions that will ensure sustainability in the regulated marijuana industry. There should also be mechanisms in place to help people transition from the illicit to the legal market.

Use tax revenue from marijuana legalization for restitution and reinvestment into communities that have been most impacted by drug war enforcement. Nearly all the wealth from the legal market has been concentrated in wealthy, white communities even though people of color continue to bear the brunt of enforcement. Marijuana revenue must be redistributed to the communities that have been most heavily impacted by drug war criminalization.

Use revenue from marijuana legalization for public good. Funding should support studies analyzing the impacts of marijuana legalization on public health, public safety, youth use, the state economy, the environment, and the criminal legal system. Resources should also be invested in public information/ education campaigns about potential risks of marijuana use, such as impaired driving. Funding should also support evidence-based services for people who use drugs, including harm reduction, substance use disorder treatment, recovery services, and harm reduction-based drug education.

Federal Legislation

- **Marijuana Opportunity Reinvestment and Expungement (MORE) Act (H.R. 3884/S. 2227):** This bicameral bill would remove marijuana from the list of controlled substances and address historical and current racial inequities through specific grant programs. By removing marijuana from the CSA and making way for the expungement and resentencing of marijuana convictions, this bill would reduce racial disparities in the criminal legal system and ensure that marijuana activity no longer jeopardizes a person's immigration status or ability to receive federal benefits. Moreover, it would provide funds for services in communities most harmed by the war on drugs and diversify the regulated marijuana industry by supporting entrepreneurs whose communities bore the brunt of this country's lopsided marijuana enforcement.

Harm Reduction

Harm reduction is a set of ideas and interventions that seek to reduce the harms associated with both drug use and ineffective, racialized drug policies. Harm reduction stands in stark contrast to a punitive approach to drug use. It is based on acknowledging the dignity and humanity of people who use drugs and bringing them into a community of care in order to minimize negative consequences and promote optimal health and social inclusion. We believe that every solution with the potential to promote the health and well-being of people who use drugs and to mitigate drug-related harm should be considered. We seek innovative approaches to drug use, drug treatment, and drug policy based on science and research.

Policy Recommendations

Refrain from prosecuting overdose prevention centers (OPCs). OPCs, also known as supervised consumption sites, provide people with a legally sanctioned place to consume pre-obtained drugs under the supervision of trained staff and are designed to reduce the health and public order issues often associated with public drug consumption. More than 120 OPCs currently operate in ten countries around the world. Currently, no OPCs operate in the United States, but several are planning to begin operation in jurisdictions across the country. One of the reasons no OPCs currently operate in the U.S. is due to fear of federal law enforcement. The next Administration should accordingly direct the Department of Justice (DOJ) to withdraw from litigation challenging the operation of OPCs and to refrain from filing new lawsuits against or from prosecuting organizations that operate OPCs. It should work with Congress to amend the CSA to make clear that OPCs do not violate federal drug laws. Research has consistently demonstrated the positive benefits of OPCs, including reducing spread

of infectious disease, reducing public disorder and injecting, reducing overdose deaths, reducing amount and frequency of drug use, and increasing access to health services, including substance use disorder treatment. In Philadelphia, a local organization, Safehouse, is working to open the first OPC in the country. The Department of Justice sued Safehouse and asked a federal court to declare OPCs in violation of a federal law that prohibits making a place available for the purpose of unlawfully using a controlled substance. Safehouse won at the trial court, and the case is on appeal in the Third Circuit Court of Appeals. Even if Safehouse prevails on appeal, organizations that want to operate OPCs may be deterred because they are in a different jurisdiction not covered by the ruling or out of fear they will be sued or prosecuted on other grounds.

Provide funding for harm reduction providers and supplies. The next Administration should work with Congress to repeal the ban on using federal funds to pay for sterile syringes and allocate funding for providing these supplies. Providing sterile syringes to people who use drugs is credited with dramatically decreasing the spread of HIV, Hepatitis C, and other infectious diseases, but federal law currently prohibits using federal money to pay for syringes for the purpose of injection drug use. The Administration should also work with Congress to allocate funding to sustain syringe services programs and other harm reduction providers that are often under resourced and under valued by policymakers but are a crucial stakeholders in the fight to end the overdose crisis and new HIV and Hepatitis C infections, playing a huge role in preventing these drug related harms among high-risk populations. Syringe services programs and other harm reduction providers serve and build trust with marginalized individuals who use drugs and often face stigma and other barriers in conventional health care services. These harm reduction organizations provide naloxone, overdose prevention education, drug checking and other health supplies directly to people who use drugs, activities especially critical as we are seeing increases in overdose deaths during the pandemic. The Administration should also direct the National Institute

Harm Reduction

on Drug Abuse to fund research investigating low cost, portable drug checking technologies. ProDrug checking supplies provide people who use drugs with the ability to see what is actually in the drugs they plan to ingest. Access to drug checking supplies is especially important with the sharp increase of overdose deaths that include fentanyl, a highly potent opioid mixed into other drugs. Federal funds should also be used to pay for naloxone, the medication that reverses opioid overdoses. More resources are needed to make sure naloxone is available to all people who use drugs.

Make naloxone available as an over-the-counter drug. The Food and Drug Administration (FDA) should exempt naloxone from applicable prescription requirements, making it available as an over-the-counter drug. All forms of naloxone currently approved by the FDA require a prescription for use. Many states have authorized physicians to issue standing orders that allow people to receive training in naloxone administration in order to obtain the medication without a personal prescription. Access to naloxone is still limited for people in need, however. If a formulation of naloxone were available for purchase over-the-counter, the medication would become much more accessible. The FDA has been encouraging development of an over-the-counter formulation of naloxone for the past two to three years, but no over-the-counter option is yet available. The FDA has the legal authority to exempt drugs from otherwise applicable prescription requirements (making the drug available over-the-counter) where those requirements are not necessary to protect public health. Naloxone meets the FDA-established criteria for exemption from prescription requirements, and the FDA should immediately make naloxone available without a prescription.

Mandate health providers offer a co-prescription of naloxone for opioid prescriptions. The Departments of Health and Human Services and Veterans Affairs and an FDA advisory panel recommend that clinicians co-prescribe naloxone to individuals at risk for opioid overdose. A growing number of states require co-prescription of naloxone to people at increased risk of

opioid overdose. Research indicates these laws have quickly increased access to the lifesaving medication. Congress authorized five years of grants aimed at increasing co-prescribing of naloxone, but never appropriated funds for the grants. The Administration should work with Congress to appropriate funds for grants to increase health care provider and pharmacist education on co-prescribing naloxone to people who are prescribed opioids. These funds could be conditioned on enactment of state laws requiring an offer of naloxone co-prescription. It is crucial to ensure naloxone is in the hands of people who are at high risk for opioid overdose, including people who obtain their opioids by prescription.

Increase housing availability for people who use drugs. The Department of Housing and Urban Development, Substance Abuse and Mental Health Services Administration (SAMHSA), and all other federal agencies that provide financial support for housing should be directed to prioritize “housing first” approaches and review regulatory actions that could be taken to improve access. Additionally, the Administration should work with Congress to allocate funds for “housing first” approaches and availability of permanent supportive housing across the country. Housing instability and homelessness are associated with a host of negative public health outcomes. The “housing first” model prioritizes providing permanent housing to people experiencing homelessness without first requiring that they engage in treatment or remain abstinent. It provides voluntary support and resources to people to help them reduce and manage their substance use and other health conditions. These programs have demonstrated efficacy in increasing housing retention and utilization of services, and reducing drug use, use of emergency healthcare, and interaction with the criminal legal system, but they remain well below the capacity needed to address the need.

Support community-based first responder programs. SAMHSA and other appropriate federal agencies should develop guidelines and technical guidance to support implementation of community-based first responder programs across the country and the

Administration should work with Congress to allocate funding for non-law enforcement community-based first responder programs. People who use drugs, particularly those who are experiencing homelessness, are at increased risk of interaction with law enforcement. Too often, police respond with excessive force, resulting in death or serious injury. Even when no physical injury occurs, people are taken to jail and put through the criminal legal system instead of offered the services that could help them address their needs. Alternative response models, such as the CAHOOTS program in Eugene, Oregon, deploy crisis workers and paramedics to respond to crises involving suspected mental health needs or substance use and direct people to social services. This program and others like it improve health outcomes and reduce negative interactions with law enforcement, all while reducing costs to police and emergency departments.

Federal Legislation

- **Emergency Support for Substance Use Disorders Act (S. 4058):** This bill requires SAMHSA to award grants to states and community-based organizations to support harm reduction services, including syringe service programs and naloxone distribution. These services are necessary to reduce spread of infectious diseases and overdose deaths. Opioid overdose deaths have spiked during the COVID-19 pandemic, making this legislation critical.

Most Americans have used alcohol or other drugs in their lifetime, but most of them will never develop a substance use disorder. Substance use occurs along a continuum from abstinence to severely problematic use, and some people may find themselves moving along this continuum at various points in their lives. While most people can manage their drug use without accessing services, there are those who benefit from harm reduction support to stay safe, and others who may seek support from professional substance use disorder treatment. People seeking treatment often run into multiple barriers. The more barriers people face, the less likely they are to access and remain in services. Treatment needs to be immediately available and accessible to prevent missing a window where people are seeking services. Even when treatment is accessible, it is often not evidence-based, provided by highly trained professionals, or subject to adequate oversight.

Policy Recommendations

Reduce barriers to methadone and buprenorphine access. Methadone and buprenorphine are FDA-approved medications that have been demonstrated to be the safest and most effective treatments for opioid use disorders. However, access is severely limited due to federal law and regulations. SAMHSA and the DEA have waived several regulations to ensure access to methadone and buprenorphine during the COVID-19 pandemic, and this progress must be sustained and built upon. SAMHSA and the DEA should be directed to make permanent the temporary changes to methadone and buprenorphine access made during the COVID-19 pandemic, including increased take-home doses

Substance Use Disorder Treatment

and authorization to access these medications via telemedicine (including telephone-only buprenorphine initiation). SAMHSA should also revise remaining opioid treatment program regulations and X-waiver patient limits to reduce access to barriers. Finally, the Administration should work with Congress to repeal the opioid treatment program structure and X-waiver requirements to allow methadone and buprenorphine access through mainstream health care systems.

Provide methadone and buprenorphine in federal prisons and DOJ programs. The DOJ should not defend against litigation to enforce people's right to methadone and buprenorphine in federal prison and the Administration should direct the BOP to establish protocols ensuring access to these medications for all people incarcerated in federal prisons who could benefit. The DOJ should also require state and local governments to provide access to these medications in order to be eligible for funding allocations. About half of the people incarcerated in federal prisons have a substance use disorder. Despite high prevalence of opioid use disorders and evidence that providing methadone and buprenorphine in correctional settings improves health and safety for both incarcerated people and prison staff, these medications are not regularly available to all incarcerated people who could benefit. Several lawsuits have been brought against the BOP to allow incarcerated people access to these medications. Access is similarly limited for people in state prisons and local jails that may receive federal funding.

Support mobile methadone and buprenorphine provisions. The Administration should direct the DEA to finalize its proposed rule with changes to allow mobile components to cross state lines and not have to return daily and work with Congress to allocate funds to increase mobile methadone and buprenorphine delivery. Many people with opioid use disorders who could benefit from methadone or buprenorphine do not have access because of where they live. Opioid treatment programs and providers with X-waivers are overwhelmingly found in urban areas, leaving many in rural areas with limited access. Difficulty finding or affording transportation also

presents an obstacle. Mobile options for reaching these populations can help alleviate barriers and reach people who otherwise might not have access. As of July 2020, the DEA is considering a change to their rules to allow established opioid treatment programs to operate mobile components, but the proposed rule would still limit access by not allowing mobile components to cross state lines and requiring them to return to the brick-and-mortar location daily. Further, financial assistance may be required to make sure mobile programs can get up and running.

Remove barriers to contingency management and encourage its implementation. Overdoses involving stimulants, such as methamphetamine and cocaine, are rising across the country. Contingency management is a highly effective form of treatment for people with substance use disorders, particularly for people who use stimulants. Contingency management involves offering motivational incentives to people who demonstrate behaviors aligned with treatment goals. While the research behind contingency management demonstrates high efficacy, implementation is very rare, due in part to federal anti-kickback and civil monetary penalties laws that limit the maximum incentive to the equivalent of \$75 annually. Providers may also not know about contingency management or have concerns with implementing it aside from payment. The Department of Health and Human Services should issue regulations exempting contingency management from anti-kickback and civil monetary penalties laws. SAMHSA should prioritize contingency management implementation through grant programs and technical assistance. Finally, the Administration should work with Congress to allocate funding for contingency management education and implementation across the country.

Develop national standards for treatment and require grantees to adhere. National standards for providing evidence-based substance use disorder treatment need to be developed. These standards should include, at a minimum, ensuring access to methadone and buprenorphine and other effective interventions, prohibiting expulsion based on relapse, not requiring abstinence, and not requiring

participation in or refraining from certain services to gain access to other services. Federal agencies that provide funding for substance use disorder treatment programs should be directed to adhere to the national standards as a requirement for receiving funding. Substance use disorder treatment often lacks oversight and accountability, allowing many providers to implement treatment modalities that have not been shown to be effective and in fact may cause harm. No national treatment standards exist to guide providers or hold them accountable for providing quality services. As such, federal agencies lack the ability to determine which grant applicants adhere to evidence-based practices and ensure funding pays for high-quality treatment.

Increase enforcement of mental health and substance use disorder treatment parity laws.

The Mental Health Parity and Addiction Equity Act of 2008 requires insurers who provide mental health and substance use disorder services to do so at parity with other medical services. This means financial requirements and limitations on treatment can be no more restrictive for mental health and substance use disorder services than they are for other medical services. The Act helped to eliminate disparities in financial requirements and quantitative limits on coverage, but stricter qualitative limits (such as formulary design, medical management, or prior authorizations) for mental health and substance use disorder services remain a pervasive problem. The Departments of Health and Human Services, Labor, and Treasury coordinate to provide guidance on parity requirements and enforce compliance. However, the current strategy is to wait until a consumer files a complaint, then to investigate. The Government Accountability Office recommended the agencies reevaluate this approach because it is likely not identifying the majority of parity violations. The Departments of Health and Human Services, Labor, and Treasury need to determine a more effective strategy for proactively identifying parity violations in the insurance plans they oversee. And, the Administration should work with Congress to ensure adequate funding for personnel to focus on proactively reviewing plans for compliance and

pursuing corrective action for noncompliance and to allocate funding for providing technical and financial assistance to state parity compliance efforts.

Federal Legislation

- **Mainstreaming Addiction Treatment Act (H.R. 2482/S. 2074):** This bill eliminates the redundant, outdated requirement that practitioners apply for a separate waiver known as the “X-waiver” through the DEA to prescribe buprenorphine for substance use disorder treatment. The X-waiver requirement has long deterred practitioners from prescribing buprenorphine for treatment to patients and perpetuated stigma towards eligible patients. The X-waiver is the only regulatory hurdle of its kind for prescription drugs, meaning that a practitioner registered to prescribe controlled substances can write a script for buprenorphine for analgesic purposes but must obtain the special waiver to prescribe the same drug to treat opioid use disorder. Eliminating the X-waiver will greatly expand access to buprenorphine for the treatment of opioid use disorder and a time when the nation continues to confront the drug overdose crisis.
- **Community Re-Entry through Addiction Treatment to Enhance (CREATE) Opportunities Act (H.R. 3496/S. 1983):** This bill establishes a grant program within the DOJ to support state and local efforts to provide medications for opioid use disorder, including methadone and buprenorphine, to people incarcerated in jails and prisons. Access to these medications for people behind bars reduces risk of overdose death and likelihood of returning to jail or prison and improves connection to care upon reentry.
- **Comprehensive Addiction Resources Emergency Act (H.R. 2569/S. 1365):** This bill would provide emergency assistance to jurisdictions that are disproportionately impacted by the opioid overdose epidemic. The need for treatment and support services vastly outweighs the current availability, and significant resources are needed to expand these services across the country.